DROPPING OUT FROM PSYCHOLOGICAL TREATMENT FOR
EATING DISORDERS:
AN ATTACHMENT PERSPECTIVE

Thesis submitted for the degree of
Doctor of Philosophy
at the University of Leicester

by

Jennifer Mahon, BA (Columbia University), BA (City University of New York)
Department of Psychiatry
University of Leicester

April 2001
To Jim

and

my parents
Jennifer Mahon

Dropping out from Psychological Treatment for Eating Disorders:
An Attachment Perspective

Abstract

Objective: The central objective of this thesis is to better understand factors affecting dropping out from psychological treatment using the specific case of eating disorders.

Methods: Following critical reviews of the drop-out literature, it was suggested that dropping out should be thought of and studied as the product of interactions taking place within the treatment relationship. The majority of previous research has unsuccessfully attempted to predict dropping out based on pre-treatment patient characteristics in isolation from therapist or therapy characteristics.

Attachment theory framed a series of studies using both qualitative and quantitative methods to explore engagement in the early treatment relationship. Two constructs were used: attachment as a pre-existing trait affecting attitudes toward treatment relationships, and attachment as a state resulting from feelings and perceptions occurring within the early relationship.

Results: Attachment concepts may improve characterisation of dropping out:

Attachment as trait: Case-note analyses of 2 independent patient series replicated a dose-effect relationship between some childhood traumatic experiences and dropping out (N=224). In multivariate analyses, parental break-up in childhood was predictive. However, the relationship between adult attachment style and dropping out remains unclear. Attachment style dimensions from the Vulnerable Attachment Style Questionnaire (VASQ) did not distinguish drop-outs from other treatment status groups in a prospective study.

Attachment as state: 26 in-depth qualitative interviews revealed that therapists’ attuned responsiveness in the early sessions was important to establishing a ‘secure base’, which patients needed to engage. The Therapy Relationship Questionnaire (TRQ) was designed to measure both patient and therapist views of the developing relationship over time (N=110).

Conclusions: Dropping out undoubtedly results from myriad interacting patient, therapist, and therapy factors. However, the therapy relationship underlies these, so measuring it dynamically may be the best way of understanding dropping out. Such an approach, informed by attachment theory, might lead to clinically useful interventions for improving engagement.
Acknowledgements

First I would like to thank my supervisors, Bob Palmer, Toni Bifulco, and Peter Harvey, whose generosity and good humour has lifted me over both real and imagined obstacles in producing this thesis. Bob, thank you for the opportunity to join the team, for your prolonged support, and for reincarnating Socrates. Toni, thank you for making these ideas seem feasible and for your keen enthusiasm for research. Pete, thank you for helping me out of the statistical mire – you made it seem like a pleasant paddling pool instead.

I would also like to thank Lucy Serpell for her patient friendship. I suspect it was tested by reading through and commenting thoroughly on early drafts of many of these chapters. Also, Tony Winston provided the initial inspiration for looking at therapeutic relationships in terms of attachment theory. Gwen Dunaif and Matthew Tivy both listened and encouraged.

I am indebted to Viki Sullivan and Nicky Bradley for help with research and systems. Charlie Terris and Jo Waine tirelessly gathered and organised data for two of the studies, trawled through case notes, and followed up missing questionnaires. Helen Birchall and Lesley Meadows provided entertainment and an informal view of the therapists’ perspective, especially emphatically after a bottle of wine. Thank you, Helen, for giving me a home in Leicester.

Lynne Reeve supplied information about administrative systems and spent many hours tracing patient details for these studies. Debra Bugler transcribed several of the in-depth interviews.

Fundamentally important has been the cheerful co-operation of the therapy team at the Leicester EDS and the altruism of the many patients who have given their time and care to participating in these studies.

Thanks also to my father, who reminded me I wanted to do this; to my mother, who helped me to enjoy it; to foetus, who inspired me to finish it; and to Jim, who has kept it in perspective and found it all rather amusing.
Statement on authorship

Some of the work presented in this thesis has previously been published or has been accepted for publication.

A modified version of Chapters 2 & 3 appeared as:

A modified version of Chapter 5 appeared as:

A modified version of Chapter 6 will appear as:

The author of this thesis designed the studies, performed the statistical and interpretative work, and prepared the manuscripts.
TABLE OF CONTENTS

ABSTRACT .................................................................................................................... 1-3
ACKNOWLEDGEMENTS ............................................................................................... 1-4
STATEMENT OF AUTHORSHIP ................................................................................... 1-5
LIST OF FIGURES .......................................................................................................... 1-14
LIST OF TABLES ............................................................................................................ 1-15

PART I

DROPPING OUT FROM PSYCHOLOGICAL TREATMENT

1.1 GENERAL INTRODUCTION ....................................................................................... 1-16
1.2 OBJECTIVE OF THE THESIS ................................................................................. 1-18
1.3 STRUCTURE OF THE THESIS ................................................................................ 1-18
1.4 DEFINITION OF TERMS .......................................................................................... 1-19
1.4.1 WHAT IS PSYCHOLOGICAL TREATMENT? ......................................................... 1-19
1.4.2 WHAT IS DROPPING OUT FROM PSYCHOLOGICAL TREATMENT? .................... 1-19
1.4.2.1 Terminology .................................................................................................. 1-20
1.4.2.2 Methodology ................................................................................................ 1-22
1.4.2.3 Epistemology ............................................................................................... 1-24
1.4.2.4 Working definitions in this thesis .................................................................. 1-25
1.5 SUMMARY ............................................................................................................... 1-25

STUDYING DROPPING OUT

2.1 WHY HAS DROPPING OUT BEEN STUDIED? ....................................................... 2-27
2.1.1 BACKGROUND .................................................................................................. 2-27
2.1.2 PREDICTION OF DROPPING OUT .................................................................... 2-28
2.1.2.1 Screening out .............................................................................................. 2-28
2.1.2.2 Special attention ......................................................................................... 2-29
2.1.3 COMPREHENSION OF DROPPING OUT ............................................................ 2-30
2.1.3.1 Reasons ..................................................................................................... 2-30
2.1.3.2 Developing interaction ............................................................................... 2-31
2.1.4 INTERVENTION ................................................................................................ 2-31
2.2 HOW HAS DROPPING OUT BEEN STUDIED? ....................................................... 2-31
2.2.1 NOTE: DROP-OUT IS DISTINCT FROM OUTCOME OR ‘PATIENT PROGRESS’ ... 2-33
2.2.2 STUDYING THE PATIENT’S CONTRIBUTION ..................................................... 2-36
2.2.2.1 Archived pre-treatment characteristics ...................................................... 2-36
2.2.2.1.1 Demographic and historical information, ‘situational’ difficulties .......... 2-37
2.2.2.1.2 Patient approach to and experience of clinics ....................................... 2-38
2.2.2.1.3 Diagnosis/ symptom severity/ level of psychological distress .............. 2-38
2.2.2.1.4 ‘Psychopathological’ personality and severe mood dimensions ......... 2-39
2.2.2.1.5 ‘Normal’ personality dimensions and intelligence .............................. 2-40
2.2.2.2 Theoretically targeted questionnaires ......................................................... 2-41
2.2.2.2.1 Personality / non-treatment-related interpersonal behaviour .............. 2-42
2.2.2.2.2 Therapist, therapy relationship, and therapy process ......................... 2-43
2.2.2.2.3 Expectations of therapy, ‘Stages of change’ .......................................... 2-44
2.2.2.2.4 Predicted and actual performance within therapy ............................... 2-45
2.2.2.2.5 Improvement ......................................................................................... 2-45
2.2.2.2.6 Satisfaction with therapy ...................................................................... 2-46
2.2.2.2.7 Multiple domains ................................................................................ 2-46
2.2.2.3 Therapist ratings of ‘prognostic’ characteristics ....................................... 2-47

1-6
3.1 BULIMIA NERVOSA ................................................................. 3-70
3.1.1 PSYCHOLOGICAL TREATMENT FOR BULIMIA NERVOSA 3-70
3.1.2 'REGULAR' TREATMENT VS. TREATMENT TRIAL ............... 3-71
3.1.3 FINDINGS 1: MAGNITUDE OF PROBLEM BN .................... 3-72
3.1.3.1 Overall drop-out rates .................................................... 3-72
3.1.3.2 By treatment type .......................................................... 3-72
3.1.3.3 By format of treatment .................................................... 3-73
3.1.3.4 By setting of treatment ................................................. 3-74
3.2 ANOREXIA NERVOSA ............................................................. 3-74
3.2.1 PSYCHOLOGICAL TREATMENT FOR ANOREXIA NERVOSA 3-74
3.2.2 FINDINGS 2: MAGNITUDE OF PROBLEM AN ................... 3-75
3.2.2.1 Overall drop-out rates .................................................... 3-75
3.2.2.2 Type of treatment .......................................................... 3-75
3.2.2.3 Format of treatment ....................................................... 3-76
3.2.2.4 Setting of treatment ...................................................... 3-76
3.3 BINGE EATING DISORDER (BED) AND OTHER EATING DISORDER NOT OTHERWISE SPECIFIED (EDNOS) ......................................................... 3-77
3.4 FINDINGS 3: CORRELATES OF DROPPING OUT ACROSS ED TREATMENTS......... 3-77
3.4.1 PATIENT DEMOGRAPHIC AND HISTORY VARIABLES .......... 3-77
3.4.2 'NORMAL' AND PSYCHOPATHOLOGICAL PERSONALITY CHARACTERISTICS 3-77
THEORETICAL AND METHODOLOGICAL FOUNDATIONS OF PART 2

4.1 THEORETICAL FOUNDATION: ATTACHMENT THEORY .................................................4-84
4.1.1 HISTORY AND TENETS OF ATTACHMENT THEORY ..............................................4-85
4.1.1.1 Secure attachment .............................................................................................4-85
4.1.1.2 Insecure attachment ..........................................................................................4-86
4.1.1.3 Stability of attachment style ..............................................................................4-86
4.1.1.4 Attachment insecurity style and psychopathology .............................................4-86
4.1.1.5 Attachment in therapeutic relationships .............................................................4-88
4.1.2 MEASUREMENT OF ATTACHMENT ...................................................................4-89
4.1.2.1 Attachment as ‘state of mind’ or as ‘style’ ............................................................4-90
4.1.2.2 Attachment as ‘style’ ..........................................................................................4-91
4.1.2.2.1 Measurement of attachment styles .................................................................4-91
4.1.2.2.2 Subclassifications of insecure attachment ......................................................4-93
4.1.2.3 Attachment as a property of a relationship dyad ................................................4-93
4.1.2.3.1 Measurement of therapeutic attachment ........................................................4-93
4.2 METHODOLOGICAL FOUNDATIONS ......................................................................4-97
4.2.1 CASE-NOTE ANALYSES OF CLINICAL SERIES (CHAPTERS 5 & 6) .................4-97
4.2.2 PATIENT SERIES: PRE-TREATMENT SELF-REPORT OF ATTACHMENT STYLE (CH 7) ...............................................................................................................4-98
4.2.3 IN-DEPTH QUALITATIVE INTERVIEWS (CHAPTER 8) ........................................4-99
4.2.4 PRESENTATION OF TOOL TO STUDY TREATMENT DYADS (CHAPTER 9) .......4-101
4.3 CONCLUDING SUMMARY .................................................................4-102

PART II

COHORT 1: DOES TRAUMA EXPERIENCED IN CHILDHOOD RELATE TO DROPPING OUT IN ADULTHOOD?

5.1 INTRODUCTION & AIMS .........................................................................................5-105
5.1.1 AIMS ....................................................................................................................5-105
5.2 METHOD: COHORT 1 .............................................................................................5-106
5.2.1 CLINIC ................................................................................................................5-106
5.2.2 THERAPISTS ......................................................................................................5-106
5.2.3 SUBJECTS .........................................................................................................5-106
5.2.4 MEASURES ........................................................................................................5-106
5.2.4.1 Definition of dropping out ..............................................................................5-107
5.2.4.2 Analysis sheet .................................................................................................5-107
5.2.4.2.1 Childhood trauma ......................................................................................5-107
5.2.4.2.2 Severity of ED characteristics .................................................................5-108
5.2.4.2.3 Comorbid psychiatric symptom severity ....................................................5-109
5.2.4.2.4 Diagnosis at assessment ............................................................................5-109
5.2.4.2.5 Self-esteem .................................................................................................5-109
5.2.4.2.6 Demographic factors ..................................................................................5-109
5.2.4.2.7 Patient experience .....................................................................................5-109
5.2.5 ANALYSIS OF DATA ..........................................................................................5-109
5.3 RESULTS: COHORT 1 ..........................................................................................5-111
5.3.1 SAMPLE DESCRIPTIVES ....................................................................................5-111

3.4.3 EATING DISORDER DIAGNOSIS ...........................................................................3-78
3.4.4 EATING DISORDER FEATURES AND OTHER CLINICAL FEATURES .............3-79
3.4.5 EXPECTATIONS OF TREATMENT; ‘STAGES OF CHANGE’ ..............................3-79
3.4.6 CURRENT FAMILY ENVIRONMENT ....................................................................3-80
3.4.7 CHILDHOOD RELATIONSHIPS AND EXPERIENCES ......................................3-80
3.5 CONCLUDING SUMMARY ....................................................................................3-81
COHORT 2: PARENTAL BREAK-UP AND CHILDHOOD TRAUMA RELATE TO DROPPING OUT

6.1 INTRODUCTION & AIMS .............................................................................................................6-123
6.1.1 AIMS .........................................................................................................................................6-123
6.2 METHOD: COHORT 2 ..................................................................................................................6-123
6.2.1 CLINIC ........................................................................................................................................6-123
6.2.2 SUBJECTS ..................................................................................................................................6-123
6.2.3 MEASURES ................................................................................................................................6-123
6.2.3.1 Definition of dropping out .....................................................................................................6-124
6.2.3.2 Analysis sheet ..........................................................................................................................6-124
6.2.3.2.1 Childhood trauma ..............................................................................................................6-124
6.2.3.2.2 Severity of ED characteristics; diagnosis .............................................................................6-124
6.2.3.2.3 Comorbid psychiatric symptom severity .............................................................................6-124
6.2.3.2.4 Self-esteem ..........................................................................................................................6-124
6.2.3.2.5 Demographic factors ..........................................................................................................6-125
6.2.3.2.6 Patient experience ..............................................................................................................6-125
6.2.4 ANALYSIS OF DATA ................................................................................................................6-125
6.2.4.1 Replication of dose-effect relationship between trauma and drop-out ..............................6-125
6.2.4.2 Comparison of Cohorts 1 & 2 .................................................................................................6-125
6.2.4.3 Replication of LR findings .....................................................................................................6-125
6.2.4.4 Double cross-validation of LR model .....................................................................................6-125
6.3 RESULTS: COHORT 2 .................................................................................................................6-126
6.3.1 SAMPLE DESCRIPTIVES .........................................................................................................6-126
6.3.2 ANALYSIS OF CHILDHOOD TRAUMA INDEX .....................................................................6-126
6.3.3 TESTING OF LR MODEL ...........................................................................................................6-126
6.3.3.1 Demographic characteristics .................................................................................................6-126
6.3.3.2 Diagnosis and Severity of ED characteristics .......................................................................6-126
6.3.3.3 Childhood Trauma ................................................................................................................6-126
6.3.3.4 Patient experience ................................................................................................................6-126
6.3.3.5 Replication of LR Analyses .................................................................................................6-130
6.3.3.5.1 Variables entered into the LR analysis ...............................................................................6-130
6.3.3.5.2 Significant variables in the LR model for Cohort 2 .........................................................6-130
6.3.3.5.3 Predicted probability of engaging/dropping out .................................................................6-133
6.3.3.6 Double cross-validation of LR models ..................................................................................6-135
6.4 DISCUSSION ..............................................................................................................................6-135
6.4.1.1 Further limitations ................................................................................................................6-137
6.4.1.2 Conclusions ..........................................................................................................................6-137
Development of themes.........................................................................................8-170
Selection of themes............................................................................................8-170
Step 2: ‘Questioning’ the data set........................................................................8-170

8.4 RESULTS ........................................................................................................8-171
8.4.1 AUXILIARY INFORMATION .........................................................................8-172
8.4.1.1 Relationships included in results, use of fictitious names.........................8-172
8.4.1.2 Reasons for consenting to the interview....................................................8-173
8.4.1.3 Patients’ self-categorisations as engagers, drop-outs, or completers.........8-173
8.4.2 ATTACHMENT: ‘GOOD’ AND ‘BAD’ TREATMENT RELATIONSHIPS ..........8-176
8.4.2.1 SECURE BASE/INSECURE BASE .........................................................8-176
8.4.2.1.1 Responsive/Rigid ....................................................................................8-177
8.4.2.1.1.1 Available/Inaccessible .........................................................................8-177
8.4.2.1.1.2 Unique relationship/Feeling treated like a number ..........................8-178
8.4.2.1.1.3 Potent therapist/Passive therapist......................................................8-180
8.4.2.1.1.4 Accepting/Rejecting ............................................................................8-181
8.4.2.1.1.5 Unshockable/disgusted ......................................................................8-182
8.4.2.1.1.6 Steadfast ..............................................................................................8-185
8.4.2.1.1.7 Respectful/Patronising ......................................................................8-185
8.4.2.1.1.8 Patient not worthy ..............................................................................8-186
8.4.2.1.2 Attuned Support/ Lack of attuned support ...........................................8-189
8.4.2.1.2.1 Containing/ Not containing ...............................................................8-189
8.4.2.1.2.2 Give a direction, goal, idea that ‘better’ exists / Never recover..8-189
8.4.2.1.2.3 Provide structure .................................................................................8-190
8.4.2.1.2.4 Get things in perspective .................................................................8-191
8.4.2.1.2.5 Anticipate feelings and ED / ‘Fooled’ by ED. ....................................8-191
8.4.2.1.2.6 Intrusive, Punitive, Defensive therapist ...........................................8-194
8.4.2.1.2.7 Capacity to process negative emotions .............................................8-196
8.4.2.1.2.8 Understanding /Doesn’t understand ...............................................8-197
8.4.2.1.2.9 Caring, interested / Uncaring, uninterested ......................................8-199
8.4.2.1.2.10 Honest ...............................................................................................8-200
8.4.2.2 EXPLORATION/WITHDRAWAL ...............................................................8-200
8.4.2.2.1 Explore ...................................................................................................8-201
8.4.2.2.1.1 Relevant ..............................................................................................8-201
8.4.2.2.1.2 Comfortable pace of change............................................................8-202
8.4.2.2.1.3 Collaborative ......................................................................................8-202
8.4.2.2.2 Withdraw ..............................................................................................8-203
8.4.2.2.2.1 No stimulation: boredom.................................................................8-203
8.4.2.2.2.2 Irrelevant ............................................................................................8-204
8.4.2.2.2.3 Not free to explore: forced ...............................................................8-205
8.4.2.2.2.4 Accept treatment goals ......................................................................8-205
8.4.2.2.2.5 To accept treatment plan .................................................................8-206
8.4.2.2.2.6 Abandoning ......................................................................................8-208
8.4.3 DISTRIBUTION ..........................................................................................8-209
8.4.4 OTHER EXPLANATIONS .............................................................................8-212

8.5 DISCUSSION ..................................................................................................8-212
8.5.1 THERAPY ATTACHMENT ........................................................................8-213
8.5.2 LINKS WITH EXISTING DROP-OUT LITERATURE ...............................8-214
8.5.3 METHOD: OPEN-ENDED INTERVIEW USING INDEPENDENT RESEARCHER 8-215
8.5.4 LIMITATIONS OF THE STUDY .................................................................8-218
8.5.5 CONCLUSIONS ..........................................................................................8-220

DEVELOPMENT OF THE THERAPY RELATIONSHIP QUESTIONNAIRE

9.1 INTRODUCTION & AIMS ...............................................................................9-221
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1.1 AIMS</td>
<td>9-221</td>
</tr>
<tr>
<td>9.1.2 PREVIOUS MEASURES</td>
<td>9-222</td>
</tr>
<tr>
<td>9.1.3 PHILOSOPHY BEHIND THE THERAPY RELATIONSHIP QUESTIONNAIRE</td>
<td>9-224</td>
</tr>
<tr>
<td>9.1.3.1 Content of the Therapy Relationship Questionnaire</td>
<td>9-225</td>
</tr>
<tr>
<td>9.1.3.2 Sources of data in the Therapy Relationship Questionnaire</td>
<td>9-226</td>
</tr>
<tr>
<td>9.1.3.2.1 Self-report</td>
<td>9-227</td>
</tr>
<tr>
<td>9.1.3.2.2 Inference unnecessary</td>
<td>9-227</td>
</tr>
<tr>
<td>9.1.3.3 Temporal structure of the Therapy Relationship Questionnaire</td>
<td>9-228</td>
</tr>
<tr>
<td>9.2 DEVELOPMENT OF QUESTIONNAIRE</td>
<td>9-229</td>
</tr>
<tr>
<td>9.2.1 Item generation, content validation, and item selection</td>
<td>9-229</td>
</tr>
<tr>
<td>9.2.2 Scale format</td>
<td>9-230</td>
</tr>
<tr>
<td>9.2.3 Instructions to participants</td>
<td>9-231</td>
</tr>
<tr>
<td>9.3 METHOD AND RESULTS</td>
<td>9-231</td>
</tr>
<tr>
<td>9.3.1 Ethical approval</td>
<td>9-231</td>
</tr>
<tr>
<td>9.3.2 The clinic and clinicians</td>
<td>9-231</td>
</tr>
<tr>
<td>9.3.3 Participant selection and characteristics</td>
<td>9-232</td>
</tr>
<tr>
<td>9.3.4 Questionnaire administration</td>
<td>9-232</td>
</tr>
<tr>
<td>9.3.5 Data analysis</td>
<td>9-234</td>
</tr>
<tr>
<td>9.3.5.1 Initial questionnaire description</td>
<td>9-234</td>
</tr>
<tr>
<td>9.3.5.2 Factor analysis</td>
<td>9-235</td>
</tr>
<tr>
<td>9.3.5.2.1 Factor results</td>
<td>9-240</td>
</tr>
<tr>
<td>9.3.5.3 Cluster analysis</td>
<td>9-245</td>
</tr>
<tr>
<td>9.3.5.3.1 Hierarchical, R-mode analysis</td>
<td>9-245</td>
</tr>
<tr>
<td>9.3.5.3.2 Non-hierarchical, Q-mode analysis</td>
<td>9-246</td>
</tr>
<tr>
<td>9.3.5.4 Internal consistency and Scale reliability</td>
<td>9-249</td>
</tr>
<tr>
<td>9.3.5.4.1 Internal consistency</td>
<td>9-249</td>
</tr>
<tr>
<td>9.3.5.4.2 Test-retest reliability</td>
<td>9-249</td>
</tr>
<tr>
<td>9.3.5.4.3 Subscale reliability</td>
<td>9-249</td>
</tr>
<tr>
<td>9.3.5.5 Validity</td>
<td>9-250</td>
</tr>
<tr>
<td>9.3.5.5.1 Content validity</td>
<td>9-250</td>
</tr>
<tr>
<td>9.3.5.5.2 Criterion validity</td>
<td>9-250</td>
</tr>
<tr>
<td>9.3.5.5.3 ‘Divergent’ validity</td>
<td>9-250</td>
</tr>
<tr>
<td>9.4 DISCUSSION</td>
<td>9-251</td>
</tr>
<tr>
<td>9.4.1 Limitations</td>
<td>9-255</td>
</tr>
<tr>
<td>9.4.2 Conclusions</td>
<td>9-256</td>
</tr>
</tbody>
</table>

**CONCLUSIONS**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1 INTRODUCTION AND CENTRAL AIMS OF THE THESIS</td>
<td>10-258</td>
</tr>
<tr>
<td>10.2 SUMMARISING AND LINKING MAIN FINDINGS</td>
<td>10-258</td>
</tr>
<tr>
<td>10.2.1 Chapters 1 &amp; 2: General introduction, literature review</td>
<td>10-259</td>
</tr>
<tr>
<td>10.2.2 Chapter 3: Dropping out from psychological treatment for ED</td>
<td>10-259</td>
</tr>
<tr>
<td>10.2.3 Chapter 4: Theoretical and methodological foundations</td>
<td>10-260</td>
</tr>
<tr>
<td>10.2.4 Chapters 5 &amp; 6: Role of childhood trauma</td>
<td>10-261</td>
</tr>
<tr>
<td>10.2.5 Chapter 7: Role of attachment dimensions</td>
<td>10-261</td>
</tr>
<tr>
<td>10.2.6 Chapter 8: Patients’ views of early engagement and drop-out</td>
<td>10-263</td>
</tr>
<tr>
<td>10.2.7 Chapter 9: The development and initial analysis of TRQ</td>
<td>10-265</td>
</tr>
<tr>
<td>10.3 SUMMARY MODEL OF DROPPING OUT</td>
<td>10-267</td>
</tr>
<tr>
<td>10.4 IMPLICATIONS FOR FUTURE RESEARCH</td>
<td>10-271</td>
</tr>
<tr>
<td>10.4.1 Research motivations and methods</td>
<td>10-271</td>
</tr>
<tr>
<td>10.4.2 Other areas of interest</td>
<td>10-273</td>
</tr>
<tr>
<td>10.5 IMPLICATIONS FOR CLINICAL PRACTICE</td>
<td>10-273</td>
</tr>
<tr>
<td>10.6 ETHICAL IMPLICATIONS</td>
<td>10-275</td>
</tr>
<tr>
<td>10.7 FINAL SUMMARY</td>
<td>10-276</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

Figure 1-1. Distinguishing drop-outs and other treatment status groups .........................1-21
Figure 2-1. Summary of methods used and results found in studying dropping out from psychological treatment .................................................................2-34
Figure 4-1. Attachment Measures ....................................................................................4-95
Figure 4-2. Studies in Part 2 of this thesis .......................................................................4-96
Figure 5-1. Additive effect of experiences of childhood trauma on dropping out ......5-114
Figure 5-2 (a) & (b). Engagers (a) and drop-outs (b) plotted according to their probability of engagement as determined by the logistic regression model ..............5-111
Figure 6-1. Additive effect of experiences of childhood trauma on dropping out ......6-128
Figure 6-2. Patient experience in childhood of parental break-up: grouped according to engagement status ........................................................................6-132
Figure 6-3 (a) & (b). Engagers (a) and drop-outs (b) plotted according to their probability of engagement as determined by the logistic regression model ..............6-134
Figure 8-1. Schematic representation of 'good' therapy relationships using attachment concepts ........................................................................................................8-175
Figure 8-2. Schematic representation of 'bad' therapy relationship using attachment concepts ........................................................................................................8-176
Figure 9-1. Initial plot of scores for Factors 1 & 2 ..............................................................9-236
Figure 9-2. Initial plot of scores for Factors 1 & 3 ..............................................................9-237
Figure 9-3. Final plot of scores for Factors 1 & 2 ..............................................................9-238
Figure 9-4. Final plot of scores for Factors 1 & 3 ..............................................................9-239
Figure 9-5. TRQ-clinician ‘Trusting’ item plotted against TRQ-patient Safety/Trust subscale derived from Factor 1 .................................................................9-242
Figure 9-6. TRQ-clinician ‘Trusting’ item plotted against TRQ-patient Accepting Therapist subscale derived from Factor 2 .........................................................9-243
Figure 9-7. TRQ-clinician ‘Trusting’ item plotted against TRQ-patient Exploration/Progress subscale derived from Factor 3 .........................................................9-244
Figure 9-8. Hierarchical Cluster Analysis of TRQ-patient items .....................................9-247
Figure 9-9. TRQ-patient total score plotted against cluster membership derived from non-hierarchical q-mode cluster analysis .................................................9-248
Figure 10-1. Model of dropping out and attachment ........................................................10-270
LIST OF TABLES

Table 5-1. Clinical severity of ED characteristics index .............................................. 5-109
Table 5-2. Steps of correlational approach to testing dose-effect relationship of experiences of childhood trauma on drop-out (Howell. 1999a&b) .... 5-111
Table 5-3. Logistic regression model of dropping out .................................................. 5-115
Table 6-1. Steps of correlational approach to testing dose-effect relationship of experiences of childhood trauma on drop-out (Howell. 1999a&b) .... 6-127
Table 6-2. Logistic regression model cross-validated on cohort of 110 women with Bulimia Nervosa or atypical BN ......................................................... 6-131
Table 7-1. Sample selection ............................................................................................... 7-142
Table 7-2. Distribution of DSM-IV diagnoses & EDI scores ..................................... 7-143
Table 7-3. Distribution of treatment status ...................................................................... 7-145
Table 7-4. Overall VASQ rating by treatment status .................................................... 7-146
Table 7-5. Rotated component matrix .............................................................................. 7-149
Table 7-6. VASQ subscale scores by treatment status group .......................................... 7-150
Table 7-7. VASQ overall rating by EDI subscale score ............................................. 7-151
Table 7-8. EDI scores by Treatment status ..................................................................... 7-152
Table 8-1. Initial and final sample structures .................................................................. 8-165
Table 8-2. Frequency of negative and positive early treatment experiences ............ 8-166
Table 8-3a. Distribution of 'security' themes ................................................................. 8-211
Table 8-3b. Distribution of 'exploration' themes ............................................................ 8-212
Table 9-1. Sample selection ............................................................................................... 9-232
Table 9-2. TRQ-patient factor scores compared to VASQ scores ......................... 9-251
1 DROPPING OUT FROM PSYCHOLOGICAL TREATMENT

1.1 General introduction

Dropping out from psychological treatment is a widespread problem in mental health services. Reviews regularly find that 30-70% of patients\(^1\) entering psychological treatments drop out by the 10\(^{th}\) session (Baekeland & Lundwall, 1975; Frank, Gliedman, Imber, Nash, & Stone, 1957; Garfield, 1994; Phillips, 1987) and up to 85% drop out by the 20\(^{th}\) (Brandt, 1965). The treatments reviewed include every theoretical orientation from psychoanalytic to cognitive-behavioural schools, with all showing similar rates of dropping out (Phillips, 1987). The treatments investigated are applied to a range of problems primarily conceived of as psychologically based, such as drug and alcohol misuse, personality problems, mood disorders, relationship problems, and, the focus of this thesis, eating disorders.

Not only is the problem of dropping out pervasive, it also has far-reaching consequences. While it cannot be said that these consequences are solely negative, patients who stop attending before their treatment is completed are not likely to recover without further treatment\(^2\) (Baekeland & Lundwall, 1975; Beumont, Russell, & Touyz, 1993; Fairburn, Jones, Peveler, & Carr, 1991; Gottheil, Sterling, & Weinstein, 1997; King, 1989; Luborsky, Auerbach, Chandler, & Cohen, 1971; Pekarik, 1983a; Pekarik, 1992a), nor are they likely to have left because they are obtaining help or treatment elsewhere (Cross, Sheehan, & Khan, 1980; Fiester & Rudestam, 1975; Garfield, 1963; Pang, Lum, Ungvari, Wong, & Leung, 1996).

\(^1\) Users of psychological services will be called 'patients' rather than 'clients' in this thesis, since this is the norm at the clinic which has hosted the research.

\(^2\) Though this point is still sometimes questioned (Fiester & Rudestam, 1975; Pekarik, 1992a; Silverman & Beech, 1979). Half a century ago, Eysenck concluded that there was no objective evidence that psychotherapy had any ameliorative effect on neurotic symptoms apart from what could be expected to occur spontaneously (Eysenck, 1952). However, none of the samples considered in this paper was large enough to detect anything other than an enormous effect (Fulkerston, 1961). Howard et al. (1986) project that 10-18% of patients (depressed, anxious, and borderline) show some measurable improvement as a function of simply initiating contact with the clinic. This may be because some improvement may occur from the reduction in anxiety brought about by thinking that help is at hand. In order to understand how many and which patients leave because they have experienced lasting and rapid recovery, drop-outs need to be followed up regularly.
Many are either re-referred or, worse, refuse to try psychotherapeutic treatment again (Fiester, Mahrer, Giambra, & Ormiston, 1974). The adverse consequences of dropping out affect more than just the drop-out: other patients who have been referred for individual treatment have to wait longer; if the drop-out leaves a group, group cohesion can be disrupted and other members might leave (Blouin et al., 1995; Connelly, Piper, de Carufel, & Debbane, 1986); and therapists can be demoralised when patients leave without explanation (DuBrin & Zastowny, 1988; Merrill, Mines, & Starkey, 1987; Sledge, Moras, Hartley, & Levine, 1990). Family members and work colleagues might undergo unnecessary stresses if the drop-out is left untreated (Mohl, Martinez, Ticknor, & Appleby, 1989). When the dropping out occurs within the context of a treatment trial or follow-up study, research results can be undermined, even when conservative measures are taken to account for missing data (Brown, 1992). In terms of mental health service auditing, dropping out diminishes the effectiveness (and cost-effectiveness) of service delivery and the ability of providers to evaluate the effects of those services (Pekarik, 1992a). Thus, dropping out from psychological treatments has negative consequences and is worthy of both clinical and research attention. In a relatively young field like eating disorders, where diagnostic categories are evolving and the development of effective treatments is ongoing, it is especially important to understand and to reduce dropping out. This thesis explores several approaches to investigating this problem and presents a tool designed to predict dropping out.

1 Some researchers view ‘the dropping out of’ some members as essential to the establishment of group cohesiveness e.g. (Lothstein, 1978). Thankfully, this view is not commonly held. There is a *Lord-of-the-Flies* flavour to this particular research report: ‘expulsion or sacrifice of a few group members...helped each group to become a more cohesive unit.’ (p 1495). The author concludes that: ‘The drop-out ritual may be basic to the establishment of group cohesiveness. [Without it] there is probably little hope of effective work for group members, so therapists should not feel guilty about “confronting a patient’s resistance and expelling him... in order to enhance their attractiveness as leaders” (p. 1494).
1.2 **Objective of the thesis**

1. The main objective of the thesis is to deepen understanding of factors affecting dropping out from psychological treatment using the special case of eating disorders. Multiple data-gathering and -analysis methods are employed in order to investigate this phenomenon from several angles. The investigations are organised within the framework of attachment theory.

2. A subsidiary aim of the thesis is to develop and present a tool for studying the early therapy dyad which can be used in predictive studies of dropping out.

1.3 **Structure of the thesis**

The thesis consists of 2 main parts. Part 1 presents the definitions and research foundations for the original work presented in Part 2.

1. **Foundations.** The first part establishes a working definition of dropping out (Chapter 1), discusses why it has been studied, and critically reviews the methods used in the existing literature to study dropping out from psychological treatments in general (Chapter 2). It then reviews the methods used to study dropping out from eating disorder treatment specifically and gives an overview of the results found in this area (Chapter 3). The theoretical and methodological foundations for the new studies reported in Part 2 are established with a brief overview of attachment theory and the qualitative and quantitative methods used (Chapter 4).

2. **Original work.** The second part presents a series of new studies which have used multiple methods for exploring factors affecting dropping out. These studies, informed by the reviews in Part 1, use attachment theory as an heuristic. They encompass replicated, retrospective case-note reviews (Chapters 5 & 6), a prospective questionnaire-based investigation (Chapter 7), in-depth qualitative interviews (Chapter 8), and the development of a new tool for studying the early development of the therapy dyad (Chapter 9).
1.4 Definition of terms

1.4.1 What is psychological treatment?

Psychological treatment is considered to be those ‘talk’ therapies which primarily emphasise insight or cognitive change as mechanisms for alleviating distress. It can be carried out one-on-one between a patient and a therapist or in groups. This thesis will give particular attention to individual treatments, where the relationship between patient and therapist is the medium through which change is effected. Pharmacological and operant-based treatments, while psychologically mediated, are not considered psychological treatments for the purpose of this thesis. Additionally, it should be remembered that the original work in this thesis is structured around the public provision of psychological treatment in the National Health Service; however, dropping out from treatments in the private sector is likely to be influenced by similar mechanisms, even if the processes of payment and referral are different.

1.4.2 What is dropping out from psychological treatment?

From the earliest drop-out studies researchers (and clinicians) have disagreed about what constitutes dropping out from psychological treatment. This lack of consensus has created one of the main obstacles to progress in drop-out research. Most fundamentally, dropping out is the product of a patient presenting for treatment, however willingly or unwillingly; that patient being accepted for treatment; treatment beginning; and the patient not continuing, whether willingly or unwillingly. However, this simple definition is not universally applied, perhaps because it hides complexities: Who is a ‘patient’? At what stage of contact does ‘treatment’ begin? How is the ending of treatment assessed? Too narrow resolution of such questions has rendered most existing definitions ungeneralisable.

This section explores some of the difficulties associated with existing definitions of dropping out and discusses some ideal solutions. It concludes with a description of the definitions actually used in this thesis (which are not ideal). Currently, definitions of dropping out suffer from confusion at the terminological level, with ‘drop-out’,

---

4 Although dropping out is a problem in pharmacological and behaviour therapies as well. See Foa & Emmelkamp, (1983).
'attrition', and 'premature termination' used interchangeably to describe any unforeseen ending of contact with therapists or researchers. There is inconsistency at the methodological level, with wide discrepancies in the criteria for 'qualifying' as a drop-out. And at an epistemological level, it is unclear whether the therapist or patient perspective is more relevant to determining the type of treatment termination.

1.4.2.1 Terminology

It makes sense to distinguish the types of unforeseen endings of contact (Figure 1-1). One solution would be to reserve 'attrition', which literally means losing 'pieces' (patients) from a 'whole' (study sample), for patients who leave a research study. 'Drop-out' could be used for a regular treatment relationship which ends by the patient's unilateral decision. And 'premature termination' could indicate a treatment relationship which ends by the therapist's unilateral decision. The treatment relationship which ends by joint decision might be a 'withdrawal' or 'transfer', depending on the circumstances. 'Treatment refuser' could be used to describe the prospective patient who does not take up therapy when it is offered.

Clarifying terminology is not just about semantics. Important differences may exist between the factors influencing a participant's decision to leave a research study (attrition from an activity aimed at the benefit of others) and a patient's decision to leave regular treatment with a therapist (drop-out from an activity aimed at personal benefit). If attrition were to be further divided into treatment and follow-up phases, the different causal factors and characteristics affecting drop-out and treatment-phase attrition could be researched independently.

This thesis specifically focuses on 'dropping out', and relies on this terminology throughout the literature reviews and in Chapters 7-10. It is not always evident in published research reports which category is being discussed. Therefore, attrition and premature termination are also considered when they provide the only indication of how many patients do not complete treatment.

1 Brandt (1965) distinguishes between those who do not take up treatment at the study clinic but who do so elsewhere and those who do not take up any treatment. The latter he calls treatment 'rejecters'. His point might well be useful to keep in mind. However, it would be difficult in most studies to determine whether a patient has gone elsewhere for treatment. Garfield (1994) on the other hand uses both 'refuser' and 'rejecter' interchangeably. I prefer the use of 'refuser', because without control, the investigator cannot be certain that the patient has not gone elsewhere. Also the idea that the patient is 'rejecting' therapy (and perhaps more importantly, the therapist) may have a lot to do with why drop-outs are viewed negatively.
Figure 1-1

Distinguishing drop-outs and other treatment status groups

All Referrals

Arrive for assessment?
  Y

Assessed

Offered Treatment?
  N

Arrive for treatment?
  N

Treatment begins

Complete treatment?
  Y

‘Regular’ or ‘Research’?

Ther. or pt decides?
  Y

Completer

Attrition

Transfer/ Withdrawal

Drop out

Premature termination

Refuser

Referred on or referred back to GP

Treatment Refuser

Assessment Refuser
1.4.2.2 Methodology

The methodological problems underlying existing drop-out definitions stem from using different methods for determining when treatment status changes. The most common difficulties lie in deciding at what point treatment has begun and at what point (and under what conditions) the patient can leave without having ‘dropped out’. This may be linked to the assumptions inherent in different treatment paradigms about how much treatment is ‘enough’ to have experienced some lasting change. It may be also be due to differing conceptions of roles of patient and therapist.

Whatever the reasons, the differences in criteria for ‘qualifying’ as a drop-out make study comparison difficult. Some authors use session counts, with cut-offs either arbitrarily defined (e.g., Bein, Torres, & Kurilla, 2000) or linked to the median number of sessions attended (e.g., Koss, 1979). In early drop-out studies, cut-offs were used to partition the data into extreme groups (e.g., Hiler, E.W. cited in Frank et al., 1957), which compounded difficulties associated with study comparison, as entire sets of patients were not discussed. One study classified drop-outs as those who had completed 6 or fewer session and engagers as those who completed 26 or more; it abandoned the middle group altogether (Lorr, Katz, & Rubinstein, 1958). This is now rare, but still comparison is difficult, because session cut-offs can be as low as 1 (Duehn & Proctor, 1977), 2 (Fiester & Rudestam, 1975) or 3 sessions (Pekarik, 1985) or as high as 100 (Frayn, 1992). Overall, cut-offs usually lie between 6 and 10 sessions (Baum, Felzer, D’Zmura, & Shumaker, 1966; NIMH, 1981; Saltzman, Luetgert, Roth, Creaser, & Howard, 1976).

Underpinning the idea of when in treatment a patient can leave without ‘dropping out’ is the understanding of the patient not having had ‘enough’ treatment to have experienced some lasting change, and therefore not being qualified to judge the appropriate termination point. This assumption about the patient’s change status may hark back to psychoanalytic concepts, where patients leave because they are unable to overcome their ‘resistance to change’. Different theoretical models create different expectations concerning what is ‘enough’ treatment, which influence concepts about the fate of patients who leave ‘early’.

More medically oriented authors will often discuss ‘non-compliance’ (e.g., Chen, 1991), which implies patients not following a set of prescriptions, or ‘defaulting’, which implies failure to perform a duty. Other practitioners will often discuss ‘termination’ (e.g., Acosta, 1980), which implies the setting of a boundary or limit, the act of ending something. In the medical construction of dropping out, there is an implication that the practitioner alone sets a plan to be executed in full. In the psychotherapeutic construction of dropping out, the patient appears to have more agency determining the boundaries (and length) of the relationship.
This is in fact the range within which most drop-out occurs (Garfield, 1994)\textsuperscript{8}. As a further complication, session cut-offs are not always used. Other criteria commonly used are length of time in contact with the clinic (e.g., Cohen, Edstrom, & Smith-Papke, 1995; Lorr et al., 1958) or partitioning of patients into those who remain until treatment has been ended by mutual consent of therapist and patient and those who do not. Some authors fail to specify what criteria are used.

This wide range of criteria might not be important if it did not affect results. However, one study has shown that different results can be generated on the same data set when different criteria are used (Pekarik, 1985). The author found that using therapist judgement as the criterion for the appropriateness of termination revealed sociodemographic differences between drop-outs and completers, but these did not appear when session counts were used. As a result of this finding, the author argues for using the therapists’ judgement rather than any other criterion. However, the author does not account for the possibility that therapists systematically might understand and work with patients from some sociodemographic backgrounds better than with those from others. Nonetheless, the point can be taken that, in order to evaluate the findings of a particular study, the criteria used to distinguish between ‘drop-outs’ and ‘engagers’ must be made explicit.

One solution might be that, to be considered a drop-out, a patient should have attended at least one therapy appointment (Garfield, 1994). Assessment appointments, if they are used by a clinic, should not count toward dropping out, because the treatment ‘contract’ is less likely to have been established during this phase. In other words, dropping out should only be considered once the ‘help-seeker’ has become a ‘patient’.

Ideally, dropping out would be reported as a proportion: the number of sessions attended related to the amount of treatment expected to produce lasting change. Such an approach would facilitate comparison of treatment types and of levels of dropping out, including ‘early’ and ‘late’ dropping out, and would also allow different cut-offs to be

\textsuperscript{8} Interestingly, it is also the time in which 50\% of many types of patients show some measurable response to treatment (Howard, Kopta, Krause, & Orlinsky, 1986). It is not clear how patients in this study terminated treatment, so it is difficult to make any assumptions about whether those who respond are also those who leave early.
applied to the data to permit comparison with existing studies. However, this goal is unlikely to be attained soon, since minimum treatment amounts are not known (Oehlschlagel & Mahon, in prep-a; Oehlschlagel & Mahon, in prep-b). Furthermore, the requirements of statistical procedures and the small numbers often available for clinical studies may mean that discussing dropping out in terms of numbers of sessions attended is unavoidable. Even in these situations, though, recording the actual numbers of sessions attended and typically offered would be useful. At minimum the criteria used to define dropping out should be specified and information about the type of therapy offered should be supplied, so that the underlying expectations about treatment might be inferred.

This thesis views drop-outs as those patients who began treatment by attending at least one session but who unilaterally decided not to complete it.

1.4.2.3 Epistemology

Finally, there is the epistemological question of whose viewpoint is used to determine whether the ending of treatment was in fact early. Many studies do not specify which viewpoint is used, or if they do, they use the therapist’s perspective exclusively (e.g., Pekarik & Finney-Owen, 1987). The therapist is relied upon perhaps because this viewpoint is accessible even after treatment ends in dropping out.

However, as the treatment is aimed at the good of the patient (usually – See Section 3.3 about treatment trials), the patient’s perspective on this termination would seem to be critical. Ideally the views of both the patient and therapist would be incorporated in determining dropping out (though it might prove to be the case that therapist views matter only in their influence on patient views).

Despite requiring more elaborate computation, a definition of dropping out which accounted for at least these two points of view might encourage more productive

---

9 Little is known about whether there are differences between those who drop out early in treatment and those who leave later (Fiester & Rudestam, 1975; Pekarik, 1985; Pekarik, 1992a), and whether the issues that are relevant to these decisions differ.

10 Use of one session as the unit of treatment has been chosen because ‘the session...is a natural quantitative unit of psychotherapy that is roughly comparable across types of treatment...[And] the more sessions a patient has, the more ‘therapy’ that patient has probably been exposed to.’ (p. 159, Howard et al., 1986). Length of time in contact with the clinic might be important for indicating duration of treatment relationship, but it conveys no meaning about the intensity of that relationship or the amount of contact patients and therapists have had.

11 Obviously there might be situations where the views of the patient could not be obtained, but usually in these situations psychotherapy as defined above would not be in use.
research\textsuperscript{12}. It would provide a ‘clean’ measure of whether or not both parties involved in treatment felt that sufficient treatment had been provided, and so might increase the generalisability of findings. And it would control for the problem that length of therapy is not always an accurate indicator of prematurity of termination (Garfield, 1994).

\textbf{1.4.2.4 Working definitions in this thesis}

The original work presented in Part 2 of this thesis contributed to the thinking behind the preceding discussion, and as a result, the definition of dropping out used in each study has evolved through the thesis. Thus the studies in Part 2 commit many of the sins listed above. However, criteria for defining dropping out are always listed, and the treatments offered are described. When definitions differed (Chapters 5 & 6 include treatment refusers as drop-outs), a subset of the uni- and bi-variate analyses were re-done using the criteria listed above. Results were similar, so multivariate analyses were not re-done. Since the clinic hosting the studies had set procedures for describing treatment ending on discharge sheets, patient views of termination were not incorporated in the studies presented. Provision for integrating patient views has been made in the Therapy Relationship Questionnaire presented in the final chapter.

\textbf{1.5 Summary}

1. Dropping out from psychological treatment, the focus of this thesis, is a widespread problem in mental health services with consequences that affect the patient, her ‘system’, the therapist, other patients, and research results. 30-70\% of new treatment relationships end in drop-out.

2. The thesis aims to deepen understanding of the factors affecting dropping out. It is divided into 2 parts:

\textsuperscript{12} Consider the difference between the factors affecting these early treatment endings: In one instance a patient might offer an excuse to stop seeing a therapist she feels is not helpful, and thus would consider herself a drop out, even though her therapist might not. In another instance, a patient might truly have received all of the help that she wants, but her therapist might like to accomplish more. She would consider herself a completer, but her therapist might not. Alternatively a patient might be incapable of meeting the demands of change, with both she and her therapist agreeing that she is a drop-out. Asking both patient and therapist about treatment endings will facilitate discovering which rules govern drop-out and engagement.
a. Part 1 ‘Foundations’ presents the existing methods used to study dropping out and reviews findings.

b. Part 2 ‘Original work’ presents a series of studies using multiple methods to explore dropping out in the special case of treatment for eating disorders.

3. ‘Psychological treatment’ is considered to be varieties of ‘talk’ therapy. The thesis focuses on individual formats.

4. ‘Drop-out’ is considered to be a treatment relationship which ended by the patient’s unilateral decision after the patient attended at least one therapy session.

5. Methodological problems associated with defining dropping out are listed. It is suggested that research reports list the criteria used to define dropping out and describe the type of therapy offered.

6. Epistemological questions are also considered. It is proposed that including both patient and therapist views in determining dropping out could increase the understanding of dropping out and the generalisability of results.

7. Methods for defining dropping out evolved during the thesis. To maximise comparability, criteria for defining dropping out are always listed, treatment offered is described, and results are double-checked where necessary.
2 STUDYING DROPPING OUT

2.1 Why has dropping out been studied?

Why bother to study dropping out? By definition, potential research participants known to be drop-outs are difficult for clinics to contact — even a large outreach effort might not produce a respectable sample size. And what could be learned from them? Since they haven’t had the full amount of treatment, they cannot add to our understanding of treatment effectiveness, which is a main preoccupation of clinically-oriented psychological research. Or so it would seem. Studying dropping out can shed light on what makes a treatment acceptable to patients. In fact, it has an even more fundamental justification: for the basic purposes of psychotherapy to be realised, both patient and therapist need to be present. Studying dropping out can help us learn more about some of these fundamental trans-theoretical therapeutic processes. Therefore, studying dropping out is worth the bother.

How far has the study of dropping out come, and what path has it taken? Brief overviews of the development of the field follow. Specific studies and results are discussed in Section 2.2 (How has dropping out been studied?).

2.1.1 Background

‘VA studies’: 40’s - 50’s Systematic research on dropping out began in the late 1940’s. During World War II in the United States the number of mental health clinics established to treat veterans increased (Veterans’ Administration Hospitals, VA) (Brandt, 1965). Government budgets and patient populations were large enough to satisfy quantitative research requirements, and a series of studies were produced (the ‘VA studies’). These focused almost exclusively on men and the prediction of their willingness to remain in treatment, and were not designed to be generalisable to other populations (e.g., Lorr et al., 1958). Since their fundamental purpose was to evaluate the utility of the VA clinics, investigators used measures that were appropriate for predicting treatment outcome rather than understanding why patients dropped out. Although their current usefulness is limited, the VA studies have influenced drop-out research by setting the focus on prediction and outcome-linked measures.
Rogerian studies: 50’s - 60’s Soon after the advent of intensive research into the effectiveness of psychotherapy led primarily by Carl Rogers in the 1950’s and ‘60’s (Davidson & Neale, 1994), dropping out became the topic of increased research interest in its own right, rather than simply as an influence on outcome. Engagement was felt to be a necessary, if not sufficient, requirement for effective psychotherapy in any setting. As a result these studies were intended to be generalisable. They also differed from the VA studies in the variables investigated, focusing in a typically Rogerian style on the qualities of the therapist, not just patient characteristics that might predict outcome (for an example of this perspective, see Barrett-Lennard, 1962).

Small-scale, predictive studies: 70’s and on More recently, the number of studies investigating dropping out has mushroomed. These are mostly small-scale projects focused on one clinic. Like the VA studies, these focus on prediction, but unlike the VA studies, they generally do not always focus on outcome-type measures. Overall they use pre-treatment patient factors to try to predict dropping out. They tend not to include therapist factors in their design. Restricting their general utility, these studies generally lack an overview of past research on dropping out or of research in fields other than the specialism of the clinic. The narrow vision of these studies is surprising given that during this same historical period, complex clinically related research has been devoted to comprehending trans-theoretical factors which affect outcome (vis. the widespread interest in the therapeutic alliance, e.g., Bordin, 1994; Luborsky, 1994). To progress in the future, the study of dropping out ideally will look beyond prediction of dropping out within one clinic or field toward comprehension of the larger mechanisms affecting dropping out. This is the purpose of the rest of this chapter, and indeed, this thesis.

2.1.2 Prediction of dropping out

The primary interest of existing drop-out research has been finding predictors or correlates of dropping out rather than discovering the larger drop-out mechanisms affecting dropping out -- but to what end? The objectives driving these efforts fall into two main categories, screening predicted drop-outs out of treatment and directing special attention toward them.

2.1.2.1 Screening out

Frequently the stated aim of drop-out studies is to learn to identify before treatment begins those who are likely to leave early in order to exclude them from treatment. This
purpose is justified in terms of making better use of resources (e.g., Beck et al., 1987). As one investigator has written, drop-out prediction is to be used for ‘screening out patients for whom ordinary psychotherapy is likely to be simply a waste of time and effort’ (p. 15, McNair, Lorr, & Callahan, 1963). This justification is shaky at best.

The emphasis on screening out patients who are not ‘suitable’ probably derives from the psychoanalytic tradition, where patient selection plays a central part in discussions of therapy effectiveness (Moras & Strupp, 1982). This concern now spans therapeutic paradigms, as pressures to ensure that treatment is cost-effective increase. However, this emphasis may be detrimental to progress in studying dropping out. The potential usefulness of screening out patients is limited by the same reality pressures that are used to justify it:

1. Accurate prediction of dropping out has thus far proven impossible, at least when using pre-treatment patient characteristics alone (which screening-out studies aim to use; see Section 2.2). Given the inability to predict who will drop out, such advice may be difficult to follow: ‘This is the single most potent tool for preventing drop-outs—do not let them in to begin with!’ (p. 408, Reibel, 1990).

2. Engagement in treatment and treatment outcome are not predicted by the same variables (Garfield, 1994). Therefore, it cannot be concluded that because someone engages they will improve or because they have not engaged that they cannot improve.

3. Given (1) and (2), screening out might prevent access to treatment for many of those who might benefit from it.

4. Therefore, screening out ends up being expensive. The costs of leaving large groups of potential patients untreated likely outweigh the costs of attempting to treat many who will drop out. This thesis examines whether efforts might be better directed at improving engagement techniques.

2.1.2.2 Special attention

Other predictive studies aim to identify those who might leave early in order to allocate special attention to help them engage (e.g., Beck, Shekim, Gilbert, & Fraps, 1983; Lorr et al., 1958). Trying to increase engagement is a reasonable use of research resources. However, the method of identifying drop-outs as special cases may limit drop-
out research by overlooking an important reality: dropping out in many fields is the norm, not the special case (Baekeland & Lundwall, 1975). Even in fields where dropping out is not the norm, thinking of drop-outs as unusual or special cases may limit research ideas and clinical development. It might prove more useful to view engagement and drop-out as inter-related phenomena which are produced within the treatment context. Each patient would then be seen as a potential engager or drop-out, depending on the circumstances he or she encounters. Research could then be directed at improving these circumstances.

In the event, drop-out studies rarely report on special interventions to reduce dropping out (such as pre-therapy training; e.g., Lothstein, 1978)(see Section 2.2.2.6 below).

2.1.3 Comprehension of dropping out

It is not unusual for reports on drop-outs to try to explain why drop-outs leave. These reports are rarely either flattering or founded on empirical evidence. The study quoted below produced only two significant results in multiple post-hoc analyses without the benefit of multivariate techniques. These were that drop-outs had higher needs for ‘aggression’ and ‘autonomy’ as determined by responses to an adjective checklist:

[The drop-outs’ response] pattern describes people who tend to act independent of and who are indifferent to the feelings of others. They are viewed as egotistical, headstrong, assertive, and argumentative. They tend to be under-controlled with strong impulses and little regard for societal conventions or courtesies. They attempt to push or stretch limits, value power, and directly express their hostility. They relish competition and are rebellious. They do not take a backseat when there is action around them, and they are impulsive and have difficulty delaying gratification. Correspondingly, they fear involvement with close relationships, distrust people, tend to feel anxious in social interactions, and tend not to seek reassurance. They lack social poise, are not reflective, are wary of others, avoid close ties, and are suspicious of others’ intentions. They are not concerned about providing emotional relief to someone else. They show little sympathy and keep people at a distance... Dropping out of treatment seems quite consistent with their personality style (p. 94, Craig & Olson, 1988).

Negative assumptions about dropping out ingrained in the psychological treatment culture might be partly responsible for the quick assumptions about why drop-outs leave. As a result, curiosity about these patients may be limited or may arouse too much anxiety about the effectiveness of psychological work. However, learning about what factors influence dropping out is especially important given the high costs of dropping out and
our poor ability to predict who will go. Thus far the research on ‘comprehension’ has been limited to asking about patient reasons for leaving.

2.1.3.1 Reasons

Comprehending dropping out requires questioning of these stereotypes. This process might begin with asking drop-outs themselves about the reasons they feel were important to deciding to leave treatment. A handful of existing studies aim to explore the reasons patients give for ending treatment (see Section 2.2.2.5). Chapter 8 reports on one study aimed at understanding the range of reasons relevant to dropping out.

2.1.3.2 Developing interaction

Once stereotypes have been revised, viewing dropping out as the result of a developing interaction between patient and therapist might lead to deeper understanding of why patients leave. To date, however, dropping out has not usually been construed and studied as the product of an interaction between patient and therapist which was not determined before treatment began (see Section 2.2.4.3). It has been discussed in terms of interaction but rarely has this discussion been translated into research designs which are capable of measuring the interaction.

2.1.4 Intervention

Finally, the aim of some drop-out studies has been to determine whether interventions to reduce dropping out are useful. Reports of even simple interventions are scarce (e.g., Chen, 1991; Pang et al., 1996), perhaps because dropping out itself is still so poorly understood that devising evidence-backed interventions is not possible. Furthermore, the studies which claim to investigate the effects of intervention do so in a retrospective or otherwise uncontrolled way, so these are difficult to assess (see Section 2.2.2.6). Intervention as a goal of drop-out research is unlikely to be realised until comprehension increases and prediction improves.

2.2 How has dropping out been studied?

What methods have researchers used to pursue these objectives in studying dropping out?

Methodology in drop-out research has suffered from bad timing. Some early ‘Rogerian’ studies appropriately conceptualised dropping out as a multi-determined
consequence of treatment interactions. Unfortunately, computation of the multivariate statistical procedures which could have analysed these data effectively was difficult. Since univariate analyses could not account for variables acting together, results were not promising. Furthermore, significant results were difficult to replicate, since many likely resulted from capitalisation on statistical chance. As the research focus turned in the 70’s to finding results that would be immediately clinically applicable, enthusiasm for true multivariate methods diminished. Nevertheless, drop-out research appears to require methods which can account for the interaction of several variables and changes over time in order to produce robust results. Technological resources which are available now can support these methods, and true multivariate analyses can be performed (cf. Fiester & Rudestam, 1975). This point will be expanded in this chapter and in Part 2 of this thesis.

In this section some representative methods for studying drop-out are reviewed. The methods are presented by topic according to whether the research primarily investigates the contributions of the patient, therapist, or the therapy process (Figure 2-1). Within each of these general topics, the defining features of particular methods are presented. The defining features are:

1. Who the informant is (patient, therapist, researcher, or archives).
2. The type of measure used (standard questionnaire, theoretically targeted questionnaire, other rating instrument, qualitative descriptions).

The variables explored with these methods are then listed. Most studies use a combination of these methods. The list is not exhaustive, but is intended to set the context for the experimental work which is discussed in Part 2. Overall findings are mentioned in order to illustrate methodological effectiveness. Finally, some limitations of these methods are explored.

The studies span a variety of treatment types, treatment populations, and theoretical models, though most investigate individual-oriented treatments and all are for non-psychotic mental disorders. This range is necessary for developing generalisations about drop-out research. What is more, in reviewing a broad spectrum of drop-out research, it becomes clear that the similarities between fields are more striking than the differences. While it is of limited use to review single, non-replicated studies when trying to draw conclusions about findings (Garfield, 1994), these studies typify those published on dropping out, so their methods, if not their individual findings, are reviewed.
2.2.1 **Note: Drop-out is distinct from outcome or 'patient progress'**

This review focuses on dropping out as distinct from outcome. There is some overlap between dropping out and the progress of patients, if only because those who remain in treatment are generally seen to do better on measures of outcome (Luborsky et al., 1971). However, dropping out and outcome are not synonymous. Predictors of dropping out differ from predictors of outcome (see: Frank et al., 1957; Fulkerston, 1961; Garfield, 1994; Kolb, Beutler, Davis, Crago, & Shanfield, 1985; Saltzman et al., 1976). In a similar vein, engagement is not simply an epiphenomenon of early gains in therapy (Horvath, 1994a).
## Summary of Chapter 2

*Methods Used and Results Found in Studying Dropping Out from Psychological Treatment*

<table>
<thead>
<tr>
<th>Informant</th>
<th>Type of Measure</th>
<th>Type of variable</th>
<th>Do overall results indicate any robust relationship with dropping out?</th>
<th>Discussed in Section:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. PATIENT AS TARGET OF DROP-OUT MODEL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Archive</td>
<td>Standard Intake or Standard Q’re or Projective Instrmt</td>
<td>Demographic &amp; Historical Information, ‘situational’ difficulties</td>
<td>No</td>
<td>2.2.2.1.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient approach to &amp; experience of clinics</td>
<td>No</td>
<td>2.2.2.1.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnosis / Symptom severity / level of psychological distress</td>
<td>No</td>
<td>2.2.2.1.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Psychopathological’ personality dimensions</td>
<td>No</td>
<td>2.2.2.1.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>‘Normal’ personality dimensions and intelligence</td>
<td>Interpersonal functioning</td>
<td>2.2.2.1.5</td>
</tr>
<tr>
<td>2 Patient</td>
<td>Theoretically Targeted Q’re</td>
<td>Personality / non-treatment-related behaviour</td>
<td>Interpersonal</td>
<td>2.2.2.2.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Therapist, therapy relationship, and therapy process</td>
<td>Active, trustworthy therapist relates to engagement</td>
<td>2.2.2.2.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expectations of therapy, ‘stages of change’</td>
<td>No</td>
<td>2.2.2.2.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self-predicted and actual performance within therapy</td>
<td>Self-predicted length of stay</td>
<td>2.2.2.2.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Improvement</td>
<td>No</td>
<td>2.2.2.2.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Satisfaction with therapy</td>
<td>Perhaps, though relationship not clear</td>
<td>2.2.2.2.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple domains</td>
<td>Combined circumstances, motivation, readiness, and suitability</td>
<td>2.2.2.2.7</td>
</tr>
<tr>
<td>3 Therapist</td>
<td>Ratings of ‘prognostic’ characteristics</td>
<td>Patient suitability or motivation for treatment</td>
<td>No</td>
<td>2.2.2.3.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient childhood relationships</td>
<td>Perhaps: poor early relationships may relate to drop-out</td>
<td>2.2.2.3.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prediction of patient compliance or engagement</td>
<td>No</td>
<td>2.2.2.3.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient involvement in therapy</td>
<td>No</td>
<td>2.2.2.3.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient improvement or ability to improve</td>
<td>No</td>
<td>2.2.2.3.5</td>
</tr>
<tr>
<td>Informant</td>
<td>Type of Measure</td>
<td>Type of variable</td>
<td>Do results indicate any robust relationship with dropping out?</td>
<td>Discussed in Section:</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------</td>
<td>------------------</td>
<td>---------------------------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>4 Researcher</td>
<td>Ratings of 'prognostic' characteristics</td>
<td>Patient involvement in, resistance to, and motivation for therapy</td>
<td>No</td>
<td>2.2.2.4.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient anxiety, hostility</td>
<td>No</td>
<td>2.2.2.4.2</td>
</tr>
<tr>
<td>5 Researcher</td>
<td>Qualitative description</td>
<td>Questionnaires and interviews about reasons for leaving treatment</td>
<td>Disliking or feeling disliked by therapist</td>
<td>2.2.2.5.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Case reports of drop-outs</td>
<td>N/A</td>
<td>2.2.2.5.2</td>
</tr>
<tr>
<td>6 Researcher</td>
<td>Intervention</td>
<td>Patient role induction</td>
<td>No</td>
<td>2.2.2.6.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduce waiting times</td>
<td>No</td>
<td>2.2.2.6.2</td>
</tr>
</tbody>
</table>

### 2. THERAPIST AS TARGET OF DROP-OUT MODEL

<table>
<thead>
<tr>
<th>Informant</th>
<th>Type of Measure</th>
<th>Type of variable</th>
<th>Do results indicate any robust relationship with dropping out?</th>
<th>Discussed in Section:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Archive</td>
<td>Pre-treatment characteristics</td>
<td>Demographic information</td>
<td>No</td>
<td>2.2.3.1.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Experience and theoretical orientation</td>
<td>No, though experience establishing relationships may be related.</td>
<td>2.2.3.1.2</td>
</tr>
<tr>
<td>2 Researcher</td>
<td>Ratings of within-treatment factors</td>
<td>Therapist personality or communication skills</td>
<td>Warmth related to engagement.</td>
<td>2.2.3.2.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Therapist’s level of activity</td>
<td>Active related to engagement.</td>
<td>2.2.3.2.2</td>
</tr>
<tr>
<td>3 Therapist</td>
<td>Expectancies regarding patient in treatment, attitudes toward patient</td>
<td>High level of interest in patient related to engagement.</td>
<td></td>
<td>2.2.3.2.3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Therapist ideas about how many and why patients drop out</td>
<td>N/A</td>
<td>2.2.3.2.4</td>
</tr>
</tbody>
</table>

### 3. TREATMENT/PROCESS AS TARGET OF DROP-OUT MODEL

<table>
<thead>
<tr>
<th>Informant</th>
<th>Type of Measure</th>
<th>Type of variable</th>
<th>Do results indicate any robust relationship with dropping out?</th>
<th>Discussed in Section:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Archive</td>
<td></td>
<td>Time-limited and time-unlimited treatments</td>
<td>No, but way structure is presented to patient may be related to drop-out.</td>
<td>2.2.4.2</td>
</tr>
<tr>
<td>2 Participant or researcher</td>
<td>Observations of or feelings about interaction</td>
<td>Patient-therapist interaction</td>
<td>Low respect, felt security, reciprocity may be related to drop-out. Drop-out relationships deteriorate over time.</td>
<td>2.2.4.3</td>
</tr>
</tbody>
</table>
2.2.2 Studying the patient’s contribution

The desire to be able to predict who will leave treatment and the limitation of resources available for research have heavily influenced which methods and variables have been used to study dropping out. Although there is a myriad of methods that could be used to study dropping out, the vast majority of research has investigated patient pre-treatment characteristics in isolation. One methodologically justifiable reason for this emphasis could be that, since it is patients who appear to do the dropping out, their qualities should be the ones investigated. Several non-methodological explanations are possible as well:

1. Using data which have already been gathered at assessment for diagnostic, audit, or general research purposes would appear to be economical.
2. Drop-outs have by definition ceased contact with the clinic and therefore are more costly to follow up.
3. It is potentially more invasive to study an on-going relationship, which might compromise the treatment relationship (and, granted, by extension the validity of the study).
4. Researchers are often also clinicians and might be more likely to endorse the self-justificatory view that drop-outs are fundamentally different from those who remain in treatment.

The patient’s contribution is most often assessed using simple research designs investigating case notes or questionnaires administered before treatment. Slightly more complex designs, involving therapist or researcher ratings, are also frequently used. Methods used to investigate the patient’s contribution to dropping out are discussed in Sections 2.2.2.1-2.2.2.5 below.

2.2.2.1 Archived pre-treatment characteristics

A retrospective, case-note design is often used to review information gathered at assessment for diagnostic, clinical, or general research purposes (recent examples from a range of treatment areas include (Gillis, Russell, & Busby, 1997; Hillis, Alexander, & Eagles, 1993; Ross, Cutler, & Sklar, 1997; Snowden, Storey, & Clancey, 1989). Demographic and clinical variables are almost invariably at the heart of these
investigations. Other items tend to be focused on intra-personal dimensions which are assessed using self-report measures. Despite the importance of interpersonal dimensions to the establishment of a therapeutic relationship, these are not usually considered in this type of study. When they are, patient self-report instruments of personality traits are used rather than state measurements of the patient’s ability to cope within the treatment relationship.

In most reports, subjects are divided into completers or drop-outs using some criterion, such as the number of sessions attended. The groups are then compared using more or less sophisticated statistical procedures, typically univariate or regression techniques. These methods and variables have revealed vanishingly few replicable predictors of dropping out, even when enormous sample sizes (e.g. 3,240, Pekarik & Zimmer, 1992) have been studied. These types of studies have examined the following variables in terms of their relationship to dropping out.

2.2.2.1.1 Demographic and historical information, situational difficulties.

Many studies have taken demographic and historical information taken from case records. These data include age, sex, marital status, usually some measure of socio-economic status (either a composite measure such as the Hollingshead (e.g., Fiester & Rudestam, 1975), or its individual components (level of education, occupation), employment status as a measure of ‘social exclusion’, occasionally race, more rarely religion, and previous experience of psychiatric treatment13.

The only variable whose relationship with dropping out has been at least informally replicated is socio-economic status (SES), especially when a composite measure is used (Baekeland & Lundwall, 1975; Garfield, 1994; Reis & Brown, 1999). This relationship is not entirely clear and depends on the statistical methods used to analyse it, but there is a suggestion that those who are in the lowest SES group (Hollingshead Class 5) are less likely to complete treatment (Hillis et al., 1993), particularly when it is long-term psychoanalytic treatment (Fiester & Rudestam, 1975).

It is difficult to assess this finding, because these patients are also less often considered to be ‘suitable’ for such treatment (e.g., Reder & Tyson, 1980), or less

---

13 This is sometimes interpreted as an indicator of severity. Only when statistical techniques could analyse it in combination with other indicators of severity could this assumption be made. These studies do not usually use any such analysis (see for example, (Connelly et al., 1986; Gunderson et al., 1989)).
"attractive" to therapists (e.g., Garfield, 1994). In one study of a public clinic, therapists with more experience in establishing therapeutic relationships were able to retain more low-SES patients than those with less experience (Baum et al., 1966), so the effect of socio-economic level might be due to some therapists being less skilled at engaging these patients. Furthermore, the correlation of race and SES might explain the significant relationship occasionally found between race and dropping out (Snowden et al., 1989). Other correlates of low SES, such as situational difficulties arising from financial problems, are not related to higher drop-out (see next).

Situational difficulties, such as problems arranging time off work, child care, or transportation, have been measured by questionnaire and interview, both before and after treatment. Objective measures of job type, financial resources, marital and parent status do not differ between the groups (Pekarik, 1983a). However, when drop-outs are interviewed they will often give "situational" reasons to explain their leaving, perhaps in order to avoid confrontation with the clinician. This may explain the continuing impression that drop-outs have greater situational difficulties than engagers.

2.2.2.1.2 Patient approach to and experience of clinics

Many studies have included clinic information from case records, such as source of referral, waiting times, presence of a telephone reminder (Chen, 1991; Pang et al., 1996; Stasiewicz & Stalker, 1999), and distance travelled to clinic (e.g., Festinger, Lamb, Kountz, Kirby, & Marlowe, 1995; Dozel cited in Frank et al., 1957). One study suggested that giving appointments within a day of receiving the referral might reduce dropping out, but beyond this "microscopic" level, waiting times had no impact (Festinger et al., 1995). No reliable relationship has been found between these variables and dropping out, even when very large samples have been used (Pekarik & Zimmer, 1992).

2.2.2.1.3 Diagnosis/ symptom severity/ level of psychological distress

Depending on the field, diagnosis and symptom severity are taken from the initial assessment interviews with clinicians, ratings made by clinicians (such as the GAS; Priola, 1999; Snowden et al., 1989) or from questionnaires. Level of psychological distress is measured with self-report checklists, such as the SCL-90, or is determined during initial interviews with clinicians. Studies have also examined the presence of deliberate self harm and suicidal behaviour as determined by questionnaire (e.g., Gunderson et al., 1989). The difficulty of comparing clinical and questionnaire-derived
diagnoses and severity ratings notwithstanding, there is no consistent evidence that within a given field either diagnosis or symptom severity (whether clinician- or self-reported) are related to dropping out (Garfield, 1994; Ross et al., 1997). There is overall evidence that those with severe alcohol problems and those who self-harm more are less likely to engage (Baekeland & Lundwall, 1975; Hillis et al., 1993), though these generalisations are not always supported (e.g., Craig & Olson, 1988).

2.2.2.1.4 'Psychopathological' personality and severe mood dimensions

'Psychopathological' personality dimensions are assessed using questionnaires such as the Minnesota Multiphasic Personality Inventory (MMPI; DuBrin & Zastowny, 1988; Hilsenroth, Handler, Toman, & Padawer, 1995; Roffe, 1981; Wolff, 1967), the Millon Clinical Multiaxial Inventory (MCMI; Craig, 1984; Hamberger & Hastings, 1989), the Personal Inventory (PI; Rubinstein & Lorr, 1956), the Eysenck Personality Inventory (EPI; Hunt & Andrews, 1992; Kolb et al., 1985), or from projective techniques, such as the Rorschach (e.g., Kotkov & Meadow, 1953), though these have been less commonly used in recent years (cf. Hilsenroth et al., 1995). Usually these questionnaires have been gathered as part of the standard assessment suite, but occasionally they have been used specifically for predicting dropping out (e.g., DuBrin & Zastowny, 1988), but the overall lack of positive results is not affected when they are used prospectively. Borderline personality disorder as diagnosed by clinicians has also been examined but shows no consistent relationship with dropping out (Gillis et al., 1997).

In early drop-out research, it was observed that drop-outs admitted to less anxiety or depression at the beginning of treatment than did remainers (Frank et al., 1957; Kotkov & Meadow, 1953; Lorr et al., 1958), though in one study this effect was found only for women (Wolff, 1967). These results were interpreted as evidence of drop-outs having higher socio-pathological features (DuBrin & Zastowny, 1988). However, it is unclear whether dislike of drop-outs influenced the variables which were chosen for examination in these studies and the way in which they were analysed (see Section 2.2.3.2.3). More recent studies have failed to replicate the association between dropping out and low anxiety and depression (Craig, 1984; Garfield, 1994). It is thought that their results might be confounded with social class (Stern, Moore, & Gross, 1975).
2.2.2.1.5 'Normal' personality dimensions and intelligence

This section has been placed here, and not under the next heading, ‘theoretically targeted questionnaires’, only after debate. Investigating ‘normal’ personality dimensions would be more theoretically appropriate to drop-out research for several reasons:

1. They might vary in response to interactions in the early stages of a treatment relationship more than personality disorders.

2. Since these dimensions are less indicative of psychopathology, they might be less confounded with the type of treatment given.

3. Therapists may allow themselves to react in a more flexible way to variations in normal dimensions, whereas they are likely to have been formally schooled in handling the ‘psychopathological’ personality dimensions.

These data are also less commonly gathered on people who are being assessed for the role of patient, so the studies which discuss them stand out from most archival studies. But in the end this section was placed here because the majority of studies looking at these data gathered them only at the assessment stage as part of the regular protocol. Thus the underlying research methods more closely resembled the archival studies.

Aspects investigated include mood states (Oei & Kazmierczak, 1997)\(^\text{14}\)(from the self-report Profile of Mood States used in Connelly et al., 1986), locus of control (Hunt & Andrews, 1992; Jones, 1985; Kolb et al., 1985), attributional style (Palmer, Palmer, & Williamson, 1995), self-descriptive adjective checklists (Craig & Olson, 1988). Studies have also investigated interpersonal functioning using questionnaires such as Interpersonal Behaviour Scale (Connelly et al., 1986), Inventory of Interpersonal Problems (IIP)(Horowitz, Rosenberg, & Bartholomew, 1993), or self-report dimensions measuring social relationships (Saltzman et al., 1976), friendliness (DuBrin & Zastowny, 1988), or social isolation (Miller, Pokorny, & Hanson, 1968). Intelligence has also been assessed with the Wechsler scales and with vocabulary tests (Rubinstein & Lorr, 1956). Only interpersonal functioning has repeatedly shown a consistent relationship with dropping out.

---

\(^{14}\) It is unclear in this study of treatment for depression whether measuring mood states daily was meant to indicate severity of illness or personality variations. The study also used the Beck Depression and Hopelessness Inventories, presumably to assess severity of symptoms.
Interpersonal functioning is clearly an important area to consider in evaluating treatment engagement, which is itself an interpersonal process. Horowitz et al. (1993) point out that interpersonal problems are also a primary reason patients seek treatment. Unfortunately, most studies that consider the relationship between interpersonal functioning and therapy focus on outcome of therapy as affected by the therapeutic alliance (e.g., Bordin, 1994; Horvath & Luborsky, 1993; Luborsky, 1994) and not on engagement in treatment. When interpersonal functioning is compared to engagement, it is often regarded as part of the clinical symptom severity spectrum, such as BPD, rather than as a style which could influence the therapeutic relationship (e.g., Connelly et al., 1986; Gunderson et al., 1989). In this context differences have not been found, perhaps also because of the univariate approach often taken to data analysis.

However, some study designers have drawn a logical parallel between the ability to establish informal supportive relationships in adulthood and the ability to establish formal ones (e.g., Cross & Warren, 1984; Lovaglia & Matano, 1994). Interpersonal functioning as operationalised by these studies has been statistically related to dropping out. Adult interpersonal relating has also been operationalised as 'social life', a measure of the quantity and depth of relationships and membership in organised groups, and this was also positively related to engagement (Frank et al., 1957).

Surprisingly, interpersonal relating in childhood, as expressed in object relations for example, has not been studied in terms of its ability to predict dropping out, though this would be likely to have a different relationship with dropping out than adult measures of social support or interpersonal comfort/distress. Piper and colleagues (1991) have pointed out that relationships considered over the lifespan might indicate stable, characterological aspects of the patient, as opposed to current interpersonal relationships, which might be more changeable. Measuring characterological aspects of the patient's interpersonal functioning would be appropriate when assessing patient background, but measuring current functioning might be more appropriate when trying to assess changes during treatment.

2.2.2.2 Theoretically targeted questionnaires

Rising a level of complexity in design, the next group of studies use theoretically targeted questionnaires to assess patient characteristics which might not be covered in the assessment or general research protocols. Many of the characteristics assessed are still essentially 'pre-treatment' characteristics. However, a theoretically driven design
distinguishes these studies from those discussed above, even when other aspects remain the same. The theoretical formulation indicates a desire to comprehend the mechanisms underlying dropping out running alongside a primary aim of predicting dropping out. These studies, however, are limited by the fact that the material covered is based on impressions held by clinicians and researchers about dropping out, not on reasons patients themselves have supplied for dropping out. This viewpoint may be partly responsible for the lack of significant findings, since clinicians and researchers may not have access to patients’ real reasons for leaving treatment.

Depending on their content, theoretically targeted questionnaires are usually administered to patients at intake or after the first therapy session. Such is the case with personality and expectations-of-therapy questionnaires. Questionnaires that reflect on therapeutic process or the helping alliance are often administered retrospectively. Obviously, waiting until a number of sessions have passed can be a problem in drop-out research, because many patients have left by this point (e.g., DuBrin & Zastowny, 1988). Occasionally questionnaires are re-administered after discharge, but interpreting these studies as drop-out research can be difficult because many drop-outs cannot be contacted after discharge. Furthermore, these studies aim more to assess outcome than drop-out factors (e.g., Pekarik, 1992a).

These studies fall into 7 main categories. The first three use patient responses as signs of the patient’s comfort in or suitability for treatment. The fourth uses a direct approach to determining how many sessions a patient will attend by asking the patient to predict a number. Two others use patient interpretations of their own outcome. The last uses a sophisticated design covering multiple patient domains to assess the likelihood of dropping out.

2.2.2.2.1 Personality / non-treatment-related interpersonal behaviour

The most common theoretically targeted questionnaires have been derived from existing scales. MMPI derivatives, such as the ‘TRT’ (presumably ‘treatment’; Chisholm, Crowther, & Ben-Porath, 1997; Munley & Busby, 1994) and ‘AMA’ (presumably ‘against medical advice’; Doweiko, 1989) subscales, have frequently been tested, and have fared no better than the entire MMPI in predicting dropping out. Sometimes these measures have been combined with other factors felt to be relevant to treatment success (though not necessarily engagement) within psychological treatment. These include vocabulary and intelligence tests and self-discrepancy ratings of actual and ideal selves.
(e.g., Lorr et al., 1958; McNair et al., 1963; Munley & Busby, 1994). The predictive ability of these scales has not been replicated (Doweiko, 1989; Kelner, 1982). Perhaps as a result, MMPI-based drop-out research has waned in popularity. Recently, the Treatment Rejection Scale of the Personality Assessment Inventory has been used to predict dropping out, but without success (Everson, 1999).

More recently, the IIP has been employed effectively in predicting dropping out. In one study, IIPs completed at intake by patients were factor-analysed to select dimensions which distinguished between drop-outs and remainers. Logistic regression of the new scale on an independent sample of 98 patients was then used to predict engagement status (Lovaglia & Matano, 1994), with accurate prediction far exceeding chance. This supports the view expressed above that measuring interpersonal problem behaviours might hold promise in predicting dropping out.

2.2.2.2 Therapist, therapy relationship, and therapy process

The patient's views of the therapist, the therapy relationship, and therapy process are often assessed with questionnaires administered retrospectively. Some studies administer questionnaires during treatment (e.g., Orlinsky and Howard's Therapy Session Report; Fiester, 1977), or after the first session (e.g., Beckham, 1992). Interviews are not commonly used, and no studies in which the patient has been interviewed while still in treatment are known. It is surprising that, given the intense interest in the relationship between the therapeutic alliance and outcome, alliance measures have so rarely been used to assess the relationship with engagement. This is discussed further in Section 2.2.4.3.

The patient's perceptions and feelings about the therapist (e.g., Hynan, 1990), his or her 'source' characteristics (e.g., McNeill, May, & Lee, 1987), and the confidence levels inspired by the therapist and therapy (e.g., McGuff, Gitlin, & Enderlin, 1996) have been assessed by questionnaire. The patient's view of the alliance established with the assessor has also been assessed with a questionnaire (Luborsky's Helping Alliance Questionnaire in Mohl, Martinez, Ticknor, Huang, & Cordell, 1991). A semantic differential task has been completed by patients about their assessors (Mohl et al., 1991). Finally, patients' views of therapists' facilitative skills have been derived from the Barrett-Lennard Relationship Inventory (Beckham, 1992; Kolb et al., 1985). Overall, clinicians who inspire more confidence about the helpfulness of therapy and who are perceived as more helpful, active, trustworthy, expert and 'potent', are more likely to retain patients in treatment. Technical details, such as assigning the patient for therapy with the clinician
who has assessed him, appear to have no effect on retention rates (Gottheil, Sterling, Weinstein, & Kurtz, 1994).

In an unusual study which took measurements from patients after each session, Fiester and Rudestam (1975) used a modified version of the Therapy Session Report (Orlinsky and Howard, cited in Fiester & Rudestam, 1975) to ask about the quality or goodness of the first session, the patients' feelings about self and therapist, and the participation in treatment and motivation of patients and therapists. The results indicated that drop-outs had more 'successful' first sessions than did engagers, finding their therapists more warm, helpful, affectionate and serious and seeing themselves as more attentive to what the therapist was trying to get across, though they reported feeling angrier and talked less about their attitudes or feelings toward the therapist. It is possible that both patient and therapist worked harder to overcome this anger and lack of communication, or perhaps drop-out patients tried harder to engage in the therapy relationship when they sensed that they were not comfortable with the therapist. It would have been interesting to measure a later session to see whether the views of drop-outs became less rosy as time passed.

In a later study Fiester (1977) found that the therapy process as perceived by the patients of therapists who had a high level of early drop-out differed from the process perceived by patients of therapists with low levels of drop-out. Frustratingly, this report did not specify in what ways the perceptions were different. However, the method of taking repeated measurements of the therapy interaction holds promise for unveiling the mechanisms that affect the decision to drop out of treatment. Comparing patient and therapist views would have been useful. It would be improved by combining these measurements with those taken from the therapist (Section 2.2.4.3).

2.2.2.2.3 Expectations of therapy, 'Stages of change'

The relationship between patient expectations of therapy and dropping out has been assessed at pre-treatment with questionnaire. Results are conflicting, probably because the 'expectations' asked about differ. Published reports often do not specify how these are defined, but in cases where definitions are given, they typically include expectations of the patient's and therapist's role or expectations concerning the amount of improvement in treatment. These do not appear to be consistently related to dropping out (e.g., Beckham, 1992; Fiester, 1977; Garfield, Affleck, & Muffly, 1963; Heine & Trosman, 1960; Zisook, Hammond, Jaffe, & Gammon, 1979).
Recently one study predicted dropping out with a measure derived from the transtheoretical model of change which assessed the patient’s ‘stage of change’ upon entry to treatment (Brogan, Prochaska, & Prochaska, 1999). The stages concern how prepared and active a patient is regarding changing behaviours. If the finding is replicable, it would seem to be more appropriate to use the information gleaned from this questionnaire as a topic of work within therapy, rather than simply as a predictor of therapy ending. Its use as a predictor of drop-out needs replication in diverse fields of psychotherapy.

2.2.2.4 Predicted and actual performance within therapy

A direct approach has also been taken to predicting dropping out. This approach involves asking patients to predict how long they will remain in treatment (Beck et al., 1987; Fraps, McReynolds, Beck, & Heisler, 1982; Zisook et al., 1979) or how many sessions they expect to attend (Pekarik, 1985). These predictions are usually measured before treatment begins or after the first assessment session.

Patients’ self-predictions of length of stay have proven possible predictors of dropping out (Fraps et al., 1982; Pekarik, 1985), but these approaches have problems. Ethically, can they be used if there is a chance that patients feel that they have to leave treatment when they predicted they would? Practically, are they useful if instrument sensitivity is low? In order to achieve a reliable level of prediction, some studies have re-coded information so that only those patients scoring at a very high level are predicted to leave (Fraps et al., 1982). These instruments might be most useful when used with other predictors.

2.2.2.5 Improvement

In a related vein, patients’ perceptions of outcome or improvement have been investigated in relation to dropping out (e.g., Pekarik, 1992a; Priola, 1999). These have usually been analysed by using symptom-focused questionnaires administered after treatment termination, though sometimes these are given shortly after the beginning of treatment. Measurements of symptomatic improvement do not appear to be consistently related to retention in treatment (Kolb et al., 1985; Priola, 1999). This could indicate either that those who did not improve had dropped out by the time the measurement was taken, or that engagement and outcome are distinct phenomena.

Following up drop-outs can be difficult, so rating symptom or other improvement from the patient perspective is not always feasible. There are several other problems
associated with trying to combine outcome and drop-out investigations. Patient ratings, as opposed to clinician assessments of improvement, have potential drawbacks. Patients may rate themselves as ‘improved’ if they feel this might impact on their immediate or future treatment or on the feelings of their therapist. Comparison of ratings may also be difficult across patients because they may not use the same criteria as clinicians or as other patients for assessing improvement. On the other hand, clinicians are trained to make balanced diagnostic judgements that questionnaires cannot achieve. But using ratings from the clinician only may not be the answer either. The clinician will not necessarily remember accurately the patient’s state at the beginning of treatment because time and feelings about the patient may affect memory. A standardised measure administered at beginning and end of treatment could allow for an ‘unbiased’ change score, but drop-outs might then be missed.

2.2.2.2.6 Satisfaction with therapy

Satisfaction with therapy has been assessed using set questionnaires and open-ended questions administered after the end of treatment. Studying patient satisfaction has a number of familiar problems. The operationalisation of ‘satisfaction’ varies between studies; therefore, it is not possible to say that one phenomenon is being measured. Often the definition of ‘satisfaction’ is subsumed under the patient’s perception of progress in treatment, even though satisfaction may not be correlated with progress in terms of symptom change. Furthermore, there may be a confounding effect in retrospective assessment of satisfaction, especially if the patient feels defensive about having left.

However, those who drop out frequently do report lower satisfaction with therapy or the therapist (McNeill et al., 1987; Priola, 1999; Zisook et al., 1979), but this relationship is not simple. Satisfying the patient does not seem to be directly related to giving them what they request at the beginning of treatment; rather, it appears to be related to acknowledging what they have requested and negotiating a mutually agreeable plan for treatment (Zisook, Hammond, Jaffe, & Lloyd, 1980). Satisfaction has been proposed as a mediator between patient perception of therapist characteristics and dropping out (Kokotovic & Tracey, 1987) (See Chapter 8).

2.2.2.2.7 Multiple domains

Finally, some measures have been developed to assess multiple domains thought to be relevant to engagement. A successful measure, the Circumstance, Motivation,
Readiness, and Suitability Questionnaire, was developed from interviews with completed, engaged, and new patients concerning their views of the factors that contributed to their entering and remaining in treatment in a drug-rehabilitation therapeutic community (CMRS)(De Leon, Melnick, Kressel, & Jainchill, 1994). ‘Circumstances’ are the external conditions, actual or feared, which influenced people to seek treatment. ‘Motivation’ is the patient’s positive and negative inner reasons for change. ‘Readiness’ and ‘suitability’ refer to the patient’s perception of his own need for treatment in general and the clinic in particular. In a double cross-validation of the CMRS, prediction of short-term treatment retention was good. Its ability to predict longer-term retention was not as good, but this may be because a measurement taken of the patient at assessment no longer reflects his CMRS later on. Indeed, one would expect participating in treatment to have this effect. Furthermore, once the patient is in treatment, one would expect the therapist views of the patient to contribute to predicting his stay. It is not clear how generalisable this instrument would be for non-residential treatments.

The greater stability of the CMRS compared to the patient measures discussed earlier in this Section might result from its unique design. It was developed solely for predicting dropping out, and so could use an appropriate theoretical model which gives weight to dynamic factors affecting treatment retention. Its designers also sought the views of the patients themselves when developing items, and validated the measure.

Another, unnamed instrument that was developed to assess the supports and stressors acting on the new patient has not shown good predictive power, perhaps because items were not derived from the patients’ responses (Cross & Warren, 1984). The items were therefore more factual, concerning amount of support, than they were perceptual. Validation of the questionnaire was not reported. Theoretically, however, asking about supports and stressors has merit.

2.2.2.3 Therapist ratings of ‘prognostic’ characteristics

In this set of studies, patient characteristics that are considered to be prognostic of engagement are rated by clinicians, usually by completing a set form. Although the characteristics rated can overlap with those gathered from case notes, usually therapist ratings are employed in order to tap more subjective dimensions thought to affect engagement, such as therapist impressions of the patient’s ability to improve with treatment. A criticism of these studies is that many of these dimensions are more
appropriate to outcome studies. That said, they have a theoretical basis which distinguishes them from the ‘fishing’ archival studies.

The aim of these studies is most often to predict dropping out, which determines the methods of data selection, acquisition, and analysis. The items which clinicians are asked to rate are not empirically derived, and there is little attention given to understanding the patient’s decision to leave.

As with the patient ratings, the timing of the therapist ratings depends on their content, but generally ratings are made at first patient contact. Despite their potential complexity, these studies are frequently analysed with univariate techniques.

2.2.2.3.1 Patient suitability or motivation for treatment

Selection of patients by suitability or ‘motivation’ for treatment has traditionally been the preserve of psychoanalytically oriented psychotherapy; however, this practice has spread to other disciplines where demand for services exceeds supply. These ratings are usually made on the strength of one session. Often they are analysed as a single variable, though they may be a composite of many judgements about the patient’s personal and clinical background, personality, and intelligence. In one case these elements were individually listed in a questionnaire (Frayn, 1992). Such ratings have proven of little value in predicting engagement (Burnham cited in Brandt, 1965; Lorr et al., 1958; McNair et al., 1963).

In the few studies where significant differences have been found, results are difficult to interpret due to methodological difficulties. In one study, ratings were made by different people (therapist or the therapist’s supervisor) at different times (beginning or end of treatment) about items such as therapist’s alliance, patient’s alliance, patient motivation, and other value-laden dimensions (Frayn, 1992). No efforts were made to control for the confounds inherent in the design.

Despite such problematic designs and inconclusive results, low motivation, for example, remains a popular explanation for patient drop-out. The study of motivation may suffer from the same design flaws as the study of dropping out. Motivation may not be a fixed entity and may be heavily influenced by the quality of the therapeutic relationship. Motivational enhancement, used as an intervention, is discussed in Section 2.2.2.2.6.
2.2.2.3.2 Childhood relationships

Few studies consider the relationship between the quality of patients' childhood relationships and early treatment engagement. This area would seem potentially useful for tapping into characterological aspects of forming relationships (see Chapters 5 & 6). When the quality of childhood relationships has been considered, therapist ratings of information disclosed within treatment have generally been used. Methodological problems hamper interpretation of one study, which found that aversive childhood experiences were related to dropping out (Frayn, 1992). However, another study using an earlier version of the same instrument found similar results (Frank et al., 1957). Replication of results points toward the potential importance of early relationships to the establishment of therapeutic ones in adulthood, at least as these are rated by clinicians.

2.2.2.3.3 Prediction of patient compliance or engagement

As with patient self-predictions, therapist predictions of patient engagement are usually asked for directly by the interviewer or by questionnaire (for example, 'How many sessions do you think this patient will attend?'). When these predictions are analysed in isolation, their accuracy usually barely exceeds chance alone (Beck et al., 1987; Heisler, Beck, Fraps, & McReynolds, 1977; Sackett & Haynes, 1976), although this may not be the case in family therapy (Bischoff & Sprenkle, 1993). Therapists' ability to predict patient attendance does not improve with therapists' years of experience or training (Affleck & Garfield, 1961; Mushlin & Appel, 1977), nor when the therapists are very certain about their ratings (Mushlin & Appel, 1977). The predictive ability of therapist ratings rises when similar ratings made by patients are taken into account (Beck et al., 1987).

Nevertheless, many therapists talk about sensing who will leave treatment (Mahon, in preparation), so perhaps the rating method is flawed. Ratings are usually asked for after only one meeting with the patient, which may be too early to make accurate assessments. Or perhaps therapists attend to theoretical rather than interpersonal cues when making these ratings, and so do not pick up on patient cues (see Chapter 9 for differences in patient and therapist frames of reference). It may also be the case that patients 'fake good' when considering leaving treatment in order to avoid confrontation with therapists (see Chapter 8).
As with patient self-predictions, there may be ethical concerns when using therapist predictions to monitor dropping out. Therapists might make fewer efforts with these patients once they have committed to a prediction.

2.2.2.3.4 Patient involvement

Therapist ratings of patient involvement have been measured by questionnaires administered retrospectively. In one study, patient improvement proved to be strongly related to outcome variables, however its relationship to dropping out was not directly analysed (Kolb et al., 1985). In another study, therapist ratings of patient behaviour in the first session were predictive of dropping out only when extreme responses were used (such as ‘patient not at all interested in what therapist was saying’; Heisler et al., 1977). It may not be possible for therapists accurately to rate the involvement of patients because they are so deeply immersed in the interaction themselves. Certainly, their ratings will be heavily influenced by their own feelings about the patient. Combining therapist ratings with patient ratings, or using independent researcher ratings, may allow better prediction of engagement (see Section 2.2.2.4.1).

2.2.2.3.5 Patient improvement or ability to improve

Therapist ratings of patient improvement or ability to improve are either taken after treatment has ended (e.g., Kolb et al., 1985; Pekarik & Finney-Owen, 1987) or early in treatment (e.g., Connelly et al., 1986; Saltzman et al., 1976). Ratings of ‘improvement’ are usually restricted to the presenting complaint (e.g., Pekarik & Finney-Owen, 1987), although some studies look at global psychological improvement (e.g., Kolb et al., 1985) or have attempted a more over-arching evaluation of the patient’s state (Saltzman et al., 1976). None has looked at improvement in the areas that patients have specified as being important to them, which might be more important than global ratings in measuring outcome (Luborsky et al., 1971) and in predicting engagement.

The theoretical basis for this enquiry is to see whether patients who improve more (at least as defined by their therapists, which may or may not relate to their own definition or to an objective definition) are more likely to tolerate the difficulties involved in coming for treatment. Results indicate that overall therapists think that drop-outs will do or have done less well (Connelly et al., 1986; Kolb et al., 1985). Interpreting these findings is difficult. Therapists report that they like drop-outs less well (Lothstein, 1978; Louks, Mason, & Backus, 1989) and feel they are less ‘significant’ than other patients.
(Connelly et al., 1986), which may affect not only their rating of drop-outs’ ability to improve but also their commitment to helping them to improve. Indeed, as this review reports, the majority of research on dropping out indicates that drop outs are viewed as unlikeable and unable to benefit from treatment, despite evidence that outcome and engagement are not governed by the same variables (Luborsky et al., 1971). Thus, while it is likely that dropping out is related to fewer therapeutic gains, the direction of causation is unclear. The objectivity of such therapist ratings may be called into question by the finding that therapists rated drop-outs as significantly less improved than engagers, even when standardised self-report measurements of improvement could not distinguish the two groups (Kolb et al., 1985).

It could be argued that this subsection really belongs under the ‘therapist as target of drop-out model’ topic heading, since the therapists’ ratings might express more about their own feelings than the patient’s condition. However, studies have not analysed the information in this way. Certainly the direction of causality when interpreting these therapist ratings and dropping out should be assessed cautiously.

2.2.2.4 Researcher rating of patient characteristics

Researcher ratings of patient characteristics are employed to achieve greater objectivity in ratings.\(^{15}\) They often take advantage of more sophisticated research methods, such as repeated sampling of tape-recorded session content or process connected to the patient. These studies concentrate more on understanding therapeutic processes than other patient-focused studies. However, several of these studies analyse patient factors in isolation, and so are not full ‘interaction’ studies. These studies often are imbedded in studies of outcome, so their choice of variables is restricted.

2.2.2.4.1 Patient involvement in, resistance to, and motivation for therapy

Content or process analysis of patient within-treatment characteristics might illuminate the developing decision to drop out. One study of group treatment has used process analysis of audiotaped early sessions (Connelly et al., 1986). Researchers rated the level of patient involvement in the therapeutic ‘work’ (meaning any attempts to

\(^{15}\)Although the usefulness of these objective ratings has been questioned in outcome studies. In studies of the predictive ability of the Working Alliance Inventory, it was found that researcher ratings were the less predictive of eventual outcome rating than were patient ratings, perhaps because reserachers did not have access to the internal state of the patient (Horvath, 1994a).
recognise, understand, and modify a problem raised in the group or the conditions that maintain it). Curiously, drop-outs were rated as working more than those who remained in the group, though they were also rated as being less well-liked by the other members of the group and by the therapists. The authors speculate that their work might have been experienced as intrusiveness (this finding is consistent with process studies; see Section 2.2.4.3). This result also recalls the finding reported in Section 2.2.2.2.2 that drop-outs reported more ‘successful’ first sessions than engagers, rating the therapist as more warm and themselves as more attentive to the therapist (Fiester & Rudestam, 1975). Since patient involvement is not a fixed variable (Henry & Strupp, 1994), investigating differences between drop-outs and engagers in the development of involvement might clarify its relevance to dropping out.

Patient resistance to and motivation for treatment has been analysed as within-treatment variables from tape-recorded session segments and has not been found to be lower in drop-outs (Hartley and Strupp, 1983; cited in Henry & Strupp, 1994).

2.2.2.4.2 Patient anxiety, hostility

Patient anxiety and hostility were analysed in the Hartley and Strupp study cited above. Drop-outs were not found to differ from completers. Assessing anxiety and hostility within session would seem more relevant to understanding dropping out than assessing pre-treatment characteristics via self-report or admission assessment.

2.2.2.5 Researcher qualitative description of patients’ reasons for leaving

Qualitative work is necessary to deepen understanding of the processes affecting dropping out and to generate hypotheses for further testing. Qualitative techniques which have been developed over the last decades are starting to be applied to these tasks. These have generally focused on patient informants.

2.2.2.5.1 Questionnaires and interviews

Several studies have given interviews or questionnaires to patients who have left (Buhrmaster, Hartman, Menefee, Shores, & Rogers, 1982; Gunderson et al., 1989; Petersen, 1999) to learn about dropping out. Even when directly approaching patients to ask their reasons for leaving, study method may affect results. The conditions under which the drop-out is interviewed or the type of questionnaire used are likely to affect the reasons given for dropping out. For example, two studies of drop-outs used telephone interviews conducted by clinicians (Pang et al., 1996; Silverman & Beech, 1979). The
majority of the drop-outs reported that they left because they had recovered, and that they were satisfied with the treatment they had received, but these results do not fit with other ‘objective’ follow-up information about drop-outs (e.g., Pekarik, 1983a). Participants may simply have given reasons that would not seem confrontational or offensive. Certainly this appeared to be the case in an early interview study (Garfield, 1963) where drop-outs listed mainly ‘external’, situational reasons for leaving.

Other studies which have used less confrontational methods have found feeling disliked by the therapist, dislike of the therapist, or perceiving no benefit from therapy to be more important reasons for dropping out (Acosta, 1980; Bein et al., 2000; Kokotovic & Tracey, 1987; McNeill et al., 1987; Pekarik & Finney-Owen, 1987; Petersen, 1999). One recent study interviewed many of the people involved in the care of the patient (general practitioners and hospital staff) as well as drop outs themselves and found that inefficient administration and lack of communication about the importance of further appointments to be the most important reasons for these drop-outs (Mason, 1992). Thus these less confrontational methods seem to produce different results.

Other methodological problems have occurred even in studies which have tried to minimise the elements of confrontation. For example, one study used home interviews with 8 drop-outs and remainers. It compared these to case-note remarks entered by their clinicians, revealed that drop-outs’ expectations of treatment differed from their clinicians’, whereas the engagers’ expectations were congruent (Borghi, 1968). Comparing therapist and patient views is potentially useful for understanding the mechanisms behind dropping out. However, no control was made in the design for the tendency of patient and therapist views to converge over time; some patients had had very little time with their therapists, while others had had a great deal. This effect was potentially compounded by the fact that patient expectations were retrospectively gathered, whereas therapist expectations were assessed from case notes taken in the early days of treatment. Even in this study aimed at comprehension, negative assumptions about drop-outs might have affected the interpretation of results. The author does not explore some salient points, such as the drop-outs’ clinicians not acknowledging the expectations that the patients had expressed in treatment, which is perhaps important for understanding dropping out. Even when the interviewees were described as feeling ‘defensive’ about their dropping out, the interview questions used were short and direct.
This method of questioning might not elicit full responses, even when the interview is conducted on the drop-out’s own ‘turf’.

While it is undoubtedly valuable to ask patients why they have left, existing qualitative studies have several limitations:

1. The measures are often given only to drop outs and not to engagers, so it is difficult to determine whether expectations of or reactions to treatment are unique to those who drop out.

2. Research designs are not prospective, so self-justificatory processes might affect interview content, especially if interviews do not encourage patients to remember contextual details of their experiences while in treatment.

3. Frequently the content of interviews and questionnaires is set from clinician or researcher concepts about dropping out, so patients’ ‘real’ reasons for leaving are not necessarily included.

4. Particularly with standardised interviews, the results tend to be analysed at face-value, without discussion of linking themes between items, so comparing studies is difficult.

5. Interviewers are rarely independent of the clinical teams, which may exacerbate respondents’ inclination to provide circumscribed answers, in particular those which do not criticise the therapist.

Overall, reasons related to feeling disliked, not respected, and not understood within the therapeutic relationship are frequently given by drop-outs when conditions are conducive to openness (Garfield, 1994). Other, clinic-related or situational reasons seem to be given when the conditions are potentially more threatening to the drop-out. No studies have been reported which use open-ended home interviews administered by a researcher independent of the clinic (see Chapter 8).

2.2.2.5.2 Case reports

To date, case reports of drop-outs have been less useful as they have tended to perpetuate negative therapist attitudes toward drop-outs, rather than allowing for detailed investigation of the details of individual experiences. In two relatively recent reports, drop-outs are described as being incapable of managing maturational crises (Reibel,
1990; Young, 1991). Most therapists would view helping with such crises as their function rather than using them as evidence of patients' irremediability.

2.2.2.6 Interventions to reduce dropping out

Interventions to reduce drop-out are few, and have generally been studied quasi-experimentally.

2.2.2.6.1 Role induction

Most theoretically important among these interventions is patient role-induction. In one study, pre-therapy training in the role expected of patients was intended to reduce dropping out by lowering the anxiety and sense of futility assumed to be felt by those who drop out (Lothstein, 1978). This intervention, which was not implemented in a controlled way, was not successful.

In a small but controlled experiment, pre-treatment 'motivational' sessions had no effect on dropping out from a prison counselling programme (Kennerley, 2000).

2.2.2.6.2 Reminding patients; Reducing waiting times

Some studies have attempted to reduce dropping out by reminding patients of appointments with either telephone or letter reminders (Chen, 1991). These interventions do not have a substantial effect on dropping out (Stasiewicz & Stalker, 1999). Others have attempted to reduce waiting times (Stasiewicz & Stalker, 1999; Festinger et al., 1995). These appear to have some effect in substance misuse clinics, but only when waiting times are reduced to 24 (Festinger et al., 1995) or 48 hours (Stasiewicz & Stalker, 1999), a goal which may be impossible for many clinics\textsuperscript{16}.

\textsuperscript{16} Since these papers focus on waiting times for initial appointments, it would appear that they are concerned with reducing treatment refusal rather than dropping out. However, this is not clear, so these interventions may have some longer-term impact that affects dropping out as well.
2.2.3 **Studying the therapist’s contribution**

In the majority of therapist-related studies, methods strongly resemble those used for studying patient characteristics. They rely on designs which look for single predictors related to dropping out in a linear way. Some are more sophisticated, at least in the derivation of the variables that are entered into analyses. For example, therapist demographic variables have been studied in terms of how they relate to patient demographics, rather than as simple predictors themselves.

Considering that the therapist is the facilitator of psychological treatment, it is surprising how little research is reported in the area of therapist characteristics as they relate to dropping out. Therapists are also studied in a less intensive or intrusive way than patients. The measurement of their personal characteristics is limited, and is generally achieved through observation rather than questionnaire or research interview. Their professional characteristics may be measured by questionnaire or from employment records. The fact that therapists, who are not difficult to access, are not 'mined' for more information indicates that the patient is usually taken to be the main actor in dropping out.

2.2.3.1 **Archived pre-treatment characteristics**

Less information is archived about therapists than about patients. The type of information is usually restricted to professional characteristics rather than personal characteristics.

2.2.3.1.1 **Demographic information**

Therapist demographics have been studied as single predictors or correlates of dropping out (e.g., Lorr et al., 1958), or, as noted above, as matched to patient demographic characteristics (e.g., Gottheil et al., 1994; Snowden et al., 1989). None of the demographic variables such as age, race, or sex of therapists is consistently related to therapists’ ability to retain patients, even when patient characteristics are considered simultaneously (Reis & Brown, 1999; Saltzman et al., 1976; Snowden et al., 1989). Unlike patients’, therapists’ socio-economic status has not been studied and has been assumed to be middle- to upper-class (e.g., Garfield, 1994).
2.2.3.1.2 Experience and theoretical orientation

The level of therapist experience, which is measured from employment records or questionnaire responses, is operationalised as years of academic training and years of clinical practice (sometimes including experience in any relationship-based clinical field; e.g., Baum et al., 1966). Its relationship with dropping out is unclear. The years or level of graduate training have not contributed to dropping out (Beck et al., 1987; Gottheil et al., 1994; Lorr et al., 1958; Pekarik & Finney-Owen, 1987), but therapists who had more experience in establishing therapeutic relationships lost fewer patients (Baum et al., 1966; Reder & Tyson, 1980). Thus experience and competence may not necessarily be the same. Theoretical orientation also does not seem to impinge on dropping out (Frayn, 1992; Mohl et al., 1991).

2.2.3.2 Investigation of therapist within treatment

Exploration of therapist attributes expressed within treatment started and flourished with the work of client-centred researchers. The main focus of these investigations was to relate therapist attributes to outcome; however, retention in treatment was viewed as a prerequisite to good outcome and so was studied in its own right (e.g., Barrett-Lennard, 1962). This exclusive focus was short-lived. As interest in the therapeutic alliance as related to outcome increased during the last quarter of last century, the study of therapist variables as related to dropping out has decreased.

2.2.3.2.1 Researcher rating of therapist personality or communication skills.

Therapist personality is not regularly measured. However, when it is measured, researcher ratings of the therapist in the therapy situation are typically used rather than interview or questionnaire ratings. Thus therapist personality is treated by researchers as a within-treatment ‘state’, unlike the majority of patient personality measures, which are treated as pre-treatment traits. Similarly, the therapist ability to communicate effectively is measured in-session, either by observation or by content analysis of taped sessions.

In one study, those therapists who were perceived by objective raters to be more ‘warm and friendly’ were more likely to retain their patients (Hiler, 1958). Similarly, therapists’ ability to establish relationships with others, as assessed by researchers, was negatively related to dropping out (Koren and Goetzel cited in Frank et al., 1957). It appears that those therapists who are able to communicate effectively with patients in terms of acknowledging and expressing understanding of what they have said and
providing appropriate content in response are more likely to retain them in treatment (Duehn & Proctor, 1977).

One early study, perhaps heavily influenced by Rogerian attitudes, used content analysis of tape recorded sessions to evaluate the demeanour of therapists in session (Baum et al., 1966). Those who more successfully engaged patients appeared to be more secure and more comfortable about the therapeutic task, were more flexible, more active, and emphasised building the relationship.

To increase understanding of dropping out, it will be important to manage reservations about studying therapists. One effective way of investigating therapist personality and communication skills might be to use measures of the ability to make and maintain relationships.

2.2.3.2.2 Researcher rating of therapists' level of activity

Researchers have rated therapist activity levels, such as giving support and setting appropriate boundaries, by analysing tape-recorded treatment sessions (e.g., Anderson et al., 1985 cited in Bischoff & Sprenkle, 1993). As with patient ratings of therapist activity, it appears that researcher ratings of therapists indicate that those who are more active are more likely to retain their patients.

2.2.3.2.3 Expectancies regarding patient in treatment, attitudes toward patient

It seems there is a reluctance in the literature to measuring therapist expectancies and attitudes. This may be because they are more difficult to measure accurately and non-invasively than other dimensions. Questionnaires administered at the beginning of treatment have been used to assess therapist expectancies regarding treatment (Pekarik & Finney-Owen, 1987), therapist interests and attitudes regarding the patient and the patient's problem (Garfield et al., 1963; Lothstein, 1978; McNair et al., 1963), or even therapist perceptions of patient physical and emotional attractiveness (Tryon, 1992). It appears that those therapists who show high levels of interest in their patients and their problems are more likely to retain them in treatment.

However, these studies have sometimes been hampered by statistical inconsistencies or biases in interpreting results. In one study, the therapist's level of interest in the patient predicted over 70% of those who would remain in treatment, regardless of the pre-treatment classification of the patient as a probable drop-out or remainder (McNair et al., 1963). Rather than supporting the validity of the pre-treatment
ratings (as the author claimed)\(^{17}\). This result showed that the ‘typing’ of patients into predicted drop-outs or remainers was not relevant to the therapist who had high levels of interest in her patients. Furthermore, analyses which showed that there were no differences in the ways that the predicted drop-outs and remainers reacted to the interested therapists were overlooked in favour of the interpretation that ‘terminators and remainers form distinguishable outpatient populations. The former reject psychotherapy, perhaps because they lack the behavioural repertoire for participation’ (p. 10).

Similarly, in another study where patients and therapists were asked about the therapy relationship, patients’ reasons for leaving were not interpreted in light of the universal statement by the therapists that they did not like the drop-outs (Lothstein, 1978). The researcher concluded that dropping out was an inevitable part of the therapeutic process and that therapists should not feel guilty about ‘expelling’ these patients. The idea that drop-outs deserve to be excluded from therapy is surprisingly common (e.g., Connelly et al., 1986) and the debate value-laden (e.g., Reibel, 1990). Thus, therapist expectancies and attitudes toward patients may have more effect on dropping out than is typically acknowledged. Interestingly, the therapist’s ‘alliance’ is more strongly associated with dropping out than the patient’s ‘alliance’ (Frayn, 1992)\(^{18}\) (unpublished work using Working Alliance Inventory, Crowder, 2000) – therapists may ‘withdraw’ from some patients they dislike and so contribute to the ending of the treatment relationship.

2.2.3.2.4 Therapist ideas about how many and why patients drop out.

One study has looked at therapist estimates of the number of patients who drop out and therapist ideas about patients’ reasons for leaving (Pekarik & Finney-Owen, 1987). 165 therapists were selected from a representative sample of United States outpatient psychotherapy clinics and were asked to estimate the drop-out rate from their own caseloads as well as the overall drop-out rate from their clinical setting. They then ranked what they believed to be 3 most common reasons for dropping out from a set list of reasons ‘frequently endorsed by’ (though not originally given by) patients. Therapists

\(^{17}\) This measure had not predicted drop-out the first time it was reported in the literature (Lorr et al., 1958).

\(^{18}\) The ‘patient alliance’ in this study was rated by the therapist or the therapist’s supervisor, not by an independent rater or the patient himself. Therefore, this rating is more an indication of the therapists’ perceptions of these patients. It seems that these raters dislike these patients but do not think the patients dislike them in return.
consistently underestimated the amount of dropping out from their own caseloads as well as from their setting and thought patients dropped out because their problems had been resolved or because they were 'resisting' treatment. Patients, in a parallel study, said they dropped out because they did not like the therapist or therapy, reasons which the therapists rarely endorsed. Because researchers are often also clinicians, the underestimation of the amount of dropping out and the misapprehension of patients' reasons for leaving might be responsible for the tenor of research on dropping out. Further studies using such an approach would be illuminating.

2.2.4 Studying the Treatment/Process contribution

Designs used to study the contribution of the treatment or process to dropping out range from the quasi-experimental to the elaborate observational. The most fruitful area for investigation would seem to be the interaction between patient and therapist. It may also be the most difficult area to study effectively, since the parameters of the interaction which are relevant to dropping out are still unknown and assessing them risks intruding on the privacy of the relationship.

2.2.4.1 Treatment paradigm and format

The effects of treatment paradigm and format on engagement have been studied by referencing case records or in the context of larger studies investigating treatment-specific or non-specific factors in effectiveness (e.g., Strupp, 1989). As in studies of outcome, treatment type on its own does not appear to have a reliable or robust influence on dropping out (Baekeland & Lundwall, 1975). However, within each disorder, controlled studies of the relationship between different treatment types and dropping out have not been done19, and comparing the same treatment types as they are applied to different disorders can be difficult because they may be implemented differently or have different specific 'modules'. Therefore, firm conclusions cannot be drawn, but currently there is no evidence of differential effects. The way in which the parameters of the various treatments are presented to patients may have an influence (see 'Time-limited and time-unlimited treatments' below).

19 Indeed treatment type and the definition of dropping out may be confounded. Those treatments which assume that change requires a large number of sessions generally also have an high session cut-off for dropping out.
One study might clarify why higher drop-out rates are thought to exist for some treatment formats (Frank et al., 1957). When group and individual treatments were examined, group had a higher initial treatment refusal rate, but there were no differences in drop-out rate. Treatment format was thought to influence patients' initial expectancies of treatment. More of those selected to enter group treatment refused, possibly because the group format did not match their expectations of treatment. The author speculates that 'once a patient is familiar with his psychiatrist, the relationship between them seems to be a more potent factor than the type of treatment in determining whether he remains.' (p. 291).

2.2.4.2 Time-limited and time-unlimited treatments

The contribution of treatment time limitation to dropping out has rarely been studied, and it is not thought that it ever has been studied in an experimentally controlled way (cf. Hunt & Andrews, 1992). In one outpatient community treatment centre, three types of treatment length were compared quasi-experimentally: long-term time-unlimited, brief but not time-limited, and short-term time-limited treatments (Sledge et al., 1990). Patients receiving the treatment which was both short-term and whose length they had been told about dropped out about half as often as those in the time-unlimited treatment or the short-term treatment whose length was not discussed at the beginning. This study seems to reveal more about the effect of informing patients about features of treatment than it does about the effect of treatment length. However, this is not entirely clear because the design was quasi-experimental (for example, differing patient assignment procedures and criteria were not controlled). Simply limiting the length of treatments might leave many patients unimproved at the end of treatment, or might cause those who benefit from the security of longer treatments to drop out. Studying outcome alongside dropping out and time limitation is important if the results are to have practical value.

2.2.4.3 Patient-therapist interaction and alliance

Few studies have investigated the treatment relationship as an interaction between two (or more) people. Most use the view of one party or the other to define the nature of the relationship, even when the stated objectives are to study the interaction (e.g., Kolb et al., 1985; Mushlin & Appel, 1977; Piper et al., 1999). The therapeutic alliance research tradition, avoiding this bias, has developed increasingly sophisticated ways of measuring the interaction between patient and therapist. However, the main thrust of this research has been to predict outcome (e.g., Bordin, 1994; Horvath & Luborsky, 1993; Luborsky,
Crits-Cristoph, Alexander, Margolis, & Cohen, 1983) rather than engagement. The few studies which have considered the relationship between the alliance and engagement offer useful insights into factors affecting engagement and are discussed in depth here. Their results can be used qualitatively.

From the early 60’s until the mid 70’s, the Barrett-Lennard Relationship Inventory (RI; Barrett-Lennard, 1962; Luborsky, 1994), a short questionnaire filled out by both patients and therapists after the first 5 therapy sessions and then again less frequently during the remaining sessions, was used to assess the patient-therapist relationship. When dropping out was considered, the RI studies indicated that therapists felt less able to work with drop-outs. In one study, while there were no differences in patients’ attitudes toward therapists, the therapists felt least ‘congruent’ with patients who eventually dropped out and had the lowest ‘esteem’ for these patients (Rapaport, Zisook, & Lyons, 1988). In another study, which considered only the patient responses at the first sessions, the RI was able to predict dropping out. The authors speculated that this measure either picked up the patients’ pre-treatment ability to form a positive relationship, or that patients were quick to sense how well the therapist’s personality and approach would meet their needs (Beckham, 1992).

From the mid 70’s, other methods for assessing the relationship were developed, including other questionnaires and judgement-of-sessions methods, such as the CALPAS (Marmar, Weiss, & Gaston, 1989), WAI (Horvath & Greenberg, 1986), VTAS (Hartley & Strupp, 1983), and Helping Alliance Questionnaire (Luborsky, 1994). These have not often been used to study dropping out (c.f., Crowder, 2000; Samstag, 1999), or only one side of the alliance has been analysed (e.g., the patient only in Mohl et al., 1991) as was the case with the RI. At the same time the Vanderbilt Psychotherapy Process Scale was developed to analyse the process in therapy, though not specifically the alliance. Only one study is known where it was used to study dropping out (Piper et al., 1999), and in this case it was modified to focus on patient characteristics.

One study using the second-generation methods explicitly viewed the contributions of the therapist and patient to dropping out as ‘intrinsic aspects of the treatment situation, not as enduring personality traits of the participants’ (p. 547, Saltzman et al., 1976). In order to measure the ‘treatment situation’, the views of 91 out-patients and their therapists were recorded on report forms after each of the first 10 therapy sessions. The patient and therapist report forms mirrored each other. These reports were rated on a set
of 10 dimensions felt to be essential to an effective therapeutic relationship, including felt respect from the therapist, communication, openness, felt security, uniqueness of the relationship to the other, and its emotional and symptom-specific relevance. In a series of univariate analyses, a pattern of significant differences was observed. The drop-outs had a persistent sense that the relationship was low on respect, security and relevance, starting at the first session. Their therapists felt little respect for the drop-outs and sensed little involvement with them, also starting at the first session. By the third session the relationship troughed, with both drop-outs and their therapists feeling that the relationship was low on almost all of the dimensions. By the 6th session, ¾ of the drop-outs had left. Engagers and their therapists did not show this clear pattern of relationship decline. Pre-treatment patient characteristics did not differentiate engagers from drop-outs. The authors postulate that 'as early as the first session, there is evidence that the viability of the therapeutic relationship rests not only on the qualities of experiences of the individual participants, but also on the pattern of interaction between them.' p. 551. The study would have been even more powerful if multivariate tests had been used which could have measured the interactions that were observed with univariate tests. However the results have face validity.

Congruent results were found in a study monitoring 'topic determination' (TD: the proportion of topic initiations subsequently followed up by the other participant) in 18 treatment dyads of non-psychotic patients (Tracey, 1986). The first three treatment sessions were tape-recorded and analysed for the content and character of each speaking turn within the session. Those dyads with particularly low TD were more likely to end in drop out than those with higher TD. The investigator did not speculate about the reasons for the low TD in these groups.

A similar pattern of accelerating change in the drop-out treatment relationship was found by Hartley and Strupp (1983; cited in Henry & Strupp, 1994). This study used 'alliance' ratings made by expert clinical raters from 15 tape-recorded minutes of each of 5 sessions for 28 therapy dyads. Good outcome, poor outcome, and drop-out pairs were compared for differences in the strength and patterning of their alliances across time. No differences were found between the groups in overall mean alliance scores, but some differences were found in the patterns of alliance. In completing dyads (no matter whether good or poor outcome), the total alliance rating decreased over time. In drop-out dyads, the total alliance ratings increased over time. The authors speculated that this was
due specifically to therapists 'trying harder' when they sensed that that relationship was not going well, and therefore making more attempts to reach the patient. Drop-outs themselves were not rated as more resistant, less motivated, or less responsible for their own recovery. The difference between the observer ratings generated in this study and the participant ratings generated in the Saltzman et al. study is striking. It may be that the observer does not have access to the kinds of data that participants use to make ratings, or that the observer picks up on behaviours first, such as therapist attempts to overcome increasing emotional disconnection from the future drop-out with 'connecting' behaviours. This area needs further investigation.

2.2.5 Limitations of these methods

2.2.5.1 General

The methods used in the majority of studies of dropping out reviewed above suffer from the problems which affect many clinical psychological studies: often hypotheses are unclear, sample sizes are small, analyses are numerous, uncorrected, post-hoc, or even inappropriate, claims are made based on 'trends' in the data, and replication is not attempted (Dar, Serlin, & Omer, 1994). These problems probably stem from the many ethical and practical constraints which restrict clinical research (Shaw & Garfinkel, 1990). However, more recent advances in data gathering and analysis may ameliorate these problems.

2.2.5.2 Specific

There are also some methodological problems particular to the drop-out field which centre on the conceptualisation of dropping out. In the majority of studies it is conceived of not as the result of an interpersonal process but rather as a stable trait residing in the patient. The logical extensions of this concept directly affect research methods.

1. If dropping out is a stable trait of the patient, then it should be possible to detect the 'drop-out trait' before the beginning of treatment. Studying pre-treatment patient factors in a predictive way would then be appropriate.

20 Some analyses are downright silly, for example, using 'length of stay' as a variable in a discriminant function analysis of drop-out data is neither useful or sensible (Beck et al., 1983). It is not surprising that it was a significant factor – in fact, it was the only one.
2. If the drop-out trait resides in the patient, then the therapist will have little chance to influence it within the few sessions that the patient will remain. Studying the therapist would not be appropriate.

3. If the process differs between drop-outs and remainers, it is because of the drop-out's attitude and behaviour. Process therefore should be studied only for characteristic drop-out behaviours, not as an interaction developing over time.

Research using these methods has not produced generally useful findings, not only because dropping out is unlikely to be due purely to pre-existing patient characteristics but also because assuming that there is only one type of 'drop-out' patient is probably too simplistic (Craig, 1984; Fiester & Rudestam, 1975; Mohl et al., 1991). Given that so many pre-treatment patient areas have been considered, it is unlikely that some potent predictor has been overlooked. And even if it were found, its clinical utility would be limited by the fact that it would be difficult to alter within the psychological treatment context.

Despite these problems, the conceptualisation of dropping out has not evolved. Why? It does not seem logical that time, effort, and journal space should repeatedly be devoted to regurgitating the same unproductive studies. Could it be that there is a problem in drop-out research which is more fundamental than methodological difficulties? The tenacity with which clinical researchers cling to the idea of the patient being the locus of dropping out might reflect the training of clinicians to act as instruments of a standardised method that must be applied scientifically to patients' presenting problems, an holdover of the medical model from which (clinical) psychology evolved (Pilgrim & Treacher, 1992). Or 'blaming' the patient may simply be a natural human reaction to feeling ineffective or rejected by the patient. Whatever the reasons, the vast majority of research into dropping uses methods which yield information of severely restricted relevance, and the compelling question of what causes the high rates of dropping out is neglected.

2.2.6 Concluding summary

Why has dropping out been studied?

1. Research into dropping out has largely been driven by the desire to predict who is likely to leave treatment early. The intention is to be able either to
screen out those patients who are thought to be unable to benefit from treatment or to allocate special attention to patients who need help engaging. However, engagement and outcome are neither synonymous nor predicted by the same variables.

2. Little attention has been devoted to understanding what factors influence dropping out. This may be (i) because the amount of dropping out is underestimated by clinicians and researchers, (ii) because drop-outs are perceived as ‘rejecting’ the therapist and so are liked less well, or (iii) because it is methodologically difficult to gather information on appropriate variables without intruding on the privacy of the therapeutic relationship or the former patient’s life.

3. Research on interventions to reduce dropping out is rare, perhaps because so little is known about the factors which affect dropping out that evidence-based intervention is not yet possible.

4. The reasons for studying dropping out influence what is learned about it. Many drop-out studies are limited by a narrow focus on identifying ‘problem’ patients.

How has dropping out been studied?

5. Most drop-out research has used univariate instead of multivariate methods. There has been an emphasis on searching for single predictors of dropping out. Multivariate methods may allow better understanding of the interactions between variables relevant to dropping out.

6. Drop-out research can be divided into the contributions made by the patient, the therapist, and the treatment or process.

7. The majority of published drop-out research focuses on patient characteristics. Patient characteristics investigated as predictors of dropping out are assessed using self-report, therapist, and researcher ratings as well as archived, pre-treatment variables. Only interpersonal functioning seems to have a robust relationship with dropping out. Some work on qualitative descriptions of patients’ reasons for leaving has shown that feeling disliked, not respected,
and not understood within the therapy relationship are common. These are found when interview conditions are not threatening to the participant.

8. Therapists' professional characteristics are assessed using employment records and questionnaires; therapists' personal characteristics are assessed by observation or by questionnaire. Therapist characteristics are treated as 'states' more often than 'traits'. As with patient pre-treatment characteristics, therapist pre-treatment characteristics are generally not related to dropping out. However, high levels of some within-treatment factors, such as therapist warmth, activity, and interest in the patient, whether assessed by the patient, the therapist, or an outside observer, do appear to be positively related to engagement.

9. The treatment and process characteristics are generally studied by observation or quasi-experimentally. Treatment characteristics do not show any consistent relationship with dropping out, though the way they are presented to the patient may affect her comfort and expectations. The process characteristics, as expressed in the patient-therapist interaction, may be related to dropping out. Treatment relationship and alliance measures completed by participants in the relationship appear to show that relationships ending in drop-out start off low on respect and felt security, deteriorate over time, and may be characterised by less reciprocity.

10. Drop-out research is limited by methodological problems which generally affect clinical psychological studies as well as some which specifically affect this field. The specific problems may be related to the common conceptualisation of dropping out as resulting from a stable trait residing in the patient rather than from interactions between the patient and the therapist. Studies based on the former conceptualisation have yielded few clinically useful results.

11. Different methods which conceptualise dropping out as the product of an interaction may increase understanding of dropping out and may produce clinically useful results. This thesis will explore several different methods for studying dropping out (Chapters 5-9) and will conclude with recommendations for further advancing drop-out methodology (Chapter 10).
3 DROPPING OUT FROM PSYCHOLOGICAL TREATMENT FOR EATING DISORDERS

Introduction & Aims

This chapter will attempt to uncover what has been learned about dropping out from treatment for eating disorders (ED). Particular attention will be paid to bulimia nervosa (BN), which is of interest because its field of research is both so new and so well documented. Methods of diagnosis and treatment for BN have evolved over only the last 20 years (Shaw & Garfinkel, 1990). Psychological treatments for BN are some of the most thoroughly researched in all of psychiatry, perhaps because the identification of BN coincided with the upsurge of interest in evidence-based treatments (Palmer, 2000). Because dropping out can undermine conclusions drawn about the efficacy of treatments, understanding and recording dropping out may be of particular importance for a new field like ED treatment. Tracking dropping out may also affect ED diagnoses developed in the coming years, since theories of aetiology, diagnosis, and effective treatment may be entwined (Everitt, 1994; Hartigan, 1975).

Furthermore, there are reasons to believe that dropping out might be a particularly serious problem for the treatment of EDs. The valued nature of some of the symptoms of EDs may cause sufferers to experience ambivalence about change (Vitousek, Watson, & Wilson, 1998). Such ambivalence may increase the difficulty of engaging in treatment. Certainly it may provide a further obstacle for potential patients to overcome before they seek care (Palmer, 2000). However studies specifically investigating dropping out from psychological treatment for EDs are infrequent. This chapter reviews the available information.

The chapter is divided into 3 main segments:

1. Dropping out from psychological treatment for BN is reviewed according to overall rates, treatment type, treatment format, and setting of treatment.

2. The same structure is used to review information in the AN treatment field.

3. Correlates of dropping out that have been investigated in ED literature are briefly reviewed and related to findings listed in Chapter 2.
3.1 Bulimia nervosa

Bulimia nervosa (BN), initially labelled an 'ominous variant' of anorexia nervosa (AN; see Section 3.2), was delineated by Russell in 1979 (Russell, 1979). It is characterised by the rapid consumption, in a discrete period of time, of a large amount of food, followed by compensation for this consumption which typically includes vomiting, exercise, fasting, or laxative or diuretic abuse (American Psychiatric Association (APA), 1994). After its identification, the reported incidence of BN rose steeply. Currently, around 1% of young women in the developed countries are estimated to suffer from the disorder (Fairburn & Beglin, 1990; Palmer, 2000). Like AN, BN is believed to have psychological origins, and is mainly treated psychologically, though psychopharmacological treatments (especially antidepressants) are commonly used as adjuncts. The course of the disorder is often chronic; however, severity and chronicity vary widely, and the composition of the population presenting for treatment has changed over the years (Palmer, 2000).

The tenth edition of the International Classification of Diseases (ICD-10; World Health Organisation (WHO), 1992) diagnostic criteria for BN are listed in Appendix 3-1. ICD-10 criteria were used for diagnoses in several studies reviewed below and in Chapters 5, 6 & 8. The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (APA, 1994) criteria are listed in Appendix 3-2. DSM-IV criteria were used for some of the studies reviewed below and for Chapters 7 & 9.

3.1.1 Psychological treatment for bulimia nervosa

Treatments for BN have originated from 2 sources: previously established treatments for AN (individual, supportive or psychodynamic) and for depression (group, CBT, IPT). These reflect the theoretical interpretations of the aetiology of BN (Schleisier-Stropp, 1984). Psychological treatment for BN is usually offered in an outpatient setting, in individual or group formats. Treatment for BN is dominated by cognitive behavioural approaches (CBT; Wilson, Fairburn, & Agras, 1997); however, Interpersonal Therapy (IPT), is becoming more common. Psychodynamic, behavioural and feminist approaches are also used (Section 3.1.3.2 for references).

CBT for BN usually involves meeting for around 20 sessions over as many weeks, divided into 3 segments (Fairburn, Marcus, & Wilson, 1993). The overall focus of the treatment is on rectifying maladaptive cognitive processes which serve to maintain
bulimic behaviour through identification of these processes and the triggers for bulimic
behaviour. IPT for BN, also a brief, structured treatment of around 20 sessions, currently
differs from CBT in that minimal explicit attention is paid to eating behaviour (Fairburn,
1997). The focus is on identifying and attending to interpersonal problem areas that
perpetuate BN. These treatments are still evolving.

3.1.2 ‘Regular’ Treatment vs. Treatment trial

The recent proliferation of treatments for BN has resulted in studies comparing
their efficacy. Such studies are the main source of information about the rates of dropping
out.

Underestimation of drop-out rates Unfortunately, the attrition data from trials are of
limited generalisability to the ‘regular’ treatment situation, because they may not reflect
accurately the frequency of dropping out from regular treatment. In trials, unusual efforts
are often made to screen and retain patients (Garfield, 1994). Thus reports of attrition
rates from treatment trials may give an overly conservative indication of rates of dropping
out (Waller, 1997).

Underestimation of differences between treatment status groups Furthermore, trial
designers often do not account for these patients once they have gone. With some notable
exceptions (e.g., Fairburn, Jones, Peveler, Hope, & O’Connor, 1993), patients who leave
treatment trials are often excluded from analyses (e.g., Davis, McVey, Heinmaa, Rockert,
& Kennedy, 1999; Elderedge et al., 1997). Authors justify their dismissal of these
patients on the basis of comparisons made with completers using pre-treatment
assessment or study data rather than data relevant to engagement. As was illustrated in
Chapter 2, pre-treatment data which are gathered for clinical or general research purposes
do not appear to be strongly related to attrition or dropping out. What is more, concluding
that trial leavers and engagers are identical on the basis of these null hypothesis tests is
not valid. The probability of the truth of the null hypothesis (that there are no baseline
differences between trial leavers and completers) cannot be estimated from the data
entered into a null hypothesis test – it is only the probability of obtaining these data given
the truth of the null hypothesis that can be estimated (Dar et al., 1994). Using such
comparisons may result in underestimating the differences between trial leavers and
engagers.
Further consequences Even if the two groups do not appear to differ in their pre-treatment measurements on the dependent variables (i.e., binge frequencies), they do differ in their ability to receive the independent variable (i.e., treatment), and these differences may be systematic. Since the aim of treatment trials is to investigate the effect of treatment, and since the amount of treatment that trial leavers and completers receive differs in an uncontrolled but possibly systematic way, simply excluding trial leavers from analyses may undermine the validity of trial results (Lasky, 1962). Ideally, trials would be designed to include data that were germane to treatment engagement, so that it would be possible to investigate differences in the acceptability of treatment before investigating differences in clinical outcome. This information could also improve the generalisability of results.

3.1.3 Findings 1: Magnitude of problem for BN

3.1.3.1 Overall drop-out rates

Treatment-phase attrition rates from BN treatment trials which include 20 or more participants range from around 5% to 40%, with a median just below 20% (Agras et al., 1989; Agras et al., 2000; Davis et al., 1999; Elderedge et al., 1997; Freeman, Barry, Dunkeld-Turnbull, & Henderson, 1988; Lee & Rush, 1986; Mitchell, 1991; Thackwray, Smith, Bodfish, & Meyers, 1993). The rates are higher for dropping out from regular treatment, ranging from around 15% to over 60%, with a median around 30% (references next and Steel et al., 2000). Regular treatments are described in papers which evaluate but do not compare treatments (e.g., Dixon & Kiecolt-Glaser, 1984; Hsu & Holder, 1986), in some prognostic/outcome and follow-up studies (e.g., Blouin et al., 1994; van Furth, van Strien, Martina, Hendrickx, & van Engeland, 1996), and in some papers focusing on drop-out (e.g., Clinton, 1996; Waller, 1997). Surprisingly, descriptive studies often do not include information about dropping out (e.g., Doyle, 1995; Fairburn, 1996), even though level of engagement would seem to be an important consideration. An exception is a paper reviewing treatments and presenting a stepped treatment programme which incorporates interventions to reduce dropping out (Tiller, Schmidt, & Treasure, 1993); however, drop-out rates are not specified.

3.1.3.2 By treatment type

The reported rate of dropping out for the dominant treatments, CBT and IPT, is around 15% in tightly controlled trials (Fairburn et al., 1991). Psychoeducation (Olmsted
et al., 1991), behaviour therapy without cognitive components (Fairburn et al., 1991; Freeman et al., 1988), and nutritional counselling (Laessle et al., 1991) have been used, but when used on their own, drop-out rates for these treatments are somewhat higher than those reported for CBT or IPT at about 30%. Use of feminist therapies (Merrill et al., 1987), family therapy (Russell, Szmukler, Dare, & Eisler, 1987), and hypnobehavioural therapy (Griffiths, 1990) has also been reported, with drop-out rates at around 40%; however, these papers have either reported on ‘regular’ uncontrolled treatment or have had unusual definitions of dropping out, so the higher drop-out rates might not reflect lower acceptability of the treatment to the patient. Longer-term treatments aimed at personality change have not been specifically investigated for BN. Increasingly treatments are combined with each other or sequenced, or ‘stepped’, from least to most intensive (Lacey, 1986; Treasure et al., 1996). These approaches might lower rates of dropping out by easing patients into treatment and addressing a broader range of their concerns.

3.1.3.3 By format of treatment

Treatment for BN is often carried out in group format. Individual treatments are probably equally if not more common, but are not reported on as often, perhaps because subject numbers are too small to allow statistical comparisons of treatment effects (McKisack & Waller, 1997). There have been some reports that the rate of dropping out from group treatment is higher than that from individual treatment (Blouin et al., 1995; Garner, Fairburn, & Davis, 1987); however, this finding is not strongly supported (cf., McKisack & Waller, 1996; Scheuble, Dixon, Levy, & Kagan Moore, 1987; Waller, 1997), and may have more to do with higher treatment refusal rates than higher drop-out (see Section 2.2.4.1).

Guided or independent self-help, where the patient is assigned a self-help manual in combination with infrequent but regular contact with a therapist who reinforces the content of the book, is being used increasingly commonly as a first-step, low-intensity treatment (Wilson & Fairburn, 1998). In treatment trials, time-limited doses of guided self-help do not appear to have higher drop-out rates than individual CBT or waiting list conditions (Downey & Freeman, 1998; Sullivan, 1999; Treasure et al., 1996). Since guided self-help maintains patients’ contact with a clinic and can be used while patients wait for other treatments, it might be a useful tool for reducing treatment refusal (Garvin, Striegel-Moore, & Wells, 1998). A current treatment trial which uses either guided or
non-guided self-help as an initial treatment step has yielded data which indicate that therapist contact, rather than book content, seems particularly effective in this regard (Sullivan, 1999).

3.1.3.4 By setting of treatment

In the US and UK, the vast majority of treatment takes place in outpatient settings, unless significant comorbidity exists. Some European countries, such as Germany and Switzerland, commonly offer inpatient treatment for BN. It is difficult to assess whether the setting of treatment contributes to the rate of dropping out, because in the US and UK the availability of inpatient treatment is confounded with ED and comorbid symptom severity, and in countries where it is widely used, comparisons with outpatient treatment are not available.

3.2 Anorexia nervosa

Anorexia nervosa (AN) is likely to be an ‘older’ psychological disorder than BN, having been medically identified in the 19th century (Gull, 1874; Lasegue, 1874; Marce, 1860). It is characterised by severe restriction of food intake resulting in significant weight loss and is accompanied by abnormal thoughts and attitudes regarding food and weight. Like BN, AN appears to be most common in young women, but is much less frequent. Estimates of detected disorder range from about 4 to 10 per 100,000 total population in developed countries (Hoek, 1993; Palmer, 2000). AN is believed to have psychological origins, and is mainly treated psychologically, though psychopharmacological treatments may be used as adjuncts, and medical stabilisation of the patient is often a priority in severe cases. The course of the disorder is often chronic, though severity and chronicity vary widely (Palmer, 2000).

The DSM-IV (APA, 1994) criteria for AN are listed in Appendix 3-3.

3.2.1 Psychological treatment for anorexia nervosa

Psychological treatment for AN may be conducted in inpatient, day patient, or outpatient settings, usually depending on the severity of the patient’s illness. In the past, much inpatient treatment was based on behavioural principles with rewards contingent on weight gain, but in more recent years weight restoration and psychological treatment have become more separate (Palmer, 2000). Psychological treatments emphasise psychodynamic (Bachar, Latzer, Kreitler, & Berry, 1999; Lunn, 1990; Wilson, 1986) and
specialised cognitive behavioural approaches (Pike, Loeb, & Vitousek, 1996; Vitousek et al., 1998), though there is a wide variety in the way these treatments are implemented. Since AN is so rare, controlled treatments trials are scarce, and clinical experience rather than research evidence tends to drive changes in treatment provision (Palmer, 2000).

3.2.2 Findings 2. Magnitude of Problem AN

3.2.2.1 Overall drop-out rates

The treatment literature on AN is largely theoretical, with few controlled comparisons (Wilson & Fairburn, 1998). Dropping out is referred to obliquely as a feature that ought to be controlled by improved engagement techniques. The few controlled studies of treatments often do not address the issue of drop-outs: one of the largest studies involving anorectics did not specify the drop-out rates from its four conditions and gave only the mean number of sessions attended (Crisp, Norton, Gowers, Halek, & et al., 1991). As the treatments investigated were of different lengths and intensities, attendance comparisons are not possible.

Therefore it is necessary to look to follow-up reports for information about drop-out rates in AN. Unfortunately, many of these follow-up studies do not describe the initial sample who entered treatment (e.g., Eisler et al., 1997), or do not separate patients with BN from those with AN (e.g., Szmukler, Eisler, Russell, & Dare, 1985).

Other follow-up studies of treatments for AN were systematically analysed (Steinhausen, Rauss Mason, & Seidel, 1991) and reported widely varying rates of dropping out and attrition. (It is unclear whether these rates are for dropping out from regular treatment, treatment-phase attrition, follow-up-phase attrition, or all of the above.) In follow-up studies conducted before 1981, the reported average rate of loss from study was 11%, with a wide range from 0 to 77%; in the remainder of the 1980s, the mean rate had risen to 24%, but the range was restricted to 0 to 27%. Reports of regular treatments cite high rates of drop-out: around 20% within 5 treatment sessions (Palmer, Gatward, Black, & Park, 2000), rising to around 50% over the first year of treatment (Vandereycken & Pierloot, 1983).

3.2.2.2 Type of treatment

Beyond the specialised cognitive-behavioural and psychodynamic treatments mentioned above, treatments for AN also span family and family-oriented (Crisp et al., 1991; Szmukler et al., 1985; Vanderlinden & Vandereycken, 1991), behavioural
(Schmidt, 1989) and, increasingly common, multidimensional (Beumont et al., 1993; Garner, Garfinkel, & Bemis, 1982) or integrated (Steiger & Israel, 1999) therapies among others. Drop-out rates do not appear to differ between these treatment types. However, motivational enhancement, a mode of therapy which specifically addresses the ambivalence associated with seeking treatment for AN, has been reported (Vitousek et al., 1998; Ward, Troop, Todd, & Treasure, 1996). Vitousek’s description anecdotally suggests that dropping out is reduced.

3.2.2.3 Format of treatment

Most treatments for AN are carried out in an individual or a family format, often depending on the age of the patient (Crisp et al., 1991; Robin, Seigel, & Moye, 1995; Szmukler et al., 1985; van Furth et al., 1996). There do not appear to be differences in the rates of dropping out from these two formats, which is curious, as the mechanics of dropping out from family therapy would appear to be more complicated. Group therapy used on its own is not common (Yellowlees, 1988); such groups are often composed of people with less severe AN and people with BN (Crisp et al., 1991; Riess & Rutan, 1992; Scheuble et al., 1987). At this stage, determining whether format has any impact on dropping out from treatment for AN is not possible; it is confounded with level of severity, study numbers are small, and results frequently mix diagnoses.

3.2.2.4 Setting of treatment

Most of the treatments for AN which have been described in the research literature involve inpatient stays (Wilson & Fairburn, 1998), even though most cases, especially the less severe, are managed as outpatients (Hsu, 1986). Increasingly day programme services are used as a substitute for inpatient treatment for severe but functioning anorectics or as a transition stage between inpatient and outpatient care (Dalle Grave, Bartocci, Todisco, Pantano, & Bosello, 1993; Palmer, 1999). No literature could be found which would allow comparison of drop-out rates from these services; however, drop-out rates of 50% from regular inpatient treatment have been reported (Vandereycken & Pierloot, 1983). It would seem that day programmes could strike an acceptable balance between safety and independence for patients whose weight is being restored, and so could have lower drop-out rates than pure inpatient programmes.
3.3 Binge Eating Disorder (BED) and other Eating Disorder Not Otherwise Specified (EDNOS)

While there have been recent reports of cognitive behavioural (Marcus, Wind, & Fairburn, 1995; Telch, Agras, Rossiter, Wilfley, & Kenardy, 1990) and interpersonal (Wilfley et al., 1993) treatments for BED, most treatments for BED reported in the literature have been behaviour-based weight-reduction programmes for obesity rather than psychotherapeutic treatments for ED as such (e.g., Ho, Nichaman, Taylor, Lee, & Foreyt, 1995). Therefore drop-out rates from their treatment will not be discussed here. Typically treatments for EDNOS are not yet reported separately for treatments for AN or BN.

3.4 Findings 3: Correlates of dropping out across ED treatments

As with other fields of psychological treatment, ED drop-out research has focused primarily on patient characteristics, despite the potential importance of other aspects such as therapist and therapy characteristics and patient-therapist interaction (Baekeland & Lundwall, 1975).

3.4.1 Patient demographic, situational, and history variables

A long list of demographic characteristics have been considered, including age, sex, marital status, employment status, socio-economic status, level of education, race, distance travelled to clinic, number of children, availability of transportation and childcare resources, and previous experience of psychiatric treatment.

As in drop-out studies in the general literature (see Section 2.2.2.1.1), in the ED literature none of these variables on its own is consistently related to dropping out. There is some indication of a relationship between level of education, dropping out, and type of therapy offered, with those in the very lowest levels of education being less likely to engage in longer-term treatments for AN (Vandereycken & Pierloot, 1983).

3.4.2 ‘Normal’ and psychopathological personality characteristics

Personality has chiefly been measured by questionnaire to assess level of hostility, dissociation, anger, anxiety, impulsivity, difficulties trusting and relating to others, locus of control, borderline personality characteristics and other personality disorder.
In two studies, drop-outs from individual CBT for BN had higher levels of borderline characteristics or personality disorder than completers (BPD; (Coker, Vize, Wade, & Cooper, 1993; Waller, 1997). However, these findings are difficult to interpret, as the drop-out sample sizes in both studies were small (N=6 and 15, respectively), and the diagnosis of BPD is not necessarily reliable, especially when it is made retrospectively from case notes (e.g., Coker, et al, 1993). Another study found trial leavers to have higher levels of impulsivity, but the difference was not large enough to be considered ‘clinically useful’ (Agras et al., 2000). As discussed in Section 2.2.2.1.4, drop-outs in the general literature have not consistently been found to have higher levels of BPD or other psychopathological personality dimensions.

The observation that drop-outs were more hostile in one study (van Strien, van der Ham, & van Engeland, 1992), was not replicated in another (Blouin et al., 1995), but the latter found them to have difficulties trusting and relating to others in group CBT for bulimia. This finding needs replication. It might be possible that these patient characteristics, in the presence of other factors which would make the patient feel unsafe, could result in dropping out. One paper reported that trial leavers had higher levels of personality disturbance as measured by questionnaire, but this was the only significant result in a large group of comparisons and might have resulted from capitalisation on chance (Fairburn, Peveler, Jones, Hope, & Doll, 1993).

3.4.3 Eating disorder diagnosis

AN, BN, and atypical syndromes have been evaluated.

As discussed above, the lack of reports of dropping out from treatment impedes quantitative comparison between the major diagnoses. Waller (1997) found no differences in dropping out between AN-BP and BN. However, this study did not include AN-R or other diagnostic subgroups, and anecdotal information discussed above indicates that psychological treatment for severe AN may have higher drop-out rates than for other diagnoses. However, these published reports may not accurately reflect overall dropping out in those with AN, and any effect may not be specific to severe AN. Perhaps any patient who has particularly highly valued positive ideas and few negative ideas about her disorder (Serpell, 1999) would be unlikely to remain in treatment unless her therapist could encourage her to re-evaluate these ideas. The difficulty of engaging patients who are ambivalent about treatment is not specific to EDs.
3.4.4 Eating disorder features and other clinical features

Many clinical features have been considered, including frequency of binge eating, vomiting, laxative misuse, other compensatory measures, percentage below ideal body weight at admission, age at onset of ED, duration of ED, ‘denial of illness’, desired weight, past BMI history, level of depression, other comorbid diagnoses, and presenting complaint. ED questionnaires and interviews (most commonly the Eating Disorders Inventory; EDI; Garner, Olmstead, & Polivy, 1983) and severity of general disorder (Symptom Checklist-90; SCL-90; Derogatis, 1977) have also been investigated.

There is evidence that people with AN who have been ill longer are less likely to remain in treatment (Vandereycken & Pierloot, 1983), whereas those with BN with a longer history are more likely to remain in treatment (Coker et al., 1993; McKisack & Waller, 1996). This might be due to the ego-syntonic nature of many anorexic symptoms and the ego-dystonic nature of the binge-purge cycle. However, neither finding has been consistently replicated (e.g., Steel et al., 2000). Interestingly, those who perceive their ED to be worse (as opposed to those whose ED symptoms are rated by clinicians as being worse) may be more likely to drop out (Agras et al., 2000; Waller, 1997) as may be those at the extremes of severity (van Furth et al., 1996). Otherwise pre-treatment symptom severity has not been found to relate to dropping out (e.g., Fairburn, Peveler, Jones, Hope & Doll, 1993; Steel et al., 2000). This may be because the range of symptom severity is too restricted in these treatment situations to show any statistical differences. Those who are at the extremes of severity are unlikely to be offered the same interventions as those in the middle. In assessing the importance of symptom severity to dropping out, AN and BN symptoms would ideally be looked at separately, and measures of how highly valued these symptoms are would also be included.

As with symptom severity in the general drop-out literature (Section 2.2.2.1.3), there is no consistent evidence of a relationship between more general psychological disorder and dropping out, other than the possible relationship with borderline characteristics mentioned above. Thus, many variables related to poor outcome are not necessarily predictive of dropping out.

3.4.5 Expectations of treatment; ‘stages of change’

Expectations of treatment have been assessed using the Eating Disorder Patient’s Expectations of Treatment Questionnaire (Clinton, 1996), which measures patients’
preconceived ideas about treatment. Stages of change have been measured by an adaptation of Prochaska and DiClemente’s stage of change measure (Prochaska, 1984).

A discrepancy between the frames of reference of therapist and patient regarding effectiveness of treatment was related to dropping out, with drop-outs expecting more help from psychodynamic interventions than continuers (Clinton, 1996). This finding needs replication, as questionnaire measures of expectations of treatment have not been shown to be consistently related to dropping out in the general literature (Section 2.2.2.2.3), but qualitative description has indicated a relationship between how therapists address patients’ expectations and dropping out (Section 2.2.2.5.1). This area is difficult to assess since patient expectations are not consistently operationalised. Unlike one study in the general literature which found a relationship between stage of change and dropping out (Section 2.2.2.2.3), another study in the ED literature did not find such a relationship (Treasure et al., 1999).

3.4.6 Current family environment

Current family environment has been measured by questionnaire (Moos Family Environment Scale; Family Assessment Device) as well as by interview (expressed emotion of parents, emotional over-involvement of parents). Psychiatric history of parents, which might affect current family environment, has also been investigated.

Current family environment seems to have a complex association with dropping out. A follow-up study at a major tertiary referral centre found that when the patient was bulimic and the treatment was family therapy, high scores on the critical comments scale of parental expressed emotion measure were positively associated with dropping out (Szmukler et al., 1985). Although this study has methodological difficulties, the finding has received support (van Furth et al., 1996). From the patient’s perspective, drop-outs from group treatment for BN saw their families as poorer at expressing emotional concern (Waller, 1997) (but treatment refusers saw their families as better at expressing emotional concern than either completers or drop-outs). A history of psychiatric illness in parents was more frequent in drop-outs from a programme for mixed EDs than in completers (van Strien et al., 1992). Current family functioning might have most impact on treatment engagement when it affects the patient’s own ability to make and maintain helping relationships.

3.4.7 Childhood relationships and experiences
Experience before the age of 16 of parental separation, divorce or death are the main childhood experiences which have been studied in relationship to dropping out. Chapters 5 & 6 of this thesis look at the effects on engagement of these experiences in combination with physical and sexual abuse.

A study which found no difference in ‘family intactness’ between drop-outs and completers (van Strien et al., 1992) is complicated by the fact that its analyses mixed diagnoses. Drop-outs in this study were mainly anorectics, who have been shown to have experienced fewer traumatic events in childhood than bulimics (Webster & Palmer, 2000). Childhood experiences are not often investigated in the general literature either, but there is some indication that early aversive experiences were related to dropping out (Section 2.2.2.3.2.). Parental break-up could be related to the ability to make and maintain therapeutic relationships in adulthood (Adshead, 1998) if it reflects a discordant early family environment where the formation of secure attachments was impaired. It is possible that the more trauma suffered by patients in childhood, the less likely forming secure attachments might have been.

### 3.5 Concluding summary

1. Understanding and recording dropping out may be particularly important in a field like BN, where new treatments and diagnoses are being developed.

2. Drop-out rates from ‘regular’ psychological treatment may be underestimated when reports of treatment trial attrition are used as the basis for estimation. Comparing trial leavers and completers on pre-treatment or study data may disguise differences between these two groups unless data relevant to engagement are also included. The acceptability of psychological treatment, for example, may differ between groups.

3. BN Overall, median drop-out rates for treatment of BN range from around 20% for more tightly controlled treatment situations to around 30% for regular treatments. There do not appear to be dramatic differences in dropping out related to treatment type, format, or setting. The increased use of sequenced treatments might reduce the amount of treatment refusal and increase levels of engagement once treatment has begun.
4. **AN** Lack of reporting on drop-outs in the present literature makes determining the rates of dropping out from treatment for AN problematic. If future treatment descriptions and comparative trials list rates of dropping out, then meta-analysis might be able to yield overall rates. Currently, rates around 50% for inpatient treatment are not unusual. However, many AN patients are treated in outpatient settings, which are not often reported on. Increased sensitivity to the ambivalence experienced by many anorectics entering treatment and the provision of more flexible treatment settings for people with severe AN might increase the acceptability of treatment to anorectic patients.

5. **Correlates of dropping out for ED** While engagement of this often ambivalent group is difficult, the severity and characteristics of the ED itself do not seem related to dropping out. This is supported by a meta-analysis of dropping out (focused on group treatments only, Fettes & Peters, 1992). Experiences of trauma in childhood and some interpersonal and family measures, possibly related to the ability to make and maintain certain types of relationships, seem to have the strongest relationship with dropping out from treatment for EDs, especially for BN.
4 Theoretical and Methodological Foundations of Part 2

Introduction & Purpose

The reviews in the preceding chapters showed that studies of dropping out need an appropriate theoretical foundation as well as methodological flexibility to be productive. This chapter describes the theoretical and methodological foundations for the original research work presented in Part 2 of this thesis (Chapters 5-9).

The theoretical foundation influences not only the type of variables that are investigated but also the format and timing of measurement. It also provides a framework for interpretation of results. Attachment theory has been used to organise the studies in Part 2. Attachment theory is a broad, evolving concept with great heuristic power. It has been interpreted and operationalised by both cognitive theorists, who view it as an interpersonal ‘style’, and by dynamic theorists, who view it as a ‘state of mind’ about past and current relationships. Since the theoretical and measurement work emerging from these two schools is largely not shared, these operationalisations are distinguished in this chapter. The basic tenets of attachment theory in general are briefly outlined in order to provide a background for its use as an organising structure in the research work presented in Part 2. Then the literature and current measurement methods of the ‘style’ school, which form the foundation for the methods used in the research work in Part 2, are more fully discussed. The application of this attachment construct to the establishment of therapeutic relationships is also explored in this chapter.

This chapter also lays out the variety of methods used to study dropping out in Part 2 (Section 4.2). Methodological flexibility permits the theoretical formulation to be adequately empirically tested. Using a variety of methods answers different types of questions and allows ‘triangulation’ on factors relating to dropping out. It also enables initial development and testing of theory using with less intrusive methods before progressing to those that are more intrusive. The chapter describes how attachment is operationalised with each of these methods for studying dropping out.
4.1 Theoretical foundation: Attachment theory

Findings reported in the literature on dropping out support conceptualising it as the product of an interaction between patient and therapist. Attachment theory, developed by John Bowlby (1969/1982) and Mary Ainsworth (Ainsworth, Blehar, Waters, & Wall, 1978), lends itself to understanding such interactions. Attachment theory provides 2 main concepts which are relevant to the studies in Part 2 of this thesis:

1. It provides an explanation of the nature and development of differences in individuals’ abilities to make and maintain close relationships, starting with the earliest caregiving relationships. In this sense it refers to a characterological trait. As far as this thesis is concerned, individual differences in attachment style might have a general effect on the ability to establish therapeutic relationships. This attachment construct informs Chapters 5, 6, & 7 (Figure 4-2).

2. It also describes the process by which close relationships are made. In this sense it refers to the properties of a developing relationship dyad. For the purposes of this thesis, the dynamic relationship between patient and therapist while establishing a therapy relationship might affect engagement. This attachment construct informs Chapters 8 & 9.

The heuristic power of attachment theory for investigating new areas of relationship formation make it particularly suited to studying dropping out from treatment. Other areas of research concerned with relationship quality, such as bonding, can be viewed as subsidiary concepts to attachment. Furthermore, bonding, for example, is mainly applicable to a parent-child process (Sroufe, Cooper, & DeHart, 1992), rather than to the current adult relationships investigated in this thesis. The most widely used bonding instrument, the Parental Bonding Instrument (PBI; Parker, Tupling, & Brown, 1979), concerns adult memories of child perceptions of parental attitudes and behaviours, which are divided into 2 dimensions of care and protection. Such an instrument would perhaps be less useful for studying the formation of new adult relationships, such as therapeutic relationships, because these dimensions do not define adult relationships as well as they do parent/child relationships. These dimensions are also unlikely to be detectable at the early stages of a relationship, which is necessary when studying dropping out. What is more, though many of the individual items listed in the PBI appear
to be relevant to patient-therapist relationships, using the PBI for adult-adult relationships might yield uninterpretable results. Scoring the PBI into the care and protection dimensions may not be appropriate for adult-adult relationships, since the PBI items were developed and factor-analysed for looking at a very different process, the long-term bonding in parent-child relationships.

Concepts and measures of adult interpersonal processes other than attachment may be also relevant to studying dropping out; however, attachment has been chosen to organise the investigation presented in this thesis because it has a wide theoretical base (as described here) and a foundation of measures developed for observing adult relationship formation. As will be discussed below, this thesis requires a theoretical foundation which can allow for investigating both trait-like and state-like concepts. Attachment theory provides this flexibility.

4.1.1 History and tenets of attachment theory in general

Attachment theory grew from Bowlby's clinical experience and his research in ethology. A psychoanalyst, he proposed the attachment system as a motivational-behavioural control system in addition to the Freudian 'drives'. He postulated that attachment behaviour serves an evolutionarily adaptive purpose, namely assuring the safety and survival of the child. At times of stress or danger, the attachment system triggers behaviour that gains and maintains the proximity of the child to its caregiver. At other times, the system is still active as the child monitors the environment and the proximity of her caregiver, assessing the need for increasing proximity.

4.1.1.1 Secure attachment

According to attachment theory, when the child is confident that the caregiver is easily accessible, responsive, and actively supportive, she will enthusiastically explore her environment, secure in the knowledge that safety is at hand if it is needed. Such a child would be called 'securely attached' and the relationship would be seen as 'secure'. Ainsworth's (1978) observation of children with their caregivers related secure attachment behaviour patterns in children to accepting, responsive, sensitive caregiving in parents. Secure children feel worthy of care and confident about getting it. Bowlby assumed that continued positive interaction with caregivers would lead to a generalisation of this concept to other close relationships, so that by adulthood a secure person would be
able to make and maintain new close confiding relationships and elicit support in times of crisis (Bowlby, 1977).

4.1.1.2 Insecure attachment

Bowlby theorised that when the child is not confident that the caregiver is accessible, exploration will be curtailed and attachment behaviours will be heightened. Ainsworth et al. (1978) found that the child's behaviour pattern is keyed into her caregiver's in an adaptive attempt to maximise proximity. Therefore, if the caregiver tends to reject the child's overtures for proximity, the child will develop means for minimising proximity-seeking behaviours, which will increase the chances of being allowed to stay close to the caregiver. If the caregiver responds inconsistently to proximity-seeking behaviour by alternately attending to the child and ignoring her, then the child will maximise proximity-seeking behaviour. In either situation, the insecure child will not be confident that she is able to elicit care when it is needed and will be less likely to explore her environment. Experimental and correlational research have further supported Ainsworth's findings (Carlson, Chicicchetti, Barnett, & Braunwald, 1989; Simpson & Rholes, 1998).

4.1.1.3 Stability of attachment style

Bowlby (1988) hypothesised that insecurity can be reversed by 'corrective' experiences in relationships. Through improvements in parents' care, later ameliorative relationships (possibly even therapeutic ones; see below), or the development of formal operational thought which would allow reinterpretation of past and present experiences. If such changes do not occur, then the insecure child will become an insecure adult, and will have greater difficulty making and maintaining close relationships and seeking or receiving informal (and potentially formal therapeutic) support.

4.1.1.4 Attachment insecurity and psychopathology

Bowlby (1977) theorised that uncorrected attachment insecurity might lead to higher risk of psychopathology, perhaps partly due to this inability to access emotional support. His theory has received corroboration in general psychological research (Rutter, 1995; Stein et al., in press) as well as in diverse fields such as schizophrenia (Crittenden, 1995; Dozier, 1990), depression (Bifulco, Moran, Ball, & Bernazzani, submitted; Mahon, Bifulco, Moran, & Harvey, submitted), and eating disorders (Armstrong & Roth, 1989; Burge et al., 1997; Candelori & Ciocca, 1998; Fonagy et al., 1996; Ward, Ramsay, &
Specifically, abuse, neglect, or trauma experienced in childhood (factors examined in Chapters 5 & 6 of this thesis) may compromise the child’s ability to form secure attachments (Bifulco et al., submitted; Carlson et al., 1989). Childhood abuse and loss of attachment figure are related to depression in adulthood (Bifulco, Brown, Moran, Ball, & Campbell, 1998; Bifulco, Brown, & Harris, 1987; Brown, 1988; Harris & Bifulco, 1991).

Attachment and eating disorders. Since this thesis focuses on attachment and dropping out from psychological treatment, as opposed to attachment and psychopathology, the literature on attachment and eating disorders will be only briefly mentioned here. Considering this area is important to assessing whether eating disorder diagnosis, attachment style, and dropping out might be confounded. Several studies in recent years have explored attachment in eating disorders (e.g., Armstrong & Roth, 1989; Burge, Hammen, Davila, Daley, Paley, Lindberg, Herzberg, Rudolph, 1997; Candelori & Ciocca, 1998; Chassler, 1997; Cole-Detke & Kobak, 1996; Fonagy, Leigh, Steele, Steele, Kennedy, Mattoon, Target & Gerber, 1996; Mahon, Terris, & Palmer, 2000; Ward, Ramsay, Turnbull, Benedettini & Treasure, 2000), and some reviews of the literature have been published (e.g., O’Keamey, 1996; Ward, Ramsay & Treasure, 2000).

Many of these studies operationalise attachment as separation anxiety (e.g., Armstrong & Roth, 1989), or as parental bonding (e.g., Palmer, Oppenheimer, & Marshall, 1988; and many other early ‘attachment’ studies); therefore, the measures these studies have used are not directly comparable to the attachment style measures considered in this thesis. More recently, studies have operationalised attachment as a ‘state of mind’ (e.g., Candelori & Ciocca, 1998, Cole-Detke & Kobak, 1996; Fonagy et al, 1996; Malinckrodt, McCreary, & Robertson, 1995; Saltzman, 1997), rather than attachment as a ‘style’ (see Section 4.1.2.1). Further limiting their applicability to this thesis, the published studies which have used an attachment ‘style’ measure have not used clinically eating-disordered populations (e.g., Brennan & Shaver, 1995; Evans & Wertheim, 1998; Suldo & Sandberg, 2000).

Determining whether eating-disordered patients and volunteers have higher rates of attachment insecurity than ‘normal’ (usually college) populations has been the main objective of many of these studies (e.g., Friedberg & Lyddon, 1996; Chassler, 1997), rather than determining whether there is any relationship between type of attachment insecurity and type of eating disorder, and some do not use a confirmed diagnosis for
their eating-disordered participants (e.g., Saltzman, 1997). However, results have indicated that, while attachment insecurity is more common in the eating-disorder than the general population, there is no consistent relationship between attachment insecurity (e.g., dismissing or avoidant) and psychopathological diagnosis, or between type of attachment insecurity and specific eating disorder diagnosis (e.g. AN-R or BN) (Cole-Detke, 1998; Ward, Ramsay, Turnbull, Benedettini & Treasure, 2000; Ward, Ramsay & Treasure, 2000; Mahon, Terris, & Palmer, 2000). Thus confounding of attachment style, eating disorder diagnosis, and dropping out is not expected.

4.1.1.5 Attachment in therapeutic relationships

Bowlby (1988) drew parallels between the therapeutic relationship and that between child and parent, where the patient can have a positive, need-gratifying experience that affects internal working models in future relationships. However, the role of attachment in therapeutic relationships has not often been researched. The little that has been published has tended more toward the theoretical or anecdotal than the empirical (e.g., Dozier & Tyrrell, 1998).

Underpinning any research on the role of attachment in the therapeutic relationship is the observation that the therapeutic relationship has important features of an attachment relationship. Holmes (1993) has enumerated the principal characteristics of a secure attachment relationship between a child and caregiver:

1. The existence of the secure base: The caregiver is a preferred figure who is responsive to the child, provides attuned support, and encourages exploration (even in insecure attachment there is a preferred figure who is used as a base).

2. Proximity seeking: The child turns to the caregiver for protection, comfort, and relief from anxiety in times of distress.

3. Separation protest: The child objects when asked to leave the caregiver.

Childhood and therapeutic attachments would differ in the relative importance of each of these features, but the core characteristic of one person using another as a secure base from which to take risks and explore should be present in both secure childhood attachment relationships and successful therapeutic relationships (Adshead, 1998). Thus the attachment paradigm seems applicable to understanding the establishment of therapy relationships.
Other aspects of the therapy situation need to be accounted for when applying an attachment relationship model to the therapy relationship. The therapeutic relationships discussed in this thesis, and in the majority of studies of dropping out, involve adults. Adult attachment relationships typically differ somewhat from child attachment relationships, if only by not being as asymmetrical as the child relationships (Stein, Jacobs, Ferguson, Allen, & Fonagy, 1998; Weiss, 1982). Furthermore, adult therapeutic relationships have specific features which distinguish them from most adult attachment relationships:

1. Most adult attachment relationships are reciprocal, confiding relationships. The therapeutic relationship is specifically meant not to be reciprocal. Thus the dynamic may be unfamiliar in the patient’s adult relationship experience.

2. An important assumption underpinning the therapeutic relationship is that there will be discussion of sensitive topics and the early disclosure of emotional issues, which would normally take much longer in other adult relationships. Thus the therapist is meant to become a secure base for the patient without the usual tests and precautionary measures that developing (secure) adult attachment relationships usually undergo.

Therefore, therapeutic relationships do not directly fit either the child or adult attachment paradigms. Methods for researching the role of attachment in these relationships cannot necessarily be directly translated from the informal to the formal setting. This is discussed further below.

4.1.2 Measurement of attachment: adult cognitive ‘style’ or dynamic ‘state of mind’

Bowlby originally conceived of attachment in terms of distinctive patterns of behavioural responses to early parenting. These were the early manifestations of mental representations (‘internal working models’) of the self and others in close, caregiving relationships. Thus, from its inception, attachment was perceived as being both a property of an individual’s mental state and a product of a particular relationship.

Bowlby, however, did not derive methods for measuring attachment. Ainsworth et al. (1978) developed the first measurement of attachment with the Strange Situation, examining the behaviour of children through a series of separations and reunions with their mothers. Measurement of attachment in adulthood followed, setting the focus of
measurement on trait-like aspects of individual differences rather than on state-like aspects of relationships. This thesis is concerned with measurement of attachment patterns in adulthood, which is discussed below.

4.1.2.1 Attachment as 'state of mind' or as 'style'

Historically, the development of measurement of adult attachment has followed two main schools (For schematic of these schools, see Figure 4-1). These can be grouped into those measuring attachment 'states of mind' through interviews designed to uncover the unconscious internal working models of attachment to childhood parental figures (e.g., Adult Attachment Interview, AAI; George, Kaplan, & Main, 1984), and those measuring attachment 'styles' through questionnaires or interviews enquiring about current interpersonal processes, usually romantic ones (e.g., Collins & Read, 1990; Hazan & Shaver, 1987), which are consciously accessible. While these concepts are all labelled 'attachment', probably several distinct constructs are being measured (Stein et al., 1998). This is supported by the fact that within each school and relationship domain measurement stability is reasonably good (Bartholomew & Shaver, 1998; Crowell, Fraley, & Shaver, 1999; Sperling, Berman, & Fagen, 1992), but it is not good across schools or domains (de Haas, Bakermans Kranenburg, & van Ijzendoom, 1994; Stein et al., in press). As a result this thesis further focuses on the attachment-as- 'style' school, whose theoretical and measurement work underlies the research presented in Part 2. The developments of this school are expanded on in the sections below.

The attachment-as-state-of-mind school has been developed by authors such as Fonagy and colleagues (e.g., Fonagy, Leigh, Kennedy, Mattoon, Steele, Target, Steele, & Higgitt; Fonagy et al, 1996), Main and colleagues (e.g., Main, 1995), Parkes and Stevenson-Hinde (e.g., Parkes & Stevenson-Hinde, 1982), van Ijzendoorn and colleagues (e.g., van Ijzendoorn & Bakermans-Kranenburg, 1996), Rutter (e.g., 1995), and Bretherton (e.g., Bretherton, 1995). These authors have been particularly concerned with applying attachment states of mind to aetiological models of psychopathology and to clinical contexts, in particular to the psychodynamic clinical context (e.g. Fonagy et al, 1995; Parkes & Stevenson-Hinde, 1982). Measures developed by this school are typically targeted at eliciting sub-conscious material about parenting experiences in childhood, as exemplified by the AAI (See Figure 4-1). To access this information, intensive interviewing and meticulous though perhaps subjective scoring methods are used. While of great interest, these measures are not applicable to this thesis.
4.1.2.2 Attachment as 'style'

The concept of attachment underlying Chapters 5, 6 & 7 is the adult interpersonal stance, or 'style', that has its origins in early childhood experience and is directly related to the ability to make and maintain close, confiding relationships. The development of this school and its measurement tools is traced below.

In the attachment 'style' school, the mechanism relating childhood experience and adult attachment style is hypothesised to be the internal working model of close relationships interactively constructed through early experience, though it is not claimed that the original internal working models can be measured in adulthood, or indeed through self-report. Adult attachment style can instead be measured by assessing adult cognitions about close confiding relationships (in this thesis the relationships are not specifically romantic ones). These cognitions are thought to relate closely to self-reported and actual behaviour in relationships (Bifulco et al., submitted). While attachment style is related to personality or temperament, it is not redundant with them (Ainsworth et al., 1978; de Haas et al., 1994; Shaver & Brennan, 1992).

4.1.2.2.1 Measurement of attachment styles

In 1987 Hazan and Shaver introduced a self-report measure which was designed to translate the childhood attachment patterns observed by Ainsworth into three adult romantic 'types': secure, avoidant and preoccupied (Hazan & Shaver, 1987). Participants endorsed one of three paragraph-long self-statements to produce a categorical rating. The simplicity of this structure was appealing, and as a result this measure has been widely used; however, statistical restrictions imposed by using categorical measurements have hindered its wider development. Several other self-report measures were produced from the Hazan and Shaver original which allowed for continuous measurement (e.g., Collins & Read, 1990; Simpson, 1990).

Alongside psychometric adjustments, theoretical advances were made. Bartholomew and Horowitz (Bartholomew & Horowitz, 1991) proposed that 2 continuous bimodal dimensions – positive or negative view of self and positive or negative view of others – might better explain the distribution of attachment styles. This revision produced 4 styles of attachment: secure (positive view of self and of others), insecure preoccupied (negative view of self, positive view of others), insecure dismissing-avoidant (positive view of self, negative view of others), and insecure fearful-avoidant (negative view of self and of others). However, this may measure attitudes
toward self and other more than it does attachment as conceptualised by Bowlby (Stein et al., 1998).

More recently, Brennan et al. (1998) factor-analysed items from all existing style measures. She found that 2 dimensions, anxiety and avoidance, better defined individual differences in attachment. This analysis defined ‘secure’ attachment only as the absence of anxiety and avoidance in relationships, which both neglects the normative element of attachment and seems unlikely in practice – many securely attached people will also display elements of anxiety and avoidance in relationships (Bifulco et al., submitted). Since the items used in her study were keyed to romantic partners, and since they did not necessarily include situations where the attachment system would theoretically be activated (i.e., when under threat), the generalisability of this measure to other situations is in some doubt. Other measures have similarly focused on the insecure rating at the expense of secure ratings (West, Sheldon, & Reiffer, 1987).

The measure chosen for Chapter 7 of this thesis asks about all close, confiding attachment relationships rather than just romantic ones. It is therefore ‘role-independent’. The Vulnerable Attachment Style Questionnaire (VASQ; Appendix 4-I)(Mahon et al., submitted), is distilled from a widely used and well-validated semi-structured interview (the Attachment Style Interview) (Bifulco et al., submitted). It measures attachment in terms of the individual’s ability to make and maintain close, confiding relationships and to elicit and utilise informal support when distressed. Unlike most questionnaires which rely on factor analysis for developing scales and subscales, the VASQ relied on cluster analysis for its rating system. Thus it was intended to identify not only insecure groups but also secure groups in their own right. However, because it is composed of discrete items rather than grouped self-statements, it retains the capacity to be analysed dimensionally as well as categorically.

The VASQ also differs from other attachment style questionnaires in that it was developed to predict psychiatric disorder and was validated on a community population. Previous attachment style questionnaires were more often used for detecting dimensions of individual styles and tended to be validated on college or university populations. An intensive epidemiological study has found VASQ insecure ratings to be predictive of depression in adulthood (Mahon et al., submitted) and secure ratings to be protective against depression, even when there is a history of abuse (Bifulco et al., submitted). These features make it more appropriate for use in the psychiatric treatment domain.
4.1.2.2 Subclassifications of insecure attachment

In the majority of recent attachment style research (e.g., Brennan, Clark, & Shaver, 1998), adult attachment insecurity has been broadly characterised as either being avoidant/dismissive of or anxious/preoccupied with affect and behaviours in close relationships. Such subclassifications are not used in this thesis, primarily because the overall security or insecurity of attachment style is the main interest in examining whether a formal helping relationship can be established. There is also increasing evidence that, while overall security or insecurity are consistent between measures, the subclassifications are unstable (Feeney, Noller, & Hanrahan, 1994; Mahon et al., submitted; Stein et al., in press). The underlying dimensionality/taxonicity of attachment is the subject of continuing debate (Fraley & Waller, 1998; Rutter, 1995).

4.1.2.3 Attachment as a property of a relationship dyad

Currently there are no published measures designed to chart the unfolding of the attachment characteristics of an adult dyad, which may be important for measuring the developing therapy relationship. All of the existing measures investigate individual differences and generalise these results to other close relationships.

4.1.2.3.1 Measurement of therapeutic attachment

Measurement of therapeutic attachment may need special tools. The relationship between patient and therapist may involve a particular brand of attachment and may call upon distinct abilities in both the patient and therapist that would not be used in most adult attachment relationships. If this is so, these qualities might not be apparent before the beginning of treatment. Certainly it seems unlikely that the romance-based attachment style tools would be appropriate measures.

Even specifically designed trait measures may not be adequate for assessing the characteristics of the treatment relationship itself. The therapy relationship is likely to be influenced by the traits of both the patient and the therapist (especially in the early stages), but its properties are unlikely to be wholly determined by them. It may be that to better understand dropping out, the developing attachment characteristics of the therapy

21 Indeed, regarding adult attachment as a trait may only be the product of the measures that have been produced thus far. Adults may have different attachment styles when interacting with different attachment figures (Stein et al., 1998). It is still not known whether, when, or through what mechanism the child’s ability to have different styles in different relationships is restricted.
dyad need to be measured over time. Chapter 9 focuses on the development of such a measure.
Attachment Measures

Figure 4-1

Bowlby's Attachment Theory

- Normative Component (Lifespan)
- Individual Difference Component

Measurement: Ainsworth's Strange Situation (Child/Caregiver)

- 'State of Mind' School (Adult)
- 'Style' School (Adult)

Parent/Caregiving-based measures

- Adult Attachment Interview (George, Caplan, & Main, 1985)
- Memories of parenting (EMBU; Perris, Jacobson, Lindstrom, von Knorring, & Perris, 1980)
- Attachment and Object Relations Inventory (Buelow, McClain, McIntosh, 1996)
- Attachment History Questionnaire (Pottharst, 1990)

Romantic Partner/Peer Measures

- Adult Attachment Questionnaire (Hazan & Shaver, 1987)
- Revised Adult Attachment Scale (Collins & Read, 1990)
- Adult Attachment Scale (Simpson, 1990)
- Relationship Questionnaire (can be used for all close; Bartholomew & Horowitz, 1991)

All Close, Confiding Relationships

- Attachment Style Interview (Bifulco et al, submitted)
- *Vulnerable Attachment Styles Questionnaire (Mahon et al, submitted) (*Chapter 8)
- Attachment Style Questionnaire (Feeney, Noller, & Hanrahan, 1994)

Therapy Relationships: (Dyad)

- *Therapy Relationship Questionnaire (*Chapter 9)

Figure adapted from Simpson (1990)
### Studies in Part 2

<table>
<thead>
<tr>
<th>Ch</th>
<th>Sample selection</th>
<th>N=</th>
<th>Data source</th>
<th>Analysis type</th>
<th>Attachment Operationalisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Patient series</td>
<td>110</td>
<td>Case Note analysis</td>
<td>Exploratory Regression</td>
<td>Childhood experience, Broad markers Patient pre-treatment trait</td>
</tr>
<tr>
<td>6</td>
<td>Patient series</td>
<td>114</td>
<td>Case Note analysis</td>
<td>Confirmatory Regression</td>
<td>Childhood experience, Broad markers Patient pre-treatment trait</td>
</tr>
<tr>
<td>7</td>
<td>Patient series</td>
<td>88</td>
<td>Patient self-report</td>
<td>Hypothesis-driven &amp; Exploratory X² &amp; Factor analysis</td>
<td>Attitudes twd attachment relationship Patient pre-treatment trait</td>
</tr>
<tr>
<td>8</td>
<td>Stratified</td>
<td>26</td>
<td>Open-ended depth interview</td>
<td>Exploratory Interpretative Phenomenology</td>
<td>Patient memory of cognitive states Patient in-treatment state</td>
</tr>
<tr>
<td>9</td>
<td>Patient series</td>
<td>110</td>
<td>Patient/Clinician self-reports Paired quantitative</td>
<td>Exploratory – potential for Confirm Factor &amp; Cluster analysis</td>
<td>Cognitive states measured over time Dyadic in-treatment states</td>
</tr>
</tbody>
</table>
4.2 Methodological Foundations

The aim of the thesis is to deepen the understanding of factors affecting dropping out from psychological treatment. The methodological approaches in Part 2 use both qualitative and quantitative techniques to produce a more rounded and convincing analysis of dropping out. The review of methods used in studying dropping out has shown that quantitative techniques used alone are unlikely to produce such an analysis.

Studying dropping out is complicated by the fact that drop-out is the product of a dynamic process. Like trying to study a butterfly under a microscope, the intrusion of the researcher into the treatment process can destroy the very thing that she is trying to study. Therefore methods need to be both appropriate to the questions that are being sought and as non-intrusive as possible.

Part 2 of this thesis comprises several studies which use different data collection and analysis techniques (Figure 4-2). Each study stemmed from the one before as different methods were used to explore dropping out and attachment was examined as a framework for understanding it. Different operationalisations of attachment have been used to organise these investigations and the interpretation of their results: initially, attachment as a trait-like characteristic of the patient was used (Chapters 5-7); subsequently, attachment as a property of the therapy dyad was used (Chapters 8 & 9). The results of these studies are integrated into a tool for studying attachment as a product of the therapy relationship (Chapter 9). This tool is intended to be used to predict dropping out. The concluding chapter presents a tentative model of dropping out using attachment as its framework.

4.2.1 Method 1: Case-note analyses of clinical series (Chapters 5 & 6)

The first type of study used in this thesis seeks:

1. To investigate whether broad markers of disordered attachment, such as childhood abuse and parental loss, relate to dropping out, using as non-invasive a method as possible for accessing this information.

2. To investigate the effect of demographic and clinical variables on dropping out in the bulimic population.
Influences on validity The data gathered with this approach are given in the context of an assessment session with an assessor who was previously unknown to the participant, and so are relatively public pieces of information. The patient is aware of being assessed, and at the same time is assessing both the agenda of the assessor and his or her credibility and potential helpfulness. The information given in this context may involve ‘faking good’ or ‘faking bad’, or trying to convince the assessor that treatment is needed, and may be influenced by the assessee’s own model of eating disorder and evaluation of the appropriateness of the assessor’s questions. Therefore when sensitive topics are covered (such as ED symptoms or experiences relating to trauma in childhood) the data supplied by the patient are coloured by the social psychological context. Such influences may not be as important in transmitting demographic information. These data may also be affected by the assessor’s methods of recording information, although the presence of standard history assessment sheets at the host centre encouraged consistency.

At heart, the purpose of this technique as used in this thesis is to explore data, rather than to make statistical inferences. Hypotheses are tested only to verify whether they merit further development (Chapter 5). Validity of findings and claims based on those findings are based on replication of results (Chapter 6).

Operationalisation of attachment: Testing attachment concepts retrospectively

As mentioned above, attachment theory holds that experiences in childhood influence the development of the ability to form close, supportive relationships (Bowlby, 1988). One broad method of testing for attachment-related difficulties is to record the presence of childhood traumatic experiences. Gathering information on ‘historical’ attachment markers might answer one type of question about the relationship between childhood traumatic experiences as acknowledged in a clinical interview and adult engagement in treatment for BN.

4.2.2 Method 2: Prospective patient series: Pre-treatment self-report of attachment style (Chapter 7)

The second type of study aims:

1. To use relatively non-invasive methods to investigate whether patients’ pre-treatment self-reported general attachment style contributes to engaging in or dropping out from treatment.
2. To explore the ability of self-reported attachment dimensions to distinguish those who drop out from those who engage in, complete, or refuse treatment.

Influences on validity. Attachment style was asked about in a pack of questionnaires concerning feelings about the self and others. These questionnaires were self-administered before the beginning of treatment, so treatment itself could not have affected attachment style. Administering the questionnaires just before treatment provided the best view of the attachment style which the patient would bring to the beginning of the treatment relationship.

The measure selected for this study (the VASQ) has several advantages:

1. It assessed all close, confiding attachment relationships, not just romantic ones. Such ‘role independence’ is particularly important in this patient group, since many ED patients may not have experienced romantic relationships.

2. It was designed for and validated in a population at risk for psychiatric disorder, rather than a college or university population.

3. It was keyed into the severity of attitudes toward attachment, rather than just descriptions of different subcategories of attachment. These subcategories, while heuristically interesting, have not been shown to be stable.

4. It provided for categorical as well as dimensional scoring.

5. It was derived from a widely used and well-validated interview measure, so all items were tested before being formulated in self-report format.

The strength of the claims made in this study is based on enumerative or statistical logic. Generalisation of the results requires that the sampling procedure be representative, and that the analysis has statistical integrity.

Operationalisation of attachment: self-report measure of attachment style

The self-report measure of attachment style accesses cognitions about close, confiding relationships. It accesses the adult’s generalised attitudes toward these relationships, and as such is felt to be a relatively stable ‘trait’. Because only the patient style is measured, this approach to attachment is essentially intra-personal.

4.2.3 Method 3: In-depth qualitative interviews (Chapter 8)

The third type of technique uses open-ended, in-depth qualitative interviews to:
1. Examine the role of attachment relationship themes in the accounts given by current and former patients about why they stayed in or dropped out of psychological treatment. This analysis is the main focus of the chapter. This chapter changed the focus of the investigation from intra-personal to inter-personal.

2. Discover the range of reasons for staying in or dropping out of treatment.

3. Understand the process and meaning of dropping out from the patient perspective.

Influences on validity Obviously, interviews are more intrusive than case-note studies. In this study, they were designed not to intrude on the therapeutic relationship itself: they were arranged via the university academic department rather than the treatment centre and were conducted by a researcher independent of the clinical team on the participants’ own ‘turf’.

The data yielded by qualitative techniques was more personal, concerning processes and meaning. Qualitative approaches in general are designed to access this type of data (Henwood & Pidgeon, 1992). Indeed, it is difficult to access such information in other ways, particularly when the topics covered are potentially embarrassing or painful (Lebowitz & Roth, 1994). Since many drop-out patients feel defensive about having left or fear being judged for having left or being coerced into coming back to treatment, the quality of the data and the method used to obtain it are intimately linked. A further consideration in studying dropping out from treatment for EDs is that eating-disordered patients may be particularly prone to these concerns (Palmer, 2000). A derivative of a specific qualitative technique, Interpretative Phenomenological Analysis (IPA) (Smith, Jarman, & Osborn, 1999), was used for data gathering and analysis.

Social psychological effects are still present in the interview situation, but attempts are made to compensate for these (techniques are discussed further in Chapter 8). The validity of any claims made in this type of study involves demonstrating that the contours of the process have been delineated, rather than that representative sampling and appropriate statistical technique have been used.

Operationalisation of attachment: Qualitative exploration

The interviews were designed to access participants’ cognitive states about the process of establishing a close, confiding relationship with a therapist. Participants were
asked to recount their experiences in treatment and to theorise about what factors affected these relationships. There was no attempt to access unconscious information about attachment.

4.2.4 Method 4: Presentation of tool to study treatment dyads (Chapter 9)

The final type of study used in this thesis aims:

1. To present the development and early analysis of a measure designed to assess attachment as a state-like characteristic of the developing relationship between patient and therapist. This tool is designed to translate the findings from the preceding investigations into a testable form which might be used for predicting dropping out.

2. To investigate the relationship between the patient's pre-treatment attachment style and the attachment characteristics of the clinical relationship.

In order to trace the development of the treatment relationship, this tool is designed to be self-administered at four time points during the beginning of treatment. This tool uses two unusual features to characterise the developing treatment relationship:

1. It includes the views of both the patient and therapist as sources of data. Results from the preceding chapters indicated that looking at both members of the dyad might be useful in understanding dropping out. Furthermore, past research has shown that including both members also improves prediction of dropping out (e.g., Fraps et al., 1982), perhaps because inferring the state of mind of the other member of the dyad is not required.

2. Data is gathered over several time points: assessment and the first three therapy sessions. This means that at least some information will be gained on all treatment relationships, even those that end in dropping out. It also means that both members of the dyad have several opportunities to record their changing impressions of the relationships to give a ‘truer’ picture of their feelings. Participants in the interviews in Chapter 8 indicated that by the second or third session they knew whether the relationship was going to be helpful for them. Other research indicates that the first three sessions are a critical period (e.g., Saltzman et al., 1976). Having data over several time points allows the vector of the developing relationship to be calculated.
In presenting the tool, data from the first time point only (assessment) are analysed, and drop-out information is not yet available.

Influences on validity The data yielded by this technique were given as part of a survey, and therefore may have been perceived as relatively public information. Certainly the data were restricted to consciously accessible feelings and attitudes. Control for the demand effects of the clinical context was attempted by asking the participants to complete the questionnaires away from the treatment context and posting them back to a group of researchers independent of the clinic at a freepost address in a city different from the one where the host clinic is located. Questionnaires were coded, so names were not linked to responses. It was hoped that as a result participants would feel less concerned about their therapists having access to the information, and therefore would be more forthright in their responses. In the interest of obtaining complete responses, the questions asked in the patient form of the questionnaire are based on the language used by participants in the open-ended interview study. Those used in the therapist form are based on the language used by therapist participants in a parallel interview study (not reported in this thesis).

The paper-based technique used was the least invasive method that was felt capable of eliciting useful information. Video-taping, audio-taping, or observing sessions might have changed the nature of the developing relationship, thus confounding the results. It is possible that being asked about feelings regarding the treatment relationship may have inspired patients to raise concerns that they otherwise might not have. Comparing drop-out rates pre- and post-study and de-briefing patients and clinicians will be useful.

Operationalisation of attachment: Dyadic measure over time.

The dyadic instrument measures the relationship developing between the patient and therapist from the perspectives of both members of the dyad. As such it operationalises attachment as a state-like property of a dyadic relationship.

4.3 Concluding summary

1. Attachment theory provides the theoretical foundation for the studies in Part 2 of this thesis.
a. Chapters 5, 6, & 7 rest on the attachment construct which explains individual differences in the ability to make and maintain close, confiding relationships. This refers to a characterological trait.

b. Chapters 8 & 9 rest on the attachment construct which examines the process through which close, confiding relationships are formed. This refers to the properties of a developing dyad.

2. Attachment theory can be applied to therapeutic relationships, but it may not be possible directly to translate methods for measuring attachment processes from informal relationships to formal relationships. Therapeutic relationships have features which distinguish them from other adult relationships, namely, non-reciprocity and early disclosure.

3. Measurement of attachment has followed 2 schools: attachment as a state of mind, and attachment as a style. The measures used in Part 2 are part of the 'style' school, which views attachment as consciously accessible cognitions about close, confiding adult relationships.

4. Measuring attachment in a therapy relationship may require using a measure appropriate for this relationship domain or even a new type of measure which assesses attachment as a product of a dyad. This is the focus of Chapter 9.

5. The methodological approaches in Part 2 include both qualitative and quantitative techniques in order to better understand dropping out. Each study stemmed from the one before as different methods were used to explore dropping out and to examine attachment as a framework for understanding it.
Part 2: Original work
5 COHORT 1: DOES TRAUMA EXPERIENCED IN CHILDHOOD RELATE TO DROPPING OUT IN ADULTHOOD?

5.1 Introduction & Aims

Given the potential importance of interpersonal and interactive factors in distinguishing drop-outs from engagers, it was thought to be useful to conceptualise dropping out as a transaction between patient and therapist in the next two chapters. Patients' early experiences in close relationships were thought to have an important effect on this transaction. It was hypothesised that patients' early attachment-related experience would influence attitudes toward forming a trusting relationship with a therapist. Therefore, as a broad approximation of early attachment-related experience, patients' experiences of physical and sexual abuse and divorce, separation or death of parents were considered.

Since the results for previous drop-out research are inconsistent, a wide data-gathering net was cast in this study. In addition to the attachment factors which were the main area of interest, demographic, clinical (both self-report and clinician-rated), and situational and clinic factors affecting patient experience were examined. In order to study a large number of cases without intruding on the patient-therapist relationship, a retrospective, case-note review method was selected for this initial study. The 'fishing' nature of this study was partly compensated for by using multivariate data-analytic methods and by a planned replication of the study (Chapter 6).

5.1.1 Aims

The study aimed:

1. To investigate whether broad markers of disordered attachment relate to dropping out, using as non-invasive a method as possible for accessing this information.

2. To further investigate the effect of demographic and clinical variables on dropping out in the bulimic population.
5.2 Method: Cohort 1

5.2.1 Clinic
The Leicester General Hospital Eating Disorders Service (EDS) hosted all of the studies described in these chapters. A secondary and tertiary referral unit, it had both inpatient and outpatient facilities at the time of this study, though typically very few women with BN were admitted as inpatients. The EDS is located in an urban area of a culturally diverse city in the English Midlands. Its catchment area includes about 950,000 people. It is run by the National Health Service, and so provides treatment free-of-charge at the point of delivery. As a result, it is also has to contend with long waiting lists.

This cohort were generally offered open-ended individual psychotherapy with pragmatic dietary advice and monitoring. Therapies offered all exceeded 10 sessions. At the time of this study, most therapists used an eclectic approach to treatment. Waiting lists often exceeded 3 months for both assessment and therapy appointments. Patients were assigned to therapists according to the caseload of the therapist. They were assessed over an average of usually 3 hours by a senior member of the team, who then presented the patient to all therapists at a weekly meeting.

5.2.2 Therapists
Following the lead of those investigating non-specific treatment factors (e.g., Frank et al., 1957; Horvath, 1994a), the study included more than one type of treatment and more than one therapist. The multi-disciplinary therapy team comprised consultant, senior registrar, and registrar psychiatrists, specialist nurse therapists, specialist occupational therapists, and clinical psychologists. All team members conducted all types of treatment, with medical supervision provided by the consultant psychiatrists.

5.2.3 Subjects
The subjects were a consecutive series of women diagnosed with BN or atypical BN (ICD10; WHO, 1992) seen for at least one assessment interview at the EDS from December 1992 - October 1994. Only patients resident in the Leicestershire at the time of assessment were included in the study. This maximised the generalisability of findings by reducing the skew toward very severe cases that would be introduced by including patients referred from outside the clinic catchment areas.

5.2.4 Measures
5.2.4.1 *Definition of dropping out*

As determined from the case notes, patients who ceased contact with the clinic *against the advice of their therapist* before their 10th therapy session were considered to have dropped out. Information about therapist advice was recorded on the clinic discharge sheets. In these early studies, patients who came for any portion of assessment but refused treatment were included as drop-outs. Assessment sessions were not included in the total number of treatment sessions. The threshold of ten sessions was chosen for two reasons. First, it was clinically considered to be a minimum at which lasting therapeutic benefit was likely to be derived in the treatment of bulimia, and no patients entering the clinic for treatment were offered fewer than 10 sessions. Second, there is research evidence that the dosage level at which about half of patients with depression and anxiety-type diagnoses show improvement lies around 8-13 sessions (Howard et al., 1986); while not directly related to EDs, this evidence gave some more objective support for the clinical opinion.

5.2.4.2 *Analysis sheet*

A 19-item analysis sheet was constructed to record retrospectively from patients’ case notes the factors selected for investigation, which are described below (Appendix 5-1).

5.2.4.2.1 *Childhood trauma*

Experiences of trauma in childhood were used as broad markers of attachment-related experience. Traumas included were sexual abuse, physical abuse, and parental loss. Patients are asked about these experiences routinely but informally.

*Sexual abuse* was defined as sexual activity occurring between a victim aged 13 or younger and a perpetrator aged 16 or older or between a victim aged 13-15 and a perpetrator 5 or more years older.

*Physical abuse* was defined as being hit, kicked, restrained, or materially neglected by a care giver before the age of 16. A care giver was considered to be either a parent or guardian or an adult living in the child’s household.

*Parental losses* rated were parental separation, divorce or death before the patient’s 16th birthday.
A childhood emotional trauma index was derived to examine the additive effect of these experiences on dropping out. Producing an additive index gave each experience equal weight, and disregarded the severity and duration of the experiences (Horvath, 1994b). Obviously the impact of each experience could not be deduced from the case-note data, so the index had to be used for heuristic purposes. It was felt that the more categories of events that a participant experienced, the less likely she would have been to get adequate support in childhood. Such lack of support in childhood might have compromised her ability to form strong relationships in childhood, which might relate to the ability to engage in treatment later.

5.2.4.2.2 Severity of ED characteristics

Frequencies per week of bingeing and vomiting and amounts of laxatives taken per week were extracted from the standardised EDS assessment sheets included in all case notes. Patients had been asked by assessors to estimate the average frequency of episodes over the month previous to assessment. Duration of ED was calculated from patients' histories taken at assessment, also recorded on the standardised sheets.

Patients were also asked to complete the Eating Disorders Inventory (EDI; Garner, Olmstead, & Polivy, 1983). The EDI is a widely-used and well validated 64-item self-report inventory of symptomatic ED behaviours and related attitudes. It comprises 8 subscales: drive for thinness, bulimia, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust [sic], interoceptive awareness, and maturity fears. An expanded version of the EDI exists, but the original version was used for this study as it is in the public domain.

A clinical severity of ED characteristics index was calculated by transforming frequencies of bingeing and vomiting, laxative doses, and duration of ED into scores considered to be clinically significant, which were then summed. The scale was then divided into two levels: low-average severity (0-3) and high (4+) severity. This step aimed to eliminate false appearance of precision.

<table>
<thead>
<tr>
<th>ED Characteristic</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Binges per week</td>
<td></td>
</tr>
<tr>
<td>0-1.9</td>
<td>2-7</td>
</tr>
<tr>
<td>over 7</td>
<td></td>
</tr>
<tr>
<td>Vomiting per week</td>
<td></td>
</tr>
<tr>
<td>0-1.9</td>
<td>2-7</td>
</tr>
<tr>
<td>over 7</td>
<td></td>
</tr>
</tbody>
</table>

5-108
5.2.4.2.3 Comorbid psychiatric symptom severity

Comorbid symptom severity was taken from Symptom Checklist-90 (SCL-90; Derogatis, 1977) responses. The SCL-90 is a widely used and well-validated 90-item questionnaire asking about levels of distress caused by a range of psychiatric symptoms over the week previous to assessment. It was scored into three main subscales measuring the severity of global symptoms, the total of positive symptoms, and an index of the level of distress caused by these positive symptoms. There are a further 11 subscales that can be derived but these were not as directly relevant to comorbid symptom severity.

5.2.4.2.4 Diagnosis at assessment

Diagnosis was made by the EDS assessor and recorded in the standardised assessment forms.

5.2.4.2.5 Self-esteem

Patients were also asked to complete the Rosenberg Self-Esteem Scale (Rosenberg, 1965) at assessment. The RSE is a short (10-item) series of self-statements about feelings of self-efficacy, self-satisfaction, and self-respect. Although originally developed for use with adolescents, it has become widely used for adult populations as well.

5.2.4.2.6 Demographic factors

Demographic variables were age, employment status (full-time, part-time, unemployed, housewife, disabled, student, other), and domestic circumstances (living with family of origin, partner, on own, in institution, other).

5.2.4.2.7 Patient experience

Distance travelled to the clinic was estimated by location of the patient’s home, either in the City of Leicester, where the clinic is situated, or in the surrounding area, the County of Leicestershire. Days spent waiting for assessment and treatment, and previous psychiatric treatment were recorded.

5.2.5 Analysis of Data
1. In order to determine whether there was a dose-effect relationship with dropping out, the childhood trauma index was analysed using a correlational approach outlined by Howell (1999a & b) which allows for the linear relationship between to categorical-type variables to be assessed. Traditional chi-square methods would ignore the ordinal quality of the trauma index. In this approach, a metric was assigned to each variable (Drop-out=0,1; Trauma=0-4). These variables were then correlated with a Pearson product-moment correlation (r), which was tested for significance using a chi-square method laid out by Agresti (1996). $M^2=(N-1)r^2$, where $M^2$ is a chi-square statistic on one degree of freedom and $N$ is the sample size. Finally, as a linear relationship is assumed in this approach, departure from linearity was tested using another chi-square technique. In this technique, a Pearson chi-square was calculated, which evaluated the overall correlation between Trauma and Drop-out. Next, the linear component (Agresti's $M^2$) was subtracted from the overall $\chi^2$, and the remaining $\chi^2$, which accounts for the non-linear components of the relationship, was tested for significance. Significance would indicate that a non-linear relationship existed between the variables (e.g., that there was something other than a simple dose-effect relationship); non-significance would indicate that the relationship was linear. For more information on this technique, see Howell (1999b).

2. Prior to running multivariate analyses, univariate and bivariate analyses were examined, and all variables were investigated for collinearity. SPSS 7.5 for Windows 95 (Nie, Hull, Jenkins, Steinberger, & Bert, 1996) was used for standard analyses.

3. Demographic, clinical (clinician-rated symptom severity and diagnosis), situational, and trauma and psychiatric history data were analysed using logistic regression (LR) with a backward stepwise Wald method. The exclusion level was set at a probability level (p) 0.08. Selected non-collinear variables were entered into the model in the first step, then, iteratively, the variable with the least significant Wald chi-square was removed, and the remaining set re-analysed, until only variables with a $p<0.08$ remained in the model. The variables which are statistically significant at $p<0.05$ are described in depth; other variables with higher $p$ values were thought to be of less clinical utility.
Slightly stretching the definition of a ‘rater’, Cohen’s kappa was used to determine the chance-corrected measure of the agreement between the status predicted by the I.R model and the actual status as measured from the case notes.

4. The EDI, SCL-90, and RSE scores and subscales were evaluated with Mann-Whitney U tests. Because ‘0’ values occurred and the means and variances were not proportional, transformation of the scores to enable parametric tests was not considered appropriate.

5. The two levels of the severity of ED characteristics index were analysed against drop-out status using Pearson \( \chi^2 \).

5.3 Results: Cohort 1

5.3.1 Sample descriptives

One hundred and eleven women with BN (71) or ABN (40), whose mean age was 24.47 (s.d. 5.9) years, were studied. Fifty-eight (52%) patients engaged, and 53 (48%) dropped out. The wide range of patients seen at the EDS was reflected in symptom severity statistics: binge mean = 4.3 (s.d.5.2), vomit mean = 6.5 (s.d.7.4).

5.3.2 Additive effect of childhood trauma

Experience of trauma had a dose-effect relationship with dropping out (Figure 5-1). The results of the correlational approach suggested by Howell can be found in Table 5-2. None of the patients who had experienced more than two of the four trauma types (6.3% of sample) stayed in therapy until her 10th session. Scores on the childhood trauma index were positively correlated with the Interpersonal Distrust subscale of the EDI (\( r= 0.27, p=0.01 \)).

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
<th>df</th>
<th>Sig, p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson r</td>
<td>-0.204</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agresti M*</td>
<td>4.595</td>
<td>1</td>
<td>.03*</td>
</tr>
<tr>
<td>Pearson X^2</td>
<td>8.918</td>
<td>4</td>
<td>.06</td>
</tr>
<tr>
<td>Deviation from linear</td>
<td>4.323</td>
<td>3</td>
<td>&gt;.05</td>
</tr>
</tbody>
</table>

Table 5-2. Steps of correlational approach to testing dose-effect relationship of experiences of childhood trauma on drop-out (Howell, 1999a&b).
Figure 5-1. Additive effect of experiences of childhood trauma on dropping out. As the number of categories of loss and trauma experienced increases, the proportion of drop-outs to engagers increases.
5.3.3 Logistic Regression

5.3.3.1 Variables entered into the analysis

Age, employment status, domestic circumstances, distance travelled to the clinic, vomiting, sexual and physical abuse, parental separation/divorce, and previous psychiatric treatment were included. These yielded a model which correctly classified the engagement status of 70.3% of participants; however, this model contained several weak variables. The final model correctly classified the engagement status of 67.6% of participants, a moderate improvement over the correct classification that would occur simply by assigning each participant to the largest group containing 52% of patients (Table 5-3; see Cohen’s kappa below).

<table>
<thead>
<tr>
<th>Variables in the Equation</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at assessment</td>
<td>.1188</td>
<td>.0459</td>
<td>6.689</td>
<td>1</td>
<td>.01*</td>
</tr>
<tr>
<td>Separation/divorce parents</td>
<td>1.0033</td>
<td>.4474</td>
<td>5.030</td>
<td>1</td>
<td>.02*</td>
</tr>
<tr>
<td>Previous Rx experience</td>
<td>.9603</td>
<td>.4320</td>
<td>4.941</td>
<td>1</td>
<td>.03*</td>
</tr>
<tr>
<td>Employment status</td>
<td>.5663</td>
<td>.2727</td>
<td>4.313</td>
<td>1</td>
<td>.04*</td>
</tr>
<tr>
<td>Constant</td>
<td>-6.863</td>
<td>1.898</td>
<td>13.062</td>
<td>1</td>
<td>.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variables not in the Equation</th>
<th>Score</th>
<th>df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of vomiting</td>
<td>3.089</td>
<td>1</td>
<td>.00</td>
</tr>
<tr>
<td>Childhood physical abuse</td>
<td>2.731</td>
<td>1</td>
<td>.10</td>
</tr>
<tr>
<td>Domestic circumstances</td>
<td>2.073</td>
<td>1</td>
<td>.15</td>
</tr>
<tr>
<td>Childhood sexual abuse</td>
<td>.0051</td>
<td>1</td>
<td>.94</td>
</tr>
<tr>
<td>Distance travelled</td>
<td>.0003</td>
<td>1</td>
<td>.99</td>
</tr>
</tbody>
</table>

Table 5-3. Logistic regression model of dropping out.

5.3.3.2 Variables not entered into the analysis

- Times elapsed from referral to assessment and from assessment to the beginning of treatment were not entered into the analysis because the waiting
patterns for the two groups were almost identical (e.g., mean referral-assessment days = 74.5 (52.2) for engagers, = 70.1 (55.1) for drop-outs) and in early regression models both were always excluded at an early stage.

- **Bingeing** was excluded because, not surprisingly, it was highly correlated with vomiting (r = 0.56, p < 0.001). In early regression models where both variables were present, bingeing was always removed at an early stage, whereas vomiting was retained.

- By definition, the amount of bingeing is linked to diagnosis. Since bingeing (continuous variable) had been removed from the final model, it was not possible for diagnosis (dichotomous) to contribute significantly more information to the model than vomiting alone, so it was removed as well.

- **Laxative use** was used by only a few patients, was highly skewed (mean = 21.0, sd = 73.1), and was shown in the early stages of modelling to have little predictive power.

- **Age and duration of ED** correlated highly (r = 0.61, p < 0.001). For the same reasons discussed above, only age was retained for the final model.

- **Parental death.** Only 5.6% of the sample had experienced early parental death, and early models removed it, so it was excluded.

### 5.3.3.3 Significant variables from LR model

Variables significant at p < 0.05 (Table 5-1) are discussed individually to indicate the direction of effect. Their interaction builds up the model.

- **Age (p = 0.01):** Those who dropped out (mean age = 23.32 (5.50)) were younger than those who engaged (mean age = 25.52 (6.11)).

- **Separation or divorce of parents (p = 0.02):** 43% of drop-outs had witnessed parental break-up, compared to only 22% of engagers.

- **Previous experience of psychiatric treatment (p = 0.03):** Drop-outs had had previous treatment (58%) more often than engagers (43%).
• Employment status (p=0.04): Students or those unemployed or not employed outside the home were less likely to drop out (43% drop out) than those employed outside the home, of whom about half dropped out.

5.3.3.4 Predicted probability of engaging/ dropping out

Figure 5-2a shows engagers plotted against their probability of engagement as predicted by the final model; Figure 5-2b shows drop-outs. On both figures, the predicted probability of engagement increases to the right of the line drawn at p=0.5, and the predicted probability of dropping out increases to the left of the line. The fact that the bulk of cases in Figure 5-2a lie to the right side of the line shows that the model correctly classifies the majority of engagers (70.7%). Similarly, the fact that the bulk of cases in Figure 5-2b lie on the left side of the line shows that the model correctly classifies the majority of drop-outs (64.2%). Cohen's kappa for the chance-corrected agreement between the status predicted by the LR model and the actual status measured from the case notes was only moderate (k=0.35) even though it was statistically significant at p<0.001.
Figure 5-2 (a) & (b). Engagers (a) and drop-outs (b) plotted according to their probability of engagement as determined by the logistic regression model. The predicted probability of engagement increases to the right of the line drawn at $p=0.5$, and the predicted probability of dropping out increases to the left of the line. In both figures the bulk of cases are correctly predicted.
5.3.4 Further Analyses

5.3.4.1 Severity of eating disorder characteristics

Those with more symptoms that were severe tended to be more likely to engage, but this relationship was not statistically significant ($X^2=3.67$, df=1, p>0.05).

5.3.4.2 Questionnaires: Self-report eating & Psychiatric symptom severity, Self-esteem.

Mann-Whitney U tests showed that none of the questionnaire scores was related to dropping out.

Drop-outs, however, were less likely than engagers to have completed the questionnaires properly (58% compared to 85%, $X^2=9.3$, df=1, p=0.002).

5.4 Discussion of Cohort 1

One of the aims of this study was to explore whether broad markers of disordered attachment relate to dropping out from treatment. This aim was largely achieved in demonstrating the additive effect of traumatic experiences in childhood on dropping out. For this finding to be reliable, though, it needs to be replicated, which is one of the goals of the next chapter. It will be more fully discussed there.

The other aim was to explore whether other pre-treatment patient variables predict dropping out from treatment. LR produced a model containing four statistically significant variables: age, previous experience of psychiatric treatment, employment status, and parental break-up. Significant variables are discussed individually; however, it is the interaction of these variables which is predictive.

The finding that those who dropped out are younger than those who engaged agrees with some (Merrill et al., 1987; Vandereycken & Pierloot, 1983) but not all (Waller, 1997) findings reported in the ED literature. Given that age has been investigated in most studies of dropping out in the ED as well as the general literature (Section 2.2.2.1.1), and is only sometimes found to be a significant predictor, it is unlikely that it has a strong or consistent effect on dropping out. In this study, it is difficult to assess just what contribution age makes to dropping out, as the distributions of ages in this sample overlap enormously.
Having had previous experience of psychiatric treatment might discourage some patients from continuing in treatment if these experiences had been unhelpful or if the patient had felt that she ‘failed’ at treatment before. Previous ‘failures’ are offered as the most common reason for discontinuation in one drop-out study (van Staden & Gerhardt, 1991). However, other studies have found that those with no previous experience of treatment are more likely to drop out (e.g., Connelly et al., 1986; Frank et al., 1957; Gunderson et al., 1989), which would support an hypothesis that having had previous experience would familiarise the patient with the process and demands of psychotherapy. Still other studies have found that treatment experience is not a significant predictor of treatment engagement (e.g., Lorr et al., 1958; Roffe, 1981). As has been observed in the introductory review, as well as in other reviews of dropping out (Brandt, 1965), the relationship between previous experience and engagement is unclear and might only be clarified by qualitative investigation of how patients construe their previous experiences.

The finding that students or those not employed or not employed outside the home were more likely to engage contradicts some previous findings (e.g., Hillis et al., 1993; Merrill et al., 1987; Pang et al., 1996) but is partially supported by others (Frank et al., 1957). As with age and previous treatment, interpretation of the relationship between employment status and engagement in treatment is hampered by lack of clear theoretical support or replication.

The negative effect on engagement of parental break-up can, however, be supported theoretically. The implications of this finding and its linkages with attachment theory will be discussed in the next chapter, which presents a replication of this study and therefore can support a more complete discussion.

*Eating disorder characteristics* ED characteristics, either individually or when combined into a index of severity, were not significantly related to dropping out. Self-reported symptoms (EDI) also did not differ between treatment groups. This agrees with the literature in general (see Section 2.2.2.1.3). There is an interesting thread of findings, however, relating to self-report of symptom severity. In one ED study, those who self-reported more severe symptoms (but whose symptoms were not actually different) were more likely to drop out (Waller, 1997). However, in other studies, those who reported higher level of distress were more likely to remain in treatment (Rubinstein & Lorr, 1956). Another study found this relationship only when the patients were from a lower
socio-economic class (Lorr et al., 1958). Yet another study found that self-report of fluctuations in the severity of symptoms was indicative of remaining in treatment (Frank et al., 1957). If there is any discernible relationship between self-report of symptom severity and dropping out, it is likely to be governed by multiple interactions affecting patients' and therapists' perceptions of prognosis and the perceived cost-benefit ratio of continuing treatment.

Comorbid symptoms and self-esteem Drop-outs and engagers did not differ on self-reported comorbid symptoms (SCL-90) or self-esteem (RSE). The power of the questionnaires may have been compromised by the fact that fewer drop-outs than engagers completed the questionnaires. This finding has been reported elsewhere (Koran & Costell cited in Garfield, 1994): it may indicate that the future drop-out lacks 'motivation', or that she experiences heightened anxiety about coming to treatment which results in lower functioning on self-report tasks.

5.4.1.1 Limitations

A number of limitations restrict this study.

It focuses only on patient characteristics, despite the probability that therapist characteristics are important to dropping out as well.

These characteristics are all pre-treatment, so no within-treatment factors could be accounted for.

Its retrospective design and the fact that data were originally collected primarily for clinical rather than research purposes limits the types of data in the analyses. For example, ideally the study would have included a more comprehensive measure of socio-economic status, measures of personality would have been included, and there would have been mechanisms in place to ensure that all questionnaires were completed properly.

The study is also limited by being essentially a 'fishing' expedition, with no explicit a-priori hypotheses. Analysing the data with multivariate methods helped curb the associated data-analytic problems, and replication will focus interpretation of the results. Conveniently, the problem most typically associated with case-note review –

---

22 This study also underscores the point that factors which are related to drop-out and outcome are not the same, even though they might overlap: those who had had a longer duration of illness were more likely to remain in treatment, but it was those who had had a shorter duration of illness who actually improved more.
inconsistent recording of information – was ameliorated by using the standardised assessment forms.

There are other limitations due to evolution of thinking since this study was designed. Current diagnostic criteria (based on DSM-IV) are more refined than those used for the ICD-10. Similarly, the researcher's thinking about the meaning of dropping out has led to the differentiation of treatment refusers and drop-outs and the understanding that dropping out need not be reported only in nominal categories. In order to check that results were not skewed by including treatment refusers with the drop-outs, the case-notes for the patients included in this study were checked to determine whether they were true drop-outs or refusers. 22 of the 53 patients listed as drop-outs had in fact refused treatment, leaving 31 true drop-outs. These levels of refusal and drop-out are similar to those reported by other ED studies which distinguish the two groups (Waller, 1997). Re-running the uni- and bi-variate analyses did not produce substantially different results. However, for Chapters 7, 8, and 9 the drop-outs and treatment refusers are distinguished.
6 COHORT 2: PARENTAL BREAK-UP AND CHILDHOOD TRAUMA RELATE TO DROPPING OUT

6.1 Introduction & Aims

One of the main difficulties in interpreting findings from drop-out research is the lack of replication of results. Since Chapter 5 was a broad, exploratory investigation, replication of its results is particularly important if they are to provide the foundation of any further research.

6.1.1 Aims

This study has two main aims, and one subsidiary one:

1. To replicate the finding that experiences of childhood trauma have an additive effect on dropping out.

2. To replicate the LR findings using data from an independent sample. Of particular interest is the role of parental break-up in the prediction, since this variable is relatively new to drop-out research and can be interpreted in a theoretical framework.

3. To cross-validate the LR model. This aim is only subsidiary because it is not felt that a sufficiently clear model of dropping out can be built from pre-treatment, patient variables only.

6.2 Method: Cohort 2

6.2.1 Clinic

The clinic was the same that hosted the study of Cohort 1. Cohort 2 were offered open-ended individual psychotherapy with dietary advice and monitoring. Interpersonal Psychotherapy (IPT; Fairburn, 1996), or Cognitive Behavioural Therapy (CBT; Fairburn, Marcus, & Wilson, 1993). The greater variability in the types of treatments offered to this cohort precludes drawing conclusions about dropping out for any particular type of psychotherapy; however, it allows the more important goal of generalisation to other settings with heterogeneous therapies. Waiting lists for this cohort had been reduced to about 2 months.
6.2.2 Subjects

As in Cohort 1, the subjects were a consecutive series of women diagnosed with BN or atypical BN (ICD10: WHO. 1992) seen for at least one assessment interview at the EDS from October 1996-September 1998. They were all resident in the local catchment area. Any re-referred patients who had been included in Cohort 1 were not included in this cohort.

6.2.3 Measures

6.2.3.1 Definition of dropping out

Dropping out was defined as for Cohort 1.

6.2.3.2 Analysis sheet

A modified version of the 19-item analysis sheet constructed for the first study was used to collect data from case notes (Appendix 5-1). Data were collected on those factors which had been entered into either the childhood trauma index (sexual and physical abuse, parental separation/divorce, and parental death) or the first study’s final LR model (Age, employment status, domestic circumstances, distance travelled to the clinic, vomiting, sexual and physical abuse, parental separation/divorce, and previous psychiatric treatment). They were also gathered on those factors which were necessary for checking the similarity of the cohorts or which warranted further investigation. Modifications are listed here.

6.2.3.2.1 Childhood trauma

No changes were made to any definitions. As in Cohort 1, parental death was included in the childhood trauma index, but not in the LR replication.

6.2.3.2.2 Severity of ED characteristics; diagnosis

Diagnosis, self-report and clinician-rated symptom severity were checked to verify that the 2 cohorts resembled each other. The clinical severity index was checked in relation to dropping out. Diagnosis and EDI scores were not analysed.

6.2.3.2.3 Comorbid psychiatric symptom severity

The SCL-90 was not analysed.
6.2.3.2.4 Self-esteem

The RSE was not analysed.

6.2.3.2.5 Demographic factors

In order to clarify the role of social class variables in this cohort, the highest level of education attained and the type of occupation were also recorded. Otherwise data gathered were the same.

6.2.3.2.6 Patient experience

Times spent waiting for referral and assessment were checked to see whether efforts to reduce waiting times had had any effect on engagement.

6.2.4 Analysis of Data

6.2.4.1 Replication of dose-effect relationship between trauma and drop-out

In order to confirm whether there was a dose-effect relationship with dropping out, the childhood trauma index was analysed using the same correlational approach outlined in Chapter 5.

6.2.4.2 Comparison of Cohorts 1 & 2

Data from Cohort 2 were compared to those from Cohort 1 to check for any important between-sample differences that would invalidate their comparison. They were first plotted and then subjected to statistical evaluation with Pearson $\chi^2$, Mann-Whitney U, or t-tests according to the nature of the variables.

6.2.4.3 Replication of LR findings

Data concerning patient experience and history were analysed using LR with a backward stepwise Wald method. All procedures were the same as those described in Chapter 5.

6.2.4.4 Double cross-validation of LR model

First, the regression coefficients obtained from Cohort 1 were applied to the data from Cohort 2, and log odds were calculated. These log odds are the natural logarithm of the calculated odds that a given participant will be a drop-out. The log odds are used so that the results can easily be dichotomised into those with odds of dropping out greater than 1/1 and those less than 1/1.
Pearson $X^2$ was used to test the resulting log odds against the observed drop-out status of participants in Cohort 2, in essence yielding a ‘correct classification’ table. Second, the regression coefficients obtained from Cohort 2 were applied to the data from Cohort 1, and these log odds were tested against the observed drop-out status for Cohort 1. Third, in order to account for any operator differences, data from the cohorts were merged and then split using random selection. Regression equations developed on each half were cross-validated. This process was repeated.

Data were analysed using SPSS 7.5 for Windows (Nie, et al., 1996) and Microsoft Excel 97.

6.3 Results: Cohort 2

6.3.1 Sample descriptives

One hundred and fourteen women, whose mean age was 26.7 (S.D. 7.6) years presented for assessment between October 1994 and September 1996 with BN (72) or ABN (42). Further descriptive characteristics of this sample are listed under Section 6.3.3, which compares Cohorts 1 & 2.

Fifty-one (44.7%) patients completed assessment and engaged in sustained therapy; 63 (55.3%) dropped out. Though the number of drop-outs is higher in this cohort than in the first, there is no statistical difference between the two rates of dropping out ($X^2=1.314, df=1, p=0.25$).

6.3.2 Analysis of childhood trauma index

The dose-effect relationship between childhood trauma and dropping out was confirmed this cohort (Figure 6-1). As the number of types of traumatic events experienced in childhood increases (from 0 to 4), the proportion of drop-outs to engagers increases. This linear relationship is statistically significant (Agresti’s $M^2=5.691, df=1, p=.01$). The results of Howell’s correlational approach can be found in Table 6-1.
Table 6-1. Steps of correlational approach to testing dose-effect relationship of experiences of childhood trauma on drop-out (Howell, 1999a&b).

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Value</th>
<th>df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson r</td>
<td>-0.224</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age esti M'</td>
<td>5.691</td>
<td>1</td>
<td>.01*</td>
</tr>
<tr>
<td>Pearson X'</td>
<td>6.010</td>
<td>4</td>
<td>.19</td>
</tr>
<tr>
<td>Deviation from linear</td>
<td>0.319</td>
<td>3</td>
<td>&gt;.05</td>
</tr>
</tbody>
</table>

Table 6-1. Steps of correlational approach to testing dose-effect relationship of experiences of childhood trauma on drop-out (Howell, 1999a&b).
Figure 6-1. Additive effect of experiences of childhood trauma on dropping out. As the number of categories of loss and trauma experienced increases, the proportion of drop-outs to engagers increases.
6.3.3 Testing of LR model

Before testing the LR model on data from this cohort, univariate analyses were performed to assess whether the cohorts differed in any way that would invalidate their comparison.

6.3.3.1 Demographic characteristics

The two cohorts do not differ statistically in terms of age or any of the other recorded demographic characteristics.

Where available, level of education and occupation were recorded for Cohort 2 in order to clarify the role of these social class variables in the ED group. No linear or curvilinear relationships with treatment status were apparent for these variables. Those patients on the educational extremes appeared to be more likely to drop out, as were those with unskilled or skilled jobs. Those having semi-skilled jobs and those who were managers and professionals seemed more likely to engage. However, these observed relationships were not analysed further due to a large amount of missing data.

6.3.3.2 Diagnosis and Severity of ED characteristics

Bingeing, vomiting, laxative use, duration of ED and the distribution of diagnosis between groups showed no significant differences between the two cohorts. As in the first cohort, age and duration of ED were highly correlated (r=0.500, p<0.001), so it was considered reasonable again to include only age in the LR.

6.3.3.3 Childhood Trauma

The prevalence rates of each of the types of traumatic events in Cohorts 1 and 2 were not statistically different.

6.3.3.4 Patient experience

Times elapsed from referral to assessment and from assessment to the beginning of treatment were shorter than they had been for the first cohort (e.g., mean waiting time from referral to assessment for Cohort 2 approximately equalled 4 weeks; for Cohort 1 it was 10.5 weeks), but in exploratory regression analyses waiting times remained unrelated to engagement.
The proportion of patients living in the city and the county was close to even in Cohort 2 (58/56), whereas in Cohort 1 the proportion has been 37/72. This may be a relatively unimportant difference, as the boundary between the city and county is a coarse approximation of the distance travelled to the clinic. Other, demographic-type variables remained the same, so the patient group does not appear to have changed from Cohorts 1 to 2 and this variable was retained in the replication. Patients' previous experience of psychiatric treatment was the same in both cohorts.

6.3.3.5 Replication of LR Analyses

Data on employment status were missing for four participants. Other data on these participants did not show any systematic differences from the rest of the cohort. Therefore, excluding them from the regression replication and cross-validation was considered to be acceptable. This resulted in a sample size of 110 (compared to 111 for Cohort 1). All variables that were entered into the model developed on Cohort 1 were again entered here.

6.3.3.5.1 Variables entered into the LR analysis

Age, employment status, domestic circumstances, distance travelled to the clinic, frequency per week of vomiting, childhood experience of sexual or physical abuse, parental separation/divorce before the patient's 16th birthday, and previous experience of psychiatric treatment were included.

These yielded an equation which predicted 66.4% of overall variation in dropping out; however, this equation contained several weak variables which were eliminated. The final model predicted 60.0% of overall variation, somewhat less than the 67.6% predicted by the final model developed on Cohort 1, and only a 4.7% improvement over assigning all patients to the largest group. The LR model for Cohort 2 correctly predicted 55.1% of those who dropped out and 65.6% of engagers. The Cohort 1 LR model correctly predicted 64.2% of drop-outs and 70.7% of engagers. Cohen's kappa, again calculated to correct for chance agreement, was low (k=0.231) but remained statistically significant (p<0.02).

6.3.3.5.2 Significant variables in the LR model for Cohort 2

The variables in the model which were significant at p<0.05 follow (Table 6-2). It is these variables acting together which build up the model; however, they are discussed separately here simply to indicate the direction of effect.
- **Employment Status** (*p* = .03): Those who were housewives, students, or 'other' (such as disabled) dropped out more often than they engaged (combined drop-out: 68%). Other groups who were employed outside the home either full- or part-time or who were looking for work dropped out less often (combined drop-out: 47%).

- **Separation or divorce of parents** (*p* = .04): 24% of drop-outs had witnessed a major disruption in their parents' marriages, compared to only 11% of engagers (Figure 6-2). This means that two thirds of patients whose parents had separated or divorced dropped out.

### Variables in the Equation

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment status</td>
<td>-.1906</td>
<td>.0878</td>
<td>4.7152</td>
<td>1</td>
<td>.030*</td>
</tr>
<tr>
<td>Separation/divorce parents</td>
<td>.8816</td>
<td>.4458</td>
<td>3.9106</td>
<td>1</td>
<td>.048*</td>
</tr>
<tr>
<td>Childhood sexual abuse</td>
<td>-.7200</td>
<td>.4350</td>
<td>2.7399</td>
<td>1</td>
<td>.098</td>
</tr>
</tbody>
</table>

### Variables not in the Equation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Score</th>
<th>df</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age at assessment</td>
<td>.0623</td>
<td>1</td>
<td>.8029</td>
</tr>
<tr>
<td>Domestic circumstances</td>
<td>.0007</td>
<td>1</td>
<td>.9796</td>
</tr>
<tr>
<td>Distance travelled</td>
<td>.4584</td>
<td>1</td>
<td>.4984</td>
</tr>
<tr>
<td>Frequency of vomiting</td>
<td>1.2964</td>
<td>1</td>
<td>.2549</td>
</tr>
<tr>
<td>Childhood physical abuse</td>
<td>.2429</td>
<td>1</td>
<td>.6221</td>
</tr>
<tr>
<td>Previous treatment experience</td>
<td>.0003</td>
<td>1</td>
<td>.9870</td>
</tr>
</tbody>
</table>

**Table 6-2.** Logistic regression model cross-validated on cohort of 110 women with BN or atypical BN.
Figure 6-2. Patient experience in childhood of parental break-up: grouped according to engagement status. Two thirds of patients whose parents had separated or divorced dropped out, a much higher proportion than for patients whose parents remained together.
6.3.3.5.3 Predicted probability of engaging/dropping out

Figure 6-3a shows engagers plotted against their probability of engagement as predicted by the final model; Figure 6-3b shows drop-outs. On both figures, the predicted probability of engagement increases to the right of the line drawn at p=0.5 and the predicted probability of dropping out increases to the left of the line. As with Cohort 1, the fact that the bulk of cases in Figure 6-3a lie on the right side of the line shows that the model correctly predicts the majority of engagers (55.1%). Similarly, the fact that the bulk of cases in Figure 6-3b lie on the left side of the line shows that the model correctly predicts the majority of drop-outs (65.6%). The range of predicted probabilities is more restricted in this model than in the one produced on Cohort 1 because it contains fewer variables.
Figure 6-3 (a) & (b). Engagers (a) and drop-outs (b) plotted according to their probability of engagement as determined by the logistic regression model. The predicted probability of engagement increases to the right of the line drawn at $p=0.5$, and the predicted probability of dropping out increases to the left of the line. In both figures the bulk of cases are correctly predicted.
6.3.3.6 Double cross-validation of LR models

Cohort 1 coefficients applied to Cohort 2 data: Pearson chi-square test on observed versus predicted engagement status was not significant at p<0.1.

Cohort 2 coefficients applied to Cohort 1 data: Non-significant chi-square at p<0.1.

Random splits of merged data: None of the chi-square tests was significant at p<0.1.

6.4 Discussion

This study had two main aims. The first was to verify on an independent cohort that experiences of childhood trauma had an additive effect on dropping out. The second was to replicate LR findings which indicated that parental break-up predicted dropping out. Both of these main goals were achieved. A third, subsidiary goal, cross-validation of an LR model on an independent sample, was not successfully attained. The covariation between variables entered into the LR equation is likely to have caused it to be unstable.

**Childhood trauma.** An index of emotionally traumatic experiences in childhood was applied to patient histories. An additive effect on dropping out was found again on this independent clinical cohort. It appears that having experienced one or no types of events has little impact on dropping out, but experiencing two or more types of events is related to higher levels of dropping out.

**Logistic regression and parental break-up.** The LR model of dropping out developed on the current cohort contained two significant variables, parental break-up and employment status, both of which had also been significant in the previous study. Employment status has often been found to be significantly related to dropping out in other studies (Baekeland & Lundwall, 1975); however, it cannot be considered a stable predictor, because its effect has not been consistently replicated (Brandt, 1965; Frank et al., 1957; Hillis et al., 1993). Even this current replication could be misleading: in Cohort 1, being employed or looking for work were related to more frequent drop-out; in Cohort 6-135
these were related to more frequent engagement. Employment status might have some relationship with dropping out, but it is currently unclear.

Parental break-up appears to predict dropping out more robustly. Those patients whose parents broke up were more likely to drop out of treatment in both cohorts (in univariate as well as multivariate analyses), and proportions of those who had experienced parental break up who later dropped out were similar. This finding is supported by preliminary findings from a large European study of ED treatment (Mahon & Toman, unpublished data).

Attachment theory might aid understanding the significance of these findings. Parental break-up might be surrounded by family discord that would affect the child’s ability to form secure attachments. It might also precede the loss of a parent and might stress the custodial parent to the point where the child would experience some neglect, all of which are related to forming insecure attachment styles (Bifulco et al., submitted; Harris & Bifulco, 1991). Having an insecure attachment style might decrease one’s ability to make and maintain supportive relationships in adulthood (Bowlby, 1977; Holmes, 1997) – possibly even therapeutic relationships (Adshead, 1998; Bowlby, 1988; Frank et al., 1957).

Of course not all patients who had witnessed parental break-up would have had these adverse effects. It is interesting, though, that those patients who had experienced more types of events thought to affect attachment style were less likely to remain in treatment. Attachment-related experiences may be related to forming therapeutic attachments.

Similarly level of education and other socioeconomic markers are uncertain indicators of dropping out. In this cohort, it appeared that those at either educational extreme were more likely to leave. This relationship could not be tested due to a large amount of missing data. Other researchers have found that those on the lower extreme were more likely to leave (Frank et al., 1957; Hillis et al., 1993). It is more likely that therapist and patient communication skills determine whether a therapy relationship will last.
This is supported by the thread of findings running through the drop-out research that shows that drop-outs declare more difficulty in interpersonal functioning (Section 2.2.2.1.5 and Lovaglia & Matano, 1994), have less access to and take less advantage of informal support (Cross & Warren, 1984), and see themselves as less ‘compatible’ with other members of groups (Connelly et al., 1986). Parental break-up and traumatic events have been relatively neglected in the general literature on dropping out; however, when they have been considered, their relationship to dropping out has consistently been replicated (Frank et al., 1957; Palmer et al., 1995).

6.4.1.1 Further limitations

In these case-note studies, it has been possible to explore attachment only coarsely by looking at archival factors which might be related to attachment style (Bifulco et al., submitted). Even the factors that were considered could only be interpreted in a cautious way. For example, it would have been better to be able to analyse the relationship of the patient to the perpetrators of abuse, as well how threatful and frequent the abuses were. Better quality data might have improved the predictive power of the regression models.

6.4.1.2 Conclusions

The studies discussed in Chapters 5 & 6 have shown that experience of traumatic events in childhood has a dose-effect relationship with dropping out, and that attachment-related factors might contribute to predicting dropping out. It does appear that conceptualising dropping out as a function of establishing attachment between patient and therapist is more useful than thinking of it purely as an endogenous patient characteristic. In using a relationship-based approach, considering the therapist’s ability to make and maintain a meaningful connection with the patient would also be necessary. Thus, a relationship-based model of dropping out might describe some patients as having a vulnerability to dropping out which is more readily expressed in certain environments than in others. The therapist’s behaviour would be a major influence on that environment.

Prospective quantitative and in-depth qualitative interview research can be used to clarify the relationship between attachment issues and engagement in psychotherapeutic treatment. These are the goals of the following chapters.
7 ATTACHMENT STYLE AND DROPPING OUT

7.1 Introduction & Aims

In light of the replicated ability of proxies for attachment to predict dropping out in Chapters 5 & 6, it was decided to use an attachment style measure to further investigate patient attachment style and dropping out. This chapter will describe the Vulnerable Attachment Style Questionnaire, explore its ability to distinguish those who drop out from other treatment status groups, and look at the relationships between the VASQ, the EDI and treatment status.

The relationship between the VASQ and treatment status will be investigated in two ways. First, treatment status groups will be compared with the established VASQ scoring technique, which provides a categorical rating. Second, these groups will also be compared on new subscales created by factor-analysing the individual VASQ responses from this eating-disordered sample. This second step will allow attachment factors to be assessed dimensionally. Further, it may be more appropriate to score the VASQ differently in the current context. Since the categorical rating was developed for a specific purpose (to detect high-risk attachment attitudes in general relationships) it may not be appropriate for another purpose (to detect differences in relating within the therapy context). Indeed, the questionnaire development literature stresses that validation and reliability tests are specific to the context in which they are performed (Streiner & Norman, 1995). Scoring systems can be seen to be extensions of these tests. Thus the second step will assess the attachment attitudes covered in the VASQ for their ability to detect differences between treatment status groups.

Although this study investigates a pre-treatment patient characteristic in isolation from other potentially pertinent factors, it is considered to have some value. The ability to make and maintain close, confiding relationships may be germane to understanding the durability of treatment relationships.

7.1.1 Aims

1. The main aim of this chapter is to explore the ability of patient trait-like attachment dimensions to distinguish those who drop out from those who engage in, complete, or refuse treatment. This will be attempted in two ways:
(1) the groups will be compared according to their overall VASQ scoring. It is expected that those who drop out will be more likely to have ‘non-standard insecure’ ratings on the VASQ. (2) The groups will be compared on new subscales generated from the individual VASQ items.

2. A subsidiary aim is to confirm that ED diagnosis and self-reported symptoms do not relate to treatment status.

7.1.2 Attachment concepts and dropping out

Attachment style itself has not previously been used to study dropping out from treatment, though attachment-related concepts have been. The concepts which are related to the patient’s trait-like attachment style are briefly reviewed here.

In recent years, the normative elements of interpersonal functioning have been studied in relationship to dropping out (e.g., Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988), with greater success than had been achieved studying ‘psychopathological’ personality dimensions. Some of these studies have investigated the patient’s ability to establish informal supportive relationships to establishing formal ones, which has been related to dropping out (e.g., Cross et al., 1980). Other research has concluded that ‘the ability to establish relationships with others, whether from the side of the psychiatrist or the patient, is positively related to both staying in psychotherapy and benefit from it’ (p. 292, Frank et al., 1957).

Lovaglia & Matano (1994) replicated findings that an empirically derived subscale of the Inventory of Interpersonal Problems predicted dropping out, with those displaying greater problems in interpersonal relationships being more likely to leave. However, interpersonal problems as expressed in the IIP are not necessarily related to the ability to make and maintain close, confiding relationships. Investigating the relationship between the ability to make and maintain such attachment relationships and dropping out presents a logical next step.

7.1.3 Measurement of attachment style

Measures of attachment style were discussed in Section 4.1.2. The Vulnerable Attachment Style Questionnaire (VASQ; Appendix 4-1 & Table 7-5) (Mahon et al., submitted) was chosen for this study. The VASQ is a brief self-report instrument asking about attitudes toward attachment relationship styles that are predictive of psychiatric disorder.
Although a new measure, the VASQ was considered to be appropriate for a range of reasons. First, one of the suppositions underlying this thesis is that adults may have somewhat different styles of attachment depending on the type of relationship they are engaging in. The VASQ is one of a few attachment style measures that asks about a range of close attachment relationships, not just romantic ones (see Figure 4-2). It was therefore more appropriate to the therapy context than a measure which focused on romantic partners. Indeed, some of the patients would never have had a partner and so would not have been able to complete the romantic-style attachment measures.

Second, the VASQ was developed empirically from a semi-structured interview (Attachment Style Interview; ASI) (Bifulco et al., submitted) which is used to distinguish those who are at high risk of developing affective disorder from those at low risk. VASQ items therefore are well-tested and validated in a population at risk for psychiatric disorder, unlike the majority of ‘style’ measures, which were developed theoretically and validated on college populations (e.g., Brennan et al., 1998; Hazan & Shaver, 1987).

Third, the rating of the VASQ is based on the severity of disorder in attitudes toward close, confiding relationships rather than solely on description of different prototypes for the ways in which people relate. While retaining its ability to be analysed dimensionally, the VASQ also makes a simple rating between those whose style is decidedly ‘abnormal’ (non-standard insecure) and those whose style is ‘normal’ (standard secure). Some other style measures do not contain a normal or ‘secure’ rating (e.g., Brennan et al., 1998). These ratings were validated against interview ratings which account for both attitudinal and behavioural aspects of attachment (the ASI). The agreement between the VASQ and the ASI ratings is very good (Cramer’s V=0.46, p<0.001) especially considering that the ASI ratings are made by trained interviewers and checked by consensus and the VASQ relies only on self-report.
7.2 Method and Results

7.2.1 The clinic

The clinic hosting this study is the same as that described in Chapter 5, and clinic procedures are described in Chapters 5 & 6. This study also includes participants with diagnoses of AN and EDNOS. Treatments for AN tend to be psychodynamically informed but pragmatic open-ended therapies, where some attention is paid to issues around weight and eating. A small portion of patients with AN are admitted as inpatients. In all cases included in this study, patients were in a psychological treatment relationship at the time of their admission. A day programme, primarily for the treatment of AN, had been established since the studies presented in Chapters 5 & 6 were conducted. The effect of the day programme on the comparability of these studies is considered negligible as day-programme patients are only a tiny percentage of the total yearly intake or patients.

7.2.2 Participant selection

Potential participants were a series of consecutive referrals to the EDS from October 1999 to January 2001. This yielded a potential participant pool of 425 (Table 7-1). Of these, 108 did not confirm the assessment appointment, 41 did not arrive for a confirmed assessment appointment, 11 were assessed only as a service to another health care unit and not for potential intake into the EDS, 19 had no ED according to DSM-IV criteria, 20 did not return their questionnaires or asked not to complete any questionnaires, 16 were participating in another research project, 24, 13 did not complete or were transferred at assessment, 38 had started treatment but had not yet had enough to be included in the sample, and 71 were still on the waiting list when data were analysed. As a result, 88 participated in the study.

---

24 A group of patients with bingeing participated in a treatment trial with its own assessment information and treatment procedures. Although the absence of these patients from the current study was systematic, it was not felt to prejudice this sample unduly. First, no link between diagnosis and treatment status had been found in past research – and it is treatment status, not eating disorder that is being studied here; second, the overlap between the studies was very small (3 months), so only a small portion of the intake period for this study was complicated by the trial. It was felt that including the trial patients in this study would have posed a greater confound, as treatment procedures were different for this group. Thus this study has a lower proportion of patients with BN than would normally be expected.
Table 7-1. Sample selection.

All patients presenting with a clinical ED were eligible for inclusion, including those with a diagnosis of eating disorder not otherwise specified (EDNOS). The DSM-IV criteria were used for diagnosis (APA, 1994). Of the participants, 28 were diagnosed with AN, 25 with BN, and 35 with EDNOS (Table 7-2). Responses for a subsample of 73 on the DT, B, and BD subscales were similar to the norms supplied by Garner et al. (1983) for the AN group (Table 7-2).²⁵

---

²⁵ Diagnostic criteria have changed slightly since these norms were developed.
Table 7-2. Distribution of DSM-IV diagnoses & EDI scores.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Frequency</th>
<th>%</th>
<th>EDI DT Mean (SD)</th>
<th>EDI B Mean (SD)</th>
<th>EDI BD Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AN-R</td>
<td>20</td>
<td>22.7</td>
<td>12.2 (7.0)</td>
<td>4.8 (6.9)</td>
<td>14.7 (9.0)</td>
</tr>
<tr>
<td>AN-BP</td>
<td>8</td>
<td>9.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BN</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BN</td>
<td>24</td>
<td>27.3</td>
<td>15.3 (4.7)</td>
<td>13.8 (5.2)</td>
<td>19.5 (8.1)</td>
</tr>
<tr>
<td>BN-NP</td>
<td>1</td>
<td>1.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EDNOS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSAN</td>
<td>16</td>
<td>18.2</td>
<td>14.2 (6.3)</td>
<td>6.1 (5.2)</td>
<td>6.2 (5.2)</td>
</tr>
<tr>
<td>PSBN</td>
<td>7</td>
<td>8.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BED</td>
<td>3</td>
<td>3.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHEREDNOS</td>
<td>9</td>
<td>10.2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total N</td>
<td>88</td>
<td>100.0</td>
<td>73</td>
<td>73</td>
<td>73</td>
</tr>
</tbody>
</table>

86 participants were female, 2 were male. Because analyses excluding males yielded very similar results to those including them, data were collapsed across sex and analysed as a whole.

7.2.3 Measures

7.2.3.1 Vulnerable Attachment Style Questionnaire.

The VASQ is a 31-item self-report instrument asking about attitudes toward attachment independent of role (discussed in Section 4.1.2.2.1; Appendix 4-1; Table 7-5). Its scoring system was developed to distinguish those at high risk for psychiatric disorder from those at lower risk, and results in either a ‘standard’ secure (1) or ‘non-standard’ insecure (2) rating. The existing scoring system contains no subscales.

Items are worded as self-statements with 5-point Likert responses ranging from ‘Strongly agree’ to ‘Strongly disagree’. Instructions to participants are restricted to:

Below are a number of statements concerning the way people feel about themselves in relation to others. Indicate whether you agree or disagree with the description as it applies to you by circling a number from 1 to 5. There are no ‘right’ or ‘wrong’ answers.

The layout of the questionnaire was designed to minimise the chances of participants skipping questions or losing their place on the page. Arranged in table format, the VASQ contains an extra blank line between each item. As a result it takes up 2 sides of an A-4 sheet; however, participants do not appear to be daunted by its length.
In the 2 years it has been used in this format, no respondent has missed an item, even when they have missed items on other measures.

### 7.2.3.2 Eating Disorders Inventory

The EDI was described in Chapter 5.

### 7.2.3.3 Criterion measure: Treatment status

Treatment status was determined from case notes, therapist meetings, or the hospital patient information system.

1. **Drop-outs** were all patients who had begun therapy, who had fewer than 8 therapy meetings, and who had terminated treatment unilaterally either by informing their therapist or by not appearing for scheduled meetings until discharged. The sample contained 10 drop outs (Table 7-3).

2. **Engagers/completers** were all participants who had had 8 sessions or more were considered to have engaged. Those who had completed treatment and had been discharged were also included in this category. There were 54 engagers/completers.

3. **Treatment refusers** were all participants who had completed assessment but who had not taken up therapy when it was offered. 24 participants refused treatment.

A lower threshold for determining ‘engagement’ was used here than was used in Chapters 5 & 6. This was because the number of patients who had had treatment was small. Originally it had been intended to operationalise treatment status as a continuous variable combined with therapist and patient views on the appropriateness of the termination. Individual session numbers were recorded for those who had entered treatment. Post-discharge questionnaires were sent to patients whose treatment had ended and discharge data were gathered from therapists. However for the majority of analyses, session numbers and therapist discharge data only were compressed into categories.

The 8-session cut-off was determined from the data: all but one of those who had unilaterally terminated left before the 8th session (the one left after 21 sessions and was counted as an engager for these analyses).
<table>
<thead>
<tr>
<th>Treatment status</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop out</td>
<td>10</td>
<td>11.4</td>
</tr>
<tr>
<td>Engaged, completed</td>
<td>54</td>
<td>61.4</td>
</tr>
<tr>
<td>Rx refuse</td>
<td>24</td>
<td>27.3</td>
</tr>
<tr>
<td>Total</td>
<td>88</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 7-3. Distribution of treatment status.

7.2.4 Procedure

The VASQ and EDI were incorporated in the standard assessment package for all referrals; therefore specific ethical approval was not required. A package of questionnaires was either posted to participants before assessment, or was handed to them at the first assessment appointment.

7.2.5 Data analysis

The main aim of this chapter is to explore the relationship between pre-treatment attachment factors and treatment status. Therefore, the VASQ will be the focus of analyses. ED severity will also be taken into account.

7.2.5.1 VASQ

VASQ data were analysed against treatment status in 2 main steps. The first step was to see whether the existing overall categorical rating system, which was developed to distinguish those at high risk for psychiatric disorder from those at lower risk, was useful in detecting drop-outs from psychiatric treatment. The second step looked at the VASQ data dimensionally. Subscales were generated from factor analysis of the responses given by this eating-disordered sample. The treatment status groups were then compared on their subscale scores.

7.2.5.1.1 Overall categorical rating and treatment status

Frequencies for overall VASQ scores for the whole sample were:

1. (standard): 32
2. (non-standard): 56.
The predominance of non-standard ratings is expected in a clinical sample, who are obviously at risk of psychiatric disorder.

The relationship between overall VASQ scores and treatment status was evaluated with Pearson $X^2$ and clustered bar charts. Despite a trend for the distribution of standard to non-standard scores to be different in the drop-out group than it was in the other groups, there were no significant differences (Table 7-4).

<table>
<thead>
<tr>
<th>Treatment status</th>
<th>VASQ 1 Obsd (Expctd)</th>
<th>VASQ 2 Obsd (Expctd)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop out</td>
<td>6 (3.6)</td>
<td>4 (6.4)</td>
</tr>
<tr>
<td>Eng/Compl</td>
<td>18 (19.6)</td>
<td>36 (34.4)</td>
</tr>
<tr>
<td>Rx refuse</td>
<td>8 (8.7)</td>
<td>16 (15.3)</td>
</tr>
<tr>
<td>Total</td>
<td>42 (42)</td>
<td>84 (84)</td>
</tr>
</tbody>
</table>

Pearson $X^2 = 2.72, df=2.00, p=0.26$

Table 7-4. Overall VASQ rating by treatment status.

7.2.5.1.2 Factor analysis: Dimensional assessment of VASQ and treatment status

In order to look at the VASQ data dimensionally, this sample's responses to individual VASQ items were factor analysed. Subscales were then generated and the treatment status groups were compared on their subscale scores.

Factor analysis A Pearson correlation matrix was used as the basis for exploratory factor analyses of the 31 VASQ items. Following the advice of Child (1970), several extraction methods with different premises were used in order to assess the 'robustness' of the factor solutions, including Principal Components, Principal Axes, and Unweighted Least Squares. Methods such as maximum likelihood, which require estimation of the number of factors as the basis of the analysis, were not used, as the purpose of the analysis was exploratory rather than confirmatory. Orthogonal and oblique rotation methods were also tried to assess whether allowing the factors to correlate with each other would increase the interpretability of the results. The results presented here used the Principal Components Analysis (PCA) for extraction and Varimax for rotation, as these were the simplest and most readily interpretable methods of those tested and made the resulting reduced variables as diverse as possible. The Kaiser criterion of eigenvalues greater than or equal to 1 was used to select factors. Scree plots were also employed to
indicate where the curve created by the eigenvalues levelled off, and the 4 factors which were found before the ‘break’ are given the most attention.

In order to explore the distribution of the main components of the reduced data from the VASQ, the scores of each participant on the first four factors were plotted (Appendices 7-1, 7-2, & 7-3). These plots were used to identify and assess outliers. Only one was apparent on Factor 3, and when her data were checked no reason to exclude her from the analysis was apparent, so she was retained. Details of the analysis are presented in Appendices 7-4 a & b. The rotated component matrix is presented in Table 7-5.

Factor results

1. **Factor 1 (Comfort with dependency)**. The first and most important factor, most heavily loaded on by Items ‘I usually rely on advice from others.’, ‘I miss the company of others when I’m alone’, ‘I (don’t) look forward to spending time on my own’, describes a patient who feels comfortable with dependency on others and seeks their company. 15% of variance in rotation.

2. **Factor 2 (Mistrust of others/Anger in relationships)**. The second factor describes a person who has difficulty trusting others and experiences anger in relationships. It is most heavily loaded on by Items ‘People let me down a lot’, ‘I feel people haven’t done enough for me’, and ‘People close to me often get on my nerves’. 12% of variance in rotation.

3. **Factor 3 (Ease with making new relationships)**. The third factor contains items which pertain to ease in making new relationships. It is loaded on most heavily by Items ‘I can make new relationships very quickly’, and ‘I enjoy meeting new people’. 12% of variance in rotation.

4. **Factor 4 (Fear in relationships)**. The fourth factor describes fear of loss or intimacy in relationships. It is loaded on most highly by Items ‘I worry a lot if people arrive back later than expected’ and ‘I feel uncomfortable when people get too close to me’. 9% of variance in rotation.

The remaining factors do not explain as much variance and do not contain many items.

**Subscales** As a further exploratory step, tentative subscales were generated from the factor analysis. The participant’s subscale score was defined as the total of that person’s responses for the items whose highest loading was on that factor. Items which
loaded negatively on a factor were transposed before the response total was calculated. At this exploratory stage, using the response total for each factor was sufficient.

**Treatment status** To check whether treatment status groups differed on the new dimensional factors, groups were compared on their subscale scores using Kruskal-Wallis H (which is treated by SPSS as $X^2$ for significance testing; see Table 7-6). The distribution-free test was used because the group sizes were different, and visual inspection of preliminary boxplots showed no differences between the treatment status groups. Kruskal-Wallis H was non-significant for all of the new subscales.
### Rotated Component Matrix for VASQ.

<table>
<thead>
<tr>
<th>VASQ Item:</th>
<th>Component:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>I usually rely on advice from others when I've got a problem.</td>
<td>.794</td>
</tr>
<tr>
<td>I miss the company of others when I'm alone.</td>
<td>.778</td>
</tr>
<tr>
<td>I look forward to spending time on my own.</td>
<td>-.729</td>
</tr>
<tr>
<td>I get anxious when people close to me are away.</td>
<td>.667</td>
</tr>
<tr>
<td>I like making decisions on my own.</td>
<td>-.636</td>
</tr>
<tr>
<td>I rely on others to help me make decisions in life.</td>
<td>.632</td>
</tr>
<tr>
<td>I'm clingy with others.</td>
<td>.556</td>
</tr>
<tr>
<td>I would like to see more of my friends than I do.</td>
<td>.539</td>
</tr>
<tr>
<td>It's important to have people around me a lot of the time.</td>
<td>.535</td>
</tr>
<tr>
<td>People let me down a lot.</td>
<td>.757</td>
</tr>
<tr>
<td>I feel people haven't done enough for me.</td>
<td>.736</td>
</tr>
<tr>
<td>People close to me often get on my nerves.</td>
<td>.728</td>
</tr>
<tr>
<td>I feel people are against me.</td>
<td>.151</td>
</tr>
<tr>
<td>I often get into arguments.</td>
<td>.149</td>
</tr>
<tr>
<td>Having people around me can be a nuisance.</td>
<td>-.389</td>
</tr>
<tr>
<td>I can make relationships very quickly.</td>
<td>-.104</td>
</tr>
<tr>
<td>I enjoy meeting new people.</td>
<td>-.141</td>
</tr>
<tr>
<td>I have lots of friends.</td>
<td>-.108</td>
</tr>
<tr>
<td>I take my time getting to know people.</td>
<td>-.292</td>
</tr>
<tr>
<td>I feel close to people very quickly.</td>
<td>.161</td>
</tr>
<tr>
<td>I feel uneasy when others confide in me.</td>
<td>.227</td>
</tr>
<tr>
<td>I worry a lot if people I live with arrive back later than expected.</td>
<td>.323</td>
</tr>
<tr>
<td>I feel uncomfortable when people get too close to me.</td>
<td>-.130</td>
</tr>
<tr>
<td>I worry about things happening to close family and friends.</td>
<td>.158</td>
</tr>
<tr>
<td>I find it hard to trust others.</td>
<td>.229</td>
</tr>
<tr>
<td>It's best not to get too emotionally close to other people.</td>
<td>.129</td>
</tr>
<tr>
<td>I find it difficult to confide in people.</td>
<td>-.105</td>
</tr>
<tr>
<td>Saving goodbye to close family and friends is difficult.</td>
<td>.411</td>
</tr>
<tr>
<td>I find it easy to ask people for help.</td>
<td>-.270</td>
</tr>
<tr>
<td>I see friends and family often.</td>
<td>-.172</td>
</tr>
<tr>
<td>It's important to have control over my life.</td>
<td>.188</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
Values < 1 suppressed. Items sorted in order of largest loading.
<table>
<thead>
<tr>
<th>Treatment status</th>
<th>Subscale 1 Mean (sd)</th>
<th>Subscale 2</th>
<th>Subscale 3</th>
<th>Subscale 4</th>
<th>Subscale 5</th>
<th>Subscale 6</th>
<th>Subscale 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop out</td>
<td>25.0 (5.8)</td>
<td>19.1 (5.6)</td>
<td>18.5 (4.5)</td>
<td>12.9 (4.7)</td>
<td>8.6 (2.9)</td>
<td>2.2 (1.1)</td>
<td>1.7 (0.8)</td>
</tr>
<tr>
<td>Eng, compl</td>
<td>25.6 (7.1)</td>
<td>18.8 (4.6)</td>
<td>17.9 (4.3)</td>
<td>12.7 (4.1)</td>
<td>7.3 (2.5)</td>
<td>2.2 (1.2)</td>
<td>1.4 (0.6)</td>
</tr>
<tr>
<td>Rx refuse</td>
<td>24.9 (6.5)</td>
<td>18.9 (4.7)</td>
<td>19.7 (4.1)</td>
<td>13.0 (3.0)</td>
<td>7.4 (2.3)</td>
<td>2.2 (1.3)</td>
<td>1.5 (0.7)</td>
</tr>
<tr>
<td>$X^2$</td>
<td>0.331</td>
<td>0.209</td>
<td>2.699</td>
<td>0.339</td>
<td>2.121</td>
<td>0.037</td>
<td>0.898</td>
</tr>
<tr>
<td>df</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sig</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
</tr>
</tbody>
</table>

**Table 7-6.** Mean VASQ subscale scores by treatment status group. Mean values are given for visual inspection only and are not appropriate for significance testing. Ranks tested by Kruskal-Wallis H.

7.2.5.1.3 *VASQ and EDI*

The influence of self-reported severity of ED symptoms on reporting of attachment attitudes was tested with Mann-Whitney U tests of EDI scores and overall VASQ ratings<sup>26</sup> (Table 7-7; see next section for further information on EDI respondents). The significance threshold was set at an higher level ($p<0.01$) due to the large number of comparisons. No differences were found between standard (1) and non-standard (2) groups on eating symptom subscales (DT: drive for thinness, B: bulimia, and BD: body dissatisfaction). On the other, interpersonal EDI subscales, differences were found between standard and non-standard groups, with the standard group lower on ineffectiveness (IE), perfectionism (P), interpersonal distrust (ID), interoceptive awareness (IA), and maturity fears (MF). This indicates that those with more severely disturbed attitudes toward attachment relationships also experience greater difficulty with self-esteem and interpersonal functioning.

<sup>26</sup> Although strictly not appropriate, mean scores and standard deviations are provided in the table for visual comparison only.
Table 7-7. VASQ overall rating by EDI subscale score.

<table>
<thead>
<tr>
<th>VASQ 1 Mean</th>
<th>DT</th>
<th>B</th>
<th>BD</th>
<th>IE</th>
<th>P</th>
<th>ID</th>
<th>IA</th>
<th>MF</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.7</td>
<td>7.3</td>
<td>16.8</td>
<td>8.2</td>
<td>4.4</td>
<td>2.8</td>
<td>7.8</td>
<td>4.0</td>
<td></td>
</tr>
<tr>
<td>Standard Dev</td>
<td>6.4</td>
<td>6.9</td>
<td>9.2</td>
<td>6.5</td>
<td>4.0</td>
<td>3.0</td>
<td>6.8</td>
<td>3.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VASQ 2 Mean</th>
<th>DT</th>
<th>B</th>
<th>BD</th>
<th>IE</th>
<th>P</th>
<th>ID</th>
<th>IA</th>
<th>MF</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.3</td>
<td>9.0</td>
<td>20.8</td>
<td>16.1</td>
<td>8.1</td>
<td>7.8</td>
<td>15.1</td>
<td>7.3</td>
<td></td>
</tr>
<tr>
<td>Standard Dev</td>
<td>5.8</td>
<td>6.7</td>
<td>7.4</td>
<td>7.7</td>
<td>4.6</td>
<td>5.0</td>
<td>6.2</td>
<td>5.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mann-Whitney</th>
<th>U on VASQ 1 or 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>625.0</td>
<td>531.0</td>
</tr>
<tr>
<td>450.5</td>
<td>256.0</td>
</tr>
<tr>
<td>338.0</td>
<td>252.0</td>
</tr>
<tr>
<td>249.5</td>
<td>392.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asymp. Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>.883</td>
</tr>
<tr>
<td>.226</td>
</tr>
<tr>
<td>.032</td>
</tr>
<tr>
<td>.000</td>
</tr>
<tr>
<td>.001</td>
</tr>
<tr>
<td>.000</td>
</tr>
<tr>
<td>.000</td>
</tr>
<tr>
<td>.005</td>
</tr>
</tbody>
</table>

7.2.5.2 EDI and treatment status

105 respondents are included in EDI analyses. 11 respondents did not complete the EDI properly. This may be due to the more confusing format of the EDI leading to larger numbers of missing values and to the disinclination of several patients to answer questions about their ED.

To check the role of symptom severity in treatment status, EDI data were analysed against treatment status with Kruskal-Wallis H (which is treated by SPSS as $X^2$ for significance testing; see Table 7-8). The distribution-free test was used because none of the EDI subscales were even close to being normally distributed. Score transformation was not appropriate, because within each subscale there were zero values and standard deviations were not proportional to means (ruling out log transformations) and data were not counts (ruling out square-root transformations) (Howell, 1997). Furthermore, visual inspection of preliminary boxplots showed no differences between the treatment status groups. Kruskal-Wallis H was non-significant for all of the EDI subscales.

---

27 Means and standard deviations are supplied here for visual inspection only. They are not appropriate for testing in this sample.
### Table 7-8. EDI scores by Treatment status.

<table>
<thead>
<tr>
<th></th>
<th>DT</th>
<th>B</th>
<th>BD</th>
<th>IE</th>
<th>P</th>
<th>ID</th>
<th>IA</th>
<th>MF</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drop out</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=10</td>
<td>M</td>
<td>13.4</td>
<td>8.7</td>
<td>18.8</td>
<td>12.4</td>
<td>4.4</td>
<td>6.5</td>
<td>9.4</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>5.1</td>
<td>8.0</td>
<td>7.8</td>
<td>10.2</td>
<td>5.2</td>
<td>6.8</td>
<td>8.2</td>
</tr>
<tr>
<td><strong>Eng. compl</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=44</td>
<td>M</td>
<td>13.8</td>
<td>7.7</td>
<td>20.1</td>
<td>13.0</td>
<td>6.4</td>
<td>5.8</td>
<td>13.0</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>6.3</td>
<td>6.5</td>
<td>7.8</td>
<td>7.9</td>
<td>4.6</td>
<td>4.9</td>
<td>7.4</td>
</tr>
<tr>
<td><strong>Rx refuse</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=19</td>
<td>M</td>
<td>15.2</td>
<td>9.6</td>
<td>17.3</td>
<td>14.4</td>
<td>8.4</td>
<td>5.6</td>
<td>11.8</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>6.1</td>
<td>7.0</td>
<td>9.8</td>
<td>8.5</td>
<td>4.4</td>
<td>4.1</td>
<td>6.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N=73</td>
<td>M</td>
<td>14.1</td>
<td>8.3</td>
<td>19.2</td>
<td>13.3</td>
<td>6.6</td>
<td>5.8</td>
<td>12.2</td>
</tr>
<tr>
<td></td>
<td>SD</td>
<td>6.0</td>
<td>6.8</td>
<td>8.3</td>
<td>8.3</td>
<td>4.8</td>
<td>5.0</td>
<td>7.3</td>
</tr>
<tr>
<td><strong>X2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.66</td>
<td>0.91</td>
<td>1.22</td>
<td>0.73</td>
<td>6.00</td>
<td>0.82</td>
<td>2.07</td>
</tr>
<tr>
<td>df</td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Sig</td>
<td></td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
<td>&gt;0.05</td>
</tr>
</tbody>
</table>

#### 7.2.5.3 Diagnosis and treatment status

There was no relationship between treatment status and DSM-IV diagnosis as tested by chi-square ($X^2=7.05$, df=4, p>0.10).

### 7.3 Discussion

The main objective of this chapter was to explore the ability of attachment dimensions to distinguish those who drop out from those who engage in, complete, or refuse treatment. This objective was pursued in 2 main steps through analyses of the overall categorical ratings of the VASQ and dimensional analysis of the VASQ through new factor analyses performed on responses given by this eating-disordered sample.

**Categorical analysis: Overall VASQ rating and treatment status** On purely visual inspection, more drop-outs had standard attachment styles than non-standard. This trend was unexpected and was not statistically significant. It would not agree with previous results in this thesis or in therapeutic alliance research. Repeating analyses on a larger sample will go some way to resolving whether there are differences in overall VASQ scores between treatment groups.
**Dimensional analysis: Factor analysis of VASQ items and status.** Factor analysis of the individual VASQ responses from this eating-disordered sample allowed attachment factors to be assessed dimensionally. Four main factors emerged, which corresponded to (1) Comfort with dependency, (2) Mistrust of others/anger in relationships, (3) Ease with making new relationships, and (4) Fear in relationships. Comparison of treatment status groups on subscales developed from these factors showed no significant differences. This result may be due either to low statistical power resulting from a small group of drop-outs or to a true lack of difference between treatment status groups on pre-treatment attachment dimensions as measured by a self-report instrument. Again, repeating analyses on a larger sample will clarify these results; however, they lend support to the idea that dropping out is not simply a function of pre-treatment patient characteristics.

**Specific purposes of scoring systems** The inability of the overall VASQ rating to detect differences between treatment status groups may indicate that using a scoring system developed for one purpose (to detect high-risk attachment attitudes in general relationships) may not be appropriate for another purpose (to detect differences in relating within the therapy context). Indeed, the questionnaire development literature stresses that validation and reliability tests are specific to the context in which they are performed (Streiner & Norman, 1995); scoring systems can be seen to be extensions of these tests.

The overall categorical VASQ scoring system was developed to distinguish community adults at high risk for psychiatric disorder from those at lower risk. This system is thought to work because it distinguishes those with severely disturbed attitudes toward regular, reciprocal adult attachment relationships from those with more normal attitudes. Since the overall VASQ scoring showed that the majority of respondents in this clinical context had severely disturbed attitudes (and so were at high risk for psychiatric disorder), it carried out its original function – as psychiatric patients they were obviously at high risk of psychiatric disorder. However, this function is not necessarily appropriate for distinguishing those who are less likely to be able to make and maintain *therapeutic* relationships. Thus, it may be necessary to derive a new scoring system for predicting the outcome of treatment relationships. Clarification of the role of attachment style in dropping out awaits gathering further data as well as performing new studies of other attachment functions.
Overall VASQ rating and EDI In post-hoc exploratory analyses, EDI scores for the 'standard' (1) and 'non-standard' (2) VASQ groups were compared. Overall VASQ rating was not related to self-reported symptom severity, but was related to other, interpersonal difficulties as reported on the EDI, such as ineffectiveness, perfectionism, maturity fears, and interpersonal distrust. In this clinical sample, those with severely disturbed attitudes toward attachment relationships appear to report greater difficulty with performance-related self-esteem and interpersonal trust. The link between attachment and self-esteem has been observed elsewhere (Bifulco et al., submitted; Mahon et al., submitted), and merits further investigation in clinical groups. Work on attachment difficulties may be of particular salience to eating-disordered women, who may be more likely to feel isolated as a result of the secretive nature of their disorder (McKisack & Waller, 1997).

EDI / diagnosis and treatment status A subsidiary aim was to confirm that ED diagnosis and self-reported symptoms did not relate to treatment status. This was pursued by comparing means of EDI subscales across treatment groups, and by analysing diagnostic and treatment status groups with chi-square. No differences were found. The drawbacks of the small sample size notwithstanding, it is felt that this aim was achieved, since the findings represent a second replication of earlier results.

7.3.1.1 Limitations

This study had a number of important limitations, most prominent of which was the limitation on statistical power caused by the small sample size. This is partly the result of situational problems in conducting this research at a publicly funded clinic with strained resources. Shortly after this study began, staff numbers fell, and waiting lists and times increased. As a result the number of patients entering treatment during the year the study was to run was smaller than originally planned.

The small sample size necessitated imposing other limitations on the study. The definition of dropping out again had to be restricted to session numbers attended, but this time to a different number than was used for earlier studies in Chapters 5 & 6. This may affect the comparability of the results, though it is not felt it made a great deal of difference, as most dropping out occurs by 4-6 sessions (Baekeland & Lundwall, 1975; Garfield, 1994; NIMH, 1981; Phillips, 1987). It will be preferable in future studies to report dropping out in continuous as well as categorical terms.
However, even when the lowered 'engagement' threshold is taken into account, it is unclear why there were so few drop-outs compared to earlier time periods. In Chapters 5 & 6 drop-outs and treatment refusers were not distinguished, resulting in a larger pool of 'drop-outs'; however, even when these groups were separated, the proportion of drop-outs to engagers was larger than it was in this study. The high treatment refuser rate for the current study may in part be due to the very long waiting lists, which may have impelled more patients to seek help elsewhere either before or after being assessed. Or, the current lower drop-out rate may just be a fluke that will disappear as the sample size increases. Therefore, for subsequent analyses of the VASQ, a more flexible definition of dropping out can be used.

The type of treatment also was not entered as a covariate. This decision was made for a number of reasons, including the small sample size. Past drop-out research has not provided good evidence that treatment type affects dropping out (see Section 2.2.4.1). Furthermore, in-depth, related research on the therapeutic alliance also showed that treatment type did not affect outcome (Luborsky, 1994). Therefore it was decided to simplify the study design and maximise generalisability to diverse treatment situations (Frank et al., 1957).

Still another limitation is that the VASQ is a new measure, particularly in the clinical population. However, its validation on a population selected for psychiatric risk makes it a better choice for studies on clinical populations than measures which have been developed and validated for university or college attenders. The novelty of the measure also needs be considered in context: it was developed directly from a well used and validated interview, the ASI. The ASI has been used in the ED population with good results (Troop, 1998). The items were therefore well tested in a wide range of populations before being transferred and validated in self-report form. However, it did appear that the VASQ scoring system would have to be modified when using it to assess durability of treatment relationships. Because the VASQ is based on a wide range of attachment relationship attitudes, it is able to accommodate such requirements.

It would have been an advantage to have controlled for comorbid depression as well, since depression is thought to affect the self-report of social support (Harris & Bifulco, 1991) and it is known to be common in the eating disordered population (Palmer, 2000). However, current depression was not found to affect reporting of attachment attitudes on the ASI or the VASQ (Bifulco et al., submitted; Mahon et al.,
submitted). Nor were eating symptoms related to reporting of attachment attitudes in this sample, even though other self-esteem and interpersonal characteristics were. It will also be of interest to look at other psychiatric symptoms in relation to the VASQ, but these investigations will have to wait for later studies.

7.3.1.2 Conclusions

Undoubtedly dropping out is governed by the complex interaction of multiple factors that exist prior to treatment and as a result of treatment. This study did not show that pre-treatment patient attitudes toward attachment could be used to distinguish those who drop out from those who do not. It is unlikely that dropping out will be accurately predicted from measuring patient attitudes in isolation. They are only a small part of the interaction that occurs in establishing a treatment relationship. The interviews and questionnaire presented in the next chapters attempt to begin unravelling this interaction.
8 PATIENTS’ VIEWS OF EARLY ENGAGEMENT AND DROP-OUT:

THE ROLE OF ATTACHMENT

But on the other hand, [clients] also need to feel that this power and authority is [sic] shared. This sense of collaboration and participation may importantly contribute to a sense of safety that is essential for the development of trust between therapist and client... (p. 568, Horvath & Luborsky, 1993).

8.1 Introduction & Aims

The case-note studies described in Chapters 5 & 6 showed that experience of trauma and parental divorce in childhood reliably relate to dropping out, at least statistically. However, in Chapter 7, patient trait-like attachment dimensions as measured by self-report were not able to distinguish drop-outs from completers. Thus the relationship between attachment factors and dropping out from psychological treatment remains unclear.

Without more conceptual groundwork completed, securing a replicated relationship between a set of variables and dropping out has limited usefulness for both research and clinical practice. Useful interventions to reduce dropping out can only be developed when it is understood how they relate. Chapter 7 indicated that the relationship between such variables and dropping out was not necessarily a simple one and might encompass more than patient pre-treatment characteristics. Furthermore, there is a good deal more practical groundwork to be done. The amount of variance explained by the LR models was small; evidently many other factors contribute to dropping out. Indeed, the studies reported in this thesis ultimately follow only one thread (attachment) of a complex fabric (establishment of therapy relationships).

The current investigation of dropping out turned toward this conceptual and practical groundwork. An intensive, open-ended interview study, one aspect of which is presented in this chapter, was conducted to further investigate the role of attachment factors in dropping out and to discover some of the other factors affecting dropping out using the point of view of patients rather than purely that of clinicians or researchers. It also aimed to learn more about the process invoked in dropping out, how patients make
sense of it, and how the factors interact with each other in their experience.\textsuperscript{28} To access this kind of data, it was important to talk the patients themselves. Techniques of qualitative data collection and analysis were used, since survey or case-note analyses were not as amenable to the pre-theoretical, observation-based goals of this study. The framework of attachment theory was then used to organise and present a selection of results from this analysis.

The introductory chapters of this thesis focused on the interplay between the way questions about dropping out were asked and analysed, the type of data they generated, and the conclusions that could be drawn from the results. In this chapter, this relationship is forefront. Since the primary objective of this chapter is ‘to contribute to a revision and enrichment of understanding, rather than to verify earlier conclusions or theory’ (p. 216, Elliott, Fisher, & Rennie, 1999), qualitative methods are appropriate. Furthermore, the method of qualitative analysis used (Interpretative Phenomenological Analysis) is well suited to increasing understanding of general research questions (Smith et al, 1999), as opposed to illuminating specific instances of an event. It allows for deep investigation of topics across a large number of interviews, as well as for revision of the foci of the interviews, analyses, and conclusions according to the picture that develops during the study (see Section 8.2.1).

Such flexibility has been critical to the data gathering, analysis, and interpretation of this study underlying this chapter. It was initially designed to compare and contrast the perceptions and experiences of patients who engaged in or dropped out of treatment from an eating disorders service, with attention given to the role of attachment style in their personal and treatment experiences. At the initial design stage, the researcher had a bias arising from conducting an initial literature review and the studies reported in Chapters 5 & 6 that participants’ own trait-like attachment styles would affect how they perceived their treatment and how they would react to the assumptions of treatment, particularly non-reciprocal, early confiding. The sample were selected in order to cover the range of treatment durations at the service (Section 8.3.3). However, during data gathering and analysis, it became clear that such simple categorisation was not adequate.

\begin{footnotesize}
\textsuperscript{28} A companion study, which is not reported in this thesis, interviewed the therapists of these patients about their views of what contributes to patients deciding to stay in treatment or to drop out in general.
\end{footnotesize}
Patients categorised their experiences differently from the researcher: whether the treatment was ‘good’ or ‘bad’ was more relevant to them than how long it lasted or where it had been received. Patients did not necessarily distinguish the care they received at the eating disorders service from the care they received at other psychological-type services or even at the GP. As a result the analysis shifted toward investigating these ‘good’ and ‘bad’ experiences. This shift also affected the researcher’s ideas about the role of attachment in dropping out. More important than the patients’ own attachment style and experiences was the manner in which the difficult attachment issues inherent in the early treatment situation were handled by the patient and the therapist. Adequately describing and organising these early experiences became the compelling task of the study. Attachment theory was able to accommodate the main issues raised by patients, and so was used to organise the description of these experiences. Taken together, participant themes build a picture of early engagement in terms of attachment concepts.

The shift in emphasis during this study required modifications of design and objective, for instance the way participants are grouped. In order to convey the initial framework to the reader, the initial design, objectives, and sampling are described. This will illuminate some of the researcher’s biases as well as ensure that the sample is ‘situated’ (p. 228, Elliott, Fischer, & Rennie, 1999). Describing this background will also situate the final objectives, analyses, and conclusions in the appropriate field.

8.1.1 Final aims

1. This chapter aims to describe the perceptions and experiences underlying the decision to stay in or leave treatment as explained by current and former patients. Initially categorised by study participants as ‘good’ versus ‘bad’ treatment experiences, they will be described in terms of attachment theory. This construct of attachment is thought of more as a state-like product of the treatment interaction than as a pre-existing patient trait.

2. It aims to provide relevant theoretical and methodological context for the interviews and their analysis.

This chapter presents one aspect of the initial study. In order provide a background for this discussion, the initial aims of the overall study are briefly described:

1. The aims of the overall study were to learn more about the range of factors affecting dropping out, and the processes governing it. Current and past patients
of the EDS were asked about their experiences during engagement with the EDS and any other treatment services. Specifically, their views of the influences which resulted in their establishing contact with the clinic, the factors that lead to either engaging or dropping out, and their understanding of the role of psychological treatment in ED were asked about. The patients’ constructs of treatment were also investigated through probing for their understanding of what treatment entailed in their case, what they think it ought to entail, their beliefs about the benefits and risks of treatment and from where these derived, and any changes they experienced in these attitudes (see Appendix 8-1 for patient topic guide).

8.2 Theoretical orientation & epistemology

8.2.1 Data collection and analysis: Interpretative Phenomenological Analysis

The analytic approach taken in this study is based on Interpretative Phenomenological Analysis (IPA) (Smith et al., 1999). IPA, like other methods based on the phenomenological paradigm, views reality as subjective, and ‘the important reality [as] what people imagine it to be’ (Bogdan & Taylor in Mason, 1992). It takes account of the social context in which human interactions occur and, through intensive open-ended interviews and recursive analysis of these data, seeks to understand the perspective of respondents. Thus it is fundamentally concerned with the cognitions underlying discourse and holds that they can be gleaned from the data (Smith et al., 1999) – in contrast to other methods which hold that the verbal information in discourse is the extent of the data (e.g., discourse analysis; Hayes, 1997). However, there is no claim to the positivist accuracy of these data, only an attempt to portray them meaningfully.

In IPA, the recursive analysis of data develops thematic categorisations of experience. The development of themes is an inherently subjective process. IPA also acknowledges the researcher’s subjective stance; indeed, it considers subjectivity to be an essential ingredient in the analytic process (Grafanaki, 1996; King, 1996; Smith et al., 1999). Without this subjectivity, the empathy needed to generate themes that reflect the respondent’s experience would be absent. IPA also attempts to manage subjective prejudices by returning at each stage of thematic development to the respondent’s actual
words to check that the abstractions still reflect the 'reality' of what was said (see below for details of this researcher's subjective stance).

This chapter compares the experiences of a range of people, rather than analysing minutely the experience of a few people, so themes represent the main data analytic 'results' (method discussed in detail in Section 8.3.7). The method does not aim to provide objective proofs; rather, it aims to understand whether previously developed ideas have any validity for patients themselves, to learn more about the processes relevant to their experience, and to generate further hypotheses about dropping out. The themes developed in this chapter are used to inform the development of the research tool presented in Chapter 9.

### 8.2.2 Researcher's subjective stance

In this particular study, my subjective stance was influenced by my role as a doctoral candidate researcher at a British university working in a clinical National Health Service context. As such my work was affected by the need for practical research that could be carried out independently. My supervisor's interest in dropping out initially introduced me to the topic. Broadly feminist views have also influenced my interest in the development of eating disorders, the people who suffer from them, and their treatment. More specific influences include assumptions made from initial literature reviews, previous quantitative research experience in the eating disorders and the attachment fields, contact with patients and therapists involved in psychological treatment (not only of eating disorders), readings about psychological treatment theory and the development of the psychological treatment field, and broader cultural influences that are not consciously accessible. These experiences influenced the initial design of the study, which was described in the introduction as a comparison of participants categorised according to their treatment duration at an eating disorders service. These experiences will also have influenced the selection and development of questions during the interviews and of themes during the analyses. Undoubtedly, they dictated the use of attachment theory to organise results.

However, efforts were made to manage this subjectivity: analyses and conclusions were tied to the actual words of the participants, and feedback was sought from attachment researchers, qualitative researchers, and eating disorder clinicians, which was then incorporated into the analysis. Participants were all provided with transcripts of their interviews and offered copies of the research results. There are indications that the
researcher’s subjective stance did not completely blind her to information which contradicted her initial biases: the research objectives were changed during the study as a result of exploring the experiences described by the participants, and the understanding of the role of attachment in these experiences shifted from a trait-like to a state-like model. Nevertheless, the subjective stance of the researcher must be kept in mind when interpreting the results and conclusions of this study.

8.2.3 Organisation and selection of results: Attachment theory

A selection of themes resulting from this analysis were organised using attachment theory. Attachment theory was described in Chapter 4 (see especially Section 4.1.1 for attachment style and therapeutic relationships) and so will not be extensively recounted here. Each theme discussed in the Results section represents an aspect of attachment theory. Taken together, these themes build a picture of early engagement in terms of attachment concepts.

From a purely theoretical standpoint, attachment was felt potentially to provide a good explanatory and predictive framework for understanding the interactions involved in dropping out. Holmes (1993) explains:

1) Attachment theory predicts that when someone is faced with illness, distress, or threat they will seek out an attachment figure from whom they may obtain relief. Once a secure base is established, attachment behaviour is assuaged, and they can begin to explore …

2) The establishment of a base depends on the interaction between the help-seeker and help-giver. The very fact that someone seeks psychotherapeutic help implies that they will have had difficulty in establishing such a base in the past…. There will be a struggle between the [patient’s insecure attachment patterns] and the skill of the therapist in providing a secure base – the capacity to be responsive and attuned to the patient’s feelings… (pp 151-152).

Portion 1 of this excerpt enumerates steps that a prospective patient might take in seeking help. This psychological chain is expected to be nearly universal in those seeking help from psychological services, and provides the theoretical background for the results presented in this chapter. Portion 2 illustrates the importance of patient-therapist interaction in the patient’s ability to achieve her goal of getting help. This chapter uses Holmes’s interaction model as a guide for understanding and presenting the experiences related by the participants.
8.3 Method

8.3.1 Ethical permission

Ethical permission for this study was obtained from the Leicestershire and Rutland NHS Trust in June 1998 (Appendix 8-2).

8.3.2 The clinic

The clinic hosting this study was the same as that described in Chapter 5.

8.3.2.1 Type of treatment

During the study design stage, the short- or long-term nature of treatment was thought to be potentially important to completion (Sledge et al., 1990). Hence both the length and type of treatment were asked about in the interviews. For treatment episodes that took place at the EDS, type of treatment was also checked in the case notes. Treatments available to participants had included open-ended psychodynamic, cognitive-behavioural, and interpersonal psychotherapies. In practice, however, treatment length and type did not seem to be important to participants. Treatment type was raised by only one patient and only as an aside, so it was not pursued in thematic analyses.

The content of the treatment (e.g. keeping a food diary, being weighed, or talking about feelings rather than food) was only important when the patient’s desires or expectations had been ignored.

8.3.3 Sample selection

8.3.3.1 Selection criteria

Initially selection criteria were limited to:

1. Having been offered an assessment appointment at the EDS,

2. Not having been referred directly on to another service,

3. Being accessible to the researchers (living somewhere within the UK at the time of the study),

4. Having a clinical ED according to DSM-IV criteria. For patients who refused assessment, it was not possible to ascertain the diagnosis before the interview; however, the presence of DSM-IV criteria at the time of the assessment appointment was estimated during the interview.
Patients with AN were also interviewed to see if their thoughts about engagement differed from those with BN. Since the correlation between persistence in therapy and age is only weak (Section 2.2.2.1.1, and Chapters 5 & 6), no attempt was made to select patients according to age. For similar reasons, sex was not a factor in selection, but in practice only women were interviewed.

8.3.3.2 Theoretical sampling structure

The sampling procedures used for qualitative data collection are driven by the need to have theoretical coverage of the construct rather than representative coverage, as would be the case in survey data collection. Therefore, the sample is modified as the study progresses in order to ensure that gaps in data are filled. This is because the salient quality of participants in a qualitative sample is their informativeness, rather than their representativeness of a particular demographic set (Richardson, 1996; Smith, 1995). Thus during the design of this study, when length of treatment was a main interest, it was thought to be important to talk to people who had had a range of treatment durations. A stratified categorisation of treatment length was constructed in the early stages of participant recruitment (Table 8-1).

The initial categories became less important once interviewing and preliminary analysis began, and in fact are presented here only to situate the sample and the study. The unit of analysis became the individual treatment experience rather than the participant, since many of the participants had had some form of counselling or treatment before, though not necessarily for an ED. (This is to be expected in a centre which combines secondary and tertiary referrals.) Some of these treatments had been completed by participants in the initial ‘drop-out’ categories, and others had not been completed by participants in the ‘engaged’ and ‘completer’ categories; therefore, if the wider range of treatment experiences were to be included in the analysis, the initial categories would no longer be relevant. Table 8-2 illustrates the distribution of participant early treatment experiences which was used in the Results section.

Despite the complications imposed by this change, it was merited because it allowed the analysis to move toward the superordinate study objective of understanding the process and factors affecting dropping out. The analysis was pushed toward creating generalised typologies of ‘good’ and ‘bad’ treatment relationships, which in turn could be discussed in terms of attachment dynamics. Therefore in the Results, participant
statements are categorised according to whether they are discussing a positive treatment experience which led to engagement or a negative one which led to dropping out.

8.3.3.2.1 Initial treatment status categories

Treatment durations were initially divided into 7 categories – the 6 seen in Table 8-1 plus a ‘long-term’ category of patients having had 80 or more sessions. The categories were later reduced to six, because the issues raised in long-term engagement were felt to be less directly relevant to early engagement. In practice, no participant fell into Category 3 (only one or two therapy sessions). Indeed, this category seems to be relatively infrequent in the service overall.

The distribution of participants was as follows:

<table>
<thead>
<tr>
<th>GROUP</th>
<th>Rx Status Category</th>
<th>Initial goal</th>
<th>Final no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Offered assessment, but did not attend.</td>
<td>Ass’t refuser</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. Attended assessment appointments only.</td>
<td>Rx refuser</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>3. Attended 1-2 therapy sessions</td>
<td>Drop-out1</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>4. Attended 3-9 therapy sessions.</td>
<td>Drop-out2</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>5. Currently engaged, but for less than 1 year.</td>
<td>Engager</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>6. Completed</td>
<td>Completer</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 8-1. Initial and final sample structures.

All treatments offered at the EDS when these participants were in contact with the clinic exceeded 10 sessions, so those leaving treatment before 10 sessions were not likely to have 'completed'. The discharge sheets were checked to verify that these patients had terminated treatment unilaterally.
Final frequency of patient experiences

The frequency of participant treatment experiences used in the Results section was as follows:

<table>
<thead>
<tr>
<th>GROUP</th>
<th>Final no.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Positive experience, leading to engagement</td>
<td>13</td>
</tr>
<tr>
<td>2. Positive experience, leading to drop-out</td>
<td>0</td>
</tr>
<tr>
<td>3. Negative experience, leading to drop-out</td>
<td>12</td>
</tr>
<tr>
<td>4. Negative experience, leading to completion (though not to 'engagement'; see Section 8.4.1.3)</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 8-2. Frequency of negative and positive early treatment experiences

8.3.3.3 Contacting potential participants

The GPs of potential participants who were no longer on the clinic register were sent a letter informing them about the study and requesting that they reply should they not want their patient to take part. If they did not do so within 10 days of the letter being sent, their patient was included in the pool of possible participants.

Initially a set of 50 letters was sent to current and former patients of the EDS. The letters briefly explained the goals of the study and requested an interview with the potential participant in a place of her choice. A response slip and a self-addressed freepost envelope was enclosed. On receipt of the response, the interviewer contacted the participant to arrange the interview. No follow-up letters were sent because the interviewer did not want to risk coercion, which might have influenced the data gathered.

In order to recruit more participants in Initial Categories 1-3 (assessment refusers, treatment refusers, and Drop-out1), a further set of 50 letters was sent to potential participants in these groups. Difficulty recruiting these participants had been anticipated; these patients may have felt little connection with the service or may not have wanted to be reminded of their disorder (Brandt, 1965).

8.3.4 Interview & location practicalities

Interviews were usually conducted in participant’s homes. A few interviews took place in the clinic, in pubs and offices. The only request that the interviewer made was
that the location be a quiet place where interruption was unlikely. The interviewer travelled throughout England.

As all of the potential participants were women, and as all of the interviews were conducted during the day or the early evening, it was considered safe for the interviewer to travel alone to these destinations. Precautions were always taken by telling another member of the team where the interviewer was going, what the contact telephone number was, and what time she should return. In the future, it would make sense for the interviewer to carry a mobile phone.

Interviews were tape-recorded, but only after the restrictions on the use of the tapes and transcripts were discussed with participants.

8.3.5 Topic guide development

A topic guide (Appendix 8-1) was constructed to provide cues for conducting the interview, if needed. Unlike semi-structured or structured interviews, these open-ended interviews did not follow a set format, though each interview at least covered the areas listed in the guide.

The guide was designed to ease the respondent into the interview. Questions started with very general information and proceeded to more personal and thought-provoking information. In practice, the guide was rarely used, except as a quick check at the end of the interview to verify that all of the main topics had been covered. Respondents, if left to approach the interview in their own way, generally covered all of the main areas without prompting. The information they gave was in depth and perhaps more accurate than it might otherwise have been if the interviewer had intervened more often. Respondents reconstructed the situations and feelings relevant to their decision to stay in treatment or to leave without being interrupted.

8.3.6 Conduct of the interview

8.3.6.1 Controlling demand effects in clinically related interview research

8.3.6.1.1 Participant-researcher relationship

No matter what the context, generating reliable information with interviews can be difficult when demand effects are particularly potent. In clinically related interview research, the patient-therapist relationship may affect the participant-researcher relationship. There is a considerable power differential between patients and clinicians,
no matter how hard clinicians try to make treatment a collaborative endeavour. When patients are in treatment, particularly if they have had to wait a long time or go to great effort to get that treatment, they are unlikely to say anything that might jeopardise its continuation or that might bias their therapist against them. Similarly, when patients have dropped out, they might not want to say anything that would make themselves look incapable of having completed the treatment or their therapist look incompetent. On the other hand, they might have an axe to grind regarding dissatisfaction with treatment. One way of reducing demand effects stemming from the clinical context is to use an interviewer independent of the clinical team who emphasises that information given in the interview will not be divulged to the clinical team.

### 8.3.6.1.2 Interview environment

The environment in which the interview is undertaken also determines the demand effects. If a patient has dropped out, or is contemplating doing so, conducting the interview at the clinic may make the patient uncomfortable and may restrict the interview content in some way. Equally, the patient may simply refuse to give the interview. Establishing that the participant will determine where the interview will take place can mitigate these effects.

### 8.3.6.1.3 Interview format

Once the interview begins, the format of the interview also contributes to the quality of the information that the respondent will give. An important limitation of other studies which have asked patients their reasons for leaving is that the information asked about has been determined by clinician or researcher theories about the factors important to dropping out. These may or may not reflect the ‘real’ reasons that patients have for leaving. Using an open-ended interview which encourages participants to expand upon any theories or details may result in unexpected and fruitful observations about the topic. The interview can be modelled on the police witness interview, which does not prejudge the relevance of details offered by the interviewee. The interviewer approaches the participant as the expert on her own experience.

### 8.3.6.2 Interview introduction

The interview was introduced with a version of following statement:

I’m trying to learn more about why people stay in treatment or leave it. I am hoping that you’ll tell me about your experience in treatment, and
what was important to you in deciding to stay in or to leave. The point isn’t about your eating disorder as such (although obviously that will come into it), but more about what the treatment was like and what it meant for you. I’d also like to know about what things were supporting you and what things were stressing you around the time you came for treatment. Any details you can remember will be relevant, so don’t feel you ought to leave anything out. I’d also like to know about any other experiences you’ve had in treatment or counselling. I might ask about your family and some childhood experiences and relationships. I have this guide just to check that we’ve covered all the main points, but it’s not meant to determine what we talk about. I’ve brought a tape recorder so that I can listen to you better, but if you would rather I didn’t use it, that’s fine.

Informed written consent was then obtained, and the interview was started.

8.3.7 Analytic method

8.3.7.1 Step 1: Theme-building through recursive interpretation of responses

As mentioned above, this study was designed to identify mechanisms underlying shared or contrasting experiences. This objective was approached by organising participants’ individual statements into ‘themes’, which are used to discuss the data and to advance hypotheses. Themes are created through a process of abstraction which rests on linking similar statements and searching for contradictory examples. However, it is essential that the abstractions still reflect the actual content of respondents’ statements. A recursive method, where the researcher returns to the individual statements after each level of theme-development to check that meaning has not been lost, was therefore required for this study. Such a method is recommended by both Smith et al (1999) and Ritchie and Spencer (1993).

8.3.7.1.1 Restrictions imposed by large sample size

The sample size was large for a qualitative study and so imposed practical restrictions on the recursive method which could be used. When trying to develop themes with data from a relatively large number of participants, too detailed examination of one person’s account is not appropriate or feasible (Smith, 1995). However, starting data interpretation at a broader level runs a greater risk of the researcher imposing her pre-conceived ideas on the data.

New methods are available for managing the restrictions associated with large qualitative data sets. Traditional paper-based methods, while useful for building up comparisons across participants and retaining their actual words, are unwieldy with large
data sets. More recently, computers have been used to analyse groups of responses. The computer-based methods still ‘ground’ the theory in the data without relying solely on the data for the creation of themes. Themes can be suggested at any time during data entry and linked to the raw data of the participant transcript. By using the computer’s cross-referencing facility, themes can still be built recursively, but analysis does not have to start at the individual sentence level.

8.3.7.1.2 Development of themes

The analysis of the qualitative data gathered in this study began during transcription of the interviews and was more fully developed using the QSR Nud*ist v.4 computer programme, which is designed for the analysis of qualitative data using a flexible indexing system. Themes were built up using 2 methods:

1. Occurrences of themes that were hypothesised to be relevant from the reviews and case-note studies were noted during the transcription process. These themes were directly entered into the Nud*ist indexing system.

2. After transcripts had been introduced into Nud*ist, they were read through and coded using the initial themes. Emerging themes were added to the initial indexing system, which was adjusted when new relationships between themes were observed.

8.3.7.1.3 Selection of themes

After the transcripts were coded and a broad set of themes was built up, a more limited set of themes were selected for closer examination, including the themes of ‘good’ and ‘bad’ therapy. Ultimately, the attachment themes relating to the relationship with the therapist were focused on, as they were directly relevant to the decision to remain in or drop out of treatment and so were most relevant to the current research. They will form the bulk of the presentation of the data in this chapter, though a further process of inquiry has been carried out termed ‘questioning’ the data set.

8.3.7.2 Step 2: ‘Questioning’ the data set

Nud*ist allows for ‘questioning’ of the data set by setting up a series of comparative data displays. This would be analogous to hypothesis-testing in quantitative statistical science, which is usually done toward the end of a study, though it may have both exploratory and confirmatory purposes. In qualitative analysis this process can be done at any time during the construction of the set of themes. Questions were as follows:
1. What reasons did the drop-outs give for leaving treatment? What reasons did engagers and completers give for staying? As discussed above, the initial categorisations assigned from clinic records of ‘drop-outs’, ‘remainders’, and ‘completers’ became less important to the analysis when the themes of ‘good’ and ‘bad’ therapy relationships emerged. As a result, the questions included in this set led to Sets (2) and (3) below.

2. The images of the ‘good’ and ‘bad’ therapists and therapy relationships were explored. What did they consist of? Were they different for different people? Did any participant who remained in a treatment relationship ever describe it as a ‘bad’ one? Did one who left ever describe the relationship as a ‘good’ one? The distribution of these responses is presented in Tables 8-3a&b (Section 8.4.3). The ‘good’ and ‘bad’ therapy relationship themes are described in depth using attachment theory as a framework (Section 8.4.2). Their presentation forms the bulk of the Results.

3. How did the respondents define themselves as far as the clinic-derived categories were concerned? Did the completers consider themselves to have appropriately terminated? Did the drop-outs consider themselves to have inappropriately terminated? Did those who were ‘engaged’ think they were? Did they seem to have different reasons for consenting to the interview? These results are presented in Section 8.4.1.

4. Did differences in participants’ own attachment styles explain their perceptions of treatment relationships as either ‘good’ or ‘bad’? These results are presented in Section 8.4.4.

8.4 Results

Establishing a secure attachment to the therapist proved to play a critical role in engagement, according to the accounts of the 26 women interviewed. Participants described their reasons for staying in treatment or leaving it in terms of what was ‘good’ or ‘bad’ about therapy and the therapist. ‘Good’ treatment relationships were characterised by the establishment of a secure base with the therapist, who was perceived as accessible and able to provide attuned support, and who encouraged exploration and
growth in the patient. The establishment of a secure base did not occur in ‘bad’ treatment relationships, where therapists were perceived as inaccessible or rejecting. Instead of feeling encouraged to take risks and explore, patients withdrew from these relationships either physically or mentally.

Bowlby’s representation of attachment relationships is used as the framework for characterising the ‘good’ and ‘bad’ relationships described by participants (Bowlby, 1969/1982) and forms the bulk of the results presented below. Figures 8-1 and 8-2 map these descriptions onto elements of the Bowlbian attachment relationships and should be used as guides when reading the text. Each ‘bubble’ contains abbreviated Section numbers for the element being discussed. Auxiliary information important to interpreting these descriptions is discussed first. Tables 8-3 a&b show the distribution of themes mentioned by participants when describing these relationships.

8.4.1 Auxiliary information

8.4.1.1 Relationships included in results, use of fictitious names

It should be noted that the results are not confined to discussion of ED therapists. Other types of therapists are included, and in some participant accounts GPs are mentioned. Most participants did not distinguish between primary and secondary care, especially when the contact with the primary care-giver was frequent, regular, and had a ‘talk-therapy’ flavour to it. However, relationships with GPs who were not seen regularly are not considered potential attachment relationships.

All participants and the people they discuss have been given fictitious names. The participant’s treatment status category is included in brackets after her name. This categorisation applies to her treatment at the EDS, which is not necessarily the treatment she is discussing in the quotation. However, the quotation is usually relevant to her EDS categorisation.

Interviewer comments are enclosed in brackets.

29 Reasons for staying in treatment other than attachment in the therapy relationship, such as being desperate to get better or not wanting to affect one’s children, were also raised by participants. However, both engagers and drop-outs talked about these reasons, so they did not distinguish the groups. They might better be considered motivations for seeking help rather than reasons for remaining in treatment. Those whose treatment relationships were good did not have to evaluate whether their reasons for seeking help differed from their reasons for remaining in treatment, whereas those whose treatment relationships were poor were confronted with the decision about whether to pursue a poor relationship.
8.4.1.2 Reasons for consenting to the interview

Given that the qualitative interview is a socially constructed event, the results must be considered alongside the reasons participants give for engaging in the interview. Many participants wished to help others by giving their time to the interview. Some felt that they had been treated badly while in therapy and wanted to express this frustration.

When I first got your letter [about this interview] I didn't really want to do it. My husband, he said, you know, you should do it. You didn't have a good time there and you should tell them about it. And that made me think about it. I'd got this letter from the lady I was seeing there telling me to send that [Overcoming Binge Eating] book back -- saying it was her book not mine. I wish I'd saved it to show you! I threw it away I was so annoyed. It was like she was saying I'd taken it! I didn't, she said it was part of the treatment, but cause I didn't finish she wanted it back. Then I saw your letter and I thought I'd do it. Can you take the book back to her, I don't want to see it anymore!
Tina

Still others had an unexpected motivation for participating. Many participants in the groups that were not currently in treatment seemed to be using the interview to test out returning to therapy. The researcher had gone to lengths to present herself as a researcher, not a clinician, and as independent of the clinical team. Nevertheless, for many patients, being asked personal questions felt similar to therapy. These types of interviews tended to be longer than those with the patients who were currently engaged, lasting at least one and a half hours.

No patients who were currently in treatment but who were thinking about dropping out of treatment consented to the interview. This may be because participating in the interview required a level of self-exposure and reflection that those unhappy with treatment would not feel comfortable with. All accounts of dropping out are therefore retrospective.

8.4.1.3 Patients' self-categorisations as engagers, drop-outs, or completers

Given that categories are often difficult to apply in psychology, it is not surprising that the clinic-derived categories did not always match up with those the participants would have chosen. However, the way in which they did not match up was surprising. It was expected that some of those classified as 'drop-outs' would say that they had had sufficient treatment. In fact this was only rarely the case.
It was not expected that several of those classified as ‘completers’ would not feel that they had completed. They said they had ‘dropped themselves out’, or had ‘removed themselves’, from treatment because they did not find the relationship helpful but wanted to avoid embarrassment, confrontation with the therapist, or being labelled as ‘difficult’. Only two of the seven completers were happy with the treatment they had received. One of these two felt that she needed more treatment. This dissatisfaction or felt need for further treatment probably motivated these women to participate in the study. It is not thought that all completers feel this way, especially since those classified as engagers all considered themselves to be engaged, were generally happy with treatment, and planned to complete treatment. However it is important to realise that categorisations that exclude patient perspectives may not be accurate.
Secure Base

RESPONSIVE

Attuned Support

EXPLORATION

Figure 8-1
8.4.2 ATTACHMENT: ‘Good’ and ‘Bad’ treatment relationships

The typologies of 'good' and 'bad' therapy which were commonly discussed by participants as reasons for deciding to stay in or leave treatment fit into a framework of attachment theory, namely the building of ‘secure’ and ‘insecure’ attachments.

Discussion of attachment in adult relationships often centres on romantic, love relationships (Section 4.1.1 and, e.g., Hazan & Shaver, 1987). However, romantic love is only one area where attachment is present in adult relationships. Attachment is said to exist when the attachment figure is used as a ‘secure base’ from which to explore the world and to which the attached can turn for reassurance or protection in times of threat (Bowlby, 1969/1982). Love does not have to be present. Indeed, in therapeutic relationships, it would not be a defining feature (Holmes, 1997). Victoria expressed this difference:

I think I find the security in [my therapist] sort of thing. I mean I trust her and I know she's there if I need her.[...] But I wouldn't say she's like someone that I can love, if you see what I mean.

(Is that good -- or bad -- or?)

Different really, I don't think she's someone that I need to love, if you see what I mean, but she's secure in the fact that I know she's there if I need her.

Victoria

8.4.2.1 SECURE BASE/INSECURE BASE

As explained in Chapter 4, a secure attachment relationship involves the provision of responsive care and attuned support which creates an emotional ‘secure base’ in the mind of the person receiving care (Bowlby, 1969/1982). Exploration and risk-taking are encouraged. The good treatment relationships described by the study participants were characterised by an atmosphere of emotional safety and the freedom and support to change. On the other hand, insecure attachment relationships, while also involving the existence of the ‘base’, lack security and so exploration and risk-taking are stifled.
Participants recounting the growth of strong relationships with their therapists describe the establishment of trust in terms of security or safety (see Victoria’s remarks above). This was seen to result from the therapist’s responsiveness and attuned support. In poor relationships, there was no sense of trust. This was discussed in terms of not liking the therapist, not feeling liked, or not ‘working as people’. Feeling ‘insecure’ was not explicitly mentioned.

The meanings of ‘safety’ and ‘security’ have many variations. In this analysis, these words refer to the sense of being ‘free from danger, secure, [...] trustworthy’ (Little, Fowler, & Couson, 1973). The senses of being ‘cautious, keeping to the safe side’ or being ‘free from risk, […] guaranteed against failure’ (Little et al., 1973) are not intended. Such ‘safety’ would not be considered a sign of good treatment, as it would mean losing the ability to care for oneself, and shutting off exploration.

*It was horrible in there. I went down to 6.5 stone. I knew I needed to be somewhere, but I didn’t agree on being there. But I came to love it, it was safe, very very safe, I didn’t want to leave. All I’ve got to do was think about me and what I was having for dinner.*

Jill (treatment refuser referring to inpatient stay elsewhere)

### 8.4.2.1.1 Responsive/Rigid

Responsiveness on the part of the caregiver is the first requirement for developing a secure attachment relationship (Bowlby, 1969/1982). The caregiver must be aware of the presence of the cared-for, aware of her needs, and be able to ‘answer’ those needs, to be ‘response-able’ to that person. In an adult attachment relationship, the question of responsibility is fraught; however, patients express a need for an answering presence in the therapist.

#### 8.4.2.1.1.1 Available/Inaccessible

In order to be responsive, therapists first must be available. Physically showing up for sessions communicates a basic level of acceptance and respect.

*(Did you feel anxious going up [to the clinic]?)*

*Yeah, and a couple of times, took me all my courage to get up there, and she wasn’t there. No one had let me know or anything.*

Sylvia
Emotional availability, expressed by accepting and working with the patient’s unique characteristics, is fundamental to establishing a good relationship.

The best thing for me was this person that was actually there listening to me...I could tell him anything and everything that I was doing to my body without him sitting there you know going ‘Oh!’ you know that horrified reaction...The best thing about it, the most helpful thing was that it was somebody I was talking to, cause I had nobody to talk to, nobody. I didn’t have a girlfriend, a best friend I could talk to....You are not on your own. There is somebody else there, in it with you, and that gives a hell of a lot of strength. I honestly believe there is no way I could have done it without the counselling, no way, cause I had nobody to talk to.

Margaret

Margaret’s relationship with this therapist was overall a good one, which progressed to the point where she felt she had an ally in her efforts to change (‘You are not on your own’). However, perhaps due to a combination of Margaret’s own attachment style and her therapist’s choice of treatment approach, the relationship was not able to overcome a rupture later in the therapy, and Margaret emotionally withdrew herself from treatment and convinced her therapist that she did not need more.

Sometimes the needs of patients are beyond the ability of a therapist to answer. Xandria, again perhaps due to her own attachment style, could only feel that her therapist was available if she never had to be separated from her.

If I was ever going to get over this, I’d need somebody that was on call like 24 hours a day, because you can’t, you can’t put yourself into therapy mode and eating disorder mode like at two o’clock on a Tuesday afternoon. You may be feeling fine, your eating may have been fine for the day, but come 11 o’clock at night and you feel like absolute crap and you need somebody to talk to -- that’s when you need somebody to talk to, you can’t just say, right, I’ve got an appointment on Tuesday. It’s when and if it arises. I don’t know, I just need to know that there’s somebody always there.

Xandria

8.4.2.1.1.1 Unique relationship/Feeling treated like a number

The therapists who were perceived by participants as being emotionally available conveyed to the participant that their relationship was in some way unique. Participants who had had such therapists felt that treatment was a special relationship that existed for her benefit. In Sarah’s case, this was important even when the ostensible reason for her attending treatment, controlling her ED, was not progressing.
Since I’ve been seeing [my therapist] I feel as though I have got it a little bit more under control. [but]...I just feel as though I have lost it again now.

(Is coming to see her still helpful to you...?)

Yeah, because it’s somebody there to discuss things with, and I suppose sort of to be there for me.

(Yeah...)

That it’s my own somebody for me.

Sarah

Participants who had had poor therapy relationships felt that they were treated on a production line and that they themselves were of no importance to the therapist. Participants felt that these therapists had not been available and had put nothing of themselves into the treatment. Jane saw this as a barrier to the development of ‘trust and confidence’.

She was telling me because that’s what the textbook is telling her to tell me to do -- she doesn’t believe it, so how can I believe it? You’re lying to me, so I’ll lie back to you is probably the honest, honest bottom... I think it’s that I felt patronised...

(She didn’t engage with you?)

No, we hadn’t made that kind of contact. I felt as though it was, it didn’t flow, today has flowed. Then, if it strayed, we went back to certain categories. I felt like a number. I think perhaps for this kind of thing to work, there has to be that trust and confidence.

Jane

For Jane, the interpersonal relationship is crucial to being able to change. In contrast, the interpersonal relationship is almost completely absent from Sylvia’s statement. However, the sense of uniqueness is still important.

It may have been good treatment for somebody else, but everybody’s different. And you seem to be treated as a majority. I know they have to have standards to go by because it is difficult, you can’t, ... to treat everybody different, to have one treatment for one person, one for another, would be too time-consuming, too expensive, you have to go on the majority, but not everybody’s the same and that didn’t suit me.

Sylvia

The feeling of being treated like a number may stem from a critical debate in psychological treatment – what is the role of diagnosis, if aetiology and treatment are not the same within a diagnostic group?
There are so many different reasons why we all do this. Not one treatment is going to be right for all of us.

Jane

8.4.2.1.1.2 Potent therapist/Passive therapist

As well as being physically and emotionally available, good caregivers are actively interested in those they care for. In treatment relationships, this increases trust partly because patients do not feel completely on their own, as though they can count on their therapist for some guidance. Participants in good relationships described how their therapist’s active interest in them helped them do the ‘hard things’ that were necessary in treatment.

She was quite straight-down-the-line. She answered my questions. She asked hard questions, but you’ve got to do hard things to fix hard things... It made me think. It convinced me that somebody could help me, that somebody was going to help me, that I wasn’t on my own.

Charlotte

Participants describing relationships that did not work often focused on the passivity of the therapist. This was construed to be as a type of inaccessibility, from which they recoiled as if from a rejection.

I’m not very good. I’m all right on a one-to one basis, I find it difficult to talk. She just used to sit there and wait, and I just went further in.

Sylvia

In Jane’s story below, the therapist not only appears to be impotent as far as responding to her but also fond of veiled put-downs (‘You’re probably the most rational person with an eating disorder that I’ve spoken to’).

I went for four weeks, it was to be a six-week thing, and at week four I said, How are we doing? And he said -- All he would do is he would ask a question and I would have to expand on it -- and I think he came up with, How do you think I’m doing, how do you think you’re doing? And I said, well, I don’t really need you to ask me that, I can ask myself that -- Are we getting anywhere, what are we doing here? And he said that I was probably the most rational person with an eating disorder that he’d spoken to, he said, You’ve read just about everything that I would tell you to go away and read, you’ve examined every reason you’ve done why what you’ve done and you find humour in everything - - and so he said, How do you feel? And I said, Well I feel probably about the same way that I came in... And I thought, well, what a complete and utter waste of time this is, cause I had to drive 30 miles from work to go and see him, and I was not telling work why I was
there, I was in a very high pressure job, what excuses can you make to have these 11 o’clock appointments, so I stopped.

Jane

Jane’s description also illustrates how ‘situational’ or ‘environmental’ barriers to attending treatment become more important once trust in the relationship has been undermined.

The passivity of the therapist sometimes was described as actually threatening, further undermining the relationship.

Not really, I don’t go out. But no, no girlfriends. That’s why I thought that going to see [the therapist], at last I’ve got somebody to talk to... but I talk better to you than I did to her.

(I’m in your ... you decide when we talk, and what we talk about, in your own home, which may help too.)

Yeah. I suppose it does.

(But I’m asking you questions as well.)

I don’t mind that, I’d sooner that. It helps me and it gives me leeway to, yeah, you know... There was things I wanted to say to her, but by the time I’d got there, they’d just gone, I’d get so anxious.

Sylvia

8.4.2.1.1.1.3 Accepting/Rejecting

One of the ways that participants expressed their understanding that the therapist was emotionally available to them was the feeling of acceptance that they had when talking to the therapist, being listened to, and not being judged.

If it had of been a group therapy I don’t think I’d have come as far as I have in such a short space of time. I just feel so relaxed and ... and if you’ve got anything you need to say, she just sits there and listens. She doesn’t judge you. Once I knew that, it made a big difference. She doesn’t sit there and think, Oh, she’s a whapper, she is. She doesn’t judge you in any way. She sits there, she listens. She tells you as it is. Hard as it is. And she tells you truthfully and I always think, Oh, the truth hurts! but it’s realistic. It’s no good someone sitting there and giving you false impressions cause it’s what you want to hear. You need to hear it as it is, and she doesn’t say it like you’re stupid.

Sarah

In Sarah’s experience, feeling ‘relaxed’ has come from her therapist listening to her without judging while taking an active approach to treatment (‘She tells you as it is’). She feels accepted, secure and challenged in this relationship.

8-181
Margaret developed a powerful attachment to her therapist during the early stages of their relationship. It was a stunning experience for her to have someone that ‘was there and ...was listening’, which led to her rapidly gaining ‘trust and confidence’ in him.

\[\text{I started seeing [my therapist] and for a while, umm, he became so important in my life and I had sort of like... feelings for him, it was very strange. I could never explain it, or try to explain it. I found myself really, really like attached to him, really like, um, the relationship... I don’t know, I think because it was the first time that there was somebody there that was...I could tell things to when I’d never ever told anything to anyone and I think that, actually telling people what you are doing without them going, Oh my god you’re not! are you not making this up? like the family would react... Somebody just there that wasn’t going to be shocked at what you are going to tell them so then you get this sort of trust and confidence in them. And, for a while it was extremely close cause this was the one and only person in my life that I was verbally telling them. Cause, I think you want to tell somebody, you want somebody... He was just there, and whatever I said didn’t matter, he just accepted it. I found him a lovely person sort of how, from most of the sessions till the end when I started getting angry, started getting used to him, I found it very, um, I really thought for a certain amount of time this guy’s really the best thing on legs cause he was there and he was listening to me.}\]

Margaret

In Margaret’s case, attachment style may have strongly influenced how this relationship progressed. She described a (sexualised?) attachment to her therapist that she was able to control by ‘getting angry’ after she ‘started getting used to him’.

8.4.2.1.1.1.4 Unshockable/disgusted

Recoiling in disgust from a patient would register as rejection in any treatment relationship. In this group of ED patients, many participants reported monitoring their therapist for signs of disgust or ‘shock’ at their behaviour. Talking to someone who took them seriously and who was ‘unshockable’ was a new freedom for participants in good relationships.

\[\text{It’s nice to be able to talk to somebody who is unshockable as well, to be able to talk to somebody who’s heard it all before and probably a thousand times worse. Without getting embarrassed.}\]

Amanda

When the relationships have not worked well, it is often an initial shock which is described as being a problem.
I told my GP, and he sat there and said, Oh, you don’t do that, do you? I was really up front, I need more than your 12 minutes, I need to talk to you about... and I told him, and he was like, Huhhh! You don’t -- you don’t eat all that! He was horrified, he’d never come across someone that had had an eating disorder before. And it made you feel even WORSE! So then I had to go away and make my diary.

He said, Can you do that?, and I said, Well you might be horrified because you were shocked last week. Right, well don’t tell me what you’ve actually eaten, just tell me whether you’ve binged, so I was just saying, binged, sicked, and laxative. I didn’t say what. And if I wasn’t binging, and just had a yoghurt for breakfast, I was to write that, and then just ‘binge’ if I did because we didn’t think we’d be able to get round that. ... I used to go see him once a week, and after a while I said, I don’t think we’re getting anywhere are we?

Jane

In acting shocked, and in judging her (‘binge’ food is not to be recorded, since it is ‘sick’, whereas ‘regular’ food is acceptable), the GP inverts the relationship so that the patient is the one accommodating him. It is not surprising that this relationship had no therapeutic use for Jane, and was in fact harmful.

Later in a relationship, the patient’s perception of being judged can be equally harmful.

When I told her that the diaries had been a lie, and she looked at me... I felt really – ooooh!... and she said, Well, thank you for being honest. [...] I still thought, I am going to do this. I did fill the diary in properly for some days, I think a week. That was hard. [...] In [therapy the following week] it felt, I felt... Cause it was a proper diary, and she looked at me that way, and I thought, She doesn’t believe me! and I came down a bit. Oh, there’s no point, she doesn’t believe it anyway, so what’s the point?

Sylvia

If the therapist had been able to negotiate the surrounding events in a way that had not come across as judgmental, the relationship might have been strengthened rather than weakened.

Sometimes, however, it does seem that patient is looking for a reason to go and becomes over-sensitive to the therapist. In the example below, Margaret perceives her therapist as judging her, but her reaction to him seems conditioned by the fact that the therapy had lost relevance for her. This may be because the relationship was strained by her frustration with his continuing passive stance. Interestingly, his ‘passivity’ was what had made her feel accepted initially. It may be that the therapeutic relationship, like all
close relationships, must evolve to remain secure. Margaret is the woman who described the very intense attachment to her therapist.

A couple of weeks it felt like I am just going through the motions, here we go, same old questions... Why did he ask that?, you know, What's the point in discussing that? I couldn't see -- I suppose, was I expecting too much, was I expecting results and... And sometimes it was like I had to start off the conversation, which used to annoy me, cause I thought, well, you know, You're the bloody one who's supposed to know what he's talking about, ask me a question!...Well, was that a part of it? [There were] a couple of things... Like at one point, nearer to the end, when I'd really, I'd really had enough... He had an opinion on something but it was nothing to do with my eating disorder. And it annoyed me, that really annoyed me. It was a question about what was I doing at the weekend, I said I was going home again. I had to go down to London because there was a funeral for my Dad's brother. And he said, How do you feel about that. Well, I said I am not looking forward to it, the thing I am really not looking forward to is, I just hope my Dad doesn't cry. And he went, Why, and I said, Well I won't be able to handle my Dad crying, cause I hate seeing men crying. He held it, absolutely horrid, horrific... He just like screwed his face up, and I thought, How dare you have an opinion of what I feel! You know, here I am telling him. So, in the end I got very angry with him and...that was the turning point. I think I went to him two more sessions after that and he kept jumping onto this subject and I thought, Well... And that really did finish it for me.

(If that hadn't happened, this sort of.)
Annoyance...Would I still be going?

(Would you still be going?)

Yes.

(So that really...)

Yeah, that was a reason. Was I looking for a reason? I don't know. Possibly I was. ...But, yeah, if you were saying, if his attitude to that one particular incident hadn't happened, I would honestly say to you more than likely, knowing me, I probably deep down was looking for a reason, because it felt like you just say the same old things every week and I really had put my mind to it and I really was getting a bit better and it was becoming a chore to go.

Margaret

Other times, participants described trying hard to talk themselves out of feeling rejected, but then suddenly succumbing to the feeling.

Then one day -- I know they only have so much time -- she looked at her watch really obviously [demonstrates] and that did it. [I thought,] It's no good.

(Did she check it frequently?)
Umm. It was like, well, get rid of this one, get the next one! I mean, I’m not complaining about her, she’s probably helped somebody else really good, but she wasn’t any good for me.

Sylvia

8.4.2.1.1.5 Steadfast

In particularly good relationships, there was an element of steadfast reliability. This is established only after the relationship has been tested over time.

The thing about all my treatment, really the only thing that I can sort-of look back and say it has been totally beneficial was my GP’s, umm, constant -- I suppose, constant belief in me. He always saw me. He didn’t, he never gave in to me. I’d try and get drugs out of him, and he wouldn’t let me. ... Really, it was his support I suppose -- though it didn’t seem like it at the time. ... Looking back I can see it that he never gave up on me. I think that was one of the most helpful things.

Carol

Carol’s excerpt also indicates the importance of providing structure and support for some patients, which will be expanded on below.

8.4.2.1.1.6 Respectful/Patronising

The ‘belief’ described above only became apparent to Carol after a long relationship. In the early stages of a good relationship, the communication of respect for the patient’s capabilities was important to establishing trust in that relationship. When a late teenager, Sue had a daughter who died in early childhood.

I suppose really, it was someone treating me as an adult regarding Darla. Um, Darla died, my Mum and Dad, my Aunt and Uncle took over everything, nothing was discussed with me, and then after the funeral and the inquest only on very rare occasions was she mentioned. It was like she never happened. So, in some ways it was having someone to talk to about her, who respected I had been her mother. I suppose making me realise she was real.

Sue

When relationships were not helpful, participants often mentioned feeling patronised rather than respected when they asked for help.

All I wanted was someone to talk to. I tried to explain to this doctor [that she wanted psychological help because she was feeling very low after the birth of her son], and he said, Look, life’s not in that line, life
doesn't go like that. It goes up and down, so don't expect too much. That's when it started getting worse. I felt let down by the doctor.

(You expected that the doctor would talk to you about it?)
Yeah, but he didn't, all he said was about life and this line. And gave me some tablets.

Jill

Often, too, participants who had dropped out expressed dismay that their experiences and their ideas about the causes and possible cures for their problems were ignored.

It's like these midwives who've never had a child, why can't they take the word and experience of people who have been through it? Why don't they listen to people who have the problem?

Sylvia

Many participants had read extensively about EDs and felt that their ideas about what might be helpful were worthy of a hearing. Participants felt undermined by the therapist when their ideas were dismissed.

She focused so much on these eating diaries, these things where you have write down. And despite me telling her that I'd done them before and they didn't work, and I'd done them myself, off my own back, without any help, I'd read books, I've got numerous books about bulimia and eating disorders and stuff, and rediscovering your inner child, and all that sort of stuff. And tried to do it by myself and couldn't, which is why I went for help. I've got brains, I'm not a thick person, if I can't do it myself, then I need help, and I wasn't getting any help from her.

(You weren't being listened to?)
No.

(And you did have experience in the area that she wasn't taking on board?)
Yeah. Three years I'd waited and I'd got here, I'd got here at last, and this woman isn't any good. That's basically what I thought.

Carol

8.4.2.1.1.1.7 Patient not worthy

The sensitivity to cues of rejection or acceptance may be better understood by attending to the fears many patients feel about not being worthy of help in the first place. This sensitivity may make establishing therapeutic attachment relationships particularly difficult, though similar sensitivity might exist in romantic attachments.
The themes of fraudulence and the classification of what is a ‘problem’ were common in participants’ accounts of coming for help and continuing to accept it. They describe a delicate balance between feeling sick enough (and therefore having a legitimate claim on the service, its resources, and help) and feeling guilty about not being sick enough or feeling pushed into accepting an undesired label.

Well, I never got over an overwhelming guilt of going every week cause I was... I still can’t call myself full-time anorexic, I can’t stand that, that to me was... I felt a phoney, I felt I was conning the system cause I wasn’t anorexic. ‘Anorexic’ to me is the four stone on a hospital drip: I’d just lost a bit too much weight and wasn’t having a period. The guilt of having to go every week, the guilt of being there... it came up in conversation every week, I feel guilty being here, I shouldn’t be here. I’m taking up your time, I felt bad about that.

Margaret

I think it is very important to make people feel when they come in that they have as much right to be there as Miss 4 stone in the bed next door, you know, they, that everybody has an equal right to be there. And as you were saying to me that you can’t quantify pain and you can’t. I think that’s, I still don’t believe it, but I think it is really important that that gets drummed in quite fast... I don’t know, I think I used to feel like the reason, one of the reasons I used to feel like such a fraud was because I don’t know, [my therapist] or Dr X...would talk about other patients... which made me feel that they are so much worse than I am, I just come along once a week for a little chat. Um, and that used to make me feel even more of a fraud. ... It’s like being at school, the inpatients were the prefects you know, they were the ones that we’re not worth, you know, you were not worthy when it came to them... I know that’s a really awful thing to say, but I do, I did feel that maybe I wasn’t as important as some of the others, which, the reason I felt that was probably because I was worried about feeling so fraudulent myself that it was all part and parcel of the same thing.

Samantha

I didn’t feel that I was gonna starve myself to death or anything like that so I didn’t think that I was, I mean when I came here and one of the first things that was done was I weighed, I can’t remember what it was but I thought they’re just gonna think I’m a waste of time, you know, I’m not too thin, you know, what’s she doing here, she’s not too thin, you know, in fact she’s probably overweight and that’s how I felt about it, that I was actually wasting time, you know, you read about these girls that are starving themselves to death but I looked OK.

Rachel

Their descriptions sometimes flip between feeling fraudulent when coming to service for help and feeling free of a problem which would merit help when others press it on them.
When I first went to the hospital, and I was waiting there to see ... and I saw like the other patients... there were some girls who were like matchsticks. I thought well, what am I doing here, they've got the biggest problem, not me, I haven't got the problem. I felt a bit of a time-waster for a start.

Anne Marie

The idea of fraudulence seems related to how what an 'eating disorders service' will do is interpreted.

I felt like a bit of a fraud.

(Because you could see people there who were very sick?)

I thought you know... a place like that would ...like them [the girls like matchsticks].

Anne Marie

The conception of what the service provides doesn’t necessarily fit what people think their problem is, as if the ‘eating disorder’ is too reductionist. They see someone who is consumed by ‘eating disorder’ (i.e., the very skinny or the very fat) representing the ‘ideal’ patient, whereas their illness is not so physically evident and therefore are not ‘ill’ in the same way. Participants describe themselves as having several problems concurrent with the ED; they may consider the eating only a symptom, especially if they have been in treatment previously (those new to treatment did not have this hierarchical notion of their eating and other problems). The ED, which they see only as the part that is easy to label, is not sufficient to explain all of what they sense is wrong. Therefore referral to an eating disorders service will not be of help to them (whereas it will be for those whose disorder has obvious physical manifestations), and presenting for help there will only subject them to rejection. Patients may be sensing a fundamental problem that the profession faces: is the treatment of ED symptoms relevant to the treatment of the eating disordered person?

I've looked at eating disorders, I've looked at it, I've read things, and I've said, that ain't me, that just isn't me. And that's what the professionals look at, things like that bulimia and anorexia, and I think, oh, no, I'm just being stupid.

(You're being stupid? Because you don't...?)

Fit that criteria.

(Why does that make you stupid?)

Because they want to know about things like that, not me. It's easy for them.

(It's easy for them to...?)
Help you if you're that!
Jill

However, concerns about acceptance are prevalent in the descriptions of both those who remained and those who dropped out. The distinguishing features are how those concerns are handled within the treatment relationship.

8.4.2.1.2 Attuned Support/ Lack of attuned support

As important as being responsive to patients and making them feel accepted, the therapist’s ability to provide attuned support is necessary for the development of a secure attachment. This would mean providing assistance, backup, and tolerance, literally to ‘carry over’ (sub-portare) the patient when needed.

8.4.2.1.2.1 Containing/ Not containing

Supporting patients initially consisted of helping them feel contained by instilling hope, providing structure, and helping them put things in perspective.

8.4.2.1.2.1.1 Give a direction, goal, idea that ‘better’ exists / Never recover

Good therapeutic relationships often started by the patient feeling a spark of hope that help might be possible. This phenomenon has been discussed by Bordin (1994) and Horvath and Luborsky (1993) in studies of the pan-theoretical processes of therapeutic alliance-building. They call the first stage the ‘remoralisation’, or boosting of morale. In relationships that became secure, early interaction with the therapist gave them a direction and helped them to feel that a ‘better’ state could exist for them.

Charlotte subscribes to a medical model of psychological illness, and was relieved to find that she fit a diagnosis, which implied she would be suitable for a ‘cure’ as well.

In a way it was quite a relief to be told that I qualified as having an eating disorder because that meant that there was something wrong with me that could be fixed possibly, or that somebody was going to work on anyway, and not that it was just me being a pig.
Charlotte

Hilary also had a positive experience in her assessment (whereas she did not in her treatment).

Obviously she was asking me a lot of things, and she did talk about things, and things ... reserved like that... But I came away thinking,
Well, yes, I might get some there. I didn’t come away feeling really
down and depressed and thinking, Oh, that was a waste of time.

Hilary

On the other hand, when this inspiration was absent, some participants could not
bring themselves to begin treatment.

You see nobody actually said, I think if somebody had actually said that
they could help, that I’d have been quite positive about it. You know --
It could take time, but we can help you. I think that that would have
been quite a big thing for me.

Anya

The concept that people with ED were beyond help was surprisingly common in
this sample. Several participants mentioned fearing that they would ‘never be rid of the
eating disorder, like an addiction’, a notion which was frequently reinforced by family
members, GPs, and other non-specialists. The instilling of hope takes on great importance
when such profound doubts exist.

8.4.2.1.2.1.2 Provide structure

Providing a structure meant helping the patient to set bounds on her worries and
focus her efforts on recovery.

I just wanted someone who knew everything about everything, to start
from the beginning with me, and try and cancel out what it wasn’t.
Alright, fine, so it ends up me just being, you know, not normal or
whatever, a psychological problem that they couldn’t fix, but I wanted
the medical side checked out, every detail looked at.

Charlotte

For Charlotte, being able to trust that her treatment would be formulated according
to an holistic assessment was necessary for her to be able to commit to therapy. For
others, simply having the structure of a weekly meeting was reassuring.

However, the structure of the hour, when it was not handled sensitively, had the
effect of making the patient feel not contained.

I was very aware that a watch was on the table. It’s very difficult to do
it, cause you have to give to do it, you’ve got to let them summarise,
you’ve got to go in five minutes, it’s like, bloody hell... your task for
next week is, learn two nice things about yourself. Well hang on, I’m
halfway through, and my time is up, and she’s clinical... and you go
away extremely empty and vulnerable to lots of things.

Jane
8.4.2.1.2.1.3 Get things in perspective

Participants who had engaged talked about the therapist helping them ‘get things in perspective’ or feel clearer about what was important. This helped them feel they could manage change.

*I feel like she’s helping me to be stronger sort of thing. It’s not, not how I thought it’d be. But I feel, I don’t know, I feel clearer, I think my thoughts are clearer.*

Victoria

8.4.2.1.2.1.4 Anticipate feelings and ED / ‘Fooled’ by ED.

The source of the feelings of hope could often be traced to the ability of therapists to anticipate feelings that patients would encounter, particularly in the context of their ED. This could be related to the caregiver’s ability to ‘enter the mind of’ the cared for in a secure attachment relationship. Participants who had had positive treatment experiences often described their therapist’s empathic abilities.

*He used to say things, and I’d think, Well, yeah, that was in my head, and he’d like, bring it out. He seemed to know what I wanted to say but couldn’t say it.*

Sylvia

When ‘empathy’ was unsuccessful, it had the opposite effect.

*She did that a couple times. ‘I feel’, she says, ‘that you’re trying to say this instead of what you just said’. And I’d think, No. I wasn’t.*

Sylvia

The ability of the therapist to anticipate the behaviours and reactions that are common for eating-disordered patients increased trust because it made them feel like their therapist could understand their condition.

*Some of the things she says, it plays on my mind... and makes me think. Even if she said it and it didn’t relate to what was happening then, if something occurs, I think, Oh god! She said that exact thing. (Like she predicted something?)
Yeah. Cause she’s said, With bulimia, you’ve got to be careful of that... and she’s been right... A lot of the things she’s said are things I’ve experienced.*

Sue

This had an initial effect of reassuring some patients that they were not ‘insane’ because their reactions were in some sense predictable. It had a secondary effect of
boosting their sense of being in control themselves, because they realised that their reactions and emotions were not completely arbitrary.

When I was going to Weight Watchers, I knew I was doing it, and I felt guilty for not telling her [because her therapist had advised against it]. Then one week she said, If you're doing something that you don't want to tell anyone else, that's fine. You're not telling me the truth, she says, that's fine. But at the end of the day, it's you that it's bothering, not me. I can go home and not think about it. The week after, I told her. I just like -- I think she knew. ... Restriction isn't it. I think at the time I needed it. For control. I just took her point on that and decided to give that up... and I lost a stone without thinking about it. [Now] I'm telling her everything.

Sarah

The participants who had positive experiences leading to engagement all described the experience of their therapist anticipating how they might react to particular situations, and found this reassuring. The ones who dropped out or who had completed but been dissatisfied all described an opposite feeling, that the therapist was 'fooled' by their ED.

It was all well and good, this allowing myself to feel ok, and trying to think positive and SETTING GOALS and then feeling good on achieving a goal and another goal, and that kind of thing, but I lied. And I thought, that's what we all do, anybody that's got an eating disorder becomes a very proficient liar ...I couldn't convince myself of it. I was paying lip service to it, but I wasn't believing it.

Jane

He'd sit there and he'd say to me things like, You should eat regularly and you should eat, you know, the right amounts of food and eat healthy. But you can't say that to a bulimic cause a bulimic's not going to listen. You know, she might be good for a week or whatever, and she'll still go back to being, you know, being bad for the rest of the week.... I felt as though he wasn't understanding what I was trying to say. ... He wasn't helping, just wasn't helping.

Anna

The lack of anticipation of their ED thoughts and behaviours was a great disappointment to patients who felt it was a sign that the therapist was not sufficiently expert to anticipate these evasions. It made them feel not contained, and not safe enough to attempt change, because the therapist seemed incompetent.

He just didn't seem to know what he was talking about. He didn't seem very expert in eating disorders, he didn't pick up on any of the food stuff, or any of the lies we all tell. I said what I had to, and he never figured it out. I just couldn't believe him.

Charlotte
I felt she was too young and too inexperienced to deal with me, because I was older. I wasn’t a youngster, so I wasn’t a sixteen-year-old coming in with a bad diet.

(Was her manner young to you, or...?)

Her manner was quite condescending.

(Did she imply that you were a silly person for not being able to control your eating, or that you were unintelligent, or...)

No, not silly, she did... I was pregnant when I saw her [...] and I was eating better than I ever had done... but I didn’t know what I would be like after I’d given birth, then the baby wouldn’t be inside me. [...] And she couldn’t understand that I was capable of looking after the baby while it was inside but I wasn’t capable of looking after myself, afterwards. Which I thought was quite obvious. You don’t have, well, I certainly didn’t, much sort-of sense of self-worth anyway, and obviously the baby is important, but you’re not. But she couldn’t understand things like that and she couldn’t do anything other than tell me I wasn’t eating enough.

Carol

When the therapist has the eating-disorder facts right but uses them against the patient rather than to help the patient, she also comes across as incompetent.

When I sat with the other counsellor, I used to look at her and think, what do you know? But that was anger I think, I don’t think it was her, I think it was how I am feeling in myself, and I used to look at her and go, what do you know what it’s like to be like me? You’re young, you’re slim, you don’t... And yet I don’t think that of you, but with her I did... Who are you to say this and tell me to do that, and write this down, and be sarcastic about what I’ve been eating? That’s why I...

‘Oh, well, the reason why you’re putting weight on is cause you’re not vomiting it all up’. To say that, actually made me worse! I actually thought, right! Let’s start drinking water then!... But the other one [her assessor], maybe it was because it was the first time I’d ever talked to anybody. I don’t know why I think it would have been more positive for me to stay with the other counsellor [the assessor]. She must have been, I don’t know, was she more experienced? I don’t know. ... I’m sure she was like the top person. And then they put me down to somebody who I think, Hmm, you’re not qualified. That’s how I felt – terrible isn’t it!

Tina

Some therapists clearly were incompetent.

I went to a therapist and she actually started crying and I never went back.
Yeah. I thought it was pathetic, I thought, Oh, I don’t need this. I couldn’t believe it! I only said a little bit. I just wanted to get out of there.

Jill

8.4.2.1.2.1.5 Intrusive, Punitive, Defensive therapist

In relationships that did not go well, the therapists’ attempts to establish rapport with the patients could be experienced as intrusions.

He talked about God, that totally put me off. It made me feel proselytised.

Charlotte

These intrusive relationships sometimes were also experienced as punitive. Unlike in a childhood attachment relationship, where the child would learn to monitor the mood of the parent while behaving in a way to maintain a comfortable closeness to or distance from the caregiver, in therapeutic relationships this experience was more likely to end in dropping out.

When in a psychiatric hospital where she had been admitted for depression and suicidality, Jill went to the hospital shop to get paracetamol and took the tablets. When she was discovered, the nurse on duty lied, saying she had not given Jill permission for the trip to the shop. This nurse ordered Jill’s stomach pumped. Jill considered this the more abusive/aggressive treatment and that Ipecac would have done. This was perceived by Jill as being done to teach her a lesson. Later the nurse approached Jill for discussions about her illness.

It made me feel nothing. How was I supposed to open up to somebody that’s treated me like that? Abusive, very abusive, same as I’d always been through, punishment -- when she [the nurse] was the one who was ill! ... I discharged myself after that.

Jill

In other cases the therapist’s punitiveness was less blatant, more a misuse of power through the insensitive use of knowledge about the patient’s personal history.

My treatment [drop-out] was definitely the person who was treating me. I didn’t like her. I felt small, undermined, she made me angry, I didn’t like her at all. She kept bringing up this pregnancy [at age 15 that had been hidden from everyone], as if it was all that. Every time I felt like I was getting on, she’d throw this at me and upset me. And I thought, I’m not happy about this. Make comments about things, about
why I'd done... She just didn't... Hm. That's the reason why I left, cause of the counsellor.
Tina

Participants also reported that some poor relationships were characterised by manipulation rather than support on the part of the therapist.

I didn't like the inference that she kept putting on my relationship with my GP [whom Carol felt had been truly helpful to her]. I didn't like the way she seemed to be making me feel -- things like, Well, your GP, you seem to have, uh, this sort of relationship with him, and I didn't like the sort of -- connotations, that's the word I suppose, she was putting on that.

(What was the connotation?)

That it was more than just a patient-doctor relationship. Inappropriate. I mean he calls me Carol, which she thought was odd. 'He should call me Mrs Hopkins'. But I mean, after you've seen somebody, sometimes weekly, more than weekly! I mean he'd been to my home, he'd frequently... well, he calls my husband Neil. I mean, she didn’t know him, she didn’t really know me. I think after the second time of meeting she said that I was a nice person, I mean, how the f**k does she know that? I mean!
Carol

The therapist as Carol described her seemed to be trying to cut her off from other sources of support to increase her own importance to Carol and to prevent a challenge to her position.

I spoke to my GP about her... And he phoned up, and she wouldn’t speak to him. She would only be in contact with him if he wrote to her. That in itself seemed a bit odd, the fact that she wouldn’t [talk to] my GP... He’s a busy man... It’s a lot quicker for him to pick up a phone and have a quick conversation than write letters.
Carol

The same therapist was described by another participant as being uneasy with friendly overtures as well. When Tina tries to make herself more comfortable in the therapy situation by offering her therapist a compliment, the therapist quickly reacts to return the dynamics to the familiar hierarchy. The therapist appeared to feel threatened by Tina’s advance.

The first one [the assessor] opened me up... and then all of a sudden I’d got this stranger – which I’d agreed to have! – which I didn’t like. I thought, Well, I’ll give her the benefit of the doubt... [One day I said] ‘Hello! Oh, you’ve had your hair cut, it looks lovely’ Then she turns her back towards me. And then she says to me, ‘Why do you feel that
you have to make friends with everybody? Do you feel that you can be better if you know somebody and you're friendly with them? ’ I just think it’s nice to have a friendly relationship with somebody, don’t you? Sit there. Oh! It was terrible, it was terrible, really. Anyway!

Tina

Carol’s description of an early encounter with this therapist also showed her reacting defensively, rather than in an attuned and flexible manner. Carol is challenging the therapist in this situation, but the therapist’s inability to contain Carol’s concern is destructive to the relationship. The therapist does not allay Carol’s worry that she will be putting herself at risk by trusting someone who isn’t qualified.

I asked her what her qualifications were. I think perhaps that might have got her back up.

(Well, you have every right to do so.)

Yeah, well, I like to know what I’m dealing with. I mean she just looked so young, but I couldn’t say how old she was. She did seem to be quite defensive when I asked what her qualifications were. But I mean, she’s trained, she should be able to deal with people like me. [...] She also said that I was very defensive. Which, yeah, I probably was.

Carol

8.4.2.1.2.1.6 Capacity to process negative emotions

In contrast to Carol and Tina’s poor therapy relationships where mistrust built up quickly, participants describing good relationships often cited instances of their therapist’s ability to manage negative reactions or emotions.

(So, you met [your therapist] and...did it feel quite comfortable quickly or?)

Yeah, very quick. But I think that was because the first time I saw him I told him how I felt about -- I was very wary about seeing a man.

(Right)

Um, I suppose, like because my first marriage failed, and I’ve got problems with my partner now, I’ve never had a male that’s actually listened to me. I told [him] right from the start I was very wary about it...

(Did he reassure you or-?)

Yeah he did, and you know, he was just great with me, and he said, Well, look, we’ll give it a go and see what happens. And after the first week it, I suppose really he made me feel as though I’d been seeing him longer than I had. I was very comfortable about going and seeing him.

Anne Marie
Often trust was established in these relationships after a challenge from the patient that the therapist handled with equanimity (compare this to Carol’s experience when asking about her therapist’s qualifications). Anne Marie was able to voice her concerns straight away and her mistrust was diffused early on. Other times issues sat for longer and it was critical to the survival of the relationship that the therapist was able to ‘really listen’ to the patient when they were brought up.

_There was a couple of things I weren’t happy with, but I didn’t tell him that to start, you know, things he said he thought I ought to do with Dot. ...I went away thinking, really, I don’t want to do this, I’ve been pushed into something I don’t want to do. But when I told him how I felt... he really listened to me...I found [seeing him] really very beneficial, he was very good._

Sarah

8.4.2.1.2.2 Understanding /Doesn’t understand

Providing attuned support implies being able to ‘tune into’ or understand the patient’s perspective as much as being able to support or contain the patient. This was different from being able to anticipate the patient’s feelings or reactions in that it was based on communicating to the patient that her experience made sense to the therapist. Communicating understanding tended to comfort patients. It is as though patients in good relationships feel ‘held’ by the therapist’s ability to understand.

_Dr. W seemed to know what I was talking about. He seemed to understand and he listened to my feelings, or at least he appeared to. He was quite fine. I saw him in my assessment. And because there was going to be a period of about three months or so before I’d get a therapist, he saw me twice more, just to check up, just to let me know that I wasn’t forgotten._

_I don’t know. If I’d have had Dr. W [for my therapist], I think I would have felt happier. Simply because he appeared to be more in tune with things, with feelings, rather than just with what you put in and what you put out as it were. [The therapist I had] seemed very interested in that sort of input and output._

Carol

Again, focus on the symptoms of EDs can come across as not understanding. It is the emotional experience behind them that participants felt was relevant.

_I was quite surprised cause the first time I saw him, he didn’t ask anything about eating or anything like that, he just wanted to know about my background. Obviously I ... I was relieved in a way that he_
didn’t sort of ask anything about the eating. And then I can’t really remember ... but I know I felt comfortable, I felt alright. And when I came out of seeing him, I thought, Yeah, it’s probably going to take time, but I feel that you know this could work.
Sylvia

Interestingly, when describing good relationships, participants did not talk about the therapist needing to understand the actual experience of being eating disordered – simply listening and understanding her experience was more important.

I suppose as well with [my therapist] it was like I realised he was actually listening to what I said, understanding, whereas I don’t think I’ve ever had that.
Sue

On the other hand, when therapists were felt not to understand, this was often blamed on the therapist not having experienced an ED.

I can’t imagine a psychiatrist or Dr F going up to a mirror and saying, God, I look horrible! (laughs)...Look at this bulge! You know, I sit there and I try and explain that to him, and it’s difficult. Cause you get a blank expression, and you think to yourself, well, you don’t understand...

(So you felt a great burden to try and explain in order to get him to connect to what you were talking about?)

Yes, and that’s not what I was going for.
Anna

However, for some participants, no therapist who had not had an ED would be able to help.

(Can you be helped by someone who hasn’t had an eating disorder or..?)

No, I think [it would have to be] someone... that had had an eating disorder. Because I found with [my therapist], fair enough, she’s a psychologist or whatever, she’s probably read every book there is to read, but if you haven’t had one yourself then you do not know. I’ll tell you that now,...I can’t describe how it feels when you look in the mirror and all you see is fat, when you won’t go out because you feel fat and you’re afraid people are looking at you.

(So if somebody hadn’t had an eating disorder and they were asking you, you know, to use fewer laxatives or something, you would feel like they were asking something of you they had no idea what it meant?)
No but... the actual nitty gritty of it and the wanting to change but not being able to and the clinging on to the eating disorder you can’t. I don’t know, they wouldn’t really understand that. It’s like a lot of people when they’ve got nothing else, they’ve always got their eating disorder to rely on, it’s always there even though it’s bad, it’s always there as their comfort, so if you tried to get better... I don’t know, I just didn’t think. I didn’t think it would really work.

Xandria

Underlying Xandria’s words seems to be a fear of being rejected for her behaviour or the extreme nature of her feelings. She also sounds wary of being stripped of her only ‘comfort’ and abandoned, with no one to ‘rely on’.

Abandonment is discussed further below.

8.4.2.1.2.2.1 Caring, interested / Uncaring, uninterested

Once the belief in the therapist’s understanding starts to be established, the sense of the therapist actually caring about the person of the patient encourages stronger attachment and allows the patient to accept the support offered by the therapist. Caring indicates some reciprocal emotional investment on the part of the therapist which participants said they looked for.

Carol’s doctor took time and made an effort to provide information for others who might have needed to treat her. This made her feel that he valued her; she described his treatment as ‘total care’.

I remember once, I used to see [my doctor], quite often. And we’d just talk, or shout, whatever. And then I went to see another doctor one time, because I don’t think he’d given me what I wanted or something, so I would try and get it out of another doctor, I can’t remember all the details, but this other doctor said that he’d written copious notes about you. And there were all these notes there, and I thought, well, when does he write them? Because he didn’t write them when I was there.

Carol

Jill did not become close enough to any one therapist during her inpatient stays in a general psychiatric ward to become attached. The nurses became ‘they’ to her. Even so she searched for signs of caring from the institution itself. Here ‘caring’ was simply respect for the patient’s welfare.

I feel like they don’t care, I’m just a number on a file.

(How would you know that they cared about you?)
If they asked your opinion, asked about your treatment. ‘You’re just discharged, how you feel about that, and have we helped you?’ Things like that. When you first go somewhere, they’re really positive, make you feel great, but then you don’t count.

Jill

8.4.2.1.2.2 Honest

Caring can also take the form of being tough. Honesty, however difficult initially to receive, was quickly responded to by most participants.

To start with I wasn’t happy. I can’t tell you why. I think it was me, you know, I don’t know whether, whether I felt it was a bit intrusive or what, but I thought, This isn’t going to work...

(Cause her style was different? [from her previous therapist’s])

I think it was, and she was obviously more dealing with the eating...

But, you know, she’ll actually tell you what she thinks, she doesn’t say one thing and mean another...I’m a lot more comfortable, I suppose I am getting to build my trust up in her now.

(Did anything she do make you trust her more or..?)

I think that was sort of... getting to know her a little bit better, umm, and like I said, being aware that she would tell me what she thought.

Sarah

She’s really. I don’t know, she’s lovely. I could really sit and say what I feel. Some of the things she comes out with, you wouldn’t expect her to say that. The truth can hurt! But she comes STRAIGHT to the point, that’s the way it is.

Sue

8.4.2.2 EXPLORATION/WITHDRAWAL

Participants talking about strong relationships use images of the secure base in a secure attachment relationship. The two overarching elements are responsiveness (availability, acceptance) and attuned support (containing, understanding, honest communication) which lead to the development of trust. However, once a sense of safety in a secure attachment relationship is established, the ability to take risks and to explore assumes equal importance. In therapy, this was usually an internal exploration.

I just thought she’d offer me, like, amazing solutions ... But there’s not [solutions], it’s about what’s in me and exploring me sort of thing.

Victoria
When the relationship was not secure, exploration was not possible. These relationships generally ended in drop-out or in a ‘mental’ dropping out, where the patient attended therapy but did not participate.

8.4.2.2.1 Explore

Indeed, the purpose of a good therapeutic relationship is to allow the patient to change. Attachment theory would posit that both *stimulation* and the knowledge that *comfort* is available if change is overwhelming are necessary for risks to be taken.

8.4.2.2.1.1 Stimulation

Amanda’s account below shows that objective structure *per se* is not necessary for the relationship to be secure and to stimulate change. Despite the seeming lack of structure, the therapy relationship is containing for her, because it ‘picks up on things’ that she would have been able to get past other people, and pushes her to expand her ‘little cylinder world’, which she finds fun.

*Basically I find it quite unstructured, whatever we start talking about we just lead on, there’s no structure to it.*

(Is that ok?)

Yes [*emphatically*].

(Because everything else in your life is quite structured for you.)

Yes, but in some ways it’s quite FUN because, although it is unstructured, it tends to lead to the same place each time I come. It all goes back to the same point, so it doesn’t really matter [where I start].

(Like there’s a central core that is understandable?)

Definitely. The therapy picks up on things and asks me a lot of questions. And there are a lot of raised eyebrows – saying, are you sure about that? And then you think, no I’m not. That’s what it’s all about: Questioning. Why you do something, why you react to something, and how you are about yourself, who you are with yourself. Going back to WHY. It’s always why why why. But that’s good. That’s what it is to me at the moment. A lot of questions that I wouldn’t have asked before that are totally, totally relevant.

Amanda

8.4.2.2.1.1 Relevant

As Amanda indicated, the stimulation of the therapeutic relationship must also be combined with a sense of relevance for the patient to want to remain in the treatment. In
this aspect treatment relationships differ from childhood attachment relationships, though perhaps not from adult romantic ones, where there is also a goal-directed element.

He made me think a lot. [...] He didn’t touch on the eating at all. As far as he was concerned, eating was simply a symptom...

(That seemed right to you?)

Yeah, in a way. Sometimes it didn’t. Cause that’s what I’d been referred to him for. It’s like you go to the doctor cause you’ve got a sore throat and he looks at your tummy. It didn’t actually solve anything.

Carol

8.4.2.2.1.2 Comfortable pace of change

The therapist provides comfort to the patient by communicating that the patient will set the areas to work on and the pace of change. She will not be forced to change before she is ready.

We can spend a whole session talking about... my relationship with my mum, whereas I think I was more expecting ...for it to be Right! Well, what have you done this week, and what did you eat and how much did you eat...But that would be quite frightening to talk that much about my food... to have to report what I’ve eaten and when. But I feel like I’ll get to talking about that soon.

Amanda

Participants said that the results of taking risks to change are feeling stronger and proud of their achievements, as would be predicted in a secure attachment relationship.

I did enjoy working with him as well. I suppose in some ways, when it was finished I came away feeling as though I’d achieved something. It wasn’t a lot but it was like I’d, like the simple things of asking people...

I felt as though I had achieved something.

Anne Marie

8.4.2.2.1.2.1 Collaborative

The exploration in strong relationships was encouraged by a sense of collaboration between patient and therapist. Anne-Marie and Sarah were able to tell their therapists about suggestions that made them unhappy. As these strong relationships evolved, therapists came to be viewed as allies in the patient’s battle to change. Participants did not feel ‘alone’ anymore.

She’s managed to make me see that it’s not all my fault, that Kevin has his faults as well... It’s made me a stronger person. If I go home and
we have a row, I don't automatically think it's my fault. That's perhaps when she'll come back [to me]... I'll want to react one way, but in my head, it's saying, No, you shouldn't react like that. And [she] will say, Yeah, but if that's the way that you want to react, then that's the way you should react, that's good, you can't fight yourself on this. That's when [she] does help me. It's like -- the little devil [me] appears on this shoulder and the one with the heart [my therapist] appears on the other.

Amanda

As time went on, I'd go for a binge, and then stop and think, ...all those sessions and think about all the things and people that we talked about, and then I'd think, right, [my therapist said] if I wanted to go for a binge, to get away from the situation... I'll go do this...That's how it got.

Anne Marie

Sometimes wanting to please the therapist, which had not felt helpful in the poorer relationships, was felt to be helpful in others where having to be responsible for one's actions was welcome.

Somebody was there to say... What have you done, let me look at your diary. So it was like somebody else was there. ...If I had like taken X amount of laxatives, and I'd gone up from the week before, then that started to feel a failure because I had to report to him, so the success/failure thing sort of turned itself around. So having somebody to report to helped immensely.

Margaret

8.4.2.2.2 Withdraw

Some treatment relationships were not able to establish an accepting or secure base because the patient did not trust the therapist. The patient could not risk change. In other cases, the therapist was nominally trusted, but the relationship did not change as the patient's needs changed. These relationships did not stimulate the patient.

8.4.2.2.2.1 No stimulation: boredom

In poor relationships, stimulation was lacking, and patients withdrew, either physically by dropping out or emotionally, by telling the therapist what he wanted to hear, so as not to 'rock the boat' by dropping out.

I said [to the therapist]...I've done this to me thousands of times... You haven't posed anything to me that I hadn't thought of... The way with the questioning and what we talked of, was nothing new, or different... It didn't work [then or now]. ... Yet I was..., because you're coming to
experts and specialists, I think that they should know something that I
don't know, because that's what they do. Why should somebody else
telling that make it better than when I tell it to myself? I was expecting
something really challenging to my thought process. I couldn't see
where it was going that was anything different.

Jane

Jane is not only looking for new information, but also a new approach to
understanding her problems and grappling with them. Although she was familiar with
many books about EDs, Sylvia also has struggled to understand her eating problems. She
was searching for a catalyst.

You see, she wasn't telling me anything I didn't know. She wasn't
helping me to understand it. So for a while I just went along with it till I
realised it wouldn't get better.

Sylvia

In some particularly poor relationships, participants described receiving a dogmatic
response when they said that the proposed treatment had been tried unsuccessfully before.

[She] actually did once say, what did I expect? it was an eating
disorders clinic! [and therefore food diaries had to be filled in]. Which
I wasn't, I wasn't that impressed with.

Carol

8.4.2.2.1.1 Irrelevant

The sense of relevance heard in the reports of the participants who had had strong
therapeutic relationships is lacking for those who had had poor relationships. In Jane's
account below, frustration at the irrelevance of her treatment is tinged with fear of
abandonment.

[Jane had had a car accident which seriously damaged her leg and
face. It took months of reconstructive surgery to rebuild her face and
she still has no sensation on the left side of it. Despite these difficulties,
she is beautiful, but she still sees her face as it was when it was in the
wire cage after the accident.]

One thing I was supposed to do was to write up one positive thing a
week, which was that, 'I look nice today', and then to say it, or 'I've got
nice hair' and I'm to think it and say it and stick it up on my fridge. I
think 'I feel good today' was as far as I got. I knew from the experience
I'd had ... that it would have been a waste of... Cause you say
anything, I'll tell whatever, that's what people with disorders do, you
lie extremely well. I knew I would have been coming back and saying,
Yes, I look great, Yes, I look really good, and I've got lovely hair, I'm a
nice person, and people love me. And I know ...

8-204
(That wouldn't have touched...)

No! ... It was all external things. So I said those things because I felt that she wanted to hear that I was doing that. And feeling that.

(Did that feel like a further falsification?)

Oh, yes! I was pleasing again. If I don't let her see that I was achieving that, do we not go any farther in trying to get to the root cause of it? because I don't know what the root cause is! ...And I think the frustration I found is, where do you go and who do you ask for the help? Cause she wasn't able to give the help.

Jane

8.4.2.2.2 Not free to explore: forced to perform

In poor treatment relationships, there was no freedom to explore, and collaboration was absent. The result was that patients withdrew in the face of what they saw as a dictatorial style.

'Alright', she'd say, 'You must eat'. Yeah, ok. Why didn't she say, you must eat because otherwise so and so will happen. And then we could go back and think, well... And if I'd say, Well, I can't, she could say, Why can't you? She didn't do any of that. That would have given me the leeway to change...

Sylvia

8.4.2.2.2.1 Accept treatment goals

Participants reported feeling forced to accept both the goals and the plan of the treatment. This sounded in some cases like misuse of the therapist’s power that resulted in the complete cessation of attempts to change because trust was damaged.

In some cases, the participants felt bullied into changing while being offered no assistance to do so. Sylvia said this just felt like a ‘waste of time’; however, her final declaration of needing help indicates she might have felt let down as well.

All she seemed concerned about was, you must eat, you must eat. Well, but I thought ... it was like, I know that was the problem, so she didn't seem to want to know anything about what caused the problem, [...] I know it's all mental. She just didn't seem interested in that side, she'd just say, you've got to eat. The object is for you to put weight on. No, it isn't. I want you to help first of all with the eating, and surely that [gaining weight] would come later, when I was more confident about the eating side. Later I wouldn't mind so much. No, I'd got to eat, 'cause I've got to put on weight. It's like with a nervous breakdown, the last thing you want to hear is, you've got to pull yourself together. We know that. You know that, but doing that is different. It's the same with
the eating. You've got to eat, yes, I know, and I want to but I don't want to. I want to but I can't. That's what I need help with.

Sylvia

Isabella, who completed according to the clinic records, describes having mentally 'dropped out' as a result of feeling forced to accept the therapist's treatment goals. She felt that the treatment had in fact made her worse by 'stirring up a nest of emotions and worries' without ever offering help.

*After a few weeks of that, he was trying to convince me that I had to be happy with what I got [her body shape - she is nearly obese], he was insisting. I decided I wasn't happy with what I got and I didn't really want to fight with him. Fighting's not the right word, but I decided just to go along for peace and quiet. I stopped trying, mentally. I know that now. Then, I wasn't completely aware. So... my bulimia didn't actually change when I was seeing Dr B, though I had said I was better and this and that. It didn't really change, in fact I would say that when I left, in the few months after it was really the worst I ever had.*

Isabella

For another participant, accepting the treatment goal of revealing past abuse to her parents felt like having her control stripped away.

*(What kept you from coming back?)*

*It was the actual thought of just coming, going through it all and other people trying to take control, cause that's how I felt, I felt like they were trying to take control.*

*(So it was like you're being told what to do all over again without your consent?)*

*Yeah. I mean she [the therapist] said you know we won't do anything unless you say we can but I felt like she was saying you must say that we can.*

Beth

8.4.2.2.2.2 To accept treatment plan

The food diaries often were the focus of participant's complaints about feeling forced into a particular treatment plan*. They often felt demeaned by the process, or as if they were being treated like 'a naughty child' (Sylvia and Tina). This might be because

---

* Food diaries were not universally despised:

*SOMtimes I think it's the fact that I don't want to write down on that diary what I've ate and that, sometimes that stops me cause I think, No I can't write that down so I can't eat it.*
they conflated themselves and their dignity with what was eaten and purged. The food diary is a good example of how an 'efficacious' tool may not be 'effective' if not handled sensitively by a skilled therapist.

She gave me these silly diaries that you had to fill in, what you ate, you had to write every time down, did you bring it back up, did you keep it down, thoughts about it. What I used to do, by the end of the week, I used to sit down and fill my diaries in. It was a lie. What should I have had for dinner Monday?, and I used to fill it in. Then one day I said, That's a load of rubbish. It's all a lie... I thought that would make her see that they were no good – but she gave me some more! And I just thought, this is useless, I just ripped them up, threw them in the bin. I mean I felt degraded anyway, but to actually put it on paper! You put it on paper and it becomes visible to you, like you can block it out your mind, but to put it on paper! I thought, I can’t do this. She didn’t seem to care about anything else.

Sylvia

Other times the participant related feeling not so much humiliated themselves about the treatment plan but afraid of humiliating and betraying their families.

[Beth was sexually abused by her brother from an early age until she stood up to him when she was in her mid-teens.]

The lady that I saw she was delving into the other side of it, the other aspect of it.
(The childhood stuff?)

Yeah, and it made me very uncomfortable. Maybe it’s wrong, maybe I should dig it all out and put a bomb under it and that, but that’s not my way of coping with it.
(Right...)

I mean, what she was trying to do was bring it all out into the open, involve mum, dad, brothers, and... No, I can’t do that, I can’t involve me mum and me dad. Me sister knows, I’ve spoken to my sister...we talk about it and I’ll cry on her shoulder now and again, ...but I can’t take it that far, I can’t take it to mum and dad...I could go up to Peter and say look, look what you’ve done, look what sort of person I am, you know, look at me, but I can’t go up to mum and dad and say look, all this happened over the years... This lady that I saw she says, Do you blame your parents for it, for not having the time to watch over you? No, I can’t blame my parents. I can see where she’s coming from when she says, You’re the youngest of seven and they never had time to look after you and all this that and the other, I can see where she’s coming from with that, but I can’t lay the blame there.
Beth also expresses some frustration that her ‘way of coping with it’ is ignored by the therapist. Several participants who dropped out remembered feeling angry that their own ideas about effective treatment were not asked for or listened to when offered. Many of them wanted more discussion about why a particular approach to treatment was being taken.

8.4.2.2.2.3 Abandoning

Several participants who had had poor treatment experiences discussed fears of abandonment should they start to trust someone who would not stand by them until they felt they could support themselves.

Sometimes I felt like [the hospital] touched a little bit of me, opened it up slightly, and then just left me.
Jill

Sometimes the prospect of engaging in treatment was clouded by the fear that help would be withdrawn as soon as physical improvement occurred, but before emotional improvement had been secured.

It’s when I’ve like lost a lot of weight and, Yeah, I need help. But as soon as I start putting on the weight it’s like, Oh, they’re not going to want to know me almost because I’ve put on weight.

(Who’s ‘they’?)
You know the people that are supposed to help here.
Natalie

In some situations, patients stayed in treatment even when they did not feel that it was helpful in order to be able to remain in the system long enough to get the help that they needed.

I felt that I HAD to fill in these stupid food diaries to eventually get the treatment I needed. It was almost like I had to go along with her.

(Like paying your dues?)
I had to do it, cause otherwise I wasn’t doing my bit.

(Did you ever think that, even doing it you weren’t going to get what you wanted?)
Not at the time, no. You’re so hopeful. You’re constantly hoping that something will come around.
Carol
8.4.3 Distribution of responses in the sample

Tables 8-3 a&b show the distribution of the security and exploration themes discussed above. Each treatment experience mentioned by a patient is listed separately. These tables are arranged according to the hierarchy of themes, from the overall concepts of security and exploration to the specific expressions of them in terms of responsivity, support, or withdrawal. They are intended to supplement the above discussion of the range of themes mentioned by participants and not to provide a definitive evaluation of the frequency of these themes in treatment relationships.
<table>
<thead>
<tr>
<th>Treatment Experience</th>
<th>Responsive/Rigid</th>
<th>Attuned Support/Lack of Attuned Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vic1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jill1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syl1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sar1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cha1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amo1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sue1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sam1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rac1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AnM1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ann2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tri2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hll2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amy1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emm1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juli2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jill1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jill2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syl2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mag1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Xan1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jane1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jane2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jane3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cha1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Car1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sam2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hll1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ann1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tri1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bet1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nat1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rut1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jul1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joa1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

in positive way and red 'X' for theme mentioned in negative way. Each row represents a separate treatment experience. Each column represents a theme discussed in the text. Column labels correspond to those used in Figures 8-1 & 8-2.
Table 8-3b. Distribution of 'exploration' themes mentioned by participants, indicated by an 'X'. Each row represents a separate treatment experience. Each column represents a theme discussed in the text. Column labels correspond to those used in Figures 8-1 & 8-2.
8.4.4 Other explanations

Whether a relationship was perceived as ‘good’ or ‘bad’ did not appear to be determined by the trait-like characteristics of the respondents. Although this judgement is based on subjective impression rather than on objective evidence (the respondents, for example, were not asked to complete the VASQ), some pseudo-objective evidence can be marshalled to support it:

1. During the interviews, perceptions of and experiences in other supportive relationships were asked about. Those who had dropped out of treatment did not appear to be any more or less likely to have dropped out of treatment previously or to express ‘non-standard’ insecure attitudes toward informal attachment relationships.

2. Three respondents with different trait-like attachment styles as assessed by these interviews all discussed similar ‘bad’ experiences with the same therapist, who did seem to act in a potentially punitive way. Several other therapists, who seemed particularly successful at creating a secure base, were able to engage people with seemingly diverse trait-like attachment styles. In another case, the therapist succeeded in establishing a secure base with one patient (who seemed relatively ‘standard’ secure herself), but not with another two, one of whose trait-like attachment style appeared to be ‘non-standard’ insecure.

8.5 Discussion

The primary objective of this chapter was to enrich understanding of the general factors affecting dropping out. Thus qualitative methods were appropriate. Interpretative Phenomenological Analysis allowed for a large number of interviews to be analysed, and for the foci of the interviews, analyses, and conclusions to shift according to the picture that developed during the study.

Such flexibility was critical to the data gathering, analysis, and interpretation of this study underlying this chapter. It was initially designed to compare and contrast the
perceptions and experiences of patients who engaged in or dropped out of treatment from an eating disorders service, with attention given to the role of attachment style in their personal and treatment experiences. However, during data gathering and analysis, it became clear that simple categorisation into eating-disorder service drop-outs and remainers was not adequate. Patients categorised their treatment experiences according to whether the treatment was 'good' or 'bad', rather than how long it lasted or where it had been received. As a result the analysis shifted toward investigating these 'good' and 'bad' experiences.

This shift also affected the researcher's ideas about the role of attachment in dropping out. More important than the patients' own attachment style and experiences was the manner in which the difficult attachment issues inherent in the early treatment situation were handled by the patient and the therapist. Thus the interactive aspects of attachment formed the focus of subsequent investigations into factors affecting dropping out. The measure described in Chapter 9 is a first attempt at operationalising this interaction in a therapeutic relationship.

8.5.1 Therapy attachment

Participants' accounts of experiences in psychological treatment support the importance to early engagement of forming an attachment relationship with the therapist. This was first illustrated by participants' strong desire to establish a secure base, which was partly determined by their assessment of the therapist's ability to be responsive and provide attuned support. Second, it was supported by the importance to the participant of the therapist fostering exploration and risk-taking. When these circumstances were not present, the treatment relationship did not last.

Dropping out is described by participants as the result of a series of interactions, which do not appear to be explained simply by the participants' own characteristics. Reiterating the quotation from Holmes (1993), in establishing a therapeutic relationship 'there will be a struggle between the [psychotherapy patient's insecure attachment patterns] and the skill of the therapist in providing a secure base – [which relates to] the capacity to be responsive and attuned to the patient's feelings... (p. 152)'. A portion of dropping out may be better understood as resulting from the failure to negotiate this struggle, rather than as the product of pre-treatment patient characteristics. Thus it may be useful to consider another construct of attachment when investigating dropping out – attachment as a state-like product of the therapy interaction.
8.5.2 Links with existing drop-out literature

From this study, it appears that understanding dropping out will require more complex relationship-based models, such as that described by attachment theory, than have been used thus far. As a result, this study does not support the negative stereotyping of drop-outs. Another interview-based study also concluded that ‘non-attenders could not be stereotyped as irresponsible’ (p. 554, Mason, 1992).

The results agree closely with an earlier study by Saltzman et al. (1976) of general psychotherapy patients described in the general literature review at the beginning of this thesis. In this study, the drop-outs had a sense from the first treatment session that the relationship was low on respect, security and relevance. This feeling lasted until ¼ of them left around the 5th or 6th session. Their therapists also felt little respect for these patients and sensed little involvement with them. Importantly, these ratings were significantly different from engagers’ and were not related to any pre-treatment patient characteristics.

Saltzman et al. postulate that ‘as early as the first session, there is evidence that the viability of the therapeutic relationship rests not only on the qualities or experiences of the individual patients but also on the pattern of interaction between them’ (p. 551). In retrospect, this pattern of interaction and the majority of the distinguishing dimensions listed in the results are relevant to attachment theory, such as felt security and respect, openness, and uniqueness of the relationship to the other. Indeed, the concepts behind the establishment of the secure base are not unique to attachment theory. The Rogerian ideals – empathy, honesty, non-possessive warmth – can be seen to map onto the responsive care and attuned support of the attachment figure; the Saltzman et al. study is influenced by these ideals. The durability of these concepts in theorising about the establishment of therapeutic relationships may be because they reflect basic aspects needed to form a secure, confiding relationship.

Individual findings receive support from other studies of dropping out. For example, the drop-outs’ dislike of the ‘passivity’ of the therapist agrees with the finding

---

31 It is interesting that our data, which are limited by having been gathered retrospectively, after a self-justificatory memory bias might have occurred, agree with the Saltzman data, which were gathered prospectively.
of an early study where patients cited low levels of therapist activity as one of the main reasons for leaving treatment (Shapiro & Budman, 1973, cited in Bischoff & Sprenkle, 1993). The finding that the therapists of drop-outs did not acknowledge their patient’s expectations (Borghi, 1968) seems to overlap with the drop-outs’ feeling that their needs and ideas had been ignored. However, the findings of most studies of dropping out do not agree with these results, at least on the surface. The methods used for gathering data, such as set-list interviews or questionnaires (e.g., Buhrmaster et al., 1982; Gunderson et al., 1989; Pekarik, 1983b), may explain these differences.

8.5.3 Method: open-ended interview using independent researcher

The methods used in this study are felt to have secured relatively high-quality data. By attempting to change the power differential between interviewer and participant, the demand effects appear to have been better controlled than in previous studies using clinically related interview methods. The data gathered therefore ought to reflect the ‘real’ reasons behind dropping out more accurately than previous studies have done.

Below is an example of how simply sitting with the participant and not restricting her speech can allow different reasons to emerge. Rachel completed assessment but refused treatment. Her account particularly highlights the advantages of using open-ended versus closed questioning when trying to elicit sensitive or complicated data. Note that she begins with the classic situational reason of not being able to arrange childcare, and then moves on to much more complicated reasons.

(1. Situational) I think one of the reasons was that I had a baby. I hadn't told anybody about what was going on, and it was problems arranging child care. I'd got one at school. I could come in school hours because they're both at school now, but I [then] couldn't make excuses up, or think of anyone. I worked for two days and had to have child care on them. And my mum wasn't well at the time, and so that was a problem, getting the baby looked after.

(2. Defences) The other thing was I really didn't feel that anybody could help me. I'd been and had the assessment and I'd done this diary. I'd started to complete all of these forms and then I didn't... and I'd ripped the diary up because once I'd written things down -- what I'd had to eat, and I took laxatives and make myself sick, how I felt that day, and having done all that... and it seemed OK writing it down at

---

It is also interesting that the differences in the Saltzman data were detectable as early as the first session, with a peak at the third. This meshes with the statement made by many participants that they knew the relationship was not a good one after only a few sessions.
the time, but then when it came, you know, to thinking somebody else is going to look at this. I just felt an utter nutcase! I looked back on it and thought, No, I can't. I can't hand this in, and I was disgusted in myself for what I'd done as well.

(3. Social) There was also I felt as though I was bringing attention to myself and that was the last thing that I wanted. I'd not, my husband knew but he only knew a little bit. I really didn't want anybody to know, and I've never told anybody about it. I can't say that I'm better now, but I mean I have good times and I have had times, but I really felt like I was bringing attention to myself which I didn't want.

(4. Fear of being forced to betray family) I'd also read a lot of things in magazines about the condition, and things in there saying, Oh it could be because you've had, been abused in childhood, and those sort of things, and I knew that I hadn't and there was a lot in the media then about people that had been interviewed and they were trying to get you to say things that really weren't there. That was a worry in my mind. You know I mean I could never hurt my dad and my mum and dad and nothing like that ever went on, you know. I mean they weren't perfect parents, but I was always knew that I was loved and wanted and there was nothing, no abuse of any sort ever went on and I wondered about that as well.

(5. Fear of rejection/patient not worthy) And the interview, the initial assessment that I'd had here, first of all when I got the letter to say that I was to come here, when I saw the heading, the Mental Health Trust, that really did put me off, you know, I thought, oh dear, you know, what are they gonna think of me, you know, when I go, and I felt too old to have this, thought it was all teenagers and it didn't happen to people my age.

(6. Fear of being manipulated/intruded upon/having own ideas ignored) When I did come and have my interview I did feel then that they were perhaps looking for things that weren't there, but whether they were or whether that was just because that was all in my mind, I really don't know. And also I felt that I was embarrassed.

(7. Fear of dependency) I really do feel that nobody can help me because I do know what I'm doing, and if I know what I do, I'm doing, and I know that it's wrong, there's nothing anybody can do for me.

(8. Incompetent care) The GP had said to me rather than it controlling you you've got to control it and I don't think you'll ever be completely cured.

Rachel

Study method may have restricted the results found by Garfield (1963) in one of the earliest interview studies of dropping out. Using a social worker from the clinical team and following up a small number of patients who terminated treatment, they found that 'early' terminators (those who left before 7 sessions) gave 'external' reasons for leaving,
such as not being able to find a babysitter or to get away from work. A couple of these early terminators also mentioned finding therapy unhelpful or not liking their therapist. (Strangely, however, the authors classify these reasons as ‘external’.) Those who remain longer gave ‘internal’ reasons, such as feeling recovered or feeling that the therapist had decided that treatment should end. Rather than supporting the authors’ conclusion that early and late terminators are different sorts of people, the results may reflect the method used to contact and interview the participants.

Indeed, a study of therapists’ ideas about patients’ reasons for dropping out supports this view. Pekarik and Finney-Owen (1987) asked 165 therapists to rank-order a set list of reasons for treatment ending. This same list of reasons had been given in the same set format to a large group of outpatient psychotherapy drop-outs. Therapists were half as likely to endorse ‘dislike of therapist/therapy’ as patients had been (11% versus 26%). They most commonly endorsed ‘problem solved or improved’ as the primary reason for dropping out (59%), which did not agree with the drop-outs’ top rankings. The second most common reason cited by therapists was ‘resistance’ (i.e., the patient’s responsibility), which not surprisingly patients did not often endorse. Pekarik and Finney-Owen conclude that therapists are more likely to choose problem-oriented reasons rather than therapist- or therapy-oriented reasons, perhaps because of their own sensitivity to rejection or attachment style.

This qualitative study has shown that the reasons behind dropping out are complex, and our understanding of the phenomenon is still immature and heavily influenced by the methods used to study it. Depending on how we ask, the reasons that patients give when leaving treatment may or may not be their ‘real’ reasons. The data we use to categorise patients into completers (those whom we deem to have ended treatment because they are well) and drop-outs (those who leave against advice who are not recovered) may be unsound. Jane’s sad account underscores the need for care when making assumptions about the reasons given for leaving treatment.

*You end up telling her what she wants to hear, and yet you’re there because you desperately want help. Perhaps now, thinking about it, that’s perhaps why I lied and said, Yes, I did try, and Yes, I felt quite good about it, and probably used the excuse of being pregnant … as the*

---

33 The authors do not specify how these questions were derived, but it does not appear that they were created from patient interviews.
reason [to leave] because you weren't convinced that it was going anywhere. That's perhaps the reality.
Jane (dropout2)

8.5.4 Limitations of the study

This study has two main limitations: the information supplied concerning treatment relationships was retrospective, and the gathering and analysis of data were subjective.34

Retrospective It was a drawback of the study that reasons for dropping out were given retrospectively, after a self-justificatory response bias could have taken place. This limits conclusions which can be drawn from the study, but its data are felt still to be useful. Measures were taken in the interview to encourage participants to remember details surrounding the experiences in treatment, so that recall would be improved. This approach was modelled on eyewitness interview techniques and the detail-based Attachment Style (ASI) and Childhood Experience of Care and Abuse Interviews (CECA) (Bifulco, Brown, & Harris, 1994; Bifulco et al., submitted). In these approaches, recall bias has been shown to be small; in the CECA, independent corroborative accounts have been taken from sisters of the main participants and show good agreement (kappa=0.6)(Bifulco, Brown, Lillie, & Jarvis, 1997).

Furthermore, two features of the current results indicate that self-justificatory bias did not obliterate the details of participants' accounts in this study:

1. Participants who had had good experiences in treatment reported similar events and feelings, as did those who had had poor ones. Within each group, participants' reporting styles, life circumstances, and clinical features were very different, yet the accounts resembled each other.

2. Three former patients of one therapist all reported similar events and therapist comments. These three participants did not know each other. All dropped out for similar reasons.

Subjective There is, however, no claim made to objective validity in these accounts. The subjective stances of both the participant and the interviewer are openly

---

34 Another limitation is that reasons for refusing treatment could not be compared to reasons for engaging or dropping out. The reasons given by those who refused treatment seemed to reflect strong fears about not fitting into the eating disorders clinic or not being able to change once there. These reasons will be further investigated in a separate report.
acknowledged in this work (see Section 8.2.2). The qualitative interview occurs only through the interaction between the interviewer and participant (the ‘co-construction’ discussed by Smith et al, 1999); therefore, the participant’s role is affected by her reactions to the person of and the questions raised by the interviewer. Likewise, the interviewer’s choice of questions and responses differ with each participant. During data analysis, the researcher’s interpretation of the data is affected by her own ideas about the participant’s experience. Thus the researcher’s subjective view pervades qualitative research.

As a result, having an independent rater check all themes would have been an advantage in this study. However, given the broad scope of this study and the number and length of transcripts involved, ‘credibility checks’ (p. 228, Elliott, Fischer, & Rennie, 1999) were restricted to obtaining feedback on early drafts of the results from other researchers in attachment and qualitative research fields as well as clinicians involved in the treatment of eating disorders. The original informants were provided with transcripts of their interviews and were offered copies of the written results, but their reactions and opinions about the results were not sought. This is an important limitation of the study and should be rectified in future written versions of this study. Nevertheless, research indicates that, despite the influence of subjective biases, independent researchers will extract substantially similar themes from the same data (Armstrong, Gosling, Weinman, & Marteau, 1997). Thus the results provided in this chapter are still thought to be useful, despite the limited credibility checks.

The flexibility provided by harnessing subjectivity in data gathering and analysis is considered to be one of the strengths of the qualitative approach. In quantitative research the processes of study design and analysis are also influenced by the researcher’s preconceived ideas about the participant. But once the study is designed and quantitative data have been gathered, changing the analyses to accommodate new understanding of the data is neither easy nor appropriate. This may result in biased results and or may disguise data which contradict the main hypotheses (Rosnow & Rosenthal, 1997).

As the main aim of this study was to explore the phenomenon of dropping out in order to generate hypotheses about the mechanisms which govern it, subjectivity is not necessarily a drawback. In every science the ‘observation’ stage is affected by the subjective lens of the observer – distortions in this lens may provide the insight needed see more clearly. This is and has been true for physics and chemistry, whose tools of
measurement and testing are usually thought of as objective, as much as for psychology. The validity of the results reported in this chapter will be proven or disproven by the formation and testing of hypotheses they have generated.

8.5.5 Conclusions

This qualitative study interviewed current and former eating-disorder patients who had a range of treatment durations about the factors they felt were most important in either engaging in or dropping out of psychological treatment. Results, organised according to attachment theory, support construing dropping out as the product of attachment processes that were not successfully negotiated in the early stages of treatment relationships. Hypothesising engagement and drop-out to be functions of attachment in therapy relationships has guided the construction of a therapy relationship questionnaire described in Chapter 9.
Development of the Therapy Relationship Questionnaire

A major frustration with previous research lies in its focus on variables beyond the control of the clinician. Because personal characteristics of the patient were examined apart from their manifestation in and impact on the treatment interaction, clinicians were often unable to utilise these findings in clinical management. While earlier literature tentatively suggested that the quality of clinician-patient interaction may be the best predictor of continuance, research has not been directed toward identifying such specific interactive behaviour (pp 284-285, Duehn & Proctor, 1977).

9.1 Introduction & Aims

Attachment-related childhood experiences appear to be able to predict dropping out, though trait-like attachment factors did not distinguish drop-outs in a small sample of eating-disordered patients. However, as Horvath and Luborsky (1993) pointed out, ‘the clients’ (and perhaps the therapists’) pre-therapy interaction patterns or capacities influence, but do not determine, the course of the alliance development’ (p. 570). As the interviews presented in Chapter 8 indicated, the same might be said for treatment engagement.

Chapters 5 & 6 looked at parental break-up and childhood trauma as proxies for attachment experiences which might affect dropping out. In Chapter 7, attachment style was measured by the VASQ also as a pre-treatment patient characteristic, so it assessed patients’ attitudes toward close, confiding attachment relationships at presentation for treatment. But it was not able to illuminate the way the relationship between patient and therapist evolved. Chapter 8 indicated that using a measure to assess attachment as a characteristic of the evolving treatment relationship could increase our understanding of – and eventually our ability to predict – dropping out. This chapter presents the development and early analysis of such a measure.

9.1.1 Aims

The aims of this chapter are to present the development and early analysis of a measure designed to predict dropping out from psychological treatment, in this instance for eating disorders. The Therapy Relationship Questionnaire (TRQ) uses the views of
both patients and therapists over several time points to characterise the developing treatment relationship.

Following description of the content and structure of the TRQ, data from the first of these time points (assessment) are explored with factor and cluster analyses. The TRQ is currently being used to track engagement and drop-out in a large number of eating disorder therapy relationships, so data from the in-therapy session and data on the predictive utility of the TRQ will be available, but are not presented here. Reliability and validity are addressed.

9.1.2 Previous measures

Measures developed for studying drop-out or for measuring attachment in therapeutic relationships are relevant to the development of the TRQ. Other measures specifically designed for studying drop-out were reviewed in Chapter 2; hence, they will be only briefly discussed here (below).

**Measures of attachment in therapy relationships** Only one other measure has been developed to assess attachment in the context of psychotherapy (Clinical Attachment to Therapist Scale)(Malinckrodt, Gantt, & Coble, 1995). Unfortunately, this measure has several features which make it inappropriate for predicting dropping out: it assesses attachment only from the patient’s perspective and thus does not address attachment as a feature of the dyad. It was designed to directly mimic established attachment style questionnaires, producing a ‘style’ rating at only one point in time which is then generalised to the later (and earlier) stages of the treatment relationship. And it is meant to be administered after 5 therapy sessions, when most drop-outs would already have left.

Measures related to the therapeutic alliance tradition have looked at both patient and therapist perspectives within the evolving treatment relationship. The concept of the therapeutic alliance is closely allied to that of attachment in therapy; however, the theoretical foundations are different. Research into the therapeutic alliance stemmed from Bordin’s (Bordin, 1994) search for trans-theoretical elements of effective therapeutic relationships, which by definition was not bound to a particular theoretical framework.

As mentioned earlier, these studies have mostly focused on outcome, rather than engagement. When dropping out has been considered in the alliance-type studies, conclusions have been thought-provoking and contribute to thinking about measure design and administration. The measure used by Saltzman et al. (1976), discussed in
depth in Section 2.2.4.3, was completed repeatedly by both patient and therapist. It recorded feelings evoked by the developing therapy relationship. The patient and therapist responses were able to distinguish drop-outs and completers on several dimensions and at several time-points. Overall, the therapy relationship of drop-outs declined over the first 3 sessions. From these results the authors constructed a tentative model of the necessary elements of treatment engagement:

First, the anxious and active appeal for help must evoke a strong sense of involvement on the part of the therapist. Second, beyond the initial session, the therapist must remain involved and the client must view his/her therapist as competent and committed. Third, client and therapist must develop a mutual respect and a shared sense of the continuity of their relationship (p. 553).

This model is useful, but its reliability is unclear, as the statistical analyses used to analyse the data were not designed for multivariate data. However, the view of dropping out as the product of the developing interaction between patient and therapist is an important contribution.

An earlier therapy relationship measure, the Relationship Inventory discussed in Section 2.2.4.3, is administered to both patient and therapist at each of the first 5 sessions of therapy. In one drop-out study, while there were no differences in the patient’s attitudes toward therapists, the therapists felt least ‘congruent’ with patients who eventually dropped out and had the lowest ‘esteem’ for these patients (Rapaport et al., 1988).

Measures designed for studying dropping out As discussed in Chapter 2, with a few exceptions previous measures designed to study dropping out focus on patient characteristics. Either patient self-report is used, or therapists are asked to make assessments of patient factors that are considered to be prognostic of engagement. The relationship itself is rarely taken into account. These measures have not been successful in predicting dropping out. An example of this type of measure is the T.I.P. Questionnaire (the author does not specify what this stands for)(Frayn, 1992), which is completed by the therapist or the therapist’s supervisor, either at the beginning of treatment or after termination. Ratings are of 16 ‘patient qualities’ thought to be predictive of dropping out. This measure has some important flaws aside from its exclusive focus on the patient: Since ratings can be done after termination, there is no control for bias in rating drop-outs and completers. Additionally, there is no control for the possible effects of participating in the treatment relationship on making subjective ratings, since either the treating
therapist or supervisor can make the ratings. Reported results are therefore difficult to interpret.

A more successful patient-characteristic scale, the Circumstances, Motivation, Readiness, and Suitability Scale (CMRS; discussed in Section 2.2.2.2.7) (De Leon et al., 1994), was framed according to therapists' 'clinical considerations' relevant to dropping out. Items themselves were derived from interviews with recovered, recovering, and new patients in a therapeutic community programme. The CMRS is designed to be administered at admission. This instrument has many strengths, including having been based on theory, using patient (though not specifically drop-out) interviews in the development stages, and having been properly validated. However, it relies on pre-treatment patient characteristics to predict the outcome of a new therapeutic relationship and does not include within-treatment measures as well. The CMRS was able to predict short-term retention, but was not able to predict longer-term retention, perhaps because the participant’s ‘CMRS’ had changed since admission.

A direct approach to prediction of length of stay has been used in the behavioural self- and therapist-prediction measures discussed in Section 2.2.2.2.4. Among other items, patients and therapists state at the beginning of treatment how many sessions they think the patient will attend. Individual items in this scale do not predict well, but when both patient and therapist predictions are considered together, prediction is improved and withstands cross-validation (Beck et al., 1987). A concern with such a measure is that it may invoke a self-fulfilling prophecy, with patients feeling the need to stick to their predictions, and therapists treating differently those they have labelled as future drop-outs. The same measure used in another study and scored using a 'critical response' technique, which counted only those responses which were above a designated high threshold, predicted dropping out with high specificity. However, using this high threshold resulted in very low sensitivity for the measure (Fraps et al., 1982).

It appears that a measure which evaluates the views of both the patient and the therapist as the relationship evolves and which uses a relationship-based approach could improve understanding and prediction of dropping out.

9.1.3 Philosophy behind the Therapy Relationship Questionnaire

The TRQ was developed for this purpose. A paired questionnaire format (TRQ-patient and TRQ-clinician) administered over several sessions was chosen in order to
elicit useful information in the least intrusive way possible. Using a minimally intrusive technique was intended to avoid altering the relationship under study.

9.1.3.1 Content of the Therapy Relationship Questionnaire

The reasons for engagement or drop out offered by current and former patients during in-depth interviews determined the type of questions used in the TRQ-patient. These were concerned with the development of trust and safety in the relationship and lent themselves to interpretation with attachment theory. The TRQ-therapist was developed from interviews with therapists, and focused on the attachment aspects of the developing relationship.

The questions in the TRQ are distinguished from other relationship-based questions, such as those used in the therapeutic alliance literature, in two ways.

1. They are concerned only with those factors that relate to the durability of the relationship rather than to outcome.

2. They focus on an earlier stage of relationship development than the therapeutic alliance literature.

The therapeutic alliance is theorised to be the result of patient and therapist negotiating the goals and tasks of treatment, a process which influences and is influenced by the bond between them (Bordin 1976, 1980, 1989 in Horvath & Luborsky, 1993). Therefore it focuses on the period when the technical aspects of therapy are under discussion. It appeared from the in-depth interviews discussed in Chapter 8 that the alliance in this sense had to post-date mutual assessment of the other as trustworthy35. From the patient's point of view, the technical aspects of therapy were initially much less fundamental than the availability and supportiveness of the therapist. In fact, focusing too early on technical aspects of treatment appeared to be harmful to the relationship36.

---

35 This early trust-building stage is acknowledged by the alliance researchers. It looks similar to Luborsky's Type I helping alliance, in which the patient experiences the 'therapist as supportive and helpful with himself as the recipient.' (p. 563; Horvath & Luborsky, 1993). However, the alliance measures do not address it explicitly.

36 In the alliance literature, sometimes the focus on goals pre-empts other factors in the development of the relationship, such as discussing patients' doubts and concerns about therapy. The concluding statement by one author illustrates this: 'We consider the following contribution to be essential to the fostering of an effective therapeutic relationship: 1. Set goals jointly with patients.' (p.16; Truant & Lohrenz, 1993).
Therefore, an initial period of establishing trust and safety is hypothesised to exist in the establishment of a therapy relationship, and is considered to be the most important to early engagement or drop-out. This period is not concerned with goal- or task-setting. Indeed, research supports this as a separate concept. Studies which compared drop-outs and completers on the patient-counsellor agreement on problem identification found no differences between those who stayed and those who left (Kokotovic & Tracey, 1987). Similarly, patients who reported that they felt their feelings had been understood in the first sessions were more likely to return; feeling that their problems had been understood in the first sessions was not related to engagement (Zisook et al., 1979).

The content of the TRQ is therefore targeted at the initial period of establishing trust. Attachment theory guides the selection of questions. The TRQ does not contain 'lie' scales, because it does not seek to draw conclusions about the accuracy of the views of the participants. Instead, it looks at the way that participants experience psychotherapy (Llewelyn, 1988). Social desirability scales were not included either, because other measures in this vein did not elicit overly positive answers (Howard and Orlinsky cited in Fiester & Rudestam, 1975), and the study was designed to emphasise that responses would not be shown to the therapist.

9.1.3.2 Sources of data in the Therapy Relationship Questionnaire

The TRQ gathers data from both patient and clinician. This design was influenced by both practical and theoretical concerns.

Practically, having data about the relationship from both participants is likely to increase the ability to predict its outcome. Previous studies mentioned above have shown that combining behavioural self-estimations from patients and therapists improves prediction of dropping out (Beck et al., 1987; Fraps et al., 1982). Therapists on their own do not reliably predict return visits, nor does their ability improve with training or experience (Mushlin & Appel, 1977).

Theoretically, in the TRQ the therapy attachment is considered to be a feature of the therapy dyad, rather than of either participant alone. The pre-treatment attachment styles of each participant influence the relationship, but do not determine it. This concept also underlies the concept of the alliance:

Where a patient lacks the absolute capacity to form an attachment (which we believe is relatively rare), then the interpersonal process of therapy may be irrelevant; however, in the most common case, where some
patient capacity is present, the alliance is seen to be the emergent result of interactive interpersonal process (p. 69, Henry & Strupp, 1994).

The relationship has unique qualities that only the participants can be aware of. In the alliance literature, outsiders' ratings of the relationship predict outcome even less well than the therapists (Luborsky, 1994). Therefore it appears to be appropriate to ask each member about the relationship.

9.1.3.2.1 Self-report

The TRQ takes as a starting point the logical presumption that it is what the participants experience that affects them in therapy. Observations made by outside observers are not necessarily relevant, nor could an observer become intimate with the relationship without changing it. Self-report is therefore not only acceptable but required. Barrett-Lennard, an early therapy relationship investigator, supports the use of self-report: 'although it is not supposed that a client’s conscious perceptions would represent with complete accuracy the way he experienced his therapist, it would seem that his own report, given under suitable conditions, would be the most direct and reliable evidence we could get of his actual experience' (p. 2, Barrett-Lennard, 1962).

9.1.3.2.2 Inference unnecessary

The TRQ, in directly asking about patients’ and therapists’ own feelings regarding the developing relationship, avoids the epistemological problem of asking one party (usually the therapist) to infer the state of mind or feelings of the other party (usually the patient). This inference may be responsible for the lack of correlation between patient and therapist versions of alliance measures (Horvath, 1994b). Therapists and patients may have divergent views of what is happening in the relationship. A study investigating patients’ and therapists’ views of important events in therapy illustrates this point (Llewelyn, 1988). Measurements were taken repeatedly directly after sessions. Patients emphasised problem solution and reassurance, whereas therapists emphasised insight events. They also disagreed which sessions had been most important. In another study, therapists viewed the relationship between themselves and patients who had been in treatment for 5 sessions more positively than the patients did (Barrett-Lennard, 1962). Patients and therapist views might only converge after a much longer term (Strupp, Wallach, & Wogan, 1964), perhaps because they have had time to accommodate to each other. Most dropping out will have already occurred by the time this happens.
The TRQ uses both patient and therapist as sources of data in order to increase the predictive power of the measure and in order to be able to measure the attachment qualities of the therapy relationship in terms of the combined experiences of the parties involved.

9.1.3.3 Temporal structure of the Therapy Relationship Questionnaire

The TRQ is administered after the first assessment session, and then after the first three therapy sessions. Again, there are practical and theoretical reasons for this structure.

On the practical side, the early sessions were used because this is the time when most dropping out occurs (Garfield, 1994; Phillips, 1987). If data were gathered at later stages only, important information about dropping out would be lost as fewer patients would remain, and these would likely be engagers.

On the theoretical side, it was felt that patients (and therapists) would be unlikely to have a clear view of the relationship until a few sessions had passed. Frank et al. (1957) point out that what patients report at first contact needs to be seen as an attempt to adapt to therapy situation, which often will be unfamiliar, rather than as an accurate report of their 'true' feelings about it. The in-depth interviews discussed in Chapter 8 corroborated the view of Frank et al. Participants often mentioned knowing 'straight away' that the relationship was not going to last, but when asked why they came back for more sessions, they said that they had worked hard to get to treatment and hoped it would work out or felt worried that their own anxiety had coloured their early reaction. Therefore, it was felt that taking measurements at the first interview only would be misleading. Similarly, waiting to start gathering data until a later session would not allow the vector of the developing relationship to be traced and would miss several drop-outs.

Other research, looking at outcome, substantiates this point. O'Malley, Suh, and Strupp (1983), using the Vanderbilt Psychotherapy Process Scale, a process (not alliance) rating instrument scale which analyses recorded segments of sessions, found that the relationship of patient involvement to outcome increased linearly over the first 3 sessions. In the first session, there was no association, but by the third the association was significant. Henry (Henry & Strupp, 1994), using the Luborsky Helping Alliance measure, found similar results. He reasoned that patient involvement is not a fixed variable, but one that changes, perhaps due to therapist factors. Bowlby (1988) predicted that this should be the case.
The first three sessions were also chosen on the strength of previous research, which has repeatedly indicated that these sessions are important to understanding the therapy relationship. Garfield (1994) found that predictions of outcome were possible by the 3rd or 4th session. Connely et al. (1986) found that these sessions were critical to understanding drop-out from group therapy. Therapeutic alliance research also suggests that 'the alliance seems to develop (or fail to develop) relatively quickly' (p. 61, Henry & Strupp, 1994), and that its quality is apparent within 3 sessions. Saltzman et al. concluded that:

It takes time for two people ... to become acquainted and to determine whether they can develop an effective way of relating to each other. At the end of the first session, the relationship remains quite tentative. Their limited experience with each other provides very little basis for predicting the future course of events. After three sessions, however, the viability of the relationship is becoming evident. The strength or weakness of the therapeutic alliance is now strongly reflected in the quality of the experience in the therapeutic situation (p. 552).

Looking at only the first three therapy sessions also meant that the differences between treatment types would be negligible, so the results would be more generalisable between disciplines. In research concerning the prognostic use of psychological tests, differences in treatment effects between types of treatment were not found to be great (Fulkerston, 1961). Other sources of variance were considered to be more important, especially in first sessions, and the investigator advised simplifying study design by not including treatment type as a covariate. Horvath (1994a) observes that in the early sessions the alliance as such is still relatively undifferentiated. Given that the alliance considers the technical aspects of treatment unlike the TRQ, viewing the TRQ as generalisable across treatment types seems reasonable.

Thus the temporal structure of the TRQ was determined by the practical considerations of the timing of most dropping out and the development of treatment relationships. It was informed by qualitative and quantitative research results indicating that the treatment relationship changes over the initial sessions.

9.2 Development of Questionnaire

9.2.1 Item generation, content validation, and item selection

Item pools for the TRQ-clinician and TRQ-patient were generated from the in-depth interviews discussed in Chapter 8 (clinician interviews are not presented in this
thesis, but were conducted in parallel with the patient interviews). Items were drawn from statements most commonly and emphatically made by those who dropped out which were different from statements made by those who remained. Preliminary forms, containing extra items, were reviewed by an expert panel of 5 researchers working in attachment theory. Two experts were psychiatrists, and 3 were research psychologists. The panel discussed items until consensus was reached on theoretical coverage.

**TRQ-patient.** The final format for the TRQ-patient consisted of 24 closed-ended items and 3 open-ended items (Appendix 9-1). The closed items asked about feelings of safety and trust within the treatment relationship, openness of communication within the relationship, felt respect from the therapist, dependency fears, feelings about accepting care, the relevance or appropriateness of the therapeutic endeavour, the therapist’s encouragement of exploration and discovery, felt commitment to the relationship, and felt progress in recovery. Open-ended items asking about the ‘good’ and ‘bad’ experiences in therapy were included to tap into further qualitative information about patients’ perceptions of treatment.

**TRQ-clinician.** The final TRQ-clinician consisted of 7 closed-ended items (Appendix 9-1) and 3 open-ended items. The closed-ended items asked about safety and trust within the relationship, ease and openness of communication within the relationship, felt competence in the care-giving role, and perceived commitment by the patient to the relationship. The open-ended items asked for qualitative information from therapists about what factors they thought might contribute to the therapy continuing or ending.

As items and wording were taken from in-depth interviews with members of the target populations, extensive piloting of items for relevance to that population was not felt to be necessary. In order to minimise questionnaire fatigue and maximise response rate, the TRQ-patient was restricted to one side of an A-4 sheet. The TRQ-clinician was restricted to ½ of an A-4 sheet.

### 9.2.2 Scale format

Items were written as self-statements with a 5-point Likert scale ranging from ‘strongly agree’ to ‘strongly disagree’. Positive and negative statements were mixed in order to avoid response sets. The questions are designed to be quickly answered without need for inference or prolonged thought. The wording used by the interviewees was
preserved as closely as possible; however, to balance the number of positively and negatively worded items, sometimes the inverse of typical statements was taken.

9.2.3 Instructions to participants

A covering page gave an introductory description of the purpose and content of the questionnaire. For the TRQ-patient, instructions emphasised confidentiality and equality of answers. They read:

This questionnaire concerns how you feel about your relationship with your therapist. All the information you give is completely confidential, and will not be shown to your therapist, or any member of the clinical team. There are no right or wrong answers – just choose the answer that is closest to how you feel.

For the TRQ-therapist, instructions also emphasised confidentiality, but were briefer as the population had had more experience with research. They read:

This questionnaire concerns how you feel about your developing relationship with your patient. All of the information you give is completely confidential and will be stored in numerical form.

9.3 Method and Results

9.3.1 Ethical approval

Ethical approval was obtained from the Leicestershire and Rutland Healthcare NHS Trust in December 1999 (Appendix 9-8).

9.3.2 The clinic and clinicians

The clinic and therapy team hosting this study are described in Chapter 5. Clinic procedures were similar to those described in Chapters 5 & 7, where procedures for the assessment and treatment of AN were described. Participants, following referral, were typically assessed over 1 or 2 meetings. This assessment was conducted by one of the senior members of the clinical team. It is not typical for the assessor subsequently to become the therapist, though assessors also do therapy.

The clinic procedure for allocating assessment appointments changed between earlier studies and the beginning of the study in this chapter. The new procedure asked potential patients to confirm assessment appointments and instructed them that unconfirmed appointments would be re-allocated. There was a waiting list for assessment of approximately 16 weeks. When patients were offered treatment and had accepted it,
they were placed on a waiting list for therapy. At the beginning of the study, treatment was due to begin within 2 months, with urgent cases seen immediately. However, due to staffing problems during the year this study ran, waiting lists grew to 6 months long. This delay in taking patients into therapy prevented analyses of the TRQ’s ability to predict drop-out being included in this chapter.

9.3.3 Participant Selection and Characteristics

Participants were a series of patients consecutively assessed at the EDS over a 1-year period from 15 January 2000 to 14 January 2001. This yielded a potential participant pool of 211 (Table 9-1). Of these, 7 were assessed only to provide an opinion for another health service, 16 had no ED, 20 refused participation in the study, 4 were excluded because the assessor did not return the TRQ, and 54 were still in the system of reminders (3 reminders sent over a period of 6-8 weeks after assessment). 110 participated in the study; 1 was later excluded because she had not completed the TRQ correctly and could not be contacted for clarification of her responses and another because the clinician inverted the response scale.

<table>
<thead>
<tr>
<th>Opinion</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>No ED</td>
<td>16</td>
</tr>
<tr>
<td>Refused study</td>
<td>20</td>
</tr>
<tr>
<td>No clinician</td>
<td>4</td>
</tr>
<tr>
<td>TRQ</td>
<td></td>
</tr>
<tr>
<td>Reminder</td>
<td>54</td>
</tr>
<tr>
<td>Study</td>
<td>110</td>
</tr>
<tr>
<td>Total</td>
<td>211</td>
</tr>
</tbody>
</table>

Table 9-1. Sample selection.

The DSM-IV criteria were used for diagnosis (APA, 1994). Of the participants, 20 were diagnosed with AN, 41 with BN, and 49 with EDNOS. 102 participants were female, 8 were male. Because analyses excluding males yielded very similar results to those including them, data were collapsed across sex and analysed as a whole. Ages were in the expected distribution of mean age= 23.3 (s.d. 6.1).

9.3.4 Questionnaire Administration

After the first assessment session, and then again after each of the first three therapy sessions, all patients were asked to complete the ‘Therapy Relationship
Questionnaire’. The study was introduced by the assessing clinician at the end of first assessment session, and an information leaflet and consent form covered with an introductory letter from the researchers were given to the patient with the TRQ-patient (Appendices 9-2, 9-3, 9-4). Phone numbers of the investigator were supplied in case patients had any questions.

The TRQ-patient for each session was folded into a freepost envelope labelled with the session number and inserted in the case notes. Patients completed the TRQ either at the clinic, handing it to the secretary, or at home, posting it in the envelope. It was felt essential to the accuracy of responses that patients did not feel compelled to complete the questionnaire in the treatment setting, where they might feel their responses could be observed. To reinforce to patients that their responses would not be shown to their assessor or therapist, the freepost address was in a city far removed from the clinic. Each patient was assigned a code number which was applied to all of the questionnaires they and their clinicians completed. As a result, patients and therapists were not asked to put their names on the forms, but their questionnaires still could be matched to their clinicians’.

Clinicians were asked to fill in the companion form of the TRQ at the same times. They were also provided with an envelope labelled with the session number and instructions to put the questionnaire in a marked box in the secretary’s office.

A reminder letter with a new questionnaire was sent to all patients who had not returned the assessment TRQ after two weeks, and then again after four weeks. No follow-ups were sent to patients who did not return the therapy TRQs, since it was not possible to send a new questionnaire to them before their next therapy session, at which point their reactions to the previous session would be ‘contaminated’. In the event, most patients returned both the assessment and therapy TRQs (see Participants above). Assessors and therapists were remarkably conscientious about completing and returning their TRQs promptly – only 4 were missing.

A ‘thank-you’ note was sent to all participants on receipt of the assessment TRQ and consent form. All assessment TRQs were checked for completeness. When questions had been missed, a note was sent to participants thanking them for agreeing to participate and asking them to fill in the missed question. Only when participants had written comments that caused concern for their safety was the consultant psychiatrist who headed both the research and clinical teams informed.
The layout of the questionnaire has proven effective in encouraging complete responses. The questionnaire is formatted as a table, with questions in one column, and responses each in a separate column. In order to minimise missed or double-answered questions, items were separated by a blank table row (see Appendix 9-1).

### 9.3.5 Data analysis

As mentioned earlier, current analysis of the TRQ is restricted to description of data gathered from patients and clinicians at assessment. The TRQ is being used to track engagement and drop-out in a large number of therapy relationships, and data from in-therapy sessions and data on the predictive utility of the TRQ will be available in the future.

Descriptive analyses presented below investigate item frequencies and relationships. Factor and cluster analyses are described which serve to uncover latent relationships between variables in linear (factor) as well as configural (cluster) formats. These analyses will be repeated on an independent data set, which is currently being gathered. As further data sets from the in-therapy TRQ dyads become available, the processes described below will be repeated.

#### 9.3.5.1 Initial questionnaire description

Once assessment TRQ data for patients and clinicians had been entered into a computer database and checked for errors, the reverse-scored items were transposed so that low scores indicated negativity and high scores positivity on all questions. Response distributions are shown in Appendix 9-1. It is evident from this table that the data are skewed and that ceiling and floor effects were encountered, especially in the TRQ-clinician, a problem which may or may not persist into the later TRQ time periods. Transformation of the skewed items was explored, but presented several problems, including negative skewing and a large number of zero values. Both Spearman-ranks and Pearson correlation tables were generated to see whether the skewing would have a marked effect on correlations and subsequent factor analyses. There were no substantial differences, so for the convenience of being able to use the SPSS factor analysis functions, the Pearson table was selected (Appendix 9-5). Correlations significant at \( p \leq 0.001 \) are in bold red; those significant at \( p \leq 0.01 \) are in bold black. Lower \( p \) values
are not highlighted, because of the large number of comparisons (well over 400). The table shows that the many of the TRQ-patient items correlate with each other (further discussion below), and that all of the TRQ-clinician items highly correlate with each other. Interestingly, the clinician items generally do not correlate with the patient items, except for the item ‘Do you feel that a trusting relationship is developing with this patient?’ (again, further discussion below).

9.3.5.2 Factor analysis

The correlation table was used as the basis for exploratory factor analyses of the TRQ-patient and -clinician data. Following the advice of Child (1970), several extraction methods with different premises were used in order to assess the ‘robustness’ of the factor solutions, including Principal Components, Principal Axes, and Unweighted Least Squares. Methods such as maximum likelihood, which require estimation of the number of factors as the basis of the analysis, were not used, as the purpose of the analysis was exploratory rather than confirmatory. Orthogonal and oblique rotation methods were also tried to assess whether allowing the factors to correlate with each other would increase the interpretability of the results. The results presented here used the Principal Components Analysis (PCA) for extraction and Varimax for rotation, as these were the simplest and most readily interpretable methods of those tested. The Kaiser criterion of eigenvalues greater than or equal to 1 was used to select factors. Scree plots were also employed to indicate where the curve created by the eigenvalues levelled off, and the factors which were found before the ‘break’ are given the most attention.

The first factor analysis included all TRQ-patient and -clinician items (Appendices 9-6 a-c). Not surprisingly, the clinician items (which were largely uncorrelated with the patient items in the correlation table) grouped together on a single factor, the first. The remaining patient items fell into 7 other factors, which were interpretable but which were less coherent than was desired. A second factor analysis included only the TRQ-patient items. This yielded 6 factors, the first 3 of which appeared to be the most important.

37 In the case of the clinician items it might more accurately be termed a 'stuck between floors' effect. The clinicians avoided the extreme points more assiduously than patients did.
Figure 9-1. Plot of scores for initial Factors 1 & 2 showing outliers.
Figure 9-2. Plot of scores for initial Factors 1 & 3 showing outliers.
Figure 9-3. Plot of scores for final Factors 1 & 2 with one remaining outlier.
Figure 9-4. Plot of scores for final Factors 1 & 3.
In order to explore the distribution of the main components of the reduced data from the TRQ-patient, the scores of each participant on the first three factors were plotted (Figures 9-1 & 9-2). These plots were used to identify and assess outliers. One participant was excluded at this stage when her questionnaire was re-examined and was found to have been completed incorrectly. The two other outliers could not be excluded. The most extreme outlier on Figure 9-1 had completed the questionnaire correctly, and had written in the qualitative section, ‘I feel if I don’t get help SOON I will die. When I told her [the assessor] this, i [sic] seemed like she laughed about it.’ Therefore her extreme low scores were supported. Nevertheless, to see whether the factors would change dramatically if she were excluded, she was filtered from the data set and a third factor analysis was run. The early factors remained the same. Some low-weighting items switched factors, but the factors’ main sense was not changed. It was decided to retain this participant in the data set. A fourth factor analysis was run, excluding the outlier who had not completed her questionnaire correctly. The scores were again plotted (Figures 9-3 & 9-4), and did not show any new outliers. The details of this analysis are presented in Appendices 9-7 a-c.

9.3.5.2.1 Factor results

The factor results fit well with attachment concepts.

1. Factor 1 (Safe/open patient). The first and most important factor, most heavily loaded on by Questions 2 (feel safe with assessor), 3 (can show real self), 1 (can discuss most important issues), 20 (trust assessor), and 15 (can tell truth to assessor), describes a patient who feels safe and open with the assessor. 17% of variance in rotation. The degree to which this factor is correlated with the VASQ results will be discussed below.

2. Factor 2 (Available/accepting therapist). The second factor describes the patient’s perception of the assessor as available, accepting, and honest. It is most heavily loaded on by Questions 18 (assessor is honest), 8 (treatment not contingent), 13 (not criticised by assessor), 16 (taken seriously by assessor), and 14 (assessor cares). 13% of variance in rotation.

3. Factor 3 (Exploration/progress). The third factor contains items which pertain to the patient’s exploration and personal progress. It is loaded on most heavily by Questions.
22 (gaining new information), 12 (good challenge), 23 (assessment helpful), and 24 (want to complete). 10% of variance.

The remaining 3 factors are somewhat less stable.

**Subscales** As a further exploratory step, tentative TRQ subscales were generated from the factor analysis. The participant’s subscale score was defined as the total of that person’s responses for the items whose highest loading was on that factor. At this exploratory stage, the purpose of the subscales was to enhance comparisons with the TRQ-clinician as well as the VASQ and to facilitate description of the TRQ-patient. Therefore, using the response total was sufficient. However, in the future when further data are available, subscales may be useful for predictive analyses, and will need to be standardised to permit comparisons between them. They will also permit the generation of ‘vectors’ for tracing the changes in a particular patient’s TRQ scores from assessment through the early therapy sessions, which can be compared with their therapist’s TRQ scores. The vectors may be more indicative of the growth of the relationship over time than any single time-point score could be.

The TRQ-clinician items were not related to the TRQ-patient subscales, except for the item asking whether the clinician felt that a trusting relationship was developing with the patient. The first three subscales, which concern (1) the patient’s perception of herself as safe and open with the therapist, (2) the patient’s perception of the therapist as available and accepting, and (3) the patient’s sense of exploration and progress, relate linearly to the therapist’s sense of the trusting relationship. Figures 9-5, 9-6, & 9-7 illustrate these positive linear relationships.
Figure 9-5. TRQ-clinician ‘Trust’ item plotted against TRQ-patient Safety/Trust subscale derived from Factor 1. (Linear-by-linear association = 12.850, df=1, p<0.001).
Figure 9-6. TRQ-clinician ‘Trust ing’ item plotted against TRQ-patient Accepting Therapist subscale derived from Factor 2. (Linear-by linear association = 6.827, df=1, p=0.009).
Figure 9-7. TRQ-clinician ‘Trusting’ item plotted against TRQ-patient Exploration/Progress subscale derived from Factor 3. (Linear-by linear association = 5.988, df=1, p=0.014).
9.3.5.3 Cluster analysis

Two types of cluster analyses were also carried out. The relationships between the TRQ items (R-mode analysis) were explored using hierarchical analysis, since the aim was to see which items were most closely related, which next most closely, and so on. The averaging of items that the hierarchical method used in creating groups would not lose any pertinent information. On the other hand, a non-hierarchical technique was used to explore patients' responses for any clusters (Q-mode analysis) since in this instance the task was to see whether there were any sets of overall response profiles. The averaging of responses that would have occurred with many of the hierarchical methods would have lost the 'profile' details.

9.3.5.3.1 Hierarchical, R-mode analysis

The R-mode analysis was carried out to see whether the item groupings identified using the factor analytic technique could also be identified using a completely different, grouping method. This would provide both support for the robustness of the factors and access to information about how the variables relate to each other. Furthermore, the cluster approach would not require linear transformations of the data, as factor analysis would do. The agglomerative method used by many hierarchical techniques is appropriate to the grouping of questionnaire items.

An average linkage, within-group clustering algorithm supplied with SPSS was used to map the relationships between the TRQ-patient items (Cluster dendrogram Figure 9-8). Items were Z-standardised and squared Euclidean distance was used for the dissimilarity calculation. A preliminary analysis was performed with TRQ-patient and -clinician items, but the clinician items again simply formed their own cluster. Since one of the purposes was to replicate the factor analysis, clinician items were removed for later analyses. It can be seen that 3 main clusters were found (gaps in linkage lines indicate grouping breaks). These correspond closely to the first three factors produced with factor analysis. Only low-weighting items do not correspond. Figure 9-8 shows that these items are later 'tag-ons' to the main groupings.
9.3.5.3.2 Non-hierarchical, Q-mode analysis

The Q-mode analysis was carried out to see whether participants could be partitioned into cohesive clusters. The iterative, non-agglomerative grouping technique was appropriate to the grouping of individuals. The larger purpose of these groupings will be realised when data about participant's engagement status becomes known; cluster membership will then be tested for its ability to predict drop-out. Using the k-means algorithm supplied with SPSS, two clusters were forced, anticipating these tests. There were 36 patients in Cluster 1 and 72 in Cluster 2. These proportions are similar to the proportions of engagers and drop-outs at the EDS. However, at this stage the clusters were simply mapped against the total scores for the TRQ-patient (Figure 9-9). Cluster membership appears to relate to scoring high or low overall on the TRQ; therefore it can be assumed that splits between answering positively to some parts of the TRQ and negatively to other parts are not common. Similarly, plotting cluster membership against scores for the first three factor analyses showed that those with higher scores consistently clustered together.
Hierarchical Cluster Analysis of TRQ-patient items

<table>
<thead>
<tr>
<th>CASE Item</th>
<th>0</th>
<th>5</th>
<th>10</th>
<th>15</th>
<th>20</th>
<th>25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impt issues</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Real self</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trust</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tell truth</td>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intimidated*</td>
<td>19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Understands u</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Competent</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contingent*</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Criticised*</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seriously</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Honest w you</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fraud*</td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Choice</td>
<td>21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gives in*</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child*</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New informtn</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helping</td>
<td>23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stay in</td>
<td>24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cares about u</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relevant</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good challing</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No ED help</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can b helped</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Reverse-scored item
Figure 9-9. TRQ-patient total score plotted against cluster membership derived from non-hierarchical q-mode cluster analysis.
9.3.5.4 Internal consistency and Scale reliability

9.3.5.4.1 Internal consistency

The internal consistency of the overall TRQ-patient was assessed using Cronbach’s alpha. While it shows good levels (alpha= 0.88, which shows that items have coherence but are not redundant with each other), it was not given much weight in the item selection process. This was due to primarily to the empirical objective of the TRQ, which was to discriminate groups of people (drop-outs and engagers) rather than to describe the phenomenon of engagement or drop-out. The question of scale and sub-scale homogeneity was therefore not central to the exploration of the questionnaire or to the data analysis (Streiner & Norman, 1995). Furthermore, in constructing the TRQ, its content validity was considered to be more important to detecting future dropping out than its internal consistency (Streiner & Norman, 1995).

9.3.5.4.2 Test-retest reliability

The state-specific nature of the TRQ ruled out the use of test-retest procedures to generate reliability estimates for the scale as a whole. The recommended delay of approximately 2 weeks between administrations (Streiner & Norman, 1995) would potentially have resulted in different answers simply because the relationship had fluctuated, or memory of the relationship had faded in the case of those who had been assessed and were on the waiting list for treatment to begin. There were also ethical concerns about ‘badgering’ the participants with requests for questionnaires and the potentially negative effect this might have had on the therapy relationship. Giving a modified form of the TRQ to a non-patient population and asking them to perform a test and re-test during the early stages of forming a trusting relationship (according to the method used by Barrett-Lennard (1962) with the Relationship Inventory) was considered, but was rejected as the non-reciprocal, ‘trusting’ presumption of the therapy relationship is relatively unique in adult relationships.

9.3.5.4.3 Subscale reliability

Similarly, reliability estimates for the subscales generated from the factor analysis were not attempted. The sub-scales were developed in order to facilitate description of
the TRQ-patient itself. Therefore, the reliability of the scale will have to be demonstrated in the future by its ability to discriminate between drop-outs and engagers.

9.3.5.5 Validity

As in other research where variables are given operational form for the first time, the possible validation steps for the TRQ were restricted.

9.3.5.5.1 Content validity

Content validity of the items which build up the scales was attempted using the procedures described above in Section 9.2.1, which used exhaustive in-depth interviews with patients and therapists as the basis for item generation. The item pool was reduced by an expert panel, who also ensured that theoretical coverage was achieved. However, the TRQ and the subscales are not intended to be used as a description of the phenomenon of engagement. The importance of theory to the development of the TRQ notwithstanding, its construction from interviews with drop-outs, engagers, and therapists was empirical rather than theoretical. This implies that the construct validity of the scale can only be established through its predictive use.

9.3.5.5.2 Criterion validity

Since no other measures exist which might provide a 'gold standard' against which to concurrently validate the TRQ, further validation will be a matter of predictive validation against dropping out.

9.3.5.5.3 'Divergent' validity

The extent to which the TRQ differs from other measures was also relevant to assessing its validity. The TRQ was intended to measure state-like feelings of attachment in the therapy relationship, rather than simply patient pre-treatment attachment traits. Therefore scores on the TRQ should not be entirely explained by attachment trait measures, such as the VASQ.

Overall VASQ ratings (1: standard attachment style, 2: non-standard attachment style) were used to compare respondent scores on the first three TRQ factors (1: safe/open patient, 2: available/accepting therapist, and 3: exploration/progress). 11 participants whose responses were used in developing the factors did not have VASQs. Their factor scores did not differ from the those who did have VASQs, so it was not felt necessary to re-run the factor analysis in order to compare factor scores between VASQ
rating groups. Since TRQ factor scores were reasonably normally distributed in each of the VASQ rating groups 1 and 2, t-tests were used to compare the TRQ factor score means (Table 9-2). There were no statistically significant differences on factor scores between VASQ groups.

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>S.D.</th>
<th>t</th>
<th>df</th>
<th>Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Factor 1 (safe/open patient)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VASQ1</td>
<td>0.246</td>
<td>1.003</td>
<td>1.366</td>
<td>95.000</td>
<td>0.175</td>
</tr>
<tr>
<td>VASQ2</td>
<td>-0.052</td>
<td>1.005</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 2 (available/ accepting clinician)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VASQ1</td>
<td>0.160</td>
<td>0.985</td>
<td>0.950</td>
<td>95.000</td>
<td>0.344</td>
</tr>
<tr>
<td>VASQ2</td>
<td>-0.049</td>
<td>1.017</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 3 (exploration/ progress)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VASQ1</td>
<td>-0.117</td>
<td>1.273</td>
<td>0.910</td>
<td>95.000</td>
<td>0.365</td>
</tr>
<tr>
<td>VASQ2</td>
<td>0.086</td>
<td>0.887</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 9-2. TRQ-patient factor scores compared to VASQ scores.

9.4 Discussion

The aim of this chapter was to present the development of a measure to be used for predicting which treatment relationships are likely to end in drop-out. The TRQ proposes to do this by measuring the quality of the therapy relationship in terms of the earliest stage of trust-building and establishment of attachment in the therapy relationship.

Questionnaire development. The development of the TRQ was governed by theoretical as well as practical concerns. Past research and in-depth interviews with patients and clinicians informed the content and temporal structure of the questionnaire. Strengths of the TRQ design are considered to include:

1. Gathering data from both patients and clinicians in order to improve prediction and to obviate the need for inferring the state of mind of either member of the treatment dyad

2. Collecting data across assessment and the early treatment sessions in order to catch all therapy participants and to enable the tracing of ‘vectors’ in the development of the treatment relationship, which is likely to change over time as the patient becomes familiar with the therapist and therapy (Horvath & Luborsky, 1993) and the therapist gets to know the patient.
TRQ-patient item factor and hierarchical cluster analysis. Results of exploratory analyses of the TRQ data gathered at assessment indicate that the TRQ-patient may comprise 3 main factors or item clusters, which correspond with attachment concepts. These are:

1. Patient’s view of herself as safe and able to be open with the clinician.
2. Patient’s view of the clinician as accepting of and available to her.
3. Patient’s sense of progress and exploration.

The robustness of these groupings is supported by the fact that two methods of analysis employing different techniques (factor analysis and hierarchical cluster analysis) arrived at similar results. These analyses will be repeated on subsequent TRQ data sets from in-therapy dyads to confirm whether this factor structure is apparent at later time points as well. Participant scores on these factors will also be tested for their ability to predict dropping out.

The relationship between these factors, which are viewed in the therapy context as ‘states’, and the VASQ scores, which are viewed as ‘traits’, will be further explored as data from the in-therapy TRQs become available. Preliminary analyses indicate that the TRQ and the VASQ do not simply measure the same patient traits. Interestingly, participant scores on Factor 1 (safe/open patient) tend to be higher for the group rated 1 (standard secure) on the VASQ, though the difference is not significant. It would be expected that the patient’s (and the therapist’s) background characteristics would influence their impression of the clinician most strongly in the initial meeting, before current relationship dynamics came to bear. Therefore, this trend would be expected to diminish in TRQs from later time periods. It will also be interesting to see whether using the TRQ and the VASQ together to predict dropping out will be more successful than using either alone.

TRQ-clinician item analysis. The clinician items showed less variability than the patient items, and were highly correlated with each other and not with patient items (except for the question asking ‘Do you feel that a trusting relationship is developing with this patient?’, which will be discussed below). This may be due to structural issues related to the TRQ-clinician, such as its having fewer items, or to the clinicians being less inclined to take a negative view of the relationship with the patient. This latter possibility may be due to the social dynamics of the assessment situation, where the assessor is
perceived as directing the meeting, or to the role of the assessor as a ‘believer’ in the utility of psychological treatment. Assessors may also be more likely to second-guess the purpose behind a question and so to ‘fake good’.

The mismatch may also reveal that assessors do not have access to the same information about the relationship that the patients do, since patients may be playing a ‘polite patient’ role that does not permit assessors to see how they are feeling. Horvath (1994b) made a similar supposition in light of client-therapist mismatches on a therapy alliance measure:

[It is] conceivable that clients form a judgement ... immediately after treatment begins, and this judgement may exert a strong influence on their commitment and willingness to follow the demands of treatment. This early alliance, however, may be quite opaque to the therapist, who does not have access to information as to the degree of commitment and collaboration until the therapeutic situation offers an opportunity to test these qualities (p. 267).

The authors do not speculate extensively on which factors influence this judgement.

It is also possible that assessors may be attending to different cues about the quality of the relationship, or placing judgements in a different time-frame than patients are. In one study on patients’ and therapists’ views of treatment, therapists were found to view the process in ‘macroanalytic’ way, attending to the overall progress of the treatment, while patients were found to focus on their feelings session-to-session, termed a ‘microanalytic’ view (Baer, Dunbar, Hamilton, & Beutler, 1980). Further exploration of the in-therapy TRQs is needed.

As for the larger, predictive purpose of the TRQ, the contribution of clinician items to predicting dropping out may be dominated by the ‘trusting relationship’ item. This item is related linearly with the main TRQ-patient factors. There may be a couple of plausible explanations for this finding.

1. The wording of the question itself may be less threatening to clinicians and so may allow them to answer in a more flexible way. The potential ‘defensive’ effect of asking questions which might be viewed as indictments of the clinician’s skill had been considered when constructing the clinician items, but nevertheless asking about the ease with which they understand a patient, the difficulty experienced in establishing a meaningful connection with a patient, or feeling comfortable with a patient may have been perceived as points of skill and training. Asking about a ‘feeling’ may not have evoked these associations.
2. The explicit focus of the question on the relationship with the patient may have directed clinicians’ attention to data more similar to those patients attend to. In the same way, asking about trust may tap into the attachment issues that patients experience in the therapeutic relationship.

This item will be used in predictive analyses of dropping out. If it contributes, it could be useful for clinicians explicitly to focus on the fostering trust in the early assessment and therapy sessions.

**Patient Q-mode clusters.** The non-hierarchical clustering of patients into two groups corresponded with high and low total scores on the assessment TRQ-patient. This may indicate that patients are generally positive about the emerging relationship or generally negative about it. This simple result is curious, given that the non-hierarchical procedure simultaneously observes all of the data in n-dimensional space, searching for coherent profiles rather than high or low scores as such. The cluster results are influenced by the initial choice of seed points for each item (which SPSS divided into higher scores for Cluster 1 and lower scores for Cluster 2), but they are not determined by these initial choices, and different seed-selection orders were forced in initial analyses.

In the few cases where a split did occur, and some factors were positive and others were negative, the qualitative information given by the patient provided an explanation. In one case, where the Factors 1 (safe-open patient) and 2 (available-accessible therapist) were high, but Factor 3 (exploration/progress) was low, the patient wrote: ‘My assessor … listened well and took lots of notes. I would see him again. I have doubts, not about people personally, but about help available. I suppose I fear ‘trusting’ and being ‘let down’ [by the system]. It hasn’t worked before.’ Thus her qualitative data provided a good explanation for the unusual distribution of her responses. Such factor splits were very unusual, though. It is interesting that patients in these outlying cases felt further explanation was necessary. Perhaps they had a sense that their reactions were in some way atypical.

**Future analyses.** The proportion of patients in Clusters 1 & 2 (about 1-2) corresponds to the proportion of drop-outs to remainers in many ED treatment centres (see Chapter 3), though as ever this depends on the way that dropping out is defined. The utility of these clusters for predicting drop-out will be determined as engagement data become available. The clusters may be most useful when generated on data from several time points, as the initial assessment results may alter when the patient starts treatment.
2. The explicit focus of the question on the relationship with the patient may have directed clinicians' attention to data more similar to those patients attend to. In the same way, asking about trust may tap into the attachment issues that patients experience in the therapeutic relationship. This item will be used in predictive analyses of dropping out. If it contributes, it could be useful for clinicians explicitly to focus on the fostering trust in the early assessment and therapy sessions.

**Patient O-mode clusters.** The non-hierarchical clustering of patients into two groups corresponded with high and low total scores on the assessment TRQ-patient. This may indicate that patients are generally positive about the emerging relationship or generally negative about it. This simple result is curious, given that the non-hierarchical procedure simultaneously observes all of the data in n-dimensional space, searching for coherent profiles rather than high or low scores as such. The cluster results are influenced by the initial choice of seed points for each item (which SPSS divided into higher scores for Cluster 1 and lower scores for Cluster 2), but they are not determined by these initial choices, and different seed-selection orders were forced in initial analyses.

In the few cases where a split did occur, and some factors were positive and others were negative, the qualitative information given by the patient provided an explanation. In one case, where the Factors 1 (safe-open patient) and 2 (available-accessible therapist) were high, but Factor 3 (exploration/progress) was low, the patient wrote: 'My assessor ... listened well and took lots of notes. I would see him again. I have doubts, not about people personally, but about help available. I suppose I fear ‘trusting’ and being ‘let down’ [by the system]. It hasn’t worked before.’ Thus her qualitative data provided a good explanation for the unusual distribution of her responses. Such factor splits were very unusual, though. It is interesting that patients in these outlying cases felt further explanation was necessary. Perhaps they had a sense that their reactions were in some way atypical.

**Future analyses.** The proportion of patients in Clusters 1 & 2 (about 1-2) corresponds to the proportion of drop-outs to remainers in many ED treatment centres (see Chapter 3), though as ever this depends on the way that dropping out is defined. The utility of these clusters for predicting drop-out will be determined as engagement data become available. The clusters may be most useful when generated on data from several time points, as the initial assessment results may alter when the patient starts treatment.
The patient also 'assesses' the assessor and the therapist, and this is an interactive phenomenon. It will also be important to include clinician responses in the clustering procedure, as particular configurations of patient and clinician responses may be more indicative of dropping out. Of course, once patient engagement status is known, discriminant function analysis will be possible and useful.

Other patient factors. In the interest of simplifying study design, other patient factors, such as symptom severity, and therapist and therapy factors, such as treatment type, are not analysed against the TRQ in this chapter. Treatment type is completely undifferentiated in the assessment stage, on which this chapter focuses. It is unlikely to be differentiated much even after 3 therapy sessions, which subsequent reports will consider. Symptom severity has not been shown to relate to other measures of attachment (Chapters 5, 6, & 7), satisfaction with therapy or therapist (Oei & Shuttlewood, 1999; Pekarik, 1992b), or to the therapeutic alliance (Horvath, 1994b), even though patients with less severe symptoms are considered by clinicians to be the psychotherapy participants most likely to benefit from treatment (Baer et al., 1980). As Horvath (1994b) found:

Clients who have difficulty maintaining social relationships or have poor family relationships prior to the commencement of therapy are less likely to develop strong alliances... Severity of symptoms, on the other hand, appears to have little impact on the ability to develop a good therapeutic relationship (p. 274).

The more important relationship appears to be between attachment-style trait dimensions and the therapeutic relationship.

9.4.1 Limitations

One of the main limitations of this study is the same that has affected other chapters: small sample size. This problem will be ameliorated as more data are gathered. However, the power of therapy studies such as this one will always be limited by the real-world events which limit even the best planned studies.

Until data on the numbers of patients refusing and dropping out of treatment are available, it will remain unclear whether the longer waiting lists which grew during the period of this study confound the ability of the TRQ to predict dropping out. Similarly, it is unclear whether being asked about the therapeutic relationship has had any effect on patient retention.
The reliability of the data is also limited by the ceiling, floor, and between-the-floors effects. Using a 7-point Likert scale with the TRQ may prove more useful in future studies.

### 9.4.2 Conclusions

Initial exploratory analysis of the TRQ shows that it can distinguish groups of patients, and that attachment concepts are useful in understanding the variability within the measure. Since the TRQ could not be compared to other measures whose characteristics have been thoroughly researched – no such instruments exist – or administered in test-retest, assertions about reliability and validity were not considered appropriate. On the other hand, factor analyses, reinforced with cluster analyses, resulted in groups of items whose presumptive validity and homogeneity is considered good. These dimensions must be developed further and strengthened in future research.

If the TRQ does prove able to predict dropping out, clinicians may be able to use it as an early warning signal that the treatment relationship is in danger. Furthermore, attachment concepts may provide a useful framework for clinicians to think about the dynamics occurring in an at-risk relationship. They may also help with direct discussion of issues of establishing trust. Indeed, alliance research has shown that therapists may be able to strengthen the alliance by focusing on the therapy relationship directly (Horvath & Luborsky, 1993), and that discussing the ‘here and now’ relationship with patients can help repair ruptures in that relationship (Safran, Muran, & Wallner Samstag, 1994). But if the TRQ does prove able to distinguish durable relationships, clinicians must be careful to guard the ‘ethical validity’ of the measure by ensuring that it is not used to exclude patients from treatment.

Despite these high hopes for the TRQ, it represents only an early attempt to take a more inclusive approach to predicting dropping out. It is more than likely that dropping out is the product of several variables acting in concert. Interacting components of risk and protection may be particularly important. As one author has observed:

> Prognosis research seems to require a different, more complex mathematical model, and thus a more complex research design, than has been generally used so far. Specifically, the one-stage design, where a predictor is correlated with an outcome measure, would appear to be inadequate in this field.’ (p. 203, Fulkerston, 1961).

Thus a model which assumes that a single factor or set of factors relate to dropping out in a linear way, without mediation by other variables, is unlikely to be sufficient to explain
dropping out. Predicting dropping out will require appropriate statistical methods as well as theoretical grounding. The concluding chapter considers how such a model might appear.
10 CONCLUSIONS

10.1 Introduction and central aims of the thesis

The central aim of the thesis was to deepen the understanding of factors affecting dropping out from psychological treatment using the special case of eating disorders. Critically examining the existing literature on dropping out from psychological treatment and using multiple methods to examine the role of attachment in dropping out have contributed to attaining this goal. These investigations have pointed toward the potential importance of systematically studying the interaction occurring within the therapy dyad, rather than just pre-treatment patient or therapist factors in isolation. However, much work still needs to be done before dropping out can be said to be 'understood'. Only with further inquiry and larger investigations will the development of interventions to reduce dropping out be a realistic possibility.

This chapter will:

1. Summarise and link the main findings from this thesis.
2. Present a summary model of dropping out suggested by these findings.
3. Consider implications for future research, clinical practice, and ethical practice.
4. Conclude with a final summary.

10.2 Summarising and linking main findings

This thesis resembled a bildungs-roman, or 'river story'. One adventure (chapter) led on from another as the author periodically jumped ashore from her raft to explore, then returned to the river (attachment) to travel further, hopefully wiser after each landing. Although she has reached the final chapter in this book, she has not yet reached New Orleans, much less the ocean.\textsuperscript{38} An even sturdier craft will be needed for the rest of the journey.

\textsuperscript{38} If you haven’t read Tom Sawyer (Mark Twain), sorry.
This section recounts the main findings of these explorations. Since many of the limitations are specific to the individual studies and have been discussed within the individual chapters, the focus here will be on the strengths of these studies.

**10.2.1 Chapters 1 & 2: General introduction, background, and literature review**

Chapters 1 & 2 were concerned with evaluating the ways in which dropping out has been studied, the results of these studies, and how study of dropping out might progress.

The terminological, methodological, and epistemological problems associated with defining dropping out were discussed in Chapter 1. It was suggested that these could acceptably be resolved by reserving ‘drop-out’ for those patients who have begun a ‘regular’ (as opposed to a ‘treatment trial’) treatment relationship by attending at least one therapy appointment, but who then leave by their own unilateral decision. In order to determine who has made the decision to end treatment, it was further suggested that both patients and therapists be consulted about the appropriateness of the ending.

Ideally the amount of treatment received would be recorded as a proportion of the amount considered necessary for lasting change to occur. However, given the lack of information about how much of the myriad of treatments is required to produce change, and indeed how ‘change’ itself should be defined, it was suggested that at minimum the way in which dropping out is defined should be recorded alongside information about the type of therapy offered.

In Chapter 2, through a critical analysis of the existing research on dropping out, an interaction or relationship-based model of dropping out was proposed as a potentially productive research approach. Reviewing the methods and results of existing drop-out investigations was organised according to the three main foci of models for dropping out: the patient, the therapist, and the treatment characteristics. Patient and therapist interpersonal factors emerged as the most consistently related to dropping out. However, none of these methods on its own was entirely satisfactory, perhaps because the models of dropping out were too narrow. It was suggested that instead of attempting to identify potential drop-outs in order to exclude them from treatment, efforts might better be spent on trying to understand the mechanisms governing dropping out in order to improve techniques for encouraging engagement. Such research would require a sound theoretical formulation as well as methodological flexibility.

**10.2.2 Chapter 3: Dropping out from psychological treatment for ED**
Chapter 3 delineated the drop-out problem in the specific situation of psychological treatment for eating disorders. Median drop-out rates for BN range from around 20% to 30%, and for AN they are thought to be higher, at least for inpatient treatment. While engaging these often ambivalent groups is evidently difficult, the severity and characteristics of EDs themselves do not appear to be related to dropping out. Some interpersonal-type variables appear to have the strongest relationship to dropping out. These observations are consistent with findings in the general literature review (Chapter 2), and add credence to using a relationship-based model for studying dropping out from treatment in the ED field.

Studying dropping out from treatment for eating disorders is particularly relevant because the field is both so new and so well documented, particularly in the case of psychological treatment for BN. Understanding dropping out may have future implications for the development of effective treatments and appropriate diagnoses. However, despite the high rates of dropping out from ED treatments, studying dropping out in this field will always be restricted by the by small numbers of ED patients. This restriction underscores the need to cast a broad research net by using multiple methods.

10.2.3 Chapter 4: Theoretical and methodological foundations

Chapter 4 further discussed the benefits of using multiple methods for studying dropping out in terms of the objectives of each of the studies in Part 2. Methodological flexibility allows the researcher to construct a more rounded and convincing analysis of dropping out through two mechanisms: (1) enabling ‘triangulation’ on factors relating to dropping out while (2) reducing the interference of the researcher into the therapeutic relationship as various aspects of the theoretical formulation are explored.

Research using multiple methods needs to be organised by theory. The theoretical foundation of the thesis, attachment theory, was introduced. Attachment theory covers a number of areas. This can pose a problem when trying to test attachment concepts, since not all areas have been covered by measurement tools. On the other hand, the flexibility of attachment concepts can provide great heuristic power, which is critical at this stage of investigating dropping out. Two attachment constructs relevant to studying dropping out were identified: (1) attachment as a trait-like ‘style’ and (2) attachment as a property of a relationship dyad. The tool which was chosen for measuring the trait-like aspects, the VASQ, was introduced, and the need for developing a dyad tool was discussed.
10.2.4 Chapters 5 & 6

These studies supplied the first investigations of attachment theory as a framework for studying dropping out. They used a non-intrusive, quantitative, case-note analysis method. Attachment was operationalised through broad markers of childhood loss or traumatic experience, namely parental break-up, death, and childhood sexual and physical abuse.

In both studies, these experiences had an additive effect on dropping out, with those experiencing two or more categories of events being more likely to drop out. In multivariate analysis, parental break-up was also replicated as a predictor of dropping out. Since not all patients who had experienced loss and trauma in childhood dropped out of treatment, it was hypothesised that adult attachment style might be acting as a mediator. Early experiences might affect the ability to form supportive attachment relationships in childhood, which might influence adult attachment style, which might in turn affect the ability to make and maintain close, confiding therapeutic relationships.

The loss and trauma variables investigated in these studies had not typically been considered in drop-out research. For example, childhood experience of sexual abuse has usually only been investigated in research on dropping out from treatment for sexual abuse, and so was construed as an isolated marker of patient severity rather than as an aspect of attachment-related experience (e.g., Mogge, 2000). It is considered an advance to look at these variables as an index of experiences which might affect attachment style, and by extension, the patient’s attitudes toward establishing a close, confiding therapy relationship.

In keeping with results from the general and ED literature reviews, none of the other demographic, clinical, or historical variables considered had a consistent relationship with dropping out.

10.2.5 Chapter 7

In order to pursue the lead supplied by Chapters 5 & 6, Chapter 7 investigated the ability of patients’ trait-like adult attachment style dimensions to distinguish drop-outs from other treatment status groups. This study used a prospective, patient-series, questionnaire-based design.

Attachment dimensions were assessed as pre-treatment patient characteristics. Such characteristics have been shown in the general literature to be poor at distinguishing
drop-outs from other treatment groups; however, this method was used because the patient’s trait-like attachment style theoretically could affect the establishment a treatment relationship. (Similarly, the therapist’s attachment style could affect the relationship; however, it was not possible to assess therapists’ styles because of ethical/political considerations.)

The measure selected for this study (the VASQ) had several advantages:

1. It assessed all close, confiding attachment relationships, not just romantic ones. Such ‘role independence’ is particularly important in this patient group, since many ED patients may not have experienced romantic relationships.

2. It was designed for and validated in a population at risk for psychiatric disorder, rather than a college or university population.

3. It was keyed into the severity of attitudes toward attachment, rather than just descriptions of different subcategories of attachment. These subcategories, while heuristically interesting, have not been shown to be stable.

4. It provided for categorical as well as dimensional scoring and used cluster analysis to discern ‘standard’ secure and ‘non-standard’ insecure groups.

5. It was derived from a widely used and well-validated interview measure, so all items were tested before being formulated in self-report format.

In this small sample, drop-outs were no more likely than other treatment groups to be rated overall on the VASQ as ‘standard’ secure or ‘non-standard’ insecure. It is unclear whether this result indicates that drop-outs are not in fact different from the other groups on pre-treatment attachment dimensions or whether (1) the small sample size compromised too much statistical power to detect actual differences or (2) the established scoring system was inappropriate for trying to distinguish differences in ability to establish close, confiding therapeutic relationships.

Following the latter point, the VASQ responses given by a sample of eating-disordered patients were factor-analysed, yielding four main factors: (1) Comfort with dependency, (2) Mistrust of others/Anger in relationships, (3) Ease with making relationships, and (4) Fear in relationships. Drop-outs and other treatment status groups did not differ on subscales developed from these factors, though sample size restrictions restrict the interpretation of this result.
In Chapters 5, 6, & 7 self-reported and clinician-rated ED symptoms were not found to be related to dropping out. Self-reported ED symptoms were not related to VASQ overall rating or derived functions.

10.2.6 Chapter 8: Patients' views of early engagement and drop-out

Even if pre-treatment attachment style dimensions were able reliably to distinguish eventual drop-outs from other treatment groups, this information would be of limited use without understanding how drop-outs perceive establishing the treatment relationship and whether their perceptions differ from other groups. Chapter 8 aimed to learn more about these perceptions using a qualitative method based on open-ended, in-depth interviews.

Chapter 8 also had a more practical purpose: the amount of variance explained by the LR models in Chapters 5 & 6 was small, so evidently many factors other than those considered in these models affect dropping out. Furthermore, results from the VASQ analyses in Chapter 7 indicated that patient attachment dimensions, at least as given pre-treatment by self-report, did not distinguish drop-outs from other treatment status groups. Thus Chapter 8 aimed to see whether other important factors would be raised by those who had dropped out.

Establishing a secure attachment to the therapist proved to play a critical role in engagement, according to the accounts of the 26 women interviewed. In presenting the results, Chapter 8 moved on to construing attachment as a state-like property of a relationship, not just as a pre-existing patient trait. ‘Good’ treatment relationships were characterised by the establishment of a secure base with the therapist, who was perceived as accessible and able to provide attuned support, and who encouraged exploration and growth in the patient. The establishment of a secure base did not occur in ‘bad’ treatment relationships, where therapists were perceived as inaccessible or rejecting. Instead of feeling encouraged to take risks and explore, patients withdrew from these relationships either physically or mentally.39

Whether a relationship was perceived as ‘good’ or ‘bad’ did not appear to be determined by the trait-like characteristics of the respondents. Although this judgement is based on subjective impression rather than on objective evidence (the respondents, for

39 It was unexpected that even some patients who completed treatment considered their treatments to have been ‘bad’. In an important sense, they were drop-outs, because they withdrew mentally from the treatment situation.
example, were not asked to complete the VASQ), some pseudo-objective evidence can be marshalled to support it:

1. During the interviews, perceptions of and experiences in other supportive relationships were asked about. Those who had dropped out of treatment did not appear to be any more or less likely to have dropped out of treatment previously or to express ‘non-standard’ insecure attitudes toward informal attachment relationships.

2. Three respondents with different trait-like attachment styles as assessed by these interviews all discussed similar ‘bad’ experiences with the same therapist, who did seem to act in a potentially punitive way. Several other therapists, who seemed particularly successful at creating a secure base, were able to engage people with seemingly diverse trait-like attachment styles. In another case, the therapist succeeded in establishing a secure base with one patient (who seemed relatively ‘standard’ secure herself), but not with another two, one of whose trait-like attachment style appeared to be ‘non-standard’ insecure.

Thus from anecdotal evidence it appears that an interactive attachment model is most appropriate for understanding the establishment of treatment relationships. When the therapist is particularly good or bad at establishing a secure base, the patient’s trait-like attachment style may have less impact on the durability of the relationship, and when the therapist is more average, the patient’s own style may have more influence. This model will be schematically presented in the next section.

The method followed in the interviews was felt to have encouraged more complete responses from participants than many previous studies asking about reasons for dropping out of treatment:

1. Efforts were made to counteract the demand effects which appear to have been present in previous interview and questionnaire studies of patient reasons for leaving treatment.
   - The interviewer was independent of the clinical team and the interview was arranged via the university department rather than the clinic, so participants’ concerns about being judged for their dropping out were hopefully reduced. Furthermore, this dynamic reduced the likelihood that participants would
play the 'polite' patient and give only socially acceptable reasons for leaving.

- The participant determined the location of the interview, which was intended to reduce the power differential between interviewer and participant.
- The interview approach was open-ended, so the participant determined the content of the interview and was able to expand on any areas she felt were important. Thus topics were not restricted to those that researchers or clinicians felt might be most important.

2. While all reports about treatment relationships were retrospective, attempts were made to control for self-justificatory biases by adopting an interview style which encouraged participants to remember contextual details of their experiences while in treatment.

Another strength of the study is that its participants were 'theoretically' sampled, so the study included not only drop-outs but also those who had completed and were engaged in treatment. As a result, the reasons given by drop-outs could be compared to those given by patients in other treatment groups.

This chapter changed the focus of the investigation from intra-personal to inter-personal. More important than the patients' own attachment style and experiences was the manner in which the difficult attachment issues inherent in the early treatment situation were handled by the patient and the therapist. The measure described in Chapter 9 was a first attempt at operationalising this interaction in a therapeutic relationship.

10.2.7 Chapter 9: The development and initial analysis of the Therapy Relationship Questionnaire

Finally, Chapter 9 aimed to translate the findings from Chapter 8 into a testable form which might be used for predicting dropping out. It presented the development and initial analysis of a tool intended to measure the attachment features of the developing therapy dyad, in this case in eating disorders (the TRQ). Thus, the TRQ was based on the construct of attachment as a state-like property of a relationship.

The Therapy Relationship Questionnaire (TRQ) was designed to use the views of both patients and therapists over several time points to characterise the developing treatment relationship. It has several strengths:
1. It includes the views of both the patient and therapist as sources of data. Results from the preceding chapters indicated that looking at both members of the dyad might be useful in understanding dropping out. Furthermore, past research has shown that including both members also improves prediction of dropping out (e.g., Fraps et al., 1982), perhaps because inferring the state of mind of the other member of the dyad is not required.

2. At least in this first version of the TRQ, data is gathered over several time points: assessment and the first three therapy sessions. This means that at least some information will be gained on all treatment relationships, even those that end in dropping out. It also means that both members of the dyad have several opportunities to record their changing impressions of the relationships to give a 'truer' picture of their feelings. Participants in the interviews in Chapter 8 indicated that by the second or third session they knew whether the relationship was going to be helpful for them. Other research indicates that the first three sessions are a critical period (e.g., Saltzman et al., 1976). Having data over several time points will also allow the vector of the developing relationship to be calculated.

3. The content of the tools and the wording of the items were drawn from interviews with members of the target groups: the TRQ-patient from interviews with past and current patients, including those who dropped out; and the TRQ-clinician from interviews with clinicians.

Following description of the content and structure of the TRQ, data from the first of these time points (assessment) were explored with factor and hierarchical cluster analyses. Initially factor and cluster analyses were performed with clinician and patient data entered together, thus treating the dyad as the unit of measurement. Clinician data were separated from patient data, however, since they formed independent factors and clusters. The initial patient item groupings corresponded with attachment concepts:

1. Patient's view of herself as safe and able to be open with the clinician.
2. Patient's view of the clinician as accepting of and available to her.

The robustness of these groupings was substantiated by the fact that two methods of data analysis using different techniques arrived at similar results.
Interestingly, the TRQ-clinician item, ‘Do you feel that a trusting relationship is developing with this patient?’, was the only clinician item related to the patient items. It is interesting that this item showed a positive linear relationship with patient items, even when other clinician items showed little variability. It may be that the wording of the item allowed clinicians to answer this item in a more flexible way, since it was not focused on areas relevant to therapeutic skills. Or it may be that explicitly directing the clinicians’ attention to feelings about trust focused them on cues more similar to those used by patients in thinking about the relationship. In any event, this result points to the potential usefulness of attachment theory as an heuristic for looking at variability in the early treatment relationship.

Importantly, initial comparisons of patients’ scores on the TRQ groupings with their VASQ scores indicate that these within-treatment attachment measurements are not simply redundant with pre-treatment attachment style trait measurements. This lends credence to the concept that an interactional attachment model may be appropriate to understanding the early stages of establishing treatment relationships. However, all of these initial analyses need to be repeated with larger data sets and on later TRQ time points. Most interestingly, when treatment status data are available, these dimensions can be tested for their ability to predict dropping out.

### 10.3 Summary model of dropping out

From the findings in this thesis, a summary model of dropping out has been constructed. It is intended as a summary of findings regarding factors affecting dropping out and the use of attachment theory as a framework for understanding them.

At heart, this model illustrates the interactional nature of dropping out. The majority of dropping out is thought to result from events, feelings and perceptions that occur within the treatment relationship, rather than from a pre-determined patient propensity for dropping out. Attachment theory is useful for understanding the nature of these feelings and through what lens events might be perceived. Attachment functions on many levels during the establishment of a psychological treatment relationship:  

1. Psychiatically ill patients may be less likely to have formed secure attachments in the past (Bowlby, 1977), and so may find the prospect of a close, confiding relationship unfamiliar or threatening. (Patient’s trait). 

10-267
2. Attachment behaviours are likely to be heightened in the patient seeking help for psychiatric disorder because the internal and external safety of the psychiatrically ill person may be compromised by the illness (Adshead, 1998). (Patient's state).

3. By admitting to having a problem and by revealing herself to a stranger, the patient is risking exposure and further compromise of safety. Thus the premise of the therapy relationship may increase importance of attachment issues for the patient at the beginning of treatment. (Patient's state).

4. As a function of her own ability to make and maintain relationships, the therapist may be more or less sensitive to the attachment needs of the patient. (Therapist's trait, but usually not measured).

5. The therapist may respond to the patient in a positive, attuned manner, thus allowing for the development of a secure base even with a patient who has an insecure attachment style. Or the therapist may be put off by the patient's behaviour or may be preoccupied with the demands of the therapy protocol and may respond in a rejecting or mechanistic manner, thus making the establishment of a secure base difficult even in patients who have a secure attachment style. (Therapist's state).

It might be useful to think about dropping out in terms of attachment factors increasing or decreasing risk of dropping out.

This model summarises the thesis as follows:

Focusing on the patient side, Chapters 5 & 6 indicated that having witnessed parental break-up or having experienced trauma in childhood serve as vulnerability factors for dropping out from psychotherapeutic treatment relationships for eating disorders. It was hypothesised that these events affected engaging in treatment via insecure attachment style. Chapter 7 further explored this hypothesis using one measure of adult attachment style. Differences between drop-outs and engagers were not apparent in this small sample; further data will be required to reach firm conclusions about the role of pre-existing adult attachment style in dropping out. It can be concluded though that any differences on pre-treatment attachment factors between drop-outs and engagers are not dramatic. Studying the interaction between patient and therapist might prove to be more productive.
The large amount of variability in dropping out not explained by patients' relationship history indicated that the model was unlikely to be simple. Analysing the in-depth interviews showed that drop-outs and engagers were distinguished by their perceptions of therapists' attitudes and behaviours in terms of the ability to provide a secure base and to encourage progress and exploration. These perceptions seemed to be grounded in real events which could not be easily explained away by the personalities or attachment styles of the participants. Thus the model needed to include protective factors against dropping out, principally the ability of the therapist to provide a secure base.

Chapter 9 presented a tool which is intended to measure the interaction between patient and therapist in terms of the development of a secure base and the encouragement of exploration. On a simple protection/vulnerability level, the TRQ may serve either role: Having a particularly positive therapy relationship may protect even those patients who are vulnerable to dropping out from doing so. Having a particularly negative therapy relationship may make even those who are not particularly vulnerable leave. Having an 'average' relationship may result in those who are more vulnerable leaving and those who are less vulnerable staying.

On a more complicated and at this point hypothetical level, the direction of the vector of the developing relationship may also prove relevant to understanding dropping out. For example, relationships which start out being very positive but decline may be more likely to end in dropping out. Furthermore, the level of agreement between the patient and clinician perspectives may also be important. Greater agreement between patient and therapist (particularly about the relationship being positive, but potentially also about it being negative) may indicate a more durable relationship. However, investigating these ideas awaits later analyses.
Interactive model of dropping out with attachment theory as framework

Attachment: Trait → State → Dyad

(Chapters 5 & 6)
Attachment experiences:
Parental break-up, childhood abuse

(Chapter 7)
Attachment style dimensions:
Insecure possible

(Chapter 8)
Attachment heightened:
Psychiatric illness

(Chapter 8)
Attachment heightened:
Seeking help

Therapist traits:
Attachment style
Therapeutic skill

Therapist response to patient attachment concerns:
1. Attuned 2. Not attuned

1. For Attuned response: Pull arrow.
Patient met by therapist
Therapist perceived as rejecting.
No trust in dyad
Negative TRQ
10.4 Implications for future research

10.4.1 Research motivations and methods

As an initial step to advancing research on dropping out, methodology could be revised from the fundamentals, starting with why such research might be carried out. Curiosity about factors affecting this phenomenon is important, but producing results that would be clinically useful would give a real reward. The concept of what constitutes a clinically useful research finding in the field also has to be altered. Currently clinical utility implies identifying pre-treatment predictors of drop out that could be used simply to exclude predicted drop-outs from treatment or to target special efforts at them. The predictors considered usually are not liable to clinical intervention, either for practical or ethical reasons (Duehn & Proctor, 1977). A more viable concept of clinically useful results would be modelling the processes which affect dropping out so that clinicians can monitor the progress of the relationship, adjust their own behaviour, and potentially reduce dropping out. This thesis is one attempt in this direction.

Methods used for drop-out research also need revision. Ideally, study design would be seamless. Conceptualisation of dropping out, hypotheses, data gathering and statistical approaches to analysis would be logically connected.

1. Conceptualisation: The research which has held the most promise has construed dropping out as the result of an interpersonal process. Both patient and therapist pre-treatment characteristics are important, but only in the way that they manifest themselves in the context of the interpersonal process of engagement. Furthermore, at this stage in our understanding of treatment engagement, comprehensive measurement of the static variables associated with variation in treatment relationships would seem practically impossible. There are hundreds of different types of therapies (Garfield, 1994), and therapists have a wide range of training types and expectations of their work. Similarly, there is a range of ways that people become patients. However, the therapy relationship is the principle which underlies these variations, so taking dynamic measurements of it is likely to be more useful to understanding the process of ‘un-becoming’ a patient than taking measurements of static factors
or even assessing interactions between static factors (Fiester, 1977; Saltzman et al., 1976).

2. Hypotheses: Drop-out research, like much psychological research, has seen a shift in more recent years toward pragmatic studies without a priori hypotheses (Dar et al., 1994). However, the statistical tests which have most commonly been used are based on the testing of a priori hypotheses (Altman, Gore, Gardner, & Pocock, 1983). Therefore results from many of these studies are difficult to interpret. It would be preferable to conduct explicitly exploratory drop-out studies which could generate sound, testable hypotheses.

3. Data gathering: Operationalisation of concepts extends to data gathering methods. In other words, when and how data are gathered determines their meaning. Measuring the interpersonal process, for example, would require data collection at frequent intervals. In studying dropping out, it appears to be important to chose variables that appear within the treatment situation.

4. Statistical analyses: Analyses ultimately need to allow for interaction of patient and therapist characteristics in a dynamic way over time. Process variables can be analysed as they develop over time. One outcome researcher has pointed out that it is anomalous in clinical research to make predictions from a single predictor to a single criterion: ‘Clinically, we never rely on one predictor. A more desirable approach would be to use multiple predictors, moreover, to use them in a multivariate form and in ways which facilitate the discovery of non-linear and configural relationships’ (Chone 1968 cited in Luborsky et al., 1971). Furthermore, the use of interaction variables would allow evaluation of differential criterion effects in different groups of patients. (Luborsky et al., 1971). The techniques would need to be truly multivariate. In some existing studies, analyses which purport to be multivariate rely on univariate techniques for determining relationship with dropping out (e.g., Fiester & Rudestam, 1975). This is a critical distinction, because even with corrections made for multiple comparisons, these analyses are not testing variables acting together. Therefore the problem with these tests is not just about Type One or Two errors, it is about missing the very mechanism which is at work.
To progress in the future, the study of dropping out ideally will look beyond prediction of dropping out within one clinic or field toward comprehension of the larger mechanisms affecting dropping out, and then ultimately toward improving mechanisms for engagement. This undoubtedly will be a complicated process, but being able to provide treatment for more people more effectively and efficiently merits the effort.

10.4.2 Other areas of interest

The current research has also emphasised the complexity and importance of another aspect of establishing treatment relationships: understanding filters on the pathway to care, or how a person ‘becomes’ a patient. Of particular interest are those potential patients who are either referred for psychological treatment but refuse even a first assessment appointment or those who attend assessment but then opt not to take up treatment.

The interviews discussed in Chapter 8 indicate that complex attachment-related issues may also apply to assessment- and treatment-refusal. For example, several participants discussed anxieties about fitting into the categories that were ‘accepted’ by the eating disorders clinic, either because their symptoms did not precisely fit the DSM-IV criteria for eating disorder (and many knew these off by heart), or because they felt that their eating problems were secondary to their ‘real’ problems, which would not be addressed by an eating disorders clinic. They feared that ‘discovery’ would result in their rejection from the clinic. In one case, such fears stopped the woman even coming for assessment. Others feared that they would be rejected if they engaged and their symptoms started to improve. Learning more about these perceptions could allow formal treatment facilities to modify their practices and perhaps equally importantly their public relations.

10.5 Implications for clinical practice

Understanding early engagement and drop-out in terms of attachment theory could have implications for the clinician’s behaviour in the early sessions of therapy, whether the clinician were working within a public setting such as the National Health Service or a private setting.

Attachment theory and the model developed in this thesis would posit that the most important step in engaging the patient would be establishing a secure base for the patient.
This may need to occur before the therapist focuses on the exercises and goals of treatment. It might sometimes be the case that the therapist’s concern for the patient is overshadowed by her concern about following correct procedures of therapy. The initial TRQ analyses indicated that therapists may be only partly aware of how patients feel in early sessions, perhaps because they are attending to different cues about how the relationship is going. The interviews discussed in Chapter 8 indicated that this might indeed sometimes be the case:

*It's been nice talking to you ... it's a lot carrying all by yourself. You think, it's your fault, you've done this to yourself, nobody else has done it to you, but it's still nice to be able to share it with someone who's not going to go, Oh you've gotta do this, and you've gotta do that. Like, you're an outsider looking in, with you being trained in all that, you can see all angles, which is nice. [Treatment is] like you've gotta do this, you've gotta do that, you just think, Oh, I just want you to listen! For now, just listen to me.*

Sylvia (drop-out)

Using attachment theory to understand factors affecting early engagement may also make establishing a secure base easier. It would indicate that an important first element in establishing the secure base would be recognising that the new patient is potentially under threat from many sources, including coming to therapy itself:

*It's frightening when you think you've got to go into a room with a professional and you are there to discuss that problem. It is for me cause I don't like to admit that I'm a failure. That I have got a problem. It's threatening cause you have to say things, you have to tell them what's wrong.*

Jill (treatment refuser)

The new patient is therefore in a bind. Attachment theory would posit that a person under such threat would retreat to her secure base. Paradoxically, though, the secure base for a new patient is meant to be the threatening therapist. While stress is theorised to lead to an enhancement of attachment behaviour even when the source of stress is the attachment figure itself (Holmes, 1993), in therapeutic relationships the therapist has not in practice been established as the attachment figure. Thus there is enhanced attachment behaviour but no clear secure base to retreat to. This can be difficult for patients to negotiate.

*(It sounds like it was brave to talk to a stranger.)*

*Who I didn't know from Adam! Yes! I think it was only I so desperately needed to get better that I came back. I think I knew that was the only way I was going to be able to get better.*

Sarah (engaged)
When the therapist is sensitive to this situation, security can be fostered and engagement can be enhanced. In Sarah’s case, the therapist she was allocated was a man, which made her anxious. However, at her second appointment, he sensed her discomfort and raised the issue for discussion, which provided her with an opportunity to discuss her fears. After this, she felt safe with him and engaged. When the patient and therapist are unable to negotiate this situation, the relationship may end in dropping out.\textsuperscript{40}

Preliminary results from the TRQ also indicated that focusing on whether a trusting relationship is being established may give clinicians a window into how the patient perceives the relationship. The TRQ could be used to give clinicians an early insight into the patient’s view of the relationship, and an early warning of developing problems.

\section*{10.6 Ethical Implications}

Alongside learning to identify which treatment relationships are at risk of ending in early drop-out will ideally come new understanding of ways to enhance engagement. It is hoped that this research will lead to efforts by therapists to adjust their practice in order to engage – rather than to exclude – more patients. Such adjustments are likely if research can change the overall ‘image’ of dropping out from being the pre-determined behaviour of a subset of patients to being the product of early interactions between therapist and patient. Ethically, adjustments of therapist behaviour would be the only acceptable outcome of learning to reliably identify dropping out before it happens. This may be especially true if high ‘protection’ provided by a secure early treatment relationship proves to have more influence on engagement than pre-treatment vulnerability. Indeed, as Bordin (1994) has pointed out in the therapeutic alliance field, the influence of pre-treatment patient factors should be viewed as valid goals for therapy, rather than determinants of the relationship.

\textsuperscript{40} Of course, not every participant seemed to experience these early barriers to trusting and confiding in the therapist. For some, the professional was the only one they would talk to. However, in this small sample, the people who had no difficulty confiding in the therapist did not drop out.

\textit{(When you said you don't want anybody to find out, is that you don't want to tell a therapist or you don't want...)}

\textit{Oh, no, no, I'd tell the therapist. That doesn't bother me, once you're in here, you're away from your other world, aren't you, sort of thing? So it doesn't matter what you say here. It's my friends and family and people that I work with that I wouldn't want to know.}

Rebecca
10.7 Final summary

Using multiple research methods organised according to an attachment-theoretical framework, this thesis has made some progress toward understanding factors affecting dropping out from psychological treatment, at least in the field of eating disorder. The main contribution of the thesis is thought to be the conceptualisation of dropping out as the product of events, feelings, and perceptions that occur within the early treatment relationship, rather than as the result of a pre-patient propensity for dropping out. The studies presented here have indicated that systematically studying the treatment dyad may be the most productive way forward.
References


de Haas, M. A., Bakermans Kranenburg, M. J., & van IJzendoorn, M. H. (1994). The Adult Attachment Interview and questionnaires for attachment style,


Appendix 3-1

ICD-10 (WHO, 1992) Diagnostic Criteria for Bulimia Nervosa

For a definite diagnosis, all of the following are required:

A. There is a persistent preoccupation with eating, and an irresistible craving for food; the patient succumbs to episodes of overeating in which large amounts of food are consumed in short periods of time.

B. The patient attempts to counteract the 'fattening' effects of food by one or more of the following: self-induced vomiting; purgative abuse; alternating periods of starvation; use of drugs such as appetite suppressants, thyroid preparations or diuretics. When bulimia occurs in diabetic patients they may choose to neglect their insulin treatment.

C. The psychopathology consists of a morbid dread of fatness and the patient sets herself or himself a sharply defined weight threshold, well below the premorbid weight that constitutes the optimum or healthy weight in the opinion of the physician. There is often, but not always, a history of an earlier episode of anorexia nervosa, the interval between the two disorders ranging from a few months to several years. This earlier episode may have been fully expressed, or may have assumed a minor cryptic form with a moderate loss of weight and/or transient phase of amenorrhoea.
DSM-IV (APA, 1994) Diagnostic Criteria for Bulimia Nervosa

A. Recurrent episodes of binge eating. An episode of binge eating is characterised by both of the following:
   1. Eating, in a discrete period of time (e.g., within any two-hour period) an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
   2. A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting, or excessive exercise.

C. The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during periods of anorexia nervosa.

Specify type:

Purging type: During the current episode of BN, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.

Non-purging type: During the current episode of BN, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics or enemas.
DSM-IV (APA, 1994) Diagnostic Criteria for Anorexia Nervosa

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of current low body weight.

D. In post-menarcheal females, amenorrhoea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhoea if her periods occur only following hormone, e.g., oestrogen, administration.)

Specify type:
Restricting type: During the current episode of AN, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Binge-eating/Purging type: During the current episode of AN, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).
The Vulnerable Attachment Style Questionnaire (VASQ):
An interview-derived measure of non-standard relationship styles that predict depressive disorder

J. Mahon, A. Bifulco, P. K. Harvey, and P. M. Moran
Lifespan Research Group, Royal Holloway, University of London

Address for correspondence
Dr. A. Bifulco
Lifespan Research Group,
Royal Holloway, University of London.
11, Bedford Square
London WC1B 3RA
ABSTRACT

Background: The Vulnerable Attachment Style Questionnaire (VASQ) was developed to provide a brief self-report tool to mirror an existing investigator-based interview (Attachment Style Interview - ASI). Both measures are used for identifying individuals with attachment relationship styles that are predictive of psychiatric disorder. This paper describes the development and scoring of the VASQ and examines its relationship to major depression and to other depressive risk factors.

Method: The VASQ was constructed from a set of 31 questions about attitudes relating to attachment relationship style, drawn directly from the ASI. To validate the VASQ, two series of community adults (total 276) completed the new measure and were interviewed with the criterion measure, the ASI. Two distinct and highly stable clusters of VASQ respondents were detected using cluster analysis. A scoring system was derived from the cluster centroids.

Results: The VASQ clusters separated those with 'standard' attachment from those with 'non-standard' attachment as determined by the ASI. VASQ ratings were also highly correlated with a well known self-report measure of insecure attachment (Relationship Questionnaire). Test-retest reliability of the VASQ was satisfactory. The 'non-standard' VASQ cluster membership proved highly related to depressive disorder and to other psychosocial vulnerability factors. Logistic regression showed that VASQ non-standard attachment, low self-esteem and childhood neglect/abuse provided the best model for 12-month depression.

Conclusion: The VASQ is a brief self-report measure which distinguishes individuals with vulnerable (non-standard) attachment style who have high rates of other depressive-vulnerability and disorder. The use of the measure for screening in research and clinical contexts are discussed.
Introduction

There is increasing evidence that attachment factors make a major contribution to mental ill-health (George and West, 1999). Investigation of the links between attachment and psychopathology, however, has been hampered by the lack of appropriate measures for the predictive potential of disordered attachment. This paper presents a self-report measure of vulnerable attachment style whose main purpose is to predict psychopathology in the form of major depression. The methods for developing the questionnaire and assessing its reliability and validity are described.

Although in recent years, self-report measures of adult attachment have proliferated e.g. (Hazan and Shaver, 1987, West et al., 1987, Bartholomew and Horowitz, 1991, Feeney et al., 1994) these have largely been designed to assess individual differences in attachment, mainly as expressed in romantic relationships. There have been parallel variations in the interpretation of the construct 'attachment' (Stein et al., 1998). The main ones involve attachment as a 'relating style' which is reflected in the quality of adult relationships, and attachment as a 'state of mind' which is reflected in discourse coherence and defensive strategy (Crowell et al., 1999). It is the former construct which is the focus of the present report and measure.

Existing self-report attachment style measures have a number of disadvantages in being used to predict psychopathology. First, they have largely been validated on young age groups such as college samples, for whom parental relationships are likely still to be central and who may not have had a full range of adult attachment relationships (Hazan and Shaver, 1987, Bartholomew and Horowitz, 1991). These measures may therefore not be appropriate for a wider age range. Secondly, most attachment measures have not been designed for use in high-risk series and items are not geared towards behaviour and feelings in situations of threat when the attachment behaviour system is most highly activated (Bowlby, 1977). The investigation of the link between psychopathology and attachment requires taking into account support-seeking behaviour in situations of threat, and in series exposed to high rates of stressors, both important factors in psychopathology (Brown et al., 1986). Third, the diverse number of measures fail to agree on attachment classification and the number and definition of insecure styles. They also variously use dimensional and categorical measurement approaches which leads to problems in comparability of measures.

Opinion on whether attachment is best conceptualised as typological or dimensional is divided (Fraley and Waller, 1998). Fraley argues that "Ultimately, only the dimensional scores matter (...) since the types are not 'real' in any case,' and their use can be justified only 'on the grounds of convenience' (p 50). However, this perspective is influenced by the purpose for which attachment is being measured and the degree of discrimination required. For the clinical purpose of identifying people who are at greater risk of psychopathology, development of a typology is necessary to differentiate those needing treatment. This may be formulated in terms of degree of insecurity of attachment or by type of insecure styles. A typology which rests on degree (or severity) of insecurity would differ from those discussed thus far in the literature, which are keyed into security and flavours of insecurity. Yet the weight of evidence suggests that it is insecure style per se which relates to disorder (Mickelson et al., 1997, Stein et al., in press, Bifulco et al., submitted).

Measurement of attachment has only recently been used to investigate psychopathology e.g. (Hammen et al., 1995, Shapiro and Levendosky, 1999, Gerlsma and Luteijn, 2000) even though it has long been a concern of attachment theory (Bowlby, 1977). Studies of attachment and psychopathology, which look at relating-style in particular, have been limited (Sperling, et al 1991). Although associations between insecure attachment and psychiatric disorder have been found, there is little consistency across types of insecure style and type of disorder (Murphy and Bates, 1997, McCarthy, 1999, Gerlsma and Luteijn, 2000). In a large, nationally representative US study insecure attachment was assessed by one of the early 'relating-style' questionnaires, designed by Hazan & Shaver. This was used, together with clinical interviews to determine several types of psychopathology (major depression, anxiety disorders, substance abuse and antisocial disorders) (Mickelson et al., 1997). Psychopathology was negatively related to secure classification and positively related to both insecure classifications (anxious/ambivalent and avoidant). There was no differentiation of attachment style with type of disorder.

The reliability and validity of the self-report scales assessing attachment style have recently been tested with meta-analyses undertaken on their agreement. Even these show inconsistency. Thus Brennan and colleagues (Brennan et al., 1998) analysed the contents of 19 different attachment measures and found that they all reliably tapped into the same two orthogonal dimensions: avoidance and anxiety. A more recent investigation of the relationships between five attachment questionnaires examined their comparability using both categorical and dimensional approaches to determine underlying constructs and found greatest agreement for the secure versus any insecure classification (Stein et al., in press). The study further investigated the relationship to self-report of psychiatric symptomatology and found secure versus insecure overall classification proved a better discriminator than any of the insecure subtypes. The authors
find evidence for two orthogonal dimensions separating security of attachment from what they term the attachment 'strategy' for coping with interpersonal difficulties. The authors conclude that the relatively weak relationships found among attachment measures may actually result from a misconception that the preoccupied and dismissing styles categorised by these measures reflect distinct styles. Instead they argue that these are variants of underlying attachment insecurity influenced by attachment 'strategy' employed for coping with interpersonal problems.

This latter finding is important for instruments used to predict psychopathology. A measure which could be used to discriminate between those who are at high and low risk for disorder needs to be keyed into a measurement of severity of insecure attachment, rather than just style of attachment, since description of attachment style on it own is usually not sufficient for obtaining a reliable identification of those who are at risk for disorder (Bifulco et al., submitted).

These methodological arguments indicate that a measure is required, designed specifically for prediction of the more severe disordered attachment for clinical and research purposes. Such a measure would ideally be;

a) role-independent, so that attachment relationships other than love relationships would be included and could be applied to individuals in a wide range of life-stages,
b) tested on community rather than collegiate or patient samples with sufficient coverage of high-risk individuals to ascertain its relationship with the psychosocial depressive risks and disorder,
c) validated against an interview measure that predicts depressive disorder and
d) scored to place respondents into high- and low-risk groups, rather than placing them on a dimensional continuum.

The VASQ was based on an investigator-based interview measure. The Attachment Style Interview (ASI) was developed to examine the degree to which insecure attachment styles were dysfunctional (or 'non-standard') and related to depression (Bifulco et al., 1998b). The interview questions not only about behaviour in specific close relationships (with partner and support figures, both kin and non-kin), but also about more general attitudes to close others. The global assessments of attachment generated by the interview accommodate a range of adult attachment relationships and therefore are potentially widely applicable in research across the lifespan. Insecure styles of Enmeshed, Fearful and Angry-dismissive all related to depressive disorder. Little differentiation between style was found, although Withdrawn style (avoidant but free of hostility) showed little association. However, the degree to which the styles were insecure or 'non-standard' was highly related to onset of depression (Bifulco et al., submitted). There was also evidence of such styles relating to chronicity of disorder. When the presence of non-standard styles was examined in relation to recovery from chronic depressive disorder in a Befriending intervention (Harris et al., 1999), 'standard' attachment style at first contact predicted remission. This together with positive event experiences and the befriending intervention provided the best model for remission. The authors conclude that assessing non-standard attachment style in the clinical context could beneficially influence choice of therapeutic intervention (op cit).

The VASQ was guided by a philosophy different from the latent-trait approach which is used in most questionnaires. The items were directly chosen from the interview to establish content validity vis-à-vis the interview. The relationship between the VASQ and outcome was then tested to see if it was similar to the interview. This method is similar to the one used to develop other self-report instruments such as the Working Alliance Inventory (Horvarth, 1994) and has been used for clinical screening questionnaires where guidelines of specific interview-based diagnostic criteria are imposed e.g. (Wittchen and Boyer, 1998).

Development of the scoring for the VASQ presented a particular challenge. Attachment is a broad construct, encompassing several factors simultaneously. While there might be thought to be a hierarchy of severity in disordered attachment, it is difficult to think of different attachment styles as being arranged in a hierarchy. However, traditional methods of scoring questionnaires are based on hierarchies: scores on items are summed into subscales identified by factor analysis, a procedure which sorts the data into a hierarchy of usually orthogonal vectors arranged by the amount of variance explained. The factors can therefore only be bimodal, and in many forms of analysis, are meant to be uncorrelated. If the measure is to be used for predictive purposes, it will often have 'cut-off' scores determined by validation exercises performed on a particular sample. Above the 'cut-off' one is a case, and below one is not. It is the score on that particular item that is of interest. However, if attachment styles are thought of as other than personality features (Crowell et al., 1999), the item of interest is the entire profile of responses for an individual, rather than a single score or set of scores. Therefore a method which can identify configurations across all factors simultaneously is better suited to the task. Non-hierarchical cluster analysis, which is inherently multi-variate, was therefore chosen for determining scoring.

Appendix 4-1 (VASQ)
The aim of the present report is to describe the development of the VASQ, specifically:

i) To develop a scoring system for the VASQ and to show its reliability through test-retest;

ii) To assess criterion validity of the VASQ in terms of its association with other attachment measures;

iii) To assess construct validity of the VASQ in terms of its association with vulnerability factors and depression;

iv) To test whether VASQ attachment scoring relates to depression over and above other previously identified vulnerability.

METHOD

The Sample

The questionnaire was tested on two related community series, part of an intergenerational study of mothers and their adult offspring conducted in 1995-99 (Bifulco, 2000). The sample comprised two groups: (i) an 'Initial series' of 149 mid-life women, two thirds of whom were selected for psychosocial risk factors for depression when originally studied in the early 1990s. These were followed up for the present study an average of 3 years later. The women were originally selected through questionnaire screening of those registered with GP practices in North London. Selection procedures, compliance rates, and other sample details are described elsewhere (Bifulco et al., 1997, Bifulco et al., 1998a). (ii) A 'validation set' of 127 newly selected family members of the first group. The validation set were from two different lifestages, a younger group aged 16-25 and an older group aged 50-75.

(i) The Initial Series: (N=149)

Nearly two-thirds (62% or 92) of this series were high-risk in terms of having been selected for psychosocial vulnerability to depressive disorder at an earlier study stage (1990-5). Vulnerability selection consisted of the presence of severe neglect or abuse in childhood (n=46) or the existence of conflictful or unsupportive close relationships at point of selection (n=46). A further 57 women, unselected for risk, formed a comparison group¹ (Bifulco et al., 1997, Bifulco et al., 1998a). Compliance at follow-up was good with 83% of women approached agreeing to participate in the interview segment of this study. Interview assessments at follow-up included attachment style, support and self-esteem together with clinical state in the period since the earlier study. Childhood experience and lifetime history of depression had been assessed at the prior interview. Of those interviewed 80% returned the VASQ. The average age of this series at interview was 40.5 (s.d. 7.4). A third of the women were working-class, nearly two-thirds were married or cohabiting (62%) and 82% were parents.

(ii) The Validation series (N=127)

The validation set were newly recruited in 1995-9 when full life history interviews were taken and VASQs completed (Bifulco, 2000). Under half the series were older mothers, aged 50-75 (n=56) and the remainder were young adult daughters and sons aged 16-25 (n=71). Thus although the average age of the series was similar to the Initial series (39.5) it covered a much greater range (s.d. 22.6). The group were similar to the Initial series in terms of social class (38% were working-class), but fewer were married/cohabiting (35%) and only half were parents (54%). Unlike the Initial series, 30 males in the young age group were included.

Test-retest series

The test-retest reliability of the VASQ was obtained by asking one quarter of the respondents from the Initial group to complete a second VASQ approximately 6 months after the first one. The 6-month time interval was chosen as optimal because a longer period might have led to confounds due to possible change in supportive context, and a briefer period might have resulted in initial responses being remembered.

MEASURES

Measurement was both by semi-structured interview and by self-report questionnaire of attachment, other psychosocial vulnerability and major depression.

1. Attachment assessments

Vulnerable Attachment Styles Questionnaire (VASQ)

A set of 31 questions concerning attachment relationship style were drawn directly from the Attachment Style Interview (ASI) (see below). Thus the set of questions utilised by the VASQ was extensively respondent- and expert-tested in an interactive interview context. Using empirically tested questions obviated the conventional questionnaire-development steps of piloting a large set of

¹ The original group were supplemented by 19 newly screened women selected in an identical way from the same surgeries. Similar response rates obtained.
questions, factor analysing results, and discarding 'non-significant' questions. Questionnaire items were written as self-statements with a 5-point Likert response scale. Response options ranged from 'strongly agree' to 'strongly disagree'. The centre point was 'unsure'. In order to minimise state effects, respondents were asked to complete items as they felt generally rather than currently. Instructions to the respondent were broad: 'Below are a number of statements concerning the way people feel about themselves in relation to others. Indicate whether you agree or disagree with the description as it applies to you by circling a number from 1 to 5. There are no 'right' or 'wrong' answers'. (See appendix 1).

The items chosen for the VASQ were taken from the main prompts of the ASI and covered 8 subscales that are used to rate the ASI (overall ability to make relationships, mistrust of others, anger in relationships, attitudinal constraints against closeness, fear of intimacy, self-reliance, intolerance of separation, and desire for engagement with close others). They were reviewed for content and construct coverage by a panel of experienced ASI interviewers researchers. The VASQ was intended to identify highly insecure attachment predictive of psychiatric disorder, with scoring determined on the basis of ASI ratings of 'standard' and 'non-standard' styles (see below).

Attachment Style Interview (ASI) (Bifulco et al., 1998b)
An investigator-based interview assessed respondents' attachment styles on the basis of their ability to make and maintain supportive relationships along with attitudes about closeness/ distance from others and fear/anger in relationships. The in-depth interview is taken to be the 'gold-standard' for determining attachment style in this study. Interviewer judgements are informed by full training and checked by consensus panels and reliability of ratings is high, for example 0.80 (K^w) agreement between independent raters for the overall attachment scale and average of 0.75 (K^w) for subscales.

The ASI utilises 7 attitudinal scales which together with a behavioural assessment of 'ability to make and maintain relationships' based on presence of close supportive relationships, allow for a classification of the type of insecure attachment (Enmeshed, Fearful, Angry-dismissive, Withdrawn and Clearly Standard) and the degree to which attachment styles are 'markedly', 'moderately' or 'mildly' insecure. The focus in this study is on the 'marked-moderate' degree of attachment insecurity ('non-standard') for Enmeshed, Fearful or Angry-dismissive style, since these best discriminate depressive disorder and psychosocial risk.

Relationship Questionnaire (RQ) (Bartholomew and Horowitz, 1991)
A self-report attachment scale, the RQ, was chosen for concurrent validation of the VASQ. This measure is based on 4 brief relationship profiles describing 'Secure' (A), 'Fearful' (B) 'Preoccupied/enmeshed' (C) or 'Dismissive' (D), attachment styles. The subject rates the degree to which each of these styles applies to her/him and then chooses one style as representing her/his overall attachment style. The analysis reported here utilises the overall self-rating. For the current validation analysis, the subtypes of the RQ were grouped into 'secure' (Style A) and 'insecure' (Styles B, C, D).

2. Other vulnerability assessments
Self-Evaluation and Social Support (SESS) (O'Connor and Brown, 1984)
The SESS interview is an intensive measure used by trained researchers to assess the meaning and context of relationships and self-esteem. SESS interview data were used to construct two indices of vulnerability to depression. **Negative Evaluation of Self (NES)** was based on ratings of high negative self-perception of either attributes, self-worth or role competence in relation to a number of questions concerning the self (Brown et al., 1990). **Lack of a True Very Close Other (LTVCO)** comprised the lack of any non-partner support figure, seen at least monthly who was defined as 'very close' and who was confided in at 'marked' or 'moderate' levels. Given a large proportion of the series with no current partner, support assessment was restricted to such figures in this analysis. **Childhood Experience of Care and Abuse (CECA)** (Bifulco et al., 1994)
The Childhood Experience of Care and Abuse (CECA) interview measure assessed the severity of neglect and physical or sexual abuse before age 17. The measure has good reliability and validity and is described elsewhere (Bifulco et al., 1994). A dichotomous index of the presence or absence of severe neglect, physical or sexual abuse was used consistent with prior analyses. This index is highly related to lifetime major depression and other depressive vulnerability.

3. Major depression
Structured Clinical Interview for DSM diagnoses (SCID) (First et al., 1996)
Major depression in the 12 months before interview was assessed using the SCID, utilising DSM-IV criteria. Lifetime episodes of depression were also questioned about in detail. An index of chronic (any episode lasting 12-months or more) or recurrent (2 or more episodes) of major depression was devised.

**Statistical analysis**
Cluster analysis: Although cluster analysis is not typically used in exploration of questionnaire items it was deemed most appropriate for determining the VASQ scoring for the following three reasons:
Redundancy of items: While for most new questionnaires the aim of data exploration is to weed out redundant, confusing, or weak items, which can be performed by factor analysis, in the case of the VASQ, this stage had already been accomplished during the development and extensive use of the ASI. The aim of this data exploration exercise was to see whether the self-report format had picked up any coherent and stable groups of respondents, and whether these groups might be understandable in terms of past research and attachment theory. Because the purpose of this measure was to separate those at higher risk from those at lower risk of disorder, and because past research indicates that attachment styles may be categorical rather than dimensional, a statistical tool which would reveal groups was necessary for adequate data exploration.

Response profiles: Because past research indicates that identifying attachment styles requires simultaneous consideration of an individual’s characteristics in several domains, the tool also had to permit multi-variate analysis. Non-hierarchical cluster analysis is inherently multi-variate and so could explore the entire data set for groups of question response profiles. In contrast factor analysis typically would only permit indication of a respondent’s location on each of several orthogonal (and therefore uncorrelated) dimensions. Thus, the item of interest in the VASQ is the entire response profile of the individual rather than a response to any single item or set of items. Non-hierarchical cluster analysis, which searches for coherent groupings in data through an iterative process of partitioning data into ‘clouds’ of multivariate data, calculating the ‘centres of gravity’ for the clouds, then moving subjects to improve the coherence of the ‘clouds’ until a target is reached, was appropriate given that a non-hierarchical and non-linear procedure was needed. Factor-analytic procedures arrange data according to a hierarchy of variance, so extreme item responses dominate in the analysis. In the ASI, extreme responses are more characteristic of the ‘non-standard’ groups but these can be at opposite ends of the same continuum. For example either extreme of the ‘desire for engagement’, indicating at one end over-dependence and at the other detachment indicate ‘non-standard’ styles. Thus ratings at either extreme on items such as ‘its important for me to have people around me a lot of the time’ or ‘I can make new relationships very quickly’ would denote non-secure attachment with ‘secure’ ratings being more central. If factor analysis alone was used responses of the ‘standard’ group would have been lost, since their responses would not account for as much variance as the responses of the ‘non-standard’ group.

Type of data: Because the VASQ data are non-normal and non-continuous, a cautious approach to exploration of the data required a non-parametric method. Their status as even ordinal data could be visualised as the centre point of the response range (‘unsure’) could possibly have different functions for different questions. Thus non-hierarchical cluster analysis was deemed appropriate, especially since all of the variables were of the same type and had the same variance/co-variance matrices.

Other statistical procedures
Factor analysis was used for a preliminary description of inter-item agreement, using principal components for factor extraction and varimax for rotation. Cramer’s phi coefficients, chi-squares and odds ratios were used to evaluate the criterion validity of VASQ. Logistic regression, using the SPSS-10 programme was utilised to examine whether VASQ ratings added to other psychosocial vulnerability in modelling depressive disorder.

RESULTS

1. Risk characteristics of the sample
For the combined Initial and Validation series psychosocial risk factors for depression were present for between a third and half the series. Thus 37% experienced NES and 36% lacked a ‘true’ VCO with 45% having experienced neglect or abuse in childhood. Just over half the series (56%) had an insecure attachment style as rated by RQ. Thirty-four per cent were rated as ‘non-standard’ using the more stringent ASI thresholds. Twenty per cent of the series had major depression in the year before interview contact, with a third having a lifetime history of chronic or recurrent disorder. The two series were similar, apart from higher rates in the Initial series of NES (46% vs 28%, p<0.001) and childhood risk (59% vs 30%, p<0.001) consistent with selection procedures. This series additionally had significantly more lifetime chronic/recurrent depression (50% vs 12% in the validation series, p<0.001) but this was less evident for 12-month rates of disorder (24% vs 14%, ns).

2. Factor analysis of VASQ items
Initial exploration of VASQ items with factor analysis indicated 9 factors with eigen values greater than 1 (see appendix 2). These factors could generally be interpreted as corresponding to the ASI subscales. The lower factors appeared to be somewhat unstable, and the scree plot showed that only first 6 factors explained meaningful amounts of variance. These could clearly be related to mistrust, fear of intimacy, ability to relate, intolerance of separation, desire for engagement, and self-reliance. This analysis supported the content validity of the VASQ.

3. VASQ scoring
Non-hierarchical cluster analysis was used to generate a global scoring of secure/insecure styles\(^2\). A main drawback of cluster analysis is that it can be vulnerable to statistical artefacts. To combat this, two different algorithms, Iterative Non-hierarchical Cluster Analysis (INCA) (Harvey, 1999) and \(k\)-means cluster analysis in SPSS v.10, were used. This allowed for (a) correcting for artefacts resulting from the arbitrary choice of initial seed points, since several different approaches to picking initial cluster seeds and distances were used and (b) controlling for effects from the order in which cases are entered into the algorithm, a feature of \(k\)-means (SPSS) cluster analysis which does not affect INCA.

Initially the algorithms were set to explore the data for any natural number of clusters in the data. The utility of these cluster configurations was evaluated by mapping the resulting cluster memberships against responses to each question in the VASQ, then against each subscale on the ASI, and finally against overall attachment style score on the ASI. Through this descriptive approach, the meaning of the cluster groupings could be explored. Subsequently the algorithms were set to partition the data into two clusters, and these clusters were evaluated in the same way. Finally, the scoring system was developed from the algorithm (INCA) which proved superior in distinguishing the overall attachment style ratings of the 'gold-standard' ASI.

(a) **Initial set:** During the initial stages of data exploration, both \(k\)-means (SPSS) and INCA algorithms showed 3 clusters within the Initial cohort. However, examining cluster memberships mapped onto each of the 31 items revealed too much discrepancy in meaning between the clusters detected by the two algorithms for either 3-cluster configuration to be considered robust. In other words, qualitative differences in the 'stories' that could be developed when looking at the item response patterns of the \(k\)-means and the INCA clusters could not be reconciled. \(k\)-means showed a more typical secure/avoidant/preoccupied pattern, whereas INCA made a more clear distinction between standard and non-standard styles. Even though the kappa of cluster membership assigned by each algorithm was unquestionably statistically significant (\(k=0.362\), S.E. = 0.055, \(p<0.000\)), for the practical purpose of developing a scoring system the amount of disagreement was felt to be too high. Subsequently a 2-cluster configuration was forced for each algorithm. Mapping these cluster memberships onto the VASQ items showed that the \(k\)-means- and INCA-derived clusters were very similar. Kappa for this configuration was 0.922 (S.E. = 0.034, \(p<0.000\)), and the algorithms disagreed on the cluster membership of only 5 out of 149 respondents. Reshuffling the order of case entry into the \(k\)-means algorithm in the 2-cluster case did not affect the cluster memberships. The phi\(^c\) coefficient for association between the INCA-derived cluster memberships and the ASI overall attachment style ratings grouped into attitudinally standard and non-standard was 0.55 (\(p<0.000\), see table 1) with 78.5% correct classification rate. The sensitivity and specificity rates were felt high enough to proceed with developing a scoring system.

(b) **Cross-validation set:** With inter-algorithm stability at an acceptable level, association between the VASQ responses of the cross-validation cohort as scored by this programme and their correlation with ASI ratings were calculated. Phi\(^c\) coefficients reached 0.367 (\(p<0.0001\)) with 76% correct classification rate, 44% sensitivity and 89% specificity. Figures for the combined series is shown on table 2 (row 3) with 76% correctly classified. Criterion validity for the VASQ against the RQ was satisfactory (see table 1).

In order to see whether correct classification of ASI groups could be increased, the two cohorts were combined and run through each clustering algorithm again; however, this did not result in significant improvement, so the original scoring was retained.

\(^2\) **Missing Values:** Where there were a number of missing values these questionnaires were discarded (\(n=6\)). When a single item was missing another item the most highly correlated with was found and substituted this response. For Q18 which refers to people living with subject where respondents considered it not applicable, a rating of '3:unsure' was substituted.
3. Reliability
Test-retest reliability was high with 94.2% of 66 test-retest respondents remaining within the same cluster at re-test. Kappa was 0.838 (S.E. = 0.069, p<0.000). Only one respondent changed from ‘standard’ to ‘non-standard’, and four changed from ‘non-standard’ to ‘standard’.

4. Validity and Prediction of risks
Psychosocial risk factors of NES, lack true VCO and childhood neglect/abuse were significantly related to the VASQ scores. The odds ratios ranged from 3.25 for NES (p<0.0001), 2.74 for childhood neglect/abuse (p<0.0001) and 2.34 for lack of ‘true’ VCO (p<0.008) (see table 2).

5. Prediction of depressive disorder
Non-standard VASQ ratings were associated with double the rate of depression in the 12 months before contact (OR = 2.96, p<0.001). VASQ ratings also related to a lifetime history of chronic/recurrent disorder, even when control for major depression at point of interview was made (OR=2.64, p<0.003, see table 3). When the VASQ and RQ were both examined in relation to 12-month depression, logistic regression confirmed that the VASQ score alone provided the best model (see table 3B).

6. VASQ attachment, other psychosocial vulnerability and depression
When all the risk factors for depression considered were entered into a logistic regression, VASQ non-standard attachment, NES and childhood neglect/abuse provided the best model (see table 4). Lack of a true VCO did not add to the model.

**DISCUSSION**
The VASQ, a brief self-report tool measuring attitudes toward attachment, is potentially useful for the prediction of disorder in community populations, yielding results similar to intensive interview methods. It has been shown to have good reliability and validity in discriminating vulnerable attachment style in terms of those rated ‘non-standard’ ('markedly' or 'moderately' Enmeshed, Fearful or Angry-dismissive) versus ‘standard’ (secure, ‘mildly’ insecure and Withdrawn). Like the Attachment Style Interview measure, the VASQ is significantly associated with retrospective assessments of childhood neglect/abuse, and concurrent measures of low self-esteem and poor support. It is also highly related to another self-report attachment measure, the RQ, but better able to predict depression in this series.

Non-hierarchical cluster analysis was used both to explore the VASQ and to develop its scoring system. Using two different algorithms on both a Initial and a Validation series showed that two groups of attachment profiles robustly occur with the VASQ. This is consistent with certain recent investigations of attachment measures which suggest that security and insecurity are the most crucial and stable attachment dimensions, particularly for predicting psychopathology (Stein et al., ). Exploratory factor analyses were also conducted, which showed that the VASQ covered the content of the criterion measure. Little evidence was found for approach/avoidance subtypes, despite these being determinable reliably in the interview measure.

There is debate about whether attachment style is better assessed with self-report or interview methods (Crowell et al., 1999). Although persuasive arguments have been made for interview investigation of situational characteristics including support in order to accurately encompass context and guard against subjective bias (Brown, 1991), such considerations could be argued to apply less to attitudinal states. Often the choice of research measure is made on pragmatic grounds depending upon the purpose and economic resources of the study. For large-scale surveys or brief screening prior to more intensive measurement, self-report scales are clearly crucial. However, for intensive investigation of contextual assessments of attachment as related to ongoing relationships and interpersonal stressors, and for clinical assessments, interviews clearly have advantages. Given the VASQ is a self-report measure complementing an interview assessment of vulnerable attachment style, the two can be used appropriately according to the demands of a particular study. Thus while the ASI has the advantage of differentiating various styles of attachment and incorporating objective assessment of support, the VASQ is a much briefer measure, more economical to use for a larger scale series which appears to discriminate high-risk individuals equally well.

Further tests of the VASQ’s prospective utility remain. The ASI has been shown to relate prospectively to new onset of depression, whereas the VASQ has not been put through this test as yet. Nevertheless, controlling for depression at point of contact did not eradicate its relationship with lifetime history of disorder, which suggests that the qualities it measures are more trait-like than state-like. The study is also limited by the relatively modest numbers of subjects in both Initial and Validation sets, which results from the time-costliness of the interview criterion assessments. In
addition the Initial and Validation subjects were dissimilar in terms of life-stage and risk selection. While this might undermine homogeneity, it provides a more rigorous validation test in a wide range of individuals. Furthermore, this analysis only considered one type of disorder (major depression), and so did not test the full range of outcomes which might be predicted by the VASQ.

As well as introducing a new self-report assessment and a novel scoring method which can benefit both researchers and clinicians, the testing of VASQ lends support to an emerging model of attachment style and disorder. This model, developed on intensively interviewed series, traces a line through childhood adversity to problems with attachment, support and self-esteem, and then to vulnerability to psychiatric disorder in adulthood. It is hoped that further use and testing of the VASQ will increase understanding of the links between vulnerable attachment and psychiatric disorder in a wider range of studies than is possible with its interview counterpart.
Acknowledgements
The research was supported by the Medical Research Council (programme grant G9827201) with additional work undertaken by Jenn Mahon as part of her PhD. We acknowledge the contribution of Professor George Brown and Tirril Harris to the research programme. We would like to thank Rebecca Baines, Amanda Bunn, Catherine Jacobs, Lucy Reader, Joanne Cavagin, Lisa Steinberg, Kate Benaim and Katherine Stanford for data collection. Also to Catherine Jacobs for additional data cleaning. Thanks are also due to Dr. Soumitra Pathare for providing training in the SCID and checking reliability of psychiatric ratings and to Laurence Letchford for computer analysis. Finally, we are grateful to the Islington families who generously, and patiently, participated in this research over the two waves of study.
Vulnerable Attachment Style Questionnaire

REFERENCES


Vulnerable Attachment Style Questionnaire


**TABLE 1: Criterion validity of VASQ**

<table>
<thead>
<tr>
<th>Validation VASQ non-standard style</th>
<th>Criterion Measure</th>
<th>Cramer's Phi</th>
<th>Sensitivity %</th>
<th>Specificity %</th>
<th>Correct classification</th>
<th>P&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial series</td>
<td>ASI non-standard attachment*</td>
<td>0.55</td>
<td>62%</td>
<td>89%</td>
<td>78%</td>
<td>0.0001</td>
</tr>
<tr>
<td>Combined series</td>
<td>ASI non-standard attachment*</td>
<td>0.46</td>
<td>55%</td>
<td>88%</td>
<td>76%</td>
<td>0.0001</td>
</tr>
<tr>
<td>Combined series</td>
<td>RQ insecure attachment**</td>
<td>0.48</td>
<td>47%</td>
<td>97%</td>
<td>69%</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

* Marked/moderate enmeshed, fearful or angry-dismissive styles versus rest.
** A (secure) versus B (fearful), C (preoccupied), D (dismissive) overall style classification.
### TABLE 2: Construct validity of VASQ in terms of relationship to psychosocial risk for depression

<table>
<thead>
<tr>
<th>RISK FACTOR</th>
<th>Absent</th>
<th>Present</th>
<th>Odds-ratio</th>
<th>P&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% non-standard VASQ</td>
<td>% non-standard VASQ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neglect/abuse&lt;17 (1 missing value)</td>
<td>19 (25/150)</td>
<td>37 (46/125)</td>
<td>2.74</td>
<td>0.001</td>
</tr>
<tr>
<td>Lack of true very close other</td>
<td>21 (36/174)</td>
<td>38 (39/102)</td>
<td>2.34</td>
<td>0.002</td>
</tr>
<tr>
<td>NES</td>
<td>19 (32/171)</td>
<td>40 (43/105)</td>
<td>3.25</td>
<td>0.0001</td>
</tr>
</tbody>
</table>
TABLE 3: Construct validity of VASQ: Relationship to depression

A. VASQ non-standard attachment and major depression

<table>
<thead>
<tr>
<th>VASQ attachment</th>
<th>Standard</th>
<th>Non-standard</th>
<th>Odds-ratio</th>
<th>P&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>% depressed in 12-months pre interview</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total series</td>
<td>14 (29/201)</td>
<td>33 (25/75)</td>
<td>2.96</td>
<td>0.001</td>
</tr>
<tr>
<td>% recurrent/ chronic lifetime depression</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Excluding (n=28) depressed at interview</td>
<td>23 (43/189)</td>
<td>44 (25/57)</td>
<td>2.64</td>
<td>0.003</td>
</tr>
</tbody>
</table>

B. Logistic regression: Attachment questionnaire assessments and 12-month depression

<table>
<thead>
<tr>
<th>Attachment Measure</th>
<th>Odds-ratio</th>
<th>Wald</th>
<th>Df</th>
<th>P&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>VASQ</td>
<td>2.65</td>
<td>7.34</td>
<td>1</td>
<td>0.006</td>
</tr>
<tr>
<td>RQ</td>
<td>1.48</td>
<td>1.00</td>
<td>1</td>
<td>NS</td>
</tr>
</tbody>
</table>

In terms of goodness of fit 81.2% of subjects correctly classified. VASQ provides best model for 12-month depression.
Vulnerable Attachment Style Questionnaire

Table 4 Psychosocial risk factors and 12-month depression

<table>
<thead>
<tr>
<th>Variable</th>
<th>Odds-ratio</th>
<th>Wald</th>
<th>P&lt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-standard attachment: VASQ</td>
<td>1.88</td>
<td>3.93</td>
<td>0.04</td>
</tr>
<tr>
<td>NES</td>
<td>5.21</td>
<td>22.32</td>
<td>0.0001</td>
</tr>
<tr>
<td>Lack of TVCO</td>
<td>0.67</td>
<td>1.36</td>
<td>NS</td>
</tr>
<tr>
<td>Childhood adversity</td>
<td>1.91</td>
<td>4.12</td>
<td>0.04</td>
</tr>
</tbody>
</table>

In terms of goodness of fit, 82.39% of subjects correctly classified.

Non-standard attachment, NES and childhood adversity provide the best model for major depression.
Appendix 1: Vulnerable Attachment Style Questionnaire items and scoring

Rated 1: strongly agree, 2:agree, 3:unsure, 4:disagree or 5: strongly disagree.

<table>
<thead>
<tr>
<th>Scoring - Cluster centroids</th>
<th>Answer</th>
<th>Standard</th>
<th>Non-stand</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I take my time getting to know people.</td>
<td>2.7895</td>
<td>2.102</td>
<td></td>
</tr>
<tr>
<td>2. I rely on others to help me make decisions in life</td>
<td>3.7789</td>
<td>3.8367</td>
<td></td>
</tr>
<tr>
<td>3. People let me down a lot</td>
<td>3.7263</td>
<td>2.6327</td>
<td></td>
</tr>
<tr>
<td>4. I see friends and family often</td>
<td>1.7895</td>
<td>2.8776</td>
<td></td>
</tr>
<tr>
<td>5. It's important to have control over my life</td>
<td>1.6316</td>
<td>1.6735</td>
<td></td>
</tr>
<tr>
<td>6. I miss the company of others when I'm alone</td>
<td>3.2947</td>
<td>3.1224</td>
<td></td>
</tr>
<tr>
<td>7. Its best not to get too emotionally close to other people</td>
<td>3.6421</td>
<td>2.6531</td>
<td></td>
</tr>
<tr>
<td>8. I worry a lot if people I live with arrive back later than expected</td>
<td>2.5789</td>
<td>2.3061</td>
<td></td>
</tr>
<tr>
<td>9. I usually rely on advice from others when I've got a problem</td>
<td>3.2211</td>
<td>3.6122</td>
<td></td>
</tr>
<tr>
<td>10. I feel uncomfortable when people get too close to me</td>
<td>3.8211</td>
<td>2.5714</td>
<td></td>
</tr>
<tr>
<td>11. I have lots of friends</td>
<td>2.1789</td>
<td>3.5306</td>
<td></td>
</tr>
<tr>
<td>12. People close to me often get on my nerves</td>
<td>3.5579</td>
<td>2.4898</td>
<td></td>
</tr>
<tr>
<td>13. I feel people are against me</td>
<td>4.4316</td>
<td>3.5102</td>
<td></td>
</tr>
<tr>
<td>14. I find it easy to ask people for help</td>
<td>2.8105</td>
<td>3.6939</td>
<td></td>
</tr>
<tr>
<td>15. I worry about things happening to close family and friends</td>
<td>2.4737</td>
<td>2.2857</td>
<td></td>
</tr>
<tr>
<td>16. I often get into arguments</td>
<td>3.8737</td>
<td>3.3469</td>
<td></td>
</tr>
<tr>
<td>17. I'm clingy with others</td>
<td>4.1053</td>
<td>3.9796</td>
<td></td>
</tr>
<tr>
<td>18. I look forward to spending time on my own</td>
<td>2.0947</td>
<td>2.0816</td>
<td></td>
</tr>
<tr>
<td>19. I would like to see more of my friends than I do</td>
<td>2.8632</td>
<td>2.4898</td>
<td></td>
</tr>
<tr>
<td>20. I like making decisions on my own</td>
<td>2.3263</td>
<td>2.4082</td>
<td></td>
</tr>
<tr>
<td>21. I get anxious when people close to me are away</td>
<td>3.3895</td>
<td>2.7347</td>
<td></td>
</tr>
<tr>
<td>22. I feel close to people very quickly</td>
<td>3.1263</td>
<td>3.7959</td>
<td></td>
</tr>
<tr>
<td>23. I feel uneasy when others confide in me</td>
<td>4.1895</td>
<td>3.898</td>
<td></td>
</tr>
<tr>
<td>24. I can make new relationships very quickly</td>
<td>2.6211</td>
<td>3.4694</td>
<td></td>
</tr>
<tr>
<td>25. I find it hard to trust others</td>
<td>3.6526</td>
<td>1.9796</td>
<td></td>
</tr>
<tr>
<td>26. Having people around me can be a nuisance</td>
<td>3.3368</td>
<td>2.3265</td>
<td></td>
</tr>
<tr>
<td>27. I feel people haven't done enough for me</td>
<td>4.0211</td>
<td>2.9388</td>
<td></td>
</tr>
<tr>
<td>28. I enjoy meeting new people</td>
<td>1.9368</td>
<td>2.7347</td>
<td></td>
</tr>
<tr>
<td>29. Its important to have people around me a lot of the time</td>
<td>3.1579</td>
<td>3.6531</td>
<td></td>
</tr>
<tr>
<td>30. I find it difficult to confide in people</td>
<td>3.7158</td>
<td>2.4898</td>
<td></td>
</tr>
<tr>
<td>31. Saying goodbye to close family and friends is difficult</td>
<td>3.0526</td>
<td>2.3673</td>
<td></td>
</tr>
</tbody>
</table>
Vulnerable Attachment Style Questionnaire

Procedure for calculating distances:
1. Subtract the respondent’s answer to Q1 from the standard cluster Q1 centroid given above. Square the result. Example: if a respondent answers ‘4’ for Q1, the distance will be: \((2.7895-4)^2 = 1.4653\). Repeat this step for each question. Sum all 31 distances.
2. Subtract the respondent’s answer to Q1 from the non-standard cluster Q1 centroid. Square the result. Example: if a respondent answers ‘4’ for Q1, the distance will be: \((2.1020-4)^2 = 3.6024\). Repeat this step for each question. Sum all 31 distances.
3. Compare sums from Steps 1 (summed distance from Standard cluster centre) and 2 (summed distance from Non-standard cluster centre). Assign respondent to the cluster whose summed distance is smaller.

To produce an Excel sheet which will automatically perform these calculations:
1. Copy Appendix 1 into an Excel sheet. Items will be in Column A, Answers in Column B, Standard centroids in Column C, and Non-standard centroids in Column D. Item 1 will be in Row 2, Item 2 in Row 3, and so on until Item 31 in Row 32.
2. Click on Cell E2. In Formula bar, type: \(=POW(E2-B2,2)\). Click on green check mark to left of your formula.
3. Click on Cell F2. In Formula bar, type: \(=POW(D2-B2,2)\). Click on green check mark to left of your formula.
4. Starting with Cell E2, highlight the block of cells from E2 to F32. In Edit menu, go to Fill, Down. This will fill Cells E2-E32 with the formula for calculating the Standard distances and Cells F2-F32 with that for the Non-standard distances.
5. Click on Cell E33. Click on Sigma symbol in Toolbar. This should automatically fill the Formula bar with: \(=SUM(B2:B32)\). Click on green check mark.
6. Repeat 5) for Cell F33.
7. Click on Cell B33. In formula bar type: \(=IF(E33>F33,2,1)\). Click on green check mark. Cell B33 will now show ‘1’ if the respondent is closer to the Standard cluster and ‘2’ if the respondent is closer to the Non-standard cluster.
8. Scoring the VASQ for a respondent now simply involves entering item answers in Column B, labelled ‘Answers’.

19 February 2002
Appendix 2: Factor analysis of VASQ subscales (Principal components with varimax rotation)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3. People let me down</td>
<td>.74</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27. Haven't done eno</td>
<td>.69</td>
<td>-.23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.16</td>
<td></td>
</tr>
<tr>
<td>13. People against me</td>
<td>.63</td>
<td></td>
<td></td>
<td></td>
<td>.17</td>
<td></td>
<td></td>
<td></td>
<td>.36</td>
</tr>
<tr>
<td>12. Get on my nerves</td>
<td>.52</td>
<td>.18</td>
<td></td>
<td>-21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26. Nuisance</td>
<td>.46</td>
<td>.23</td>
<td>-.20</td>
<td>-.42</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. Difficult to confide</td>
<td>.26</td>
<td>.67</td>
<td></td>
<td></td>
<td></td>
<td>.17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Uncomfortable close</td>
<td>.66</td>
<td>-.28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.17</td>
<td>.17</td>
</tr>
<tr>
<td>22. Feel close quickly</td>
<td>-.61</td>
<td>.36</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Best not get close</td>
<td>.53</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Time getting to know</td>
<td>.50</td>
<td></td>
<td>.17</td>
<td>-.28</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25. Hard to trust</td>
<td>.44</td>
<td>.47</td>
<td>-.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.16</td>
<td></td>
</tr>
<tr>
<td>28. Enjoy meeting new</td>
<td>-.16</td>
<td>.75</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Make new relations quickly</td>
<td>-.36</td>
<td>.62</td>
<td>.17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Lots of friends</td>
<td>.27</td>
<td>-.23</td>
<td>.62</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Easy ask help</td>
<td>-.27</td>
<td>-.31</td>
<td>.42</td>
<td>.21</td>
<td>.24</td>
<td></td>
<td></td>
<td></td>
<td>-.24</td>
</tr>
<tr>
<td>21. Anxious close or away</td>
<td></td>
<td></td>
<td>.73</td>
<td>.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Worry if o late</td>
<td>.22</td>
<td>-.15</td>
<td></td>
<td>.71</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Worry what happen to o</td>
<td></td>
<td></td>
<td>.70</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.23</td>
</tr>
<tr>
<td>31. Saying goodbye hard</td>
<td>.22</td>
<td>.69</td>
<td></td>
<td>-.18</td>
<td>-.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Enjoy spend time alone</td>
<td></td>
<td></td>
<td>-.77</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.11</td>
</tr>
<tr>
<td>6. Miss company if alone</td>
<td>.20</td>
<td>.72</td>
<td>.19</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. Need people around</td>
<td>.41</td>
<td>.19</td>
<td>.59</td>
<td>.20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Rely on o decisions</td>
<td></td>
<td></td>
<td>.83</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Rely on advice others</td>
<td></td>
<td></td>
<td>.79</td>
<td>.17</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Make decisions alone</td>
<td>.27</td>
<td></td>
<td>-.26</td>
<td>-.60</td>
<td>-.21</td>
<td>.28</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Get into arguments</td>
<td>.23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.72</td>
</tr>
</tbody>
</table>

19 February 2002
### Vulnerable Attachment Style Questionnaire

<table>
<thead>
<tr>
<th>Item</th>
<th>Correlation</th>
<th>Correlation</th>
<th>Correlation</th>
<th>Correlation</th>
<th>Correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 Clingy with o</td>
<td>-.18</td>
<td>.23</td>
<td>.67</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 Want to see more friends</td>
<td></td>
<td>.15</td>
<td></td>
<td></td>
<td>.81</td>
</tr>
<tr>
<td>20 See friends/fam often</td>
<td>-.29</td>
<td>.28</td>
<td></td>
<td></td>
<td>-.46</td>
</tr>
<tr>
<td>23 Uneasy o confide</td>
<td>.18</td>
<td>.36</td>
<td>.43</td>
<td>.23</td>
<td>.35</td>
</tr>
<tr>
<td>5 Important have control</td>
<td>-.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Eigen values</strong></td>
<td>5.34</td>
<td>3.03</td>
<td>2.29</td>
<td>2.07</td>
<td>1.69</td>
</tr>
</tbody>
</table>

( Correlations over .15 only included)
Data Acquisition List

Patient Name: ..............................................................................................................................

Patient Eddie Number: ................................................................................................................

Patient Study Number: ................................................................................................................

Q1: Date of First Appointment: ....................................................................................................

Q2: Residence in Leicestershire?
   1. City
   2. County

Q3: Diagnosis at assessment?
   1. BN
   2. PSBN

Q4: Failed to appear for treatment against the advice of therapist before 10th ses?
   1. Y
   2. N

Q5: If yes,
   1. Failed to complete assessment.
   2. Completed assessment but did not attend first therapy appointment.
   3. Attended 3 or fewer sessions.
   4. Attended 4-9 sessions.

Q6: Age at assessment ...................................................................................................................

Q7: Employment status at assessment?
   1. Employed F-T
   2. Employed P-T
   3. Unemployed
   4. Housewife/husband
   5. Disabled
   6. Student
   7. Other

Q8: Domestic circumstances?
   1. Fm. Origin
   2. Partner
   3. On own
   4. Institution
   4. Other

Q9: How much time elapsed from referral letter to start of assessment? ..................
Q10: How much elapsed from end of assessment to start of treatment?  

Q11 Has patient reported previous experience with IP or OP psychiatric 
trmt for ED or other problem?  
1. Y
2. N

*Q12 SCL-90 scores  
GSI:  
PST:  
PSDI:  

Q13 Patient vomits how often per week?  

Q14 Patient uses how many laxatives how often per week?  

Q15 Patient has been affected by any form of ED for how long?  

Q16 Has patient reported any childhood sexual abuse?  
1. Y
2. N

CSA defined as sexual contact occurring between a victim aged 13 or younger and 
a perpetrator aged 16 or older or between a victim aged 13-15 and a perpetrator 5 
or more years older.

Q17 Has patient reported any childhood physical abuse?  
1. Y
2. N

CPA defined as being hit, kicked, restrained, or materially neglected by a 
caregiver before age of 16. Care giver is parent or guardian or an adult living in 
child’s home.

Q18 Were patient's parents separated or divorced before p's 16th birthday?  
1. Y
2. N

Q19 Did either of patient's parents die before p's 16th birthday?  
1. Y
2. N

^ Q  Educational qualifications (highest level attained to date) 

☐ Level 1 (no qualifications/CSE only/no GCSE higher than grade D)  
☐ Level 2 (O level or GCSE -- at least one reaching Grade C)  
☐ Level 3 (A levels/B tech/Equivalent)  
☐ 4. First Degree or Equivalent  
☐ 5. Higher Degree  
☐ 6. Other

^ Q  What is patient’s occupation?  


Eating Disorders Inventory

DT:
B:
BD:
IE:
P:
ID:
IA:
MF:

* Rosenberg Self-Esteem
Score:

* Data gathered only for Chapter 5.
^ Data gathered only for Chapter 6.
Appendix 7-1. Plot of scores for Factors 1 & 2. No major outliers apparent.
Appendix 7-2. Plot of scores for Factors 1 & 3. No major outliers apparent, though high score on Factor 3 checked for possible error.
Appendix 7-3. Plot of scores for Factors 1 & 4. No major outliers apparent.
### Vulnerable Attachment Styles Questionnaire

#### Factor Analysis Communalities

<table>
<thead>
<tr>
<th>Items</th>
<th>Extraction</th>
</tr>
</thead>
<tbody>
<tr>
<td>I take my time getting to know people.</td>
<td>0.636</td>
</tr>
<tr>
<td>I rely on others to help me make decisions in life.</td>
<td>0.650</td>
</tr>
<tr>
<td>People let me down a lot.</td>
<td>0.638</td>
</tr>
<tr>
<td>I see friends and family often.</td>
<td>0.723</td>
</tr>
<tr>
<td>It's important to have control over my life.</td>
<td>0.759</td>
</tr>
<tr>
<td>I miss the company of others when I'm alone.</td>
<td>0.671</td>
</tr>
<tr>
<td>It's best not to get too emotionally close to other people.</td>
<td>0.628</td>
</tr>
<tr>
<td>I worry a lot if people I live with arrive back later than expected.</td>
<td>0.632</td>
</tr>
<tr>
<td>I usually rely on advice from others when I've got a problem.</td>
<td>0.740</td>
</tr>
<tr>
<td>I feel uncomfortable when people get too close to me.</td>
<td>0.589</td>
</tr>
<tr>
<td>I have lots of friends.</td>
<td>0.516</td>
</tr>
<tr>
<td>People close to me often get on my nerves.</td>
<td>0.595</td>
</tr>
<tr>
<td>I feel people are against me.</td>
<td>0.634</td>
</tr>
<tr>
<td>I find it easy to ask people for help.</td>
<td>0.681</td>
</tr>
<tr>
<td>I worry about things happening to close family and friends.</td>
<td>0.538</td>
</tr>
<tr>
<td>I often get into arguments.</td>
<td>0.517</td>
</tr>
<tr>
<td>I'm clingy with others.</td>
<td>0.606</td>
</tr>
<tr>
<td>I look forward to spending time on my own.</td>
<td>0.610</td>
</tr>
<tr>
<td>I would like to see more of my friends than I do.</td>
<td>0.650</td>
</tr>
<tr>
<td>I like making decisions on my own.</td>
<td>0.661</td>
</tr>
<tr>
<td>I get anxious when people close to me are away.</td>
<td>0.648</td>
</tr>
<tr>
<td>I feel close to people very quickly.</td>
<td>0.597</td>
</tr>
<tr>
<td>I feel uneasy when others confide in me.</td>
<td>0.399</td>
</tr>
<tr>
<td>I can make relationships very quickly.</td>
<td>0.688</td>
</tr>
<tr>
<td>I find it hard to trust others.</td>
<td>0.579</td>
</tr>
<tr>
<td>Having people around me can be a nuisance.</td>
<td>0.588</td>
</tr>
<tr>
<td>I feel people haven't done enough for me.</td>
<td>0.619</td>
</tr>
<tr>
<td>I enjoy meeting new people.</td>
<td>0.617</td>
</tr>
<tr>
<td>It's important to have people around me a lot of the time.</td>
<td>0.657</td>
</tr>
<tr>
<td>I find it difficult to confide in people.</td>
<td>0.686</td>
</tr>
<tr>
<td>Saying goodbye to close family and friends is difficult.</td>
<td>0.603</td>
</tr>
</tbody>
</table>

*Extraction Method: Principal Component Analysis.*
**Factor Analysis of VASQ**

*Details of components with eigenvalues >1.0 before and after Varimax rotation*

<table>
<thead>
<tr>
<th>Component</th>
<th>Initial Eigenvalues</th>
<th>Rotation Sums of Squared Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>% of Variance</td>
</tr>
<tr>
<td>1</td>
<td>8.35</td>
<td>20.103</td>
</tr>
<tr>
<td>2</td>
<td>3.94</td>
<td>14.051</td>
</tr>
<tr>
<td>3</td>
<td>1.94</td>
<td>9.347</td>
</tr>
<tr>
<td>4</td>
<td>1.59</td>
<td>5.847</td>
</tr>
<tr>
<td>5</td>
<td>1.41</td>
<td>4.714</td>
</tr>
<tr>
<td>6</td>
<td>1.24</td>
<td>4.418</td>
</tr>
<tr>
<td>7</td>
<td>1.13</td>
<td>3.953</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.
TOPIC GUIDE FOR CHAPTER 8

Introduction

Study Explanation.
Who I am (Research Assistant in the Psychiatry Department, University of Leicester, also working on a PhD in eating disorders).

Why I am doing interviews. Trying to find out more about reasons people have for staying in therapy for eating disorders or leaving it.

There are no right answers, no wrong answers, just trying to find out the range of reasons people have for staying in therapy or leaving it. Also trying to find out about the process people go through while in therapy that leads to their staying in or leaving.

Anything said is confidential, will not be shared with anyone involved in your treatment, past, present or future.

Interview will last around an hour.

Tape recording is confidential. Only I will listen to it. I use it just so I don’t miss anything you say by trying to write your words down while you’re talking. I will transcribe bits of it to clarify specific issues, but any identifying details will be changed. You’re welcome to a copy.

Patient Background
Tell me a little about yourself (how old are you, who do you live with, where do you live, what do you do for living)? Expand on this area for attachment info, for contextual information about coming for treatment. Lead on to treatment episodes if comfortable.

General Information Regarding Service Contact
How did you come into contact with the service (originally/this most recent time) (Some people came because their GP referred them, or someone close to them asked them to come, or they decided it was time for a change: Were any of these reasons relevant for you)?

When was that?

Have you been in contact with the service before? With any other services?

What are some of the reasons you came into contact with the service (this time)? (Sometimes people come into the service because things have reached a crisis and they feel they need to sort them out, whereas other people come
because they want to please someone close to them. Still other people come for reasons that have nothing to do with their eating disorder. Were your reasons anything like these, or were they totally different)?

**Description of Treatment Period**

How long did you go/have you been coming to treatment (this time)?

How frequently did/do you come (every week, off-and-on, etc)?

*For those no longer in treatment:*
When did you stop going to treatment?

How was this accomplished (Negotiated? Not negotiated?)

**Reasons for Persistence/Termination**

Reasons

*For those no longer in treatment:*
What were some of the reasons that you stopped?

*/ not negotiated:*
Was leaving a conscious decision? Or did it just happen?

Was treatment meeting your needs or not? What were some of those?

Was it meeting your expectations or not? What were some of those?

Did you find yourself thinking about your treatment when you weren’t in a session? What were some of the things you thought? (using work done in session afterwards? Replaying mental ‘tape’ of therapist to help in difficult situations?)

Did you talk about your treatment with anyone outside the hospital (other than me!)?

What do you imagine might have happened if you had stayed in?

Do you wish you had?

What would have needed to be different for you to be able to stay in?

*For those still in treatment or who completed treatment:*

Back during assessment and the first couple of months of treatment, what were some of the reasons you had for staying?

(Was it helping you? Were you determined to finish something you had begun?)

Was treatment meeting your needs? What were some of those?

Was it meeting your expectations? What were some of those?
Did you find yourself thinking about your treatment when you weren’t in a session? What were some of the things you thought? (using work done in session afterwards? Replaying mental ‘tape’ of therapist to help in difficult situations?)

Did you talk about your treatment with anyone outside the hospital (other than me!)?

Did you think about leaving treatment at all?

What do you imagine might have happened if you had left?

Have your reasons for staying in treatment changed at all since those early weeks?

**Consequences**

*For those left early or completed:*

What did it feel like when you did stop? (Relieved? Lost? Guilty?)

What were some of the effects on you after you stopped? (Any pressure from parents? Symptoms worse? Better? Feel more/less in control?)

*For those still in treatment:*

How would you feel if you had to stop going to treatment?

**Decision Process**

**Process**

Some people talk about decision-making as a process. If you think of it like this, how would you describe how you came to decide to stay in/leave treatment? What were contributory factors?

What was it like in the beginning? How did you feel about coming to assessment and then to therapy?

Was there a ‘middle’ period? How did you feel staying in treatment?

Was there an end?

Do you think YOU changed at all during this process? In what ways?

**Changes over time**

Were there any changes in your feelings about treatment over the time you were in treatment? (Was there anything that surprised you? Was there anything that you hadn’t expected?)

How about after you stopped going? Have there been any changes since then?
For previous referrals:
How about other times you’ve been in treatment, did you feel different then?

Overall Definition of Treatment

Definition of construct
How do you see treatment, what did it mean for you? How would you describe it for someone who has never heard of it before?

Benefits/Drawbacks
For you, what are/were some of the good things about going for treatment (dealing with problem, liking therapist, understanding more about self)?
Anything else?
What are/were some of the bad things (having to gain weight, inconvenient, stigmatising)?
Anything else?
How did you come to believe these things (other people, experiences)?

Change over time
Did you always feel this way, or have your beliefs changed at any time?
What influenced those changes (other people, experiences)?

Agents
When you started treatment, did you have a clear idea of what was being offered?
What were your assumptions?
What did you think your role would be in treatment?
How about your therapist’s?

Suggestions for Change
What would you change about treatment if you could?
Do you think that treatment addresses/addressed things that were relevant to your being eating disordered?
If not, what would be more helpful?
Would you want to see your therapist more often? Why?
18 June, 1998

Ms J Mahon
Research Assistant
Academic Department of Psychiatry
Brandon Mental Health Unit
Leicester General Hospital

Dear Ms Mahon

Clients' reasons for engaging in or terminating treatment for eating disorders - our ref. no. 5113

Further to your application dated 21 May 1998, you will be pleased to know that the Leicestershire Ethics Committee at its meeting held on the 5 June 1998 approved your request to undertake the above-mentioned research conditional upon all the investigators being listed, and the documents for patients being put on to headed notepaper.

Your attention is drawn to the attached paper which reminds the researcher of information that needs to be observed when ethics committee approval is given.

Yours sincerely

R F Bing
Chairman
Leicestershire Ethics Committee

(NB All communications relating to Leicestershire Ethics Committee must be sent to the Committee Secretariat at Leicestershire Health)
**Therapy Relationship Questionnaire (Patient and Clinician)
Items, Scale, and Response Distribution**

<table>
<thead>
<tr>
<th>Patient items:</th>
<th>No, Not at All</th>
<th>Not Sure</th>
<th>Yes, Definitely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you feel you could talk to your assessor about the issues that are most important to you?</td>
<td>0</td>
<td>4</td>
<td>22</td>
</tr>
<tr>
<td>2. Did you feel safe with your assessor?</td>
<td>0</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td>3. Did you feel you could show your real self to your assessor?</td>
<td>1</td>
<td>10</td>
<td>37</td>
</tr>
<tr>
<td>4. Did your assessor ask about things that seem relevant to your problems?</td>
<td>1</td>
<td>7</td>
<td>12</td>
</tr>
<tr>
<td>5. Did you feel your assessor treated you like a child?*</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>6. Did you feel your assessor understood you?</td>
<td>3</td>
<td>9</td>
<td>32</td>
</tr>
<tr>
<td>7. Did you feel your assessor was competent?</td>
<td>2</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>8. Did you feel you needed to do what your assessor wanted or you wouldn't be given treatment?*</td>
<td>2</td>
<td>11</td>
<td>20</td>
</tr>
<tr>
<td>9. Do you feel it is possible for someone who has not had an eating disorder to help you recover from your eating disorder?</td>
<td>4</td>
<td>11</td>
<td>54</td>
</tr>
<tr>
<td>10. Do you feel you can be helped to recover from your eating disorder?</td>
<td>3</td>
<td>12</td>
<td>43</td>
</tr>
<tr>
<td>11. Did you find yourself wondering whether your assessor will think you are a fraud?*</td>
<td>14</td>
<td>28</td>
<td>17</td>
</tr>
<tr>
<td>12. Did your assessor challenge you in a good way?</td>
<td>2</td>
<td>5</td>
<td>45</td>
</tr>
<tr>
<td>13. Did you feel criticised by your assessor?*</td>
<td>3</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>14. Did you feel your assessor cared about you as a person?</td>
<td>1</td>
<td>7</td>
<td>41</td>
</tr>
<tr>
<td>15. Did you feel you could tell your assessor the truth?</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>16. Did you feel that your assessor took you seriously?</td>
<td>1</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>17. Did you feel your assessor gave in to you?*</td>
<td>1</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>18. Did you feel your assessor was honest with you?</td>
<td>1</td>
<td>1</td>
<td>12</td>
</tr>
</tbody>
</table>
19. Did you feel intimidated by your assessor?*
   3 13 17 27 48

20. Did you trust your assessor?
   1 5 17 46 39

21. Did you feel you had a choice about what you did in assessment?
   8 19 30 26 25

22. Has assessment given you any new information?
   20 24 23 27 14

23. Did you feel that assessment was helpful to you?
   4 13 32 34 25

24. Do you want to complete assessment with this assessor?
   3 1 20 28 56

Clinician items:

1. Do you feel comfortable with this patient as a person?
   0 5 26 54 23

2. Do you feel you easily understand this patient?
   1 7 34 52 14

3. Do you feel this patient is honest with you?
   0 6 29 56 17

4. Do you feel this patient is overly critical of you?*
   0 4 20 23 61

5. Do you feel that a trusting relationship is developing with this patient?
   0 9 52 42 5

6. Do you think this patient will complete the course of therapy?
   2 12 53 37 4

7. Are you finding it difficult to establish a meaningful connection with this patient?*
   2 16 28 28 34

* Items reverse-scored.

Qualitative items for the TRQ (patient):

25. What are some of the good things that happened in the session today?
26. What are some of the bad things?
27. Is there anything you would like to add at this stage about your relationship with your assessor?

Qualitative items for the TRQ (clinician):

8. Do any factors make you think this patient will complete assessment? What are they?
9. If they differ from Q9, which factors make you think this patient will complete therapy?
10. Do any factors make you think this patient will leave treatment prematurely? What are they?
Appendix 9-2

RESEARCH PROJECT ON ENGAGING IN OR TERMINATING TREATMENT FOR EATING DISORDERS
Jennifer Mahon 0116-*** or 01342-***

INFORMATION LEAFLET

**What is the purpose of the study?**
We are exploring why people stay in or leave psychological treatment for eating disorders. We are trying to get a picture of how people’s relationships with their therapists affect their decision to stay in or to go, and how some of their relationships in the past might affect their decision to stay in or to go. This study will build on three other studies we have recently finished which have been looking at the same important problem.

**What will be involved if I agree to take part?**
There will be two parts of the study.
- First, you will be asked to fill in a set of questionnaires when you finish your first assessment session. These will ask about relationships you are in today, as well as ones you’ve had in the past. These will probably take you about half an hour to fill in, depending on how much you want to add.
- Second, you will be asked to fill in a short questionnaire after your assessment session, then again after each of your first three therapy sessions, should you decide that you want to take up therapy. This questionnaire will ask about your feelings toward your therapist. It should take about 5 minutes to fill in.

**Will the information collected in the study be confidential?**
The questionnaires will be strictly confidential and will not be revealed to anyone outside the research team. You might notice that all of the questionnaires are coded, so your name will never be on the same sheet as your responses.

**Are there risks to me in taking part?**
As with most research of this kind, it is possible that you might find filling in questionnaires about your experiences upsetting. We would like to assure you, however, that your feelings will be respected. You will be able to talk about any concerns which may arise as a result of the questionnaires. You will of course have the right to withdraw from the study at any time.

**What are the potential benefits of this research?**
We hope this research will increase our understanding of the factors that contribute to people’s decision to stay in or leave treatment. This should help us tailor treatment to better meet the needs of clients.

Please call Jennifer Mahon between 8 am and 6 pm on the above numbers if you have ANY questions.
PATIENT CONSENT FORM

RESEARCH PROJECT ON ENGAGING IN OR TERMINATING TREATMENT FOR EATING DISORDERS
Jennifer Mahon 0116-225-6184 or 01342-810-492

This form should be read in conjunction with the patient information leaflet.

I agree to take part in the above study as described in the patient information leaflet.

I understand that I may withdraw from the study at any time without justifying my decision and without affecting my normal care and medical management.

I understand that members of the research team may wish to review relevant sections of my medical records, but that all the information will be treated as confidential.

I understand that medical research is covered for mishaps in the same way as for patients undergoing treatment in the NHS, i.e. compensation is only available if mishap occurs.

I have read the patient information leaflet on the above study and have had the opportunity to discuss the details with Jennifer Mahon and ask any questions. The nature and the purpose of the study have been explained to me and I understand what will be required if I take part in the study.

Signature of patient .................................................................
Date .........................................................................................
Name in BLOCK LETTERS............................................................

I confirm that I have explained the nature of the Study, as detailed in the patient information leaflet, in terms which in my judgement are suited to the understanding of the patient.

Signature of the investigator..........................................................
Date .........................................................................................
Name in BLOCK LETTERS............................................................
Dear Client,

We are currently conducting a study in order to learn more about what affects people’s decision to stay in or leave treatment. We need the help of people who are coming into the clinic for assessment – that means you! If we can understand better what people’s experience of treatment is like, we might be able to improve the treatment we offer. An information leaflet about the study is attached.

This is a joint study between the University of Leicester and Royal Holloway, University of London. The researchers are independent of the therapy team, so none of the information you provide will be passed on to your assessor or therapist.

If you are willing to help with this study, you will be asked to fill in 1 long set of questionnaires and then 3 short individual questionnaires over the first few weeks of treatment. The questionnaires have been developed from a series of in-depth interviews with clients. The questionnaires will ask about your feelings about the session you just had. Ideally, you would fill in the questionnaire soon after the session, so it is still fresh in your mind.

Each time you are given a questionnaire, you will be provided with a freepost envelope to post the questionnaires back to the researchers, so participating will not cost you any money. The freepost envelope can be posted in any post box, or, if this is not convenient for you, you can give it to the secretary, who will post it for you.

If you would like to help us with this study, please sign the attached consent form after reading the information leaflet, and return it in the freepost envelope with your first questionnaire. In order to safeguard your privacy, the consent form will be stored separately from your questionnaires and medical records. Keep the information leaflet for your own records.

If you have any questions, ring Jennifer Mahon on 0116-*** or 01342-***.

Thank you.

Jennifer Mahon and Antonia Bifulco
(with approval from Dr. R.L. Palmer)
### Appendix 9-5

**Therapy Relationship Questionnaire (1-24 patient and 1-7 clinician)**

**Correlation Matrix**

<table>
<thead>
<tr>
<th>TRQ item</th>
<th>1.000</th>
<th>0.301</th>
<th>0.280</th>
<th>0.235</th>
<th>-0.104</th>
<th>0.241</th>
<th>0.043</th>
<th>0.096</th>
<th>0.394</th>
<th>1.000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 important issues</td>
<td>1.000</td>
<td>0.285</td>
<td>0.296</td>
<td>0.235</td>
<td>-0.104</td>
<td>0.241</td>
<td>0.043</td>
<td>0.096</td>
<td>0.394</td>
<td>1.000</td>
</tr>
<tr>
<td>2 safe</td>
<td>0.549</td>
<td>1.000</td>
<td>1.000</td>
<td>0.280</td>
<td>0.106</td>
<td>0.235</td>
<td>0.245</td>
<td>0.114</td>
<td>0.038</td>
<td>-0.038</td>
</tr>
<tr>
<td>3 real self</td>
<td>0.712</td>
<td>0.578</td>
<td>0.100</td>
<td>0.295</td>
<td>0.177</td>
<td>0.229</td>
<td>0.165</td>
<td>0.396</td>
<td>0.107</td>
<td>0.047</td>
</tr>
<tr>
<td>4 relevant</td>
<td>0.385</td>
<td>0.164</td>
<td>0.712</td>
<td>0.288</td>
<td>0.234</td>
<td>0.329</td>
<td>0.221</td>
<td>0.185</td>
<td>0.226</td>
<td>0.326</td>
</tr>
<tr>
<td>5 (not)child</td>
<td>0.156</td>
<td>0.098</td>
<td>0.012</td>
<td>0.158</td>
<td>1.000</td>
<td>0.295</td>
<td>0.229</td>
<td>0.165</td>
<td>0.396</td>
<td>0.107</td>
</tr>
<tr>
<td>6 understands you</td>
<td>0.387</td>
<td>0.310</td>
<td>0.331</td>
<td>0.305</td>
<td>0.347</td>
<td>1.000</td>
<td>0.295</td>
<td>0.229</td>
<td>0.165</td>
<td>0.396</td>
</tr>
<tr>
<td>7 competent</td>
<td>0.315</td>
<td>0.384</td>
<td>0.387</td>
<td>0.268</td>
<td>0.040</td>
<td>0.234</td>
<td>0.341</td>
<td>0.185</td>
<td>0.226</td>
<td>0.326</td>
</tr>
<tr>
<td>8 (not) contingent</td>
<td>0.346</td>
<td>0.430</td>
<td>0.359</td>
<td>0.221</td>
<td>0.210</td>
<td>0.240</td>
<td>0.288</td>
<td>0.185</td>
<td>0.226</td>
<td>0.326</td>
</tr>
<tr>
<td>9 no ED help</td>
<td>0.273</td>
<td>0.215</td>
<td>0.296</td>
<td>0.173</td>
<td>0.267</td>
<td>0.210</td>
<td>0.143</td>
<td>0.226</td>
<td>0.326</td>
<td></td>
</tr>
<tr>
<td>10 can be helped</td>
<td>0.120</td>
<td>0.285</td>
<td>0.296</td>
<td>0.235</td>
<td>-0.104</td>
<td>0.241</td>
<td>0.043</td>
<td>0.096</td>
<td>0.394</td>
<td>1.000</td>
</tr>
<tr>
<td>11 (not)/fraud</td>
<td>0.274</td>
<td>0.192</td>
<td>0.256</td>
<td>0.280</td>
<td>0.096</td>
<td>0.233</td>
<td>0.135</td>
<td>0.268</td>
<td>0.214</td>
<td>0.182</td>
</tr>
<tr>
<td>12 good challenge</td>
<td>0.237</td>
<td>0.204</td>
<td>0.236</td>
<td>0.235</td>
<td>0.015</td>
<td>0.245</td>
<td>0.211</td>
<td>0.114</td>
<td>0.038</td>
<td>-0.038</td>
</tr>
<tr>
<td>13 (not) criticised</td>
<td>0.413</td>
<td>0.363</td>
<td>0.312</td>
<td>0.268</td>
<td>0.254</td>
<td>0.455</td>
<td>0.288</td>
<td>0.171</td>
<td>0.396</td>
<td>0.107</td>
</tr>
<tr>
<td>14 cares about you</td>
<td>0.338</td>
<td>0.312</td>
<td>0.312</td>
<td>0.232</td>
<td>0.295</td>
<td>0.356</td>
<td>0.239</td>
<td>0.272</td>
<td>0.326</td>
<td></td>
</tr>
<tr>
<td>15 tell truth</td>
<td>0.484</td>
<td>0.442</td>
<td>0.545</td>
<td>0.338</td>
<td>0.171</td>
<td>0.344</td>
<td>0.211</td>
<td>0.322</td>
<td>0.134</td>
<td>0.165</td>
</tr>
<tr>
<td>16 seriously</td>
<td>0.470</td>
<td>0.590</td>
<td>0.483</td>
<td>0.326</td>
<td>0.157</td>
<td>0.389</td>
<td>0.339</td>
<td>0.571</td>
<td>0.323</td>
<td>0.240</td>
</tr>
<tr>
<td>17 (not) give in</td>
<td>0.124</td>
<td>0.096</td>
<td>0.201</td>
<td>0.052</td>
<td>0.106</td>
<td>0.082</td>
<td>0.245</td>
<td>0.235</td>
<td>-0.028</td>
<td>-0.110</td>
</tr>
<tr>
<td>18 honest with you</td>
<td>0.337</td>
<td>0.225</td>
<td>0.290</td>
<td>0.179</td>
<td>0.026</td>
<td>0.193</td>
<td>0.310</td>
<td>0.466</td>
<td>0.386</td>
<td>0.036</td>
</tr>
<tr>
<td>19 (not) intimidated</td>
<td>0.402</td>
<td>0.408</td>
<td>0.373</td>
<td>0.152</td>
<td>0.177</td>
<td>0.229</td>
<td>0.165</td>
<td>0.396</td>
<td>0.107</td>
<td>0.047</td>
</tr>
<tr>
<td>20 trust</td>
<td>0.502</td>
<td>0.531</td>
<td>0.479</td>
<td>0.159</td>
<td>0.106</td>
<td>0.337</td>
<td>0.398</td>
<td>0.353</td>
<td>0.234</td>
<td>0.226</td>
</tr>
<tr>
<td>21 choice</td>
<td>0.383</td>
<td>0.267</td>
<td>0.318</td>
<td>0.340</td>
<td>0.056</td>
<td>0.276</td>
<td>0.123</td>
<td>0.299</td>
<td>0.184</td>
<td>0.130</td>
</tr>
<tr>
<td>22 new information</td>
<td>0.197</td>
<td>0.090</td>
<td>0.191</td>
<td>0.314</td>
<td>0.179</td>
<td>0.277</td>
<td>0.136</td>
<td>0.154</td>
<td>0.105</td>
<td>0.276</td>
</tr>
<tr>
<td>23 helping</td>
<td>0.450</td>
<td>0.392</td>
<td>0.360</td>
<td>0.336</td>
<td>0.126</td>
<td>0.377</td>
<td>0.229</td>
<td>0.330</td>
<td>0.262</td>
<td>0.449</td>
</tr>
<tr>
<td>24 stay in</td>
<td>0.454</td>
<td>0.371</td>
<td>0.379</td>
<td>0.369</td>
<td>0.281</td>
<td>0.385</td>
<td>0.241</td>
<td>0.213</td>
<td>0.184</td>
<td>0.157</td>
</tr>
<tr>
<td>1 comfortable</td>
<td>0.188</td>
<td>0.083</td>
<td>0.205</td>
<td>0.169</td>
<td>0.006</td>
<td>0.060</td>
<td>0.161</td>
<td>0.237</td>
<td>-0.016</td>
<td>0.178</td>
</tr>
<tr>
<td>2 understand pt</td>
<td>0.267</td>
<td>0.101</td>
<td>0.200</td>
<td>0.280</td>
<td>0.029</td>
<td>0.122</td>
<td>0.104</td>
<td>0.098</td>
<td>0.017</td>
<td>0.223</td>
</tr>
<tr>
<td>3 pt honest</td>
<td>0.187</td>
<td>0.038</td>
<td>0.165</td>
<td>0.200</td>
<td>-0.044</td>
<td>0.003</td>
<td>0.124</td>
<td>0.151</td>
<td>0.012</td>
<td>0.161</td>
</tr>
<tr>
<td>4 pt (not) critical</td>
<td>0.084</td>
<td>0.134</td>
<td>0.040</td>
<td>0.061</td>
<td>-0.035</td>
<td>-0.118</td>
<td>-0.011</td>
<td>0.235</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 trusting rel</td>
<td>0.266</td>
<td>0.175</td>
<td>0.258</td>
<td>0.121</td>
<td>0.020</td>
<td>0.135</td>
<td>0.217</td>
<td>0.305</td>
<td>-0.034</td>
<td>0.200</td>
</tr>
<tr>
<td>6 complete</td>
<td>0.106</td>
<td>0.071</td>
<td>0.117</td>
<td>0.068</td>
<td>-0.022</td>
<td>0.049</td>
<td>0.115</td>
<td>0.220</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 connect (not) dfclt</td>
<td>0.150</td>
<td>0.138</td>
<td>0.135</td>
<td>0.188</td>
<td>-0.072</td>
<td>0.054</td>
<td>0.067</td>
<td>0.212</td>
<td>-0.035</td>
<td>0.169</td>
</tr>
<tr>
<td>13 (not) criticised</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 cares about you</td>
<td>0.346</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 tell truth</td>
<td>0.396</td>
<td>0.322</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 seriously</td>
<td>0.548</td>
<td>0.492</td>
<td>0.499</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 (not) give in</td>
<td>0.130</td>
<td>0.031</td>
<td>0.272</td>
<td>0.050</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 honest with you</td>
<td>0.522</td>
<td>0.344</td>
<td>0.394</td>
<td>0.570</td>
<td>0.131</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 (not) intimidated</td>
<td>0.481</td>
<td>0.207</td>
<td>0.429</td>
<td>0.310</td>
<td>0.260</td>
<td>0.310</td>
<td>1.000</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 trust</td>
<td>0.469</td>
<td>0.350</td>
<td>0.527</td>
<td>0.538</td>
<td>0.133</td>
<td>0.409</td>
<td>0.421</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21 choice</td>
<td>0.344</td>
<td>0.379</td>
<td>0.321</td>
<td>0.443</td>
<td>-0.009</td>
<td>0.368</td>
<td>0.220</td>
<td>0.202</td>
<td>1.000</td>
<td></td>
</tr>
<tr>
<td>22 new information</td>
<td>0.247</td>
<td>0.352</td>
<td>0.249</td>
<td>0.265</td>
<td>0.029</td>
<td>0.273</td>
<td>0.126</td>
<td>0.110</td>
<td>0.314</td>
<td>1.000</td>
</tr>
<tr>
<td>23 helping</td>
<td>0.336</td>
<td>0.486</td>
<td>0.323</td>
<td>0.496</td>
<td>-0.009</td>
<td>0.408</td>
<td>0.336</td>
<td>0.347</td>
<td>0.421</td>
<td>0.595</td>
</tr>
<tr>
<td>24 stay in</td>
<td>0.309</td>
<td>0.382</td>
<td>0.337</td>
<td>0.392</td>
<td>0.106</td>
<td>0.278</td>
<td>0.372</td>
<td>0.270</td>
<td>0.215</td>
<td>0.438</td>
</tr>
<tr>
<td>1 comfortable</td>
<td>0.221</td>
<td>0.023</td>
<td>0.107</td>
<td>0.074</td>
<td>-0.021</td>
<td>0.091</td>
<td>0.330</td>
<td>0.107</td>
<td>0.095</td>
<td>0.276</td>
</tr>
<tr>
<td>2 understand pt</td>
<td>0.125</td>
<td>0.112</td>
<td>0.133</td>
<td>0.070</td>
<td>-0.082</td>
<td>0.074</td>
<td>0.222</td>
<td>0.091</td>
<td>0.093</td>
<td>0.189</td>
</tr>
<tr>
<td>3 pt honest</td>
<td>0.136</td>
<td>0.018</td>
<td>0.067</td>
<td>0.038</td>
<td>-0.065</td>
<td>0.114</td>
<td>0.209</td>
<td>0.108</td>
<td>0.158</td>
<td>0.273</td>
</tr>
<tr>
<td>4 pt (not) critical</td>
<td>0.136</td>
<td>0.058</td>
<td>-0.087</td>
<td>0.026</td>
<td>-0.072</td>
<td>0.096</td>
<td>0.127</td>
<td>0.026</td>
<td>0.022</td>
<td>0.122</td>
</tr>
<tr>
<td>5 trusting rel</td>
<td>0.323</td>
<td>-0.082</td>
<td>0.137</td>
<td>0.120</td>
<td>-0.009</td>
<td>0.243</td>
<td>0.347</td>
<td>0.273</td>
<td>0.007</td>
<td>0.166</td>
</tr>
<tr>
<td>6 complete</td>
<td>0.194</td>
<td>-0.034</td>
<td>0.046</td>
<td>-0.012</td>
<td>0.032</td>
<td>0.141</td>
<td>0.228</td>
<td>0.116</td>
<td>0.019</td>
<td>0.185</td>
</tr>
<tr>
<td>7 connect (not) dfclt</td>
<td>0.070</td>
<td>0.033</td>
<td>0.078</td>
<td>0.069</td>
<td>-0.084</td>
<td>0.042</td>
<td>0.229</td>
<td>0.053</td>
<td>0.259</td>
<td>0.248</td>
</tr>
<tr>
<td></td>
<td>1 comfortable</td>
<td>2 understand pt</td>
<td>3 pt honest</td>
<td>4 pt (not) critical</td>
<td>5 trusting rel</td>
<td>6 complete</td>
<td>7 connect (not) dfclt</td>
<td>8 stay in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---------------</td>
<td>-----------------</td>
<td>------------</td>
<td>--------------------</td>
<td>---------------</td>
<td>-----------</td>
<td>---------------------</td>
<td>---------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1.000</td>
<td>0.581</td>
<td>0.698</td>
<td>0.457</td>
<td>0.683</td>
<td>0.520</td>
<td>0.579</td>
<td>0.579</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>1.000</td>
<td>1.000</td>
<td>0.684</td>
<td>0.344</td>
<td>0.556</td>
<td>0.334</td>
<td>0.497</td>
<td>0.497</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>1.000</td>
<td>1.000</td>
<td>0.605</td>
<td>1.000</td>
<td>0.619</td>
<td>0.484</td>
<td>0.642</td>
<td>0.642</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>0.407</td>
<td>0.347</td>
<td>0.562</td>
<td>0.562</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>1.000</td>
<td>0.479</td>
<td>1.000</td>
<td>1.000</td>
<td>0.519</td>
<td>0.598</td>
<td>1.000</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1.000</td>
<td>0.106</td>
<td>0.106</td>
<td>0.106</td>
<td>0.106</td>
<td>0.106</td>
<td>0.106</td>
<td>0.106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>stay in</td>
<td>1.000</td>
<td>0.155</td>
<td>0.240</td>
<td>0.097</td>
<td>0.177</td>
<td>0.016</td>
<td>0.106</td>
<td>0.106</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Therapy Relationship Questionnaire (Patient and Clinician)

#### Initial Factor Analysis Communalities

**Patient items:**

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Communalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Did you feel you could talk to your assessor about the issues that are most important to you?</td>
<td>0.689</td>
</tr>
<tr>
<td>2.</td>
<td>Did you feel safe with your assessor?</td>
<td>0.765</td>
</tr>
<tr>
<td>3.</td>
<td>Did you feel you could show your real self to your assessor?</td>
<td>0.752</td>
</tr>
<tr>
<td>4.</td>
<td>Did your assessor ask about things that seem relevant to your problems?</td>
<td>0.630</td>
</tr>
<tr>
<td>5.</td>
<td>Did you feel your assessor treated you like a child?</td>
<td>0.694</td>
</tr>
<tr>
<td>6.</td>
<td>Did you feel your assessor understood you?</td>
<td>0.603</td>
</tr>
<tr>
<td>7.</td>
<td>Did you feel your assessor was competent?</td>
<td>0.561</td>
</tr>
<tr>
<td>8.</td>
<td>Did you feel you needed to do what your assessor wanted or you wouldn't be given treatment?</td>
<td>0.635</td>
</tr>
<tr>
<td>9.</td>
<td>Do you feel it is possible for someone who has not had an eating disorder to help you recover from your eating disorder?</td>
<td>0.600</td>
</tr>
<tr>
<td>10.</td>
<td>Do you feel you can be helped to recover from your eating disorder?</td>
<td>0.792</td>
</tr>
<tr>
<td>11.</td>
<td>Did you find yourself wondering whether your assessor will think you are a fraud?</td>
<td>0.740</td>
</tr>
<tr>
<td>12.</td>
<td>Did your assessor challenge you in a good way?</td>
<td>0.637</td>
</tr>
<tr>
<td>13.</td>
<td>Did you feel criticised by your assessor?</td>
<td>0.691</td>
</tr>
<tr>
<td>14.</td>
<td>Did you feel your assessor cared about you as a person?</td>
<td>0.590</td>
</tr>
<tr>
<td>15.</td>
<td>Did you feel you could tell your assessor the truth?</td>
<td>0.593</td>
</tr>
<tr>
<td>16.</td>
<td>Did you feel that your assessor took you seriously?</td>
<td>0.733</td>
</tr>
<tr>
<td>17.</td>
<td>Did you feel your assessor gave in to you?</td>
<td>0.496</td>
</tr>
<tr>
<td>18.</td>
<td>Did you feel your assessor was honest with you?</td>
<td>0.704</td>
</tr>
<tr>
<td>19.</td>
<td>Did you feel intimidated by your assessor?</td>
<td>0.570</td>
</tr>
<tr>
<td>20.</td>
<td>Did you trust your assessor?</td>
<td>0.617</td>
</tr>
<tr>
<td>21.</td>
<td>Did you feel you had a choice about what you did in assessment?</td>
<td>0.708</td>
</tr>
<tr>
<td>22.</td>
<td>Has assessment given you any new information?</td>
<td>0.673</td>
</tr>
<tr>
<td>23.</td>
<td>Did you feel that assessment was helpful to you?</td>
<td>0.727</td>
</tr>
<tr>
<td>24.</td>
<td>Do you want to complete assessment with this assessor?</td>
<td>0.575</td>
</tr>
</tbody>
</table>

**Clinician items:**

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Communalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do you feel comfortable with this patient as a person?</td>
<td>0.724</td>
</tr>
<tr>
<td>2.</td>
<td>Do you feel you easily understand this patient?</td>
<td>0.641</td>
</tr>
<tr>
<td>3.</td>
<td>Do you feel this patient is honest with you?</td>
<td>0.775</td>
</tr>
<tr>
<td>4.</td>
<td>Do you feel this patient is overly critical of you?</td>
<td>0.633</td>
</tr>
<tr>
<td>5.</td>
<td>Do you feel that a trusting relationship is developing with this patient?</td>
<td>0.775</td>
</tr>
<tr>
<td>6.</td>
<td>Do you think this patient will complete the course of therapy?</td>
<td>0.604</td>
</tr>
<tr>
<td>7.</td>
<td>Are you finding it difficult to establish a meaningful connection with this patient?</td>
<td>0.713</td>
</tr>
</tbody>
</table>

* Items reversed for analyses. Extraction method: Principal Component Analysis
**Appendix 9-6b**

*Initial Factor Analysis of TRQ-Patient and –Clinician*

**Details of components with eigenvalues >1.0 before and after Varimax rotation**

<table>
<thead>
<tr>
<th>Component</th>
<th>Total</th>
<th>% of Variance</th>
<th>Total</th>
<th>% of Variance</th>
<th>Cumulative %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>8.35</td>
<td>26.92</td>
<td>4.55</td>
<td>14.68</td>
<td>14.68</td>
</tr>
<tr>
<td>2</td>
<td>3.94</td>
<td>12.70</td>
<td>4.05</td>
<td>13.06</td>
<td>27.74</td>
</tr>
<tr>
<td>3</td>
<td>1.94</td>
<td>6.26</td>
<td>3.08</td>
<td>9.94</td>
<td>37.67</td>
</tr>
<tr>
<td>4</td>
<td>1.59</td>
<td>5.11</td>
<td>2.32</td>
<td>7.50</td>
<td>45.17</td>
</tr>
<tr>
<td>5</td>
<td>1.41</td>
<td>4.56</td>
<td>1.84</td>
<td>5.94</td>
<td>51.12</td>
</tr>
<tr>
<td>6</td>
<td>1.24</td>
<td>3.99</td>
<td>1.71</td>
<td>5.51</td>
<td>56.63</td>
</tr>
<tr>
<td>7</td>
<td>1.13</td>
<td>3.64</td>
<td>1.66</td>
<td>5.35</td>
<td>61.98</td>
</tr>
<tr>
<td>8</td>
<td>1.05</td>
<td>3.40</td>
<td>1.43</td>
<td>4.61</td>
<td>66.58</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.
## Initial Rotated Component Matrix for TRQ-patient and -therapist.

<table>
<thead>
<tr>
<th>TRQ Item:</th>
<th>Component:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you feel this patient is honest with you?</td>
<td>0.855</td>
</tr>
<tr>
<td>Do you feel comfortable with this patient as a person?</td>
<td>0.839</td>
</tr>
<tr>
<td>Do you feel that a trusting relationship is developing with this patient?</td>
<td>0.808</td>
</tr>
<tr>
<td>Are you finding it difficult to establish a meaningful connection with this patient?</td>
<td>0.765</td>
</tr>
<tr>
<td>Do you feel you easily understand this patient?</td>
<td>0.712</td>
</tr>
<tr>
<td>Do you think this patient will complete the course of therapy?</td>
<td>0.710</td>
</tr>
<tr>
<td>Do you feel this patient is overly critical of you?</td>
<td>0.647</td>
</tr>
<tr>
<td>Did you feel safe with your assessor?</td>
<td>0.822</td>
</tr>
<tr>
<td>Did you feel you could show your real self to your assessor?</td>
<td>0.112</td>
</tr>
<tr>
<td>Did you feel you could talk to your assessor about the issues that are most important to you?</td>
<td>0.134</td>
</tr>
<tr>
<td>Did you trust your assessor?</td>
<td>0.634</td>
</tr>
<tr>
<td>Did you feel you could tell your assessor the truth?</td>
<td>0.588</td>
</tr>
<tr>
<td>Did you feel intimidated by your assessor?</td>
<td>0.300</td>
</tr>
<tr>
<td>Did you feel your assessor was honest with you?</td>
<td>0.136</td>
</tr>
<tr>
<td>Did you feel you needed to do what your assessor wanted or you wouldn't be given treatment?</td>
<td>0.212</td>
</tr>
<tr>
<td>Did you feel criticised by your assessor?</td>
<td>0.167</td>
</tr>
<tr>
<td>Did you feel that your assessor took you seriously?</td>
<td>0.488</td>
</tr>
<tr>
<td>Did your assessor challenge you in a good way?</td>
<td>0.170</td>
</tr>
<tr>
<td>Has assessment given you any new information?</td>
<td>0.239</td>
</tr>
<tr>
<td>Did you feel that assessment was</td>
<td>0.286</td>
</tr>
</tbody>
</table>

* indicates items which if scored `1` or `2` on the Likert scale were treated as negative.
<table>
<thead>
<tr>
<th>Question</th>
<th>0.382</th>
<th>0.469</th>
<th>0.403</th>
<th>0.167</th>
<th>-0.217</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you want to complete assessment with this assessor?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you feel your assessor cared about you as a person?</td>
<td>-0.110</td>
<td>0.276</td>
<td>0.373</td>
<td>0.385</td>
<td>0.342</td>
</tr>
<tr>
<td>Did you feel your assessor treated you like a child?*</td>
<td>0.106</td>
<td></td>
<td></td>
<td></td>
<td>0.812</td>
</tr>
<tr>
<td>Did you feel your assessor understood you?</td>
<td>0.293</td>
<td>0.225</td>
<td>0.584</td>
<td>0.156</td>
<td>0.255</td>
</tr>
<tr>
<td>Do you feel you can be helped to recover from your eating disorder?</td>
<td>0.188</td>
<td>0.184</td>
<td></td>
<td>0.828</td>
<td>0.144</td>
</tr>
<tr>
<td>Did you feel it is possible for someone who has not had an eating disorder to help you recover from your eating disorder?</td>
<td>0.148</td>
<td>0.418</td>
<td>-0.125</td>
<td></td>
<td>0.610</td>
</tr>
<tr>
<td>Did your assessor ask about things that seem relevant to your problems?</td>
<td>0.145</td>
<td>0.178</td>
<td>0.365</td>
<td>0.105</td>
<td>0.107</td>
</tr>
<tr>
<td>Did you find yourself wondering whether your assessor will think you are a fraud?*</td>
<td>0.169</td>
<td>0.412</td>
<td>-0.308</td>
<td></td>
<td>0.140</td>
</tr>
<tr>
<td>Did you feel you had a choice about what you did in assessment?</td>
<td>0.242</td>
<td>0.429</td>
<td>0.327</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you feel your assessor gave in to you?*</td>
<td>0.130</td>
<td>0.142</td>
<td></td>
<td>-0.258</td>
<td>0.117</td>
</tr>
<tr>
<td>Did you feel your assessor was competent?</td>
<td>0.305</td>
<td>0.223</td>
<td>0.248</td>
<td>0.125</td>
<td></td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
*Items sorted in order of largest loading.*
### Therapy Relationship Questionnaire (Patient)
#### Final Factor Analysis Communalities

**Items:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Communality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you feel you could talk to your assessor about the issues that are most important to you?</td>
<td>0.632</td>
</tr>
<tr>
<td>2. Did you feel safe with your assessor?</td>
<td>0.712</td>
</tr>
<tr>
<td>3. Did you feel you could show your real self to your assessor?</td>
<td>0.752</td>
</tr>
<tr>
<td>4. Did your assessor ask about things that seem relevant to your problems?</td>
<td>0.646</td>
</tr>
<tr>
<td>5. Did you feel your assessor treated you like a child?*</td>
<td>0.734</td>
</tr>
<tr>
<td>6. Did you feel your assessor understood you?</td>
<td>0.535</td>
</tr>
<tr>
<td>7. Did you feel your assessor was competent?</td>
<td>0.413</td>
</tr>
<tr>
<td>8. Did you feel you needed to do what your assessor wanted or you wouldn’t be given treatment?*</td>
<td>0.585</td>
</tr>
<tr>
<td>9. Do you feel it is possible for someone who has not had an eating disorder to help you recover from your eating disorder?</td>
<td>0.520</td>
</tr>
<tr>
<td>10. Do you feel you can be helped to recover from your eating disorder?</td>
<td>0.701</td>
</tr>
<tr>
<td>11. Did you find yourself wondering whether your assessor will think you are a fraud?*</td>
<td>0.732</td>
</tr>
<tr>
<td>12. Did your assessor challenge you in a good way?</td>
<td>0.632</td>
</tr>
<tr>
<td>13. Did you feel criticised by your assessor?*</td>
<td>0.669</td>
</tr>
<tr>
<td>14. Did you feel your assessor cared about you as a person?</td>
<td>0.537</td>
</tr>
<tr>
<td>15. Did you feel you could tell your assessor the truth?</td>
<td>0.572</td>
</tr>
<tr>
<td>16. Did you feel that your assessor took you seriously?</td>
<td>0.710</td>
</tr>
<tr>
<td>17. Did you feel your assessor gave in to you?*</td>
<td>0.442</td>
</tr>
<tr>
<td>18. Did you feel your assessor was honest with you?</td>
<td>0.743</td>
</tr>
<tr>
<td>19. Did you feel intimidated by your assessor?*</td>
<td>0.469</td>
</tr>
<tr>
<td>20. Did you trust your assessor?</td>
<td>0.615</td>
</tr>
<tr>
<td>21. Did you feel you had a choice about what you did in assessment?</td>
<td>0.514</td>
</tr>
<tr>
<td>22. Has assessment given you any new information?</td>
<td>0.666</td>
</tr>
<tr>
<td>23. Did you feel that assessment was helpful to you?</td>
<td>0.724</td>
</tr>
<tr>
<td>24. Do you want to complete assessment with this assessor?</td>
<td>0.571</td>
</tr>
</tbody>
</table>

* Items reversed for analyses.

Extraction method: Principal Component Analysis
**Final Factor Analysis of TRQ-Patient**

*Details of components with eigenvalues >1.0 before and after Varimax rotation*

<table>
<thead>
<tr>
<th>Component</th>
<th>Initial Eigenvalues</th>
<th>Rotation Sums of Squared Loadings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>% of Variance</td>
</tr>
<tr>
<td>1</td>
<td>7.742</td>
<td>32.259</td>
</tr>
<tr>
<td>2</td>
<td>1.884</td>
<td>7.851</td>
</tr>
<tr>
<td>3</td>
<td>1.571</td>
<td>6.544</td>
</tr>
<tr>
<td>4</td>
<td>1.371</td>
<td>5.710</td>
</tr>
<tr>
<td>5</td>
<td>1.177</td>
<td>4.903</td>
</tr>
<tr>
<td>6</td>
<td>1.081</td>
<td>4.503</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.
## Final Rotated Component Matrix for TRQ-patient.

<table>
<thead>
<tr>
<th>Fctr:</th>
<th>TRQ Item:</th>
<th>Component:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>Did you feel safe with your assessor?</td>
<td>0.791</td>
</tr>
<tr>
<td></td>
<td>Did you feel you could show your real self to your assessor?</td>
<td>0.773</td>
</tr>
<tr>
<td></td>
<td>Did you feel you could you talk to your assessor about the issues that are most important to you?</td>
<td>0.677</td>
</tr>
<tr>
<td></td>
<td>Did you trust your assessor?</td>
<td>0.672</td>
</tr>
<tr>
<td></td>
<td>Did you feel you could tell your assessor the truth?</td>
<td>0.548</td>
</tr>
<tr>
<td></td>
<td>Did you feel intimidated by your assessor?*</td>
<td>0.519</td>
</tr>
<tr>
<td></td>
<td>Did you feel your assessor was competent?</td>
<td>0.493</td>
</tr>
<tr>
<td>2</td>
<td>Did you feel your assessor was honest with you?</td>
<td>0.151</td>
</tr>
<tr>
<td></td>
<td>Did you feel you needed to do what your assessor wanted or you wouldn’t be given treatment?*</td>
<td>0.345</td>
</tr>
<tr>
<td></td>
<td>Did you feel criticised by your assessor?*</td>
<td>0.283</td>
</tr>
<tr>
<td></td>
<td>Did you feel that your assessor took you seriously?</td>
<td>0.423</td>
</tr>
<tr>
<td></td>
<td>Did you feel your assessor cared about you as a person?</td>
<td>0.191</td>
</tr>
<tr>
<td>3</td>
<td>Has assessment given you any new information?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did your assessor challenge you in a good way?</td>
<td>0.200</td>
</tr>
<tr>
<td></td>
<td>Did you feel that assessment was helpful to you?</td>
<td>0.276</td>
</tr>
<tr>
<td></td>
<td>Do you want to complete assessment with this assessor?</td>
<td>0.376</td>
</tr>
<tr>
<td>4</td>
<td>Did your assessor ask about things that seem relevant to your problems?</td>
<td>0.173</td>
</tr>
<tr>
<td></td>
<td>Did you find yourself wondering whether your assessor will think you are a fraud?*</td>
<td>0.175</td>
</tr>
<tr>
<td></td>
<td>Did you feel you had a choice about what you did in assessment?</td>
<td>0.408</td>
</tr>
<tr>
<td>5</td>
<td>Did you feel your assessor treated you like a child?*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did you feel your assessor understood you?</td>
<td>0.316</td>
</tr>
<tr>
<td>6</td>
<td>Do you feel you can be helped to recover from your eating disorder?</td>
<td>0.260</td>
</tr>
<tr>
<td></td>
<td>Did you feel your assessor gave in to you?*</td>
<td>0.306</td>
</tr>
<tr>
<td></td>
<td>Do you feel it is possible for someone who has not had an eating disorder to help you recover from your eating disorder?</td>
<td>0.193</td>
</tr>
</tbody>
</table>

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.

*Values < 1 suppressed. Items sorted in order of largest loading.*
7 December 1999

Ms J Mahon
Honorary Research Assistant/Information Officer
Academic Department of Psychiatry
Brandon Mental Health Unit
Leicester General Hospital

Dear Ms Mahon

**Predicting drop-out from psychotherapeutic treatment for eating disorders — our ref. No. 5703**

Further to your application dated 19 October, you will be pleased to know that the Leicestershire Research Ethics Committee at its meeting held on the 3 December 1999 approved your application to undertake the above-mentioned study.

Your attention is drawn to the attached paper which reminds the researcher of information that needs to be observed when ethics committee approval is given.

Yours sincerely

[Signature]

Dr R F Bing
Chairman
Leicestershire Research Ethics Committee

(NB All communications relating to Leicestershire Ethics Committee must be sent to the Committee Secretariat at Leicestershire Health)