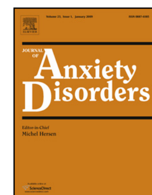
Journal of Anxiety Disorders 42 (2016) 10–18

Contents lists available at ScienceDirect

Journal of Anxiety Disorders



The role of treatment delivery factors in exposure-based cognitive behavioral therapy for panic disorder with agoraphobia

Florian Weck[a,*], Florian Grikscheit[b], Volkmar Höfling[b], Anne Kordt[c], Alfons O. Hamm[d], Alexander L. Gerlach[e], Georg W. Alpers[f], Volker Arolt[g], Tilo Kircher[h], Paul Pauli[i], Winfried Rief[j], Thomas Lang[c,k]

[a] Department of Clinical Psychology and Psychotherapy, University of Potsdam, Potsdam, Germany
[b] Department of Clinical Psychology and Psychotherapy, Goethe University, Frankfurt, Germany
[c] Christoph-Dornier-Foundation for Clinical Psychology, Bremen, Germany
[d] Department of Psychology, Ernst Moritz Arndt University Greifswald, Greifswald, Germany
[e] Department of Psychology, University of Cologne, Cologne, Germany
[f] Department of Psychology, University of Mannheim, Mannheim, Germany
[g] Department of Psychiatry and Psychotherapy, University of Münster, Münster, Germany
[h] Department of Psychiatry and Psychotherapy, University of Marburg, Marburg, Germany
[i] Department of Psychology, University of Würzburg, Würzburg, Germany
[j] Department of Psychology, University of Marburg, Marburg, Germany
[k] Department of Clinical Psychology and Psychotherapy, University of Hamburg, Hamburg, Germany

A R T I C L E   I N F O

Article history:
Received 5 January 2016
Received in revised form 12 May 2016
Accepted 12 May 2016
Available online 13 May 2016

Keywords:
Interpersonal behavior
Panic disorder with agoraphobia
Therapeutic alliance
Therapist adherence
Therapist competence

A B S T R A C T

Treatment delivery factors (i.e., therapist adherence, therapist competence, and therapeutic alliance) are considered to be important for cognitive behavioral therapy (CBT) for panic disorder and agoraphobia (PD/AG). In the current study, four independent raters conducted process evaluations based on 168 two-hour videotapes of 84 patients with PD/AG treated with exposure-based CBT. Two raters evaluated patients' interpersonal behavior in Session 1. Two raters evaluated treatment delivery factors in Session 6, in which therapists provided the rationale for conducting exposure exercises. At the 6-month follow-up, therapists' adherence ($r = 0.54$) and therapeutic alliance ($r = 0.31$) were significant predictors of changes in agoraphobic avoidance behavior; therapist competence was not associated with treatment outcomes. Patients' interpersonal behavior in Session 1 was a significant predictor of the therapeutic alliance in Session 6 ($r = 0.17$). The findings demonstrate that treatment delivery factors, particularly therapist adherence, are relevant to the long-term success of CBT for PD/AG.

© 2016 Elsevier Ltd. All rights reserved.

1. Introduction

Research has demonstrated that exposure-based interventions are highly effective in treating panic disorder and agoraphobia (PD/AG; e.g., Fava et al., 2001; Sánchez-Meca, Rosa-Alcázar, Martin-Martínez, & Gómez-Conesa, 2010). Evidence indicates that exposure exercises in particular are an important strategy for improvement (Ito et al., 2001; Lang, Helbig-Lang, Petermann, 2009; Öst, Thulin, & Ramnerö, 2004; Ruhmland & Margraf, 2001). Thereby, patient behavior during exposure exercises (e.g., safety behavior or avoidance behavior) influences the success of treatment (Sloan & Telch, 2001; Telch & Lancaster, 2012). Thus, the method employed to deliver the rationale for exposure exercises may be an important factor for the success of treatment because this delivery may influence how a patient behaves during exposure exercises. Critical treatment delivery factors include therapist adherence, therapist competence, and therapeutic alliance (Dimidjian & Hollon, 2011).

Therapist adherence refers to the extent to which a therapist follows the treatment manual when delivering interventions. *Therapist competence* describes the therapist's skill level in delivering treatment and includes the therapist's consideration of and response to relevant contextual variables (Waltz, Addis, Koerner, & Jacobson, 1993). Therapist adherence and competence are rarely investigated as potential predictors of the outcome of treatment for anxiety disorders (Perepletchikova, Treat, & Kazdin, 2007).

For PD/AG, only few previous studies have investigated the importance of therapist adherence and competence for treatment

* Corresponding author at: Department of Clinical Psychology and Psychotherapy, University of Potsdam, Karl-Liebknecht-Straße 24-25, D-14476 Potsdam, Germany.
E-mail address: fweck@uni-potsdam.de (F. Weck).

http://dx.doi.org/10.1016/j.janxdis.2016.05.007
0887-6185/© 2016 Elsevier Ltd. All rights reserved.

outcomes (Boswell et al., 2013; Haug et al., 2016; Huppert et al., 2001; Huppert, Barlow, Gorman, Shear, & Woods, 2006). Two of these investigations (Huppert et al., 2001, 2006) were based on a large treatment study that compared cognitive behavioral therapy (CBT), imipramine, and the combination of the two treatments in patients with panic disorder without agoraphobia or with mild agoraphobia ($N = 312$; Barlow, Gorman, Shear, & Woods, 2000).

In the first process analysis performed by Huppert et al. (2001), therapist adherence and competence in the treatment of 186 selected patients were evaluated. Trained raters used one global 7-point item to evaluate therapist adherence (ranging from *not done* to *extensively covered*) and therapist competence (ranging from *clearly inadequate* to *excellent*). In total, 330 videotapes were assessed to evaluate therapist adherence, and 526 videotapes were analyzed to evaluate therapist competence. The authors stated that the raters reached a high level of reliability prior to rating sessions, but no further information about the reliability of the conducted ratings was provided. Unexpectedly, no differences in the levels of adherence and competence were found for therapists whose patients exhibited above- and below-average treatment outcomes.

The second process analysis performed by Huppert et al. (2006) assessed 320 videotapes to evaluate therapist adherence (therapist competence was not investigated). In addressing a limitation of their previous study, the authors chose not to use a single global adherence item and evaluated the level of therapist adherence with 7–15 items (the item number was dependent on the evaluated treatment session). The raters were trained in the use of the rating scales, but this study did not evaluate the reliability of the conducted ratings. Again, the results indicated no significant relationships between therapist adherence and therapy outcomes.

A relevant study conducted by Boswell et al. (2013) considered patients with panic disorder with and without agoraphobia ($N = 276$). These authors analyzed 495 randomly selected audiotapes to evaluate of therapist adherence and competence. In that study, therapist adherence and competence were both assessed with one global item. The adherence item varied in dependency from the observed session (response format: 0% to 100%). The competence item reads as follows: Overall, how effectively did the therapist accomplish the goal of this part of the session? The competence item was answered using a 6-point scale ranging from 0 (*did not attempt*) to 5 (*excellently*). The adherence item (ICC = 0.80) and the competence item (ICC = 0.77) demonstrated adequate reliability. This study also found no significant relationships between therapist adherence and outcomes or between therapist competence and outcomes.

In summary, three large previous studies have provided no evidence that therapist adherence or therapist competence is important in the treatment of panic disorder or PD/AG. However, an important restriction is that most of the previous studies evaluated adherence and competence based on only a single item. Moreover, for two of the three studies, it is unclear whether adherence and competence were assessed reliably. One can question whether a single item can be used to adequately assess complex factors such as therapist adherence and competence. Scale scores, which include several items, would allow researchers to consider several aspects of therapist adherence and competence and thus complete a more comprehensive assessment of these factors, potentially leading to significant adherence-outcome and/or competence-outcome relationships. Recent findings from a smaller study, which used a more comprehensive scale to evaluate therapist adherence/competence (Haug et al., 2016), are in line with these considerations. In that study, the treatment delivery factors of CBT administered to 31 patients with panic disorder were evaluated with the revised version of the Cognitive Therapy Adherence and Competence Scale (including 18 items; Barber, Liese, & Abrams, 2003). The authors found strong relationships between therapist adherence/competence and treatment outcome ($r = 0.48$; Haug et al., 2016). However, the raters of therapist adherence/competence were not completely independent, potentially influencing the rating process.

One further relevant aspect of the three larger studies (Boswell et al., 2013; Huppert et al., 2001, 2006) is that the evaluated therapy sessions were selected randomly. A positive aspect of this approach is that different contents of the treatment were considered in the evaluation of therapists' adherence and competence. However, this approach ignores the possibility that specific aspects of the treatment are especially relevant for therapy success. For the treatment of PD/AG, the provision of the rationale for exposure can be considered as an essential therapeutic process for treatment success. Thus, therapist adherence and competence should be especially relevant during this process.

The *therapeutic alliance* refers to the quality of the relationship between the therapist and the patient. In a large meta-analysis that considered more than 14,000 treatments, the correlation between therapeutic alliance and therapy outcome was $r = 0.275$ (Horvath, Del Re, Flückiger, & Symonds, 2011). Research examining the treatment of PD/AG has reported inconsistent findings regarding the alliance-outcome relationship. Some studies have found significant relationships between the therapeutic alliance and therapy outcomes (e.g., Haug et al., 2016; Huppert et al., 2014), whereas other studies have failed to find a significant relationship (e.g., Casey, Oei, & Newcombe, 2005; Ramnerö & Öst, 2007; Weiss, Kivity, & Huppert, 2013). Therefore, further research is necessary to clarify the role of the therapeutic alliance in the treatment of PD/AG.

The generic model of psychotherapy (Orlinsky, 2009; Orlinsky, Rønnestad, & Willutzki, 2004) postulates interactions between treatment delivery factors (i.e., therapist adherence, therapist competence, and therapeutic alliance) and patients' interpersonal behavior. Research has also provided empirical evidence of the interaction between patients' interpersonal behavior and treatment delivery factors. In a recent study, the association between patients' interpersonal behavior (i.e., patients' behavioral resistance) and the implementation of CBT for panic disorder was investigated (Zickgraf et al., 2015). The study revealed a relationship between patients' behavioral resistance and therapist adherence; a higher level of patient resistance was associated with a lower level of therapist adherence. Similar relationships between therapeutic competence and patients' interpersonal behavior were found in a study that investigated interpersonal therapy for depression (Foley, O'Malley, Rounsaville, Prusoff, & Weissman, 1987). In that study, a higher level of patient hostility was associated with a lower level of therapist competence. Boswell et al. (2013) found that a higher level of patient interpersonal aggression was associated with reductions in therapist adherence and competence. Therefore, it is important to consider patients' interpersonal behavior in the investigation of treatment delivery factors.

The current study aimed to investigate the role of treatment delivery factors (i.e., therapist adherence, therapist competence, and therapeutic alliance) in exposure-based CBT for PD/AG. Accordingly, we focused on therapists' provision of a rationale for exposure exercises because this process was considered to be especially important for treatment success. Additionally, we investigated the impact of patients' interpersonal behaviors on treatment delivery factors.

We hypothesized that treatment delivery factors would be significantly related to therapy outcomes. Specifically, we proposed that stronger therapist adherence, therapist competence, and therapeutic alliance would be associated with better treatment outcomes. Moreover, we hypothesized that patients' problematic interpersonal behavior would have negative effects on the treatment delivery factors (i.e., therapist adherence, therapist com-

Download English Version:

https://daneshyari.com/en/article/7267067

Download Persian Version:

https://daneshyari.com/article/7267067

Daneshyari.com