



Therapist adherence in individual cognitive-behavioral therapy for binge-eating disorder: Assessment, course, and predictors



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ABSTRACT

While cognitive-behavioral therapy (CBT) is the most well-established treatment for binge-eating disorder (BED), little is known about process factors influencing its outcome. The present study sought to explore the assessment of therapist adherence, its course over treatment, and its associations with patient and therapist characteristics, and the therapeutic alliance.

In a prospective multicenter randomized-controlled trial comparing CBT to internet-based guided self-help (INTERBED-study), therapist adherence using the newly developed Adherence Control Form (ACF) was determined by trained raters in randomly selected 418 audio-taped CBT sessions of 89 patients (25% of all sessions). Observer-rated therapeutic alliance, interview-based and self-reported patient and therapist characteristics were assessed. Three-level multilevel modeling was applied.

The ACF showed adequate psychometric properties. Therapist adherence was excellent. While significant between-therapist variability in therapist adherence was found, within-therapist variability was non-significant. Patient and therapist characteristics did not predict the therapist adherence. The therapist adherence positively predicted the therapeutic alliance.

The ACF demonstrated its utility to assess therapist adherence in CBT for BED. The excellent levels of therapist adherence point to the internal validity of the CBT within the INTERBED-study serving as a prerequisite for empirical comparisons between treatments. Variability between therapists should be addressed in therapist trainings and dissemination trials.

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Extensive investigations led to the inclusion of binge-eating disorder (BED) in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5; American Psychiatric Association [APA], 2013). While meta-analytical reviews and treatment guidelines identified cognitive-behavioral therapy (CBT) as being the

most efficacious treatment for BED (APA, 2006; Hay, Bacaltchuk, Stefano, & Kashyap, 2009; Herpertz, Herpertz-Dahlmann, Fichter, Tuschen-Caffier, & Zeeck, 2011; Vocks et al., 2010), therapist adherence has not yet been systematically investigated in the treatment of BED. Defined as the extent to which an intervention is delivered by a therapist as outlined in the treatment manual or model (Waltz, Addis, Koerner, & Jacobson, 1993), therapist adherence is essential to establish experimental validity in randomized-controlled trials (RCTs).

Therapist adherence constitutes a major component of treatment integrity (Moncher & Prinz, 1991; Waltz et al., 1993; Webb, DeRubeis, & Barber, 2010) and is assumed to be a (theory-)specific

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or technical factor facilitating symptom changes within treatments (Castonguay & Holtforth, 2005; Loeb et al., 2005). The manipulation check (i.e., proof of experimental validity) is of essential value within psychotherapy research (Perepletchikova & Kazdin, 2005; Waltz et al., 1993). Only after demonstrating sufficient treatment integrity, one can conclude that treatment effects are attributable to the treatment itself and not to confounding other factors, thus, indicating the treatment's internal experimental validity (e.g., Moncher & Prinz, 1991). Furthermore, treatment integrity checks are necessary to establish external validity as a second aspect of experimental validity assuring potential replications of the treatment and its effects as well as its transfer to various settings and patient samples.

Overall, most clinical research on treatments of mental disorders including BED focused on establishing efficacy, while information on treatment integrity is sparse (Perepletchikova, Treat, & Kazdin, 2007). Across various mental disorders and treatments, therapist adherence-outcome associations can be described as inconsistent at best; Webb et al. (2010) reported a heterogeneous "close to zero"-effect in their meta-analysis. However, interpretations are limited because of substantial methodological variability in the assessment of therapist adherence, varying intervals between therapist adherence and outcome ratings and assumptions of linear therapist adherence-outcome associations, although nonlinear associations were reported in the literature (Barber et al., 2006; Huppert, Barlow, Gorman, Shear, & Woods, 2006). In contrast to therapist adherence, the common or relational factor (Castonguay & Holtforth, 2005; Loeb et al., 2005) of therapeutic alliance defined as the therapist's and patient's collaborative and affective bond (Bordin, 1979) consistently predicted outcome (e.g., Horvath, Del Re, Flückiger, & Symonds, 2011). Overall, therapeutic alliance and therapist adherence have been shown to be positively associated (Loeb et al., 2005) and the therapist adherence moderated the therapeutic alliance-outcome relationship (Barber et al., 2006).

Besides the therapist adherence-therapeutic alliance associations, few studies focused on potential factors influencing the therapist adherence (Perepletchikova & Kazdin, 2005). Recently, patient characteristics (e.g., interpersonal problems, motivation) were found to predict therapist adherence in CBT for panic disorder (Boswell et al., 2013) and motivational enhancement therapy for substance misuse (Imel, Baer, Martino, Ball, & Carroll, 2011). Regarding therapist characteristics, only one study treating patients with anxiety disorders in a primary care setting related therapist experience to therapist adherence, however, documenting insignificant associations (Brown et al., 2013). Investigations on patient and therapist characteristics influencing therapist adherence in BED are lacking.

This study sought to investigate therapist adherence of CBT for BED in a prospective multicenter randomized-controlled trial (INTERBED-study; de Zwaan et al., 2012) comparing individual CBT to internet-based guided self-help (GSH-I). The first aim was to evaluate the psychometric properties of a measure created for the assessment of therapist adherence of CBT for BED, the Adherence Control Form (ACF). Based on our assumption of adequate reliability and validity of the ACF, this study's second aim was to investigate variability in therapist adherence between and within therapists when treating more than one patient in CBT for BED as previous studies pointed to a substantial between- and within-therapist variability (Boswell et al., 2013; Imel et al., 2011). This variability in therapist adherence could, for example, influence dissemination efforts after establishing treatment efficacy in RCTs (McHugh & Barlow, 2012). The third aim was to examine the impact of patient and therapist characteristics on therapist adherence. Fourth, the impact of therapist adherence on therapeutic alliance

within CBT for BED was analyzed as associations of therapist adherence and therapeutic alliance were previously reported for mental disorders including eating disorders other than BED (e.g., Loeb et al., 2005).

Method

Patients

The INTERBED-study was conducted at seven eating disorder outpatient clinics (Germany: $N = 6$, Switzerland: $N = 1$) and was approved by all local ethic committees. Patients recruited via local media advertisements between August 2010 and January 2013 were included. Patients had to meet several inclusion criteria: diagnostic criteria for BED according to DSM-IV-TR or sub-syndromal BED, age 18 years or older, body mass index between 27 and 40 kg/m², written informed consent of the patient, and availability of internet access. Exclusion criteria were current bulimia nervosa, substance abuse, suicidal ideation, psychotic disorder, bipolar disorder, serious unstable medical problems or conditions that influence weight or eating, ongoing psychotherapy, current intake of antipsychotic or weight-affecting drugs, and pregnancy or lactation. A detailed methodological description of the INTERBED-study can be found in de Zwaan et al. (2012).

The subsample of patients randomized to CBT consisted of $N = 89$ patients ($N = 77$ female, 86.5%). Patients had a mean age of 43.14 years ($SD = 11.81$), a mean BMI of 34.37 kg/m² ($SD = 3.88$), and $N = 43$ (48.3%) reported having less than twelve years of education.

The diagnosis of BED and global eating disorder psychopathology were assessed using the *Eating Disorder Examination Interview* (EDE; Fairburn & Cooper, 1993; Hilbert, Tuschen-Caffier, & Ohms, 2004) at baseline (T0), mid-treatment (T1), end of treatment (T2), 6 months-follow-up (T3), and 1.5 year-follow-up (T4). The 1.5 year-follow-up was conducted until the end of 2013. The EDE as a semi-structured clinical expert interview has established reliability and validity.

Therapists

Patients receiving CBT were treated by $N = 25$ therapists ($N = 21$ female, 84.0%). All therapists received repeated trainings on the CBT manual throughout the trial (Hilbert & Tuschen-Caffier, 2010). The training sessions lasted between one and three days. Mean age of the therapists was 31.84 years ($SD = 5.83$). Regarding their professional backgrounds, $N = 21$ (84.0%) were psychologists and $N = 4$ (16.0%) physicians, most having a background in CBT (psychologists: 100.0%; physicians: 75.0%). The average professional experience encompassed 5.08 years ($SD = 4.85$). Eight therapists were licensed therapists (32.0%), $N = 13$ (52.0%) were currently enrolled in postgraduate CBT training, and $N = 4$ (16.0%) were prior to postgraduate CBT training. The average number of previously treated eating disorder patients was 44.04 ($SD = 107.04$; outpatient settings: $M = 8.93$, $SD = 12.3$; day-clinic settings: $M = 7.28$, $SD = 25.32$; inpatient settings: $M = 26.16$, $SD = 77.31$). Therapists received regular on-site supervision, detailed feedback from the therapist adherence ratings via email by AB, and were encouraged to contact the manuals' first author (AH) in case of additional questions.

Treatment

Patients in the CBT condition were offered 20 sessions over four months (with a maximum of six additional weeks; see de Zwaan et al., 2012). Individual CBT was based on the evidence-supported German manual "Binge Eating and Obesity: Cognitive-Behavioral

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