

THE ROLE OF THERAPIST ADHERENCE
IN A MULTICENTER RANDOMIZED CLINICAL TRIAL
OF PATIENTS WITH PANIC DISORDER AND AGORAPHOBIA



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Note. The four publications will not be printed in this manuscript.

THE ROLE OF THERAPIST ADHERENCE

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ABBREVIATION

The following table describes the significance of various abbreviations used throughout the dissertation. The page on which each one is defined is also given.

Abbreviation	Meaning	Page
ACT	Acceptance and Commitment Therapy	10
CBT	Cognitive Behavioral Therapy	10
e.g.	exempli gratia (lat.): for example	14
ICC	Intraclass correlation coefficients	17
IRR	Interrater Reliability	16
KVT	Kognitive Verhaltenstherapie	11
N, n	Sample size	9
PD/AG	Panic Disorder with Agoraphobia	9
SD	Standard deviation	17
T-	Exposure without therapist guidance	9
T+	Therapist- guided exposure	9
TACRS	Therapist Adherence and Competency Rating Scales	10

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LIST OF PUBLICATIONS

Publication I (co-authored paper):

Gloster, A. T., **Hauke, C.**, Höfler, M., Einsle, F., Fydrich, T., Hamm, A., Ströhle., A., Wittchen, H.-U. (2013). Long-Term Stability of Cognitive Behavioral Therapy Effects for Panic Disorder with Agoraphobia: A Two-Year Follow-Up Study. *Behaviour Research and Therapy*, 51 (12), 830–839. <http://dx.doi.org/10.1016/j.brat.2013.09.009>

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Publication IV (co-authored paper):

Gloster, A.T., Hummel, K.V., Lyudmirskaya, I., **Hauke, C.**, & Sonntag, R.F. (2012). Aspects of Exposure Therapy in Acceptance and Commitment Therapy. In P. Neudeck & H.-U. Wittchen (eds.), *Exposure Therapy: Rethinking the Model - Refining the Method*, (pp. 127-152). Berlin: Springer. http://dx.doi.org/10.1007/978-1-4614-3342-2_8

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DECLARATION OF CONTRIBUTION

3.1 Publication I (co-authored paper)

Long-Term Stability of Cognitive Behavioral Therapy Effects for Panic Disorder with Agoraphobia: A Two-Year Follow-Up Study (2013) by Gloster, A. T., **Hauke, C.**, Höfler, M., Einsle, F., Fydrich, T., Hamm, A., Ströhle, A., & Wittchen, H.-U.

My contribution: In publication I, I contributed to the first author to the design of the general study concepts. I was responsible for data collection by coordinating the assessments and supplying the database. I supported the writing process, reviewed the first drafts before submission and contributed to the development of the paper after the reviewers respond.

3.2. Publication II and III (first-author papers)

Because my input in the first-author papers is congruent to each other, the declaration of contribution in both publications will be summarized in the following section.

Publication II: *Therapist adherence to a treatment manual influences outcome and dropout rates: Results from a multicenter randomized clinical CBT trial for Panic with Agoraphobia (2013)* by **Hauke, C.**, Gloster, A. T., Gerlach, A. L., Hamm, A. O., Deckert, J., Fehm, L., Alpers, G. W., Kircher, T., Ströhle, A., Arolt, V., & Wittchen, H.-U.

Publication III: *Standardized Treatment Manuals: Does Adherence matter? (2014)* by **Hauke, C.**, Gloster, A.T., Gerlach, A., Richter, J., Kircher, T., Fehm, L., Stoy, M., Lang, T., Klotsche, J., Einsle, F., Deckert, J., & Wittchen, H.-U.

My contribution: I formulated the scientific hypotheses based on theoretical assumptions and literature research. I planned the study design and analyses of both papers supported by my mentor Dr. Andrew T. Gloster. I used data from the MAC network (Gloster et al., 2011) and added data reflecting on treatment integrity. Specifically, I was responsible for the selection of integrity data including assessing videotapes (50%), training and supervision of raters (100%). Furthermore, I was responsible for the data analytical work. In case of statistical questions I was advised by Dipl.-Math. Jens Klotsche. I was also responsible for the initial interpretation and discussion of data. The first version of the paper was sent to all MAC center partners with the invitation to be a co-author. Authors were ranked in the paper in accordance with their input given to the final version. Prof. Dr. Hans-Ulrich Wittchen as the general director of both the MAC study and the institution I belonged to was senior author. I then was 100% responsible for writing the final draft, as well as for the submission and review process.

I presented intermediate results of the first paper at the *43rd annual conference of the Association for Behavioral and Cognitive Therapies (ABCT)*, New York, USA; and preliminary results of the second paper at the *23rd European College of Neuropsychopharmacology (ECNP)*, Amsterdam, The Netherlands.

3.3. Publication IV (co-authored paper)

Aspects of Exposure Therapy in Acceptance and Commitment Therapy (2012) by Gloster, A.T., Hummel, K.V., Lyudmirskaya, I., **Hauke, C.**, & Sonntag, R.F.

My contribution: In publication IV, I was responsible for the literature search of exposure-based studies. I contributed equally to my colleagues Katrin V. Hummel and Irina Lyudmirskaya to the writing procedure. I supported the review process of the article by giving critical appraisal of content.

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SUMMARY

Securing treatment integrity is a substantial precondition for valid conclusions when conducting psychotherapeutic studies. Therefore, an overarching aim of this cumulative dissertation was to determine the role of therapist adherence in treatment outcome. Data analyses in the presented outcome studies based on a multicenter randomized controlled trial, which examined the mechanisms of action (MAC) in exposure therapy (Gloster et al., 2011). In this therapy study, patients diagnosed with Panic Disorder and Agoraphobia (PD/AG; $N = 369$) were randomized to either one of two conditions of Cognitive Behavioral Therapy (CBT) or to a waitlist control group. Exposures in the active treatment groups were implemented with (T+) or without (T-) explicit therapist-guidance.

Publications resulted from this project are embedded in an introduction and a concluding discussion. The introduction part reports structure and main outcomes of the MAC study highlighting the essential verification of therapist adherence for analyses of effectiveness. In this regard, the current status of adherence in psychotherapy literature is reviewed. Because of the rare presence of outcome studies, which moreover tend to show an inconsistent picture of the role of adherence, some specific recommendations for further research are discussed. Following the introduction, four publications of the dissertation are presented.

The first paper provides results of a two-year follow-up of the MAC study. The exposure-based CBT treatment was found to be still efficient across treatment variations after 24 months. Changes to post-treatment and the 6-month follow up are discussed.

The second paper reports the effect of therapist adherence in the MAC study by special consideration of patients' dropout risk and potential co-variables. As a main

result, therapist adherence was observed to vary in clinical outcome as a function of therapist competence, the status of treatment completeness and treatment conditions (T+ or T-): Whereas in T+ low levels of adherence were related to symptomatic improvement in dropouts, in T-, this association was observed only for treatment completers.

The third paper focuses on treatment completers by considering specific patient variables. Study results found, that the negative pattern found across adherence-outcome associations was mainly driven by exposure-based treatment elements. Moreover, analyzes revealed an interesting interaction effect between patient motivation, symptom severity, and the point of low and high therapist adherence, which differed across treatment variants. In accordance with the previous adherence paper, results indicate rather an adapted than a strict adherent procedure as efficient for exposure-based CBT.

The fourth article is a book chapter printed in “Exposure Therapy: Rethinking the Model - Refining the Method“ by P. Neudeck & H.-U. Wittchen (eds.) and presents possibilities of implementing exposures in an alternative treatment conceptualization, such as Acceptance and Commitment Therapy (ACT). Differences in delivery and effectiveness of exposure-based exercises to a traditional CBT form are discussed.

Finally, the discussion and conclusion section summarizes results of the presented outcome studies and presents conceptual and methodological aspects for a promising compromise between strict therapist adherence and unlimited flexibility. Limitations of the studies and this dissertation are discussed.

The appendix contains the German version of the Therapist Adherence and Competency Rating Scales (TACRS; Gloster, Einsle, Lang, Hauke, & Wittchen, unpub.).

Zusammenfassung

Die Sicherstellung der Behandlungsintegrität gilt als wesentliche Voraussetzung für das Ziehen gültiger Schlussfolgerungen aus Psychotherapiestudien. Das übergeordnete Ziel der vorliegenden Dissertation war es daher, den Einfluss der therapeutischen Adhärenz (Manualtreue) auf Therapieergebnisse zu untersuchen. Ausgangslage für die angefertigten Publikationen bot eine multizentrische randomisiert-kontrollierte Therapiestudie, die sich den Wirkungsmechanismen bei Expositionstherapie widmete (Mechanisms of Action in CBT, MAC; Gloster et al., 2011). In dieser Untersuchung wurden Panikpatienten mit Agoraphobie einer von zwei Varianten kognitiver Verhaltenstherapie (KVT) zugeordnet bzw. waren Teil der Warte-/Kontrollbedingung. Die Expositions-sitzungen innerhalb der KVT wurden mit (T+) oder ohne (T-) ausdrückliche Begleitung eines Therapeuten durchgeführt.

Die kumulative Dissertation umfasst vier Publikationen, welche von einer Einführung und einer abschließenden Diskussion ummantelt werden. Der Einführungsteil geht dabei auf die wichtigsten Ergebnisse der MAC Studie ein und weist daraufhin, dass derartige Wirksamkeitsanalysen eine Behandlungsdurchführung erfordern, die dem überprüften Therapiemanual entspricht. Weiterhin wird die Wichtigkeit der therapeutischen Adhärenz anhand psychotherapeutischer Literatur erörtert. Gut durchgeführte Studien zu dieser Thematik sind bis heute leider selten und der aktuelle Forschungsstand zur Bedeutung von Manualtreue in der Psychotherapie muss als uneinheitlich eingeschätzt werden. Konkrete Empfehlungen für weitere Forschungsvorhaben werden daher in einem weiteren Absatz diskutiert. Nachfolgend wird ein Ausblick auf die vier Publikationen dieser Dissertation gegeben.

Der erste Beitrag widmet sich einer Nachuntersuchung der MAC Studie mit dem Resultat, dass die expositionsbasierte KVT auch nach 24 Monaten in beiden Behandlungsvarianten als erfolgreich eingestuft werden konnte. Veränderungen zur Postmes-sung sowie zu der 6-Monatsuntersuchung werden diskutiert.

Die zweite Studie untersucht die Behandlungsintegrität in der MAC Studie und geht dabei gezielt auf das Abbruchrisiko bei Patienten sowie auf den Einfluss möglicher Co-variablen ein. Dabei zeigte sich, dass sich die therapeutische Adhärenz in Abhän-gigkeit von der Kompetenz, dem Zeitpunkt der Therapiebeendigung und der Behand-

lungsvariante (T+ oder T-) unterschiedlich auf das Behandlungsergebnis auswirkte. Während in T+ eine geringere Manualtreue positiv mit der Symptomatik von Therapieabbrüchern einherging, wurde in T+ ein solcher Zusammenhang nur für Patienten verzeichnet, welche die Therapie bis zum Ende hin absolvierten.

In einem dritten Beitrag, der sich rein auf diese letzte Patientengruppe und deren Merkmale bezog, konnte gezeigt werden, dass negative Effekte einer zu starren Manualdurchführung ausschließlich bei expositionsbasierten Behandlungselementen relevant wurden. Zwischen der Motivation der Patienten, der Symptomschwere und dem Zeitpunkt einer niedrigeren vs. hohen Adhärenz wurde zudem ein interessanter Interaktionseffekt in beiden Behandlungsvarianten nachgewiesen. In Übereinstimmung mit der vorhergehenden Studie wird damit eher ein adaptiertes als ein strikt adhärentes Vorgehen in einer expositionsbasierten KVT nahegelegt.

Der abschließende vierte Text entspricht einem Kapitel aus dem Buch "Exposure Therapy: Rethinking the Model - Refining the Method" von P. Neudeck & H.-U. Wittchen (Hrsg.). Hier werden Möglichkeiten zur Implementierung von Expositionselementen in der Akzeptanz- und Commitment-Therapie - einer alternativen Therapieform - erörtert. Zudem werden Unterschiede, welche die Durchführung und Wirksamkeit von Konfrontationsübungen betreffen, diskutiert und solchen in der traditionellen KVT gegenübergesetzt.

Die sich anschließende Diskussion geht artikelübergreifend und zusammenfassend auf die Ergebnisse der Dissertation ein und präsentiert konzeptionelle und methodische Aspekte für einen vielversprechenden Kompromiss zwischen strenger Manualtreue und einer unbegrenzten Anwendungsflexibilität. Einschränkungen der vorliegenden Arbeit werden diskutiert.

Im Anhang befindet sich ein Exemplar der deutschen Version der Therapist Adherence and Competency Rating Scales (TACRS; Gloster, Emsle, Lang, Hauke, & Wittchen, unpub.).

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INTRODUCTION

Cognitive Behavioral Therapy (CBT) is generally known as the treatment for mental disorders with the best evidence base (Emmelkamp, 2013; Olatunji, Cisler, & Deacon, 2010), particularly for Panic Disorder with Agoraphobia (PD/AG) (McHugh, Smiths, & Otto, 2009b; Neudeck & Wittchen, 2012). The behavioral component consists basically of efficacious exposure techniques that confront patients with their fear-related stimuli, such as exposure in sensu or in vivo (Emmelkamp et al., 2014). High effect sizes - resulting in lower levels of anxiety and avoidance (Mitte, 2005; Sánchez-Meca, Rosa-Alcázar, Marín-Martínez, & Gómez-Conesa, 2010) and a reduction in panic attacks and catastrophic cognitions as assessed by self-ratings (Meyerbröker, Morina, Kerkhof, & Emmelkamp, 2013) - define exposure-based interventions as the gold standard of treatment for PD/AG. However, not only exposure itself but also the role of the therapist might be an important core mechanism in this effectual psychotherapy procedure. A large multicenter study examining mechanisms of action of exposures in CBT (MAC) in a randomized controlled trial for PD/AG ($N = 365$; Gloster et al., 2011) revealed significant benefits of therapist-guided exposure (T+) compared to exposure without therapist guidance (T-). The superiority of T+ was reflected in reduced avoidance behavior, higher global functioning and a lower number of panic attacks compared to T-.

In a two-year follow-up assessment both treatment variations maintained clinically meaningful effects ($n = 146$; Gloster et al., 2013), but differed saliently in a continued greater reduction of agoraphobic avoidance, which was again higher in the therapist guided group (T+). Therefore, the degree of avoidance behavior defined as a main treatment goal in exposure-based CBT for PD/AG (Fava, Zielezny, Savorn, & Grandi,

1995; Powers, Smits, & Telch, 2004) was assumed to be part of the mechanisms in which the two treatment groups differ (Gloster et al., 2013).

Before a reduction of agoraphobic avoidance can be attributed to the effect of therapist guidance in exposure, however, it is important to ensure that examined interventions were administered as intended in the treatment manual. This aspect is known as therapist adherence, which refers to the degree to which a therapist is compliant with an intended intervention by using prescribed aspects as conceptualized in a specific manual (Perepletchikova, 2009; Perepletchikova & Kazdin, 2005).

Therapist adherence is part of a multidimensional construct named treatment integrity (Moncher & Prinz, 1991; Perepletchikova, Treat, & Kazdin, 2007). Treatment integrity also includes competence (how skillfully or poorly the treatment techniques are used) and differentiation (if the treatment is contaminated by techniques from other therapy forms). As such, therapist adherence contributes to the internal and external validity of outcome studies (Emmelkamp et al., 2014; Perepletchikova, 2009), and might have therefore important implications for treatment planning and implementation (Hogue et al., 2008; Webb, DeRubeis, & Barber, 2010). Therapist adherence applied to CBT for PD/AG, for instance, implies that treatment elements such as psychoeducation, behavioral analyses of symptoms, cognitions and behaviors as well as the treatment rationale and exposure exercises were implemented as intended in the corresponding CBT manual.

Although the number of clinical studies collecting integrity data is growing, only a few studies systematically examined the association between therapist adherence and its effect on treatment outcome as well as related practical consequences (Emmelkamp et al., 2014). Therefore, currently no consensus exists whether high or low levels of adherence are associated with clinical improvement in cognitive-behavioral interventions (Smith, Daunic, & Taylor, 2007; Webb et al., 2010). Whereas some studies found that adhering to a specific protocol clearly led to a better treatment outcome (e.g. Emmelkamp, Bouman, & Blaauw, 1994; Feeley, DeRubeis, & Gelfand, 1999; Schulte, Künzel, Pepping, & Schulte-Bahrenberg, 1992), others reported that high levels of adherence were negatively associated (Huey, Henggeler, Brondino, & Pickrel, 2000) or were at least not necessarily advantageous for symptomatic improvement (Ghaderi, 2006; Jacobson et al., 1989). As such, Barber and colleagues (2006) suggested that moderate levels rather than low or high levels of adherence were associated with a re-

duction of cocaine addiction. A comparable curvilinear effect was found by Hogue et al. (2008) with respect to internalizing behaviors. There is also evidence that the effect of therapist adherence on outcome is moderated by additional factors such as the severity level of symptoms (Webb et al., 2012), patient therapy motivation (Huppert, Barlow, Gorman, Shear, & Woods, 2006), or therapist competence (Barber et al., 2006). Further, an adherent assignment of homework was related to both successful implementation and better treatment outcome (Bryant, Simons, & Thase, 1999). Some authors, however, found no association between therapist adherence and treatment outcome (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Godfrey, Chalder, Ridsdale, Seed, & Ogden, 2007; Huppert et al., 2001; Loeb et al., 2005). Such null-findings of adherence-outcome associations were discussed in detail by Webb et al. (2010). Their meta-analytic review comprised 32 studies and found no significant correlation between adherence and outcome ($r = 0,02$). The authors argue that these inconclusive results reflect the suboptimal conceptualization of independent variables and dependent variables, as well as the heterogeneity of examined disorders, interventions modules, treatment phases, number of selected sessions, raters qualification and training, and the unfavorable psychometric properties of the measures of both adherence and treatment outcome (see also Kazantzis, 2003; Perepletchikova & Kazdin, 2005).

Alternatively, the impact of adherence might be concealed by the fact that some treatment components are more related to positive outcome than others (Webb et al. 2010). Arguably, treatment studies using methodology that relies more heavily on non-specific treatment factors (i. e. problem-focused vs. abstract and less focused cognitive therapy methods) may also result in findings that emphasize the role of common, non-specific factors in CBT (e.g. DeRubeis & Feeley, 1990; Feeley et al., 1999).

Besides conceptual and methodological issues, the difficulty to find consistent positive findings with regard to the relevance of treatment adherence might be also attributed to the small number of outcome studies that actually report treatment integrity data (Bhar & Beck, 2009; Perepletchikova et al., 2007, 2009). The failure of many studies to include adherence checks is likely the result of neglecting the potential importance of therapist adherence for treatment planning and implementation, the high costs involved in measuring treatment adherence, as well as, missing gold standards with regard to measurement and implementation of treatment integrity measures in outcome studies (Perepletchikova et al., 2009).

To encourage more researchers to implement treatment integrity measures, recently, some recommendations for their implementation have been suggested (Bellg et al., 2004; Gresham, MacMillan, Beebe-Frankenberger, & Bocian, 2000; Perepletchikova et al., 2009; Perepletchikova & Kazdin, 2005; Waltz, Addis, Koerner, & Jacobson, 1993; Weck, Bohn, Ginzburg, & Stangier, 2011b). For example, it is suggested to conceptualize therapist adherence prior to the start of treatment, which in turn requires a thorough description of desired and unwanted components of the intervention. A strict treatment protocol might be important, especially if the effects of more than one treatment modalities are compared that are more similar than different from each other's (Nezu & Nezu, 2008). Therapists should also not only be instructed with regard to number, frequency and duration of sessions, but also with regard to sub-ordinate goals that should be achieved in a session, in pre- and proscribed interventions (Perepletchikova et al., 2009), and in the context in which the manual is used (Carroll & Nuro, 2002). To ensure that all therapists implement the treatment as intended, it is necessary to offer careful training and ongoing supervision, for example in form of standard roll plays for decisive treatment situations or video feedback after a session. The measurement of therapist adherence should be preferably based on audio- or videotaped sessions assessed by independent, blind and trained raters to ensure an objective rating procedure (Waltz et al., 1993; Weck, Ginzburg, Höfling, & Stangier, 2014). Although standardized integrity measures might facilitate the comparability of treatments (Weck et al., 2011b), they do not reflect the specificity of a treatment manual for which the respective outcome study was conceptualized. Also, independent raters that are familiar with the treatment manual and the rating procedure are needed. Moreover, raters should be carefully trained to a high degree of interrater reliability (IRR). According to established criteria, IRRs higher than .74 are considered as excellent, between an interval of .60 and .74 as good, between .40 and .60 as fair and poor when below .40 (Cicchetti, 1994; Shrout & Fleiss, 1979). A 10 hour training was found to be sufficient including knowledge transfer of the ratings scales, rating exercises and certification procedures - in which raters had to assess several treatment sessions, e.g. within a two point range compared to experts (Weck, Hautzinger, Heidenreich, & Stangier, 2010). The gold standard for the right number of rated sessions might be based on a randomized selection including an equal amount of sessions of each therapy stage (Dennhag, Gibbons, Barber, Gallop, & Crits-Chrisoph, 2012). This procedure controls for both curvilinear

adherence effects across the course of therapy and therapist development by an increased number of patients (Nezu & Nezu, 2008).

Despite the usually restricted amount of time and cost available in research and clinical settings, it is important to address these recommendations to ensure an adequate evaluation of cognitive-behavioral treatment packages. Some researchers propose that even the rating of few sessions might strengthen the quality of any outcome study (Plumb & Vilardaga, 2010; Weck, Bohn, Ginzburg, & Stangier, 2011a), particularly based on the finding that only a small minority of studies attempt to assess integrity data (Perepletchikova et al., 2009).

The multicenter MAC trial mentioned in the beginning (Gloster et al., 2011, 2013) is a good example for how to carefully translate these integrity issues into clinical research. CBT components of this outcome study were specified in a treatment manual (Lang, Helbig-Lang, Westphal, Gloster, & Wittchen, 2012) including psychoeducation, interoceptive exposure, anticipatory anxiety, exposure in vivo and relapse prevention. Therapist adherence to the manual was measured by rating a randomized selection of videotaped therapy sessions. Carefully trained independent raters used the Therapist Adherence and Competency Rating Scales (TACRS; Gloster, Einsle, Lang, Hauke, & Wittchen, unpub.), which were specially developed and tested for the treatment manual. The mean overall rating of therapist adherence based on a 9-point Likert-type scale ranging from 0 (nonexistent) to 8 (very high adherence) was 5.53 ($SD = 1.29$). Intra-class correlation coefficients (ICC) indicated a good interrater agreement for the assessment of adherence ($ICC = .72$).

The MAC outcome reports (Gloster et al., 2011, 2013) were followed by two research studies examining adherence-outcome associations for specific subsamples (Hauke et al., 2013; 2014). The research question of the first paper ($n = 265$; Hauke et al., 2013) focused on the role of therapist adherence in patients who discontinue treatment (drop-outs). Research looking into reasons of treatment failure is largely missing, thus this study has the potential to increase clinically relevant knowledge. Another area that has received too little attention are studies looking at the effect of common therapist variables on adherence-outcome relationships (Barber, 2007; Smith et al., 2007; Webb et al., 2010). As such, some authors assumed that therapist competence is related to adherence and outcome on a medium to high but not on a low level (Barber et al., 2006). Others argued, however, that adherence and competence are not significantly associated

(e.g. Paivio, Holowaty, & Hall, 2004). A factor closely connected to competence is known as therapist experience (e.g. Beutler, 1997; Perepletchikova & Kazdin, 2005), which is assumed to be negatively associated with therapist adherence (Henry, Strupp, Butler, Schacht & Binder, 1993; Siqueland et al., 2000). Whereas beginners might rely more strongly on a treatment manual, experienced therapists may tend to implicitly or explicitly stick to previously learned methods of doing therapy (Margison et al. 2000; Miller & Binder, 2002). Because studies in this area are rare, and the consideration of therapists' competence and experience in adherence-outcome analyses seems to be fundamentally relevant, these therapist variables were also addressed in the first adherence study.

The optimal level of therapist adherence for good treatment outcome is assumed to not only differ across the course of therapy (Barber et al., 2006; Hogue et al., 2008) but also across patients (Insel, 2009; McHugh, Murray, & Barlow, 2009a; Perepletchikova & Kazdin, 2005). Therefore, the second adherence study examined several patient characteristics across treatment completers, which are theoretical important for therapist adherence but also rarely explored ($n = 220$; Hauke et al., 2014). In the multitude of variables influencing adherence-outcome associations, there is evidence that the performance of therapy may vary as a function of symptom severity (Webb et al., 2012) and patient motivation (Huppert et al., 2006). As such, patients with high severity levels and, similarly, those with low treatment motivation are expected to benefit rather from the use of additional treatment techniques or from more time as intended for particular treatment elements than from a strict treatment implementation (Borreli, 2011; Foley, Malley, Rounsville, Prusoff, & Weissmann, 1987; Huppert, et al., 2006; Perepletchikova & Kazdin, 2005). These results, however, could be biased by the fact that an adherently implementation of treatment procedures might be easier in patients with better therapy commitment (de Haan et al., 1997; Elkin, 1999). Because the relationship between adherence and treatment outcome needs to be interpreted with respect to the context in which treatment elements are implemented, the second adherence paper considered the course of therapist adherence and patient variables in several therapy phases. This procedure enables an examination of how therapist adherence affects subsequent values of patient characteristics and how these variables might affect levels of adherence.

In summary, the determination of the role of therapist adherence in psychotherapy might facilitate the conclusion of meaningful outcomes in clinical trials and contributes to an identification of the core mechanisms of action in CBT. An adequate interpretation of adherence- outcome association requires, in turn, that the treatment to be tested is relevant for the target disorder. Therefore, adherence studies are preceded by the report of the effect of exposure-based CBT in patients with PD/AG (publication I). The main part of this dissertation focuss on the examination of the relative importance of therapist adherence predicting patient change in CBT (publication II) and the influence of treatment, therapist and patient characteristics on adherence-outcome associations (publication III). For the reason that exposures were defined as a core element in the MAC study, possibilities of alternative implementation forms were reviewed detecting differences and effectiveness by taken the example of Acceptance Commitment Therapy (publication IV).

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DISCUSSION

The central objective of this dissertation was the examination of therapist adherence in CBT in a randomized controlled trial for PD/AG based on treatment outcome on the one hand and on therapist and patient characteristics on the other hand.

Results of the overall MAC outcome study revealed that patients with PD/AG can be effectively treated with CBT (Gloster et al., 2011). These effects were maintained for two years following the end of treatment as demonstrated using a subsample of the treated PD/AG patients (Gloster et al., 2013). Although the effect sizes 24 months after the treatment were somewhat lower than at the 6-month follow up and at post-treatment, most patients still reported clinically meaningful changes. High levels of therapist adherence measured in the MAC study ensured that these positive outcomes could be attributed to CBT interventions given that they were delivered as intended and described in the treatment manual. However, based on the fact that in the MAC outcome study only one overall adherence score was reported across the total sample, the generally high adherence level may be influenced by treatment conditions, specific sessions or both therapist and patient characteristics by implying a ceiling effect.

In order to consider the interaction and joint contribution of such characteristics, two adherence-outcomes studies based on the MAC randomized controlled trial for PD/AG more closely examined the association between therapist adherence and treatment outcome under several conditions (Hauke et. al, 2013; 2014). As a main result, the optimal level of therapist adherence was found to vary as a function of treatment, therapist and patient features. Whereas the general level of adherence did not matter for outcome when averaged across the entire sample, there was evidence that adherence-outcome associations might differ in the two varieties of exposure implemented in the study (Hauke et al., 2013). Specifically, the following two different implementation

variations were studied: In the first condition, the therapist delivered active guidance outside the therapy room (T+) by three standardized exposure exercises (session 6-8: bus, department store, forest) and also by two individualized fear-related situations (session 10-11). In the second condition, the therapist intervention was confined to the therapist room (T-) discussing possible barriers and giving instructions similar to T+ (e.g. not to use safety or avoidance behaviors) without actively accompanying the patient in exposure exercises. Although, besides the implementation of exposure *in vivo*, both variants (T+ and T-) were identical in ingredients and duration, they differed in adherence-outcome associations: Whereas lower levels of adherence in T+ were found to be beneficial for agoraphobic avoidance in treatment dropouts, a different picture occurred in T- showing benefits of low adherence for general anxiety and global clinical functioning in treatment completers (Hauke et al., 2013). Detailed analyzes across sessions revealed that the negative linear relationship between adherence and outcome in completers was mainly driven by specific treatment elements, namely interoceptive, standard and individual exposures (Hauke et al., 2014). If replicated, these correlations might advise against a too strict instructing, preparing and rehearsing of exposures, especially in an outpatient setting in which patients usually completing exposures as homework.

Based on the results of the MAC outcome study that found the T+ variation to be somewhat more effective (Gloster et al., 2011; 2013), it is recommended to accompany the patient during exposure treatments. Doing this implies two important issues: Firstly, a guided exposure allows the therapist to react flexibly in an emergency such as behavioral or cognitive avoidance and thoughts of dropping out. Secondly, the presence of the therapist during exposure might mitigate the negative effects of too strict adherence on symptomatic change as suggested by Hauke et al. (2013; 2014). Therefore and because exposures are critical for PD/AG patients by focusing on aversive stimuli and symptoms which were previously avoided for mostly a long time (Olatunji, Deacon & Abramowitz, 2009; Richard & Gloster, 2006), it is highly recommended to flexibly apply strategies tailored for the individual needs of patients in order to reduce dropout risk and to ensure symptomatic improvement (Hauke et al., 2013). In this context, treatment interventions should be implemented as described in the manual but allowing some flexibility, such as spending more time as intended for specific treatment elements if this is considered as necessary by the therapist (Kendall & Beidas, 2007; Kendall, Gosch, Furr, & Sood, 2008).

For an adequate understanding of the role of therapist adherence in therapeutic change is further recommended to consider the impact of several therapist, patient, and contextual factors (Hauke et al., 2013, 2014).

As such, the presence of therapist experience examined in the first adherence study (Hauke et al., 2013) did not moderate adherence-outcome relationships suggesting that therapists were successfully trained to an acceptable level of expertise. Without ongoing supervision, however, there might be evidence that well experienced therapists implement the treatment manual with lower levels of adherence as it was shown in patients who dropped out due to issues surrounding the exposure (Hauke et al., 2013).

The presence of therapist competence, however, mitigated the negative effect of high adherence, but also the positive effect of low adherence on treatment outcome (Hauke et al., 2013). In the literature of treatment integrity, strict therapist adherence is assumed to preclude competence in some situations, e.g. when life events occur during the treatment (e.g., Emmelkamp et al., 2014; Waltz et al., 1993). Therefore, the influence of competence might only become relevant if e.g. a patient is not willing to complete an exposure exercise and runs into the risk of drop out. In this situation, the therapist has to decide if a deviation from the manual by adopting treatment procedures to the client is appropriate. Consequently, the use of strategies that are not directly intended in the protocol might not show high adherence but might actually reflect competence. Therefore, when examining the role of adherence it is highly recommended to also assess competence. This can be done with at least one global item at the end of a therapy session asking about the degree of addressing patients' needs, of responding to patients' reactions to therapy goals, or of clear implementation of treatment interventions (Plumb & Vilardaga, 2010).

Patient motivation and symptom severity examined in the second adherence study (Hauke et al., 2014) were found to interact specifically with therapist adherence. As such, the influence of patient motivation on adherence-outcome relations was moderated by symptom severity: Motivated patients with low symptom severity experienced a reduction of panic and agoraphobia symptoms in case of a strict adherent implementation of the first therapy part (psychoeducation, behavioral analysis, rationale for exposure and interoceptive exposures; Hauke et al., 2014). For motivated patients with high symptom severity, however, the later stage of therapy was relevant with respect to adherence-outcome relations in that standardized and individualized in vivo exposure as

well as relapse prevention had to be implemented in a more flexible way to avoid worsening of general anxiety symptoms (Hauke et al., 2014). Considering treatment conditions the benefit of strict adherence was reported for both variants, whereas the advantage of a low adherence was only found in patients in guided exposures (T+; Hauke et al., 2014). Thus, the results of the mixed-effects linear regression models (MELR; Rabe-Hesketh & Skrondal, 2005) suggest quite distinct procedures depending on motivation and treatment modality that can be implemented in a specific treatment setting.

Symptom severity by itself did influence the effect of therapist adherence on treatment outcome only in therapist-guided exposures (T+; Hauke et al., 2014). Although the effect was very small and did not consider other covariates, it correspond to the assumption of some authors that therapists of patients with lower clinical functioning might more significantly deviate from a treatment manual (Foley, et al. 1987; Perekhchikova & Kazdin, 2005; Waltz et al., 1993).

Transporting the results of Hauke et al. (2013, 2014) into a clinical setting suggests that some individual modification of specific treatment components might enhance symptomatic improvement in psychotherapy treatment. However, these data contain several potential sources of bias that should be noted as limitations. First, we have to keep in mind that these findings were reported under conditions of a relatively high standard of adherence. Thus, effects of adherence on outcome may have been restricted by a reduced variance in actual adherence. Another important limitation is that the active part of exposure *in vivo* sessions was not videotaped. Therefore, results regarding an adherent implementation of exposures are limited to those aspects that were delivered in the therapy room such as instructing, preparing, rehearsing and debriefing of the respective exercise. Finally, outcomes are limited to persons with PD/AG who participate in outpatient mental health services at psychology and psychiatry departments of research universities.

For further attempts to delineate optimal ways to implement CBT, it is important to note that not only therapist adherence but also therapist flexibility is a dimensional term. A too high degree of flexible treatment adaptation might result in unfavorable outcomes just as much as a too strict adherence. As such, spending more time as intended to remove individual barriers of exposures might not threatening treatment integrity, whereas delaying the implementation of exposures without a specific reason might result in failing therapy goals. For the goal to adapt the manual to situational require-

ments, “meta-competences” such as the ability to implement treatment procedures with flexible adherence (Roth & Pilling, 2007) should much better be developed, described and trained in therapists working with treatment manuals. The goal to achieve therapist competence may consequently also be achieved by applying a manual following the rule “flexibility within fidelity”, which means to individualize a manual-based treatment within the boundaries of adherence (compare Kendall, Gosch, Furr and Sood; 2008).

A promising comprise for maximizing the benefits of both adherence and flexibility might be defined by treatment strategies which identify and address concurrently patients’ requirements based on common core mechanism of multiple patients’ problems (Wilamowska et al., 2010). Such transdiagnostic interventions focus on similarities among disorders, offer possibilities of adaption in the treatment content and enable internal validity checks (McHugh, et al., 2009a). Additionally, they are associated with positive outcome, even in severely affected patients (Brown & Barlow, 1995; Jones, Cumming, & Horowitz, 1988), and in patients suffering from comorbid disorders (Duffy, Gillespie, & Clark, 2007; Gillespie, Duffy, Hackmann, & Clark, 2002; Schoenwald, Halliday-Boykins, & Henggeler, 2003). One well-known transdiagnostic treatment is an unified protocol focusing on key elements in emotional disorders by addressing four modules: increasing emotional awareness, facilitating flexibility in appraisals, identifying and preventing behavioral and emotional avoidance, and situational and interoceptive exposure to emotion cues (The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders; Allen, McHugh, & Barlow, 2008; Farchione et al., 2012). Moreover, especially for the class of anxiety disorders several effective transdiagnostic treatment variants already exists, such as the collaborative care model (Roy-Byrne et al., 2005), a group format for primary care (e.g., Erikson, 2003; Norton & Hope, 2005) or computer-based CBT interventions (Craske et al., 2009).

Besides transdiagnostic treatments, modular and principle-based interventions are also designed to optimally balance adherence and flexibility (McHugh et al. 2009a). Modular interventions offer flexibility by allowing patient characteristics to guide selection of individual treatment targets. For example, motivation and severity of symptoms are the basis for an adherent implementation of the treatment structure in mindfulness-based cognitive therapy for depression (Bohus, 2012), in the modular therapy for cannabis abuse (Zimmermann et al., 2011), in the treatment of psychotic disorders (Addington & Gleeson, 2005; Cather, Penn, Mueser, & Otto, unpublished manual), or in

anxiety disorders (Craske & Barlow, 2007). Principle-based interventions try to connect evidence-based treatments with individualized care models by compressing different treatments into versatile-used models according to patient's requirements and evidenced science (Chorpita & Daleiden, 2009). Such up to date treatment models can also be found in modern treatment manuals developed to increase children's mental health, such as the Modular Approach to Therapy for Children (MATCH; Chorpita & Weisz, 2009) including treatment pathways for anxiety, depression or disruptive behavior problems. These modules can be flexibly implemented based on clinical decisions of the treatment team. Other examples are known as "Relevance Mapping", a computer-automated comparison of evidence based services sorted by patient characteristics (Chorpita, Bernstein, & Daleiden, 2011) or the Managing and Adapting Practice (MAP) system, which attempts to match particular child characteristics to the selection, adaptation, or construction of effective treatment strategies (Chorpita & Daleiden, 2009).

One relatively new and possibly especially flexible form of cognitive-behavior therapy currently discussed is Acceptance and Commitment Therapy (ACT, Hayes, Strosahl, & Wilson, 1999). Empirical studies examining elements of ACT reported several benefits for acceptance-based procedures in exposure compared to the use of analogue paradigms (e.g. Arch & Craske, 2010; Campbell-Sills, Barlow, Brown, & Hofmann, 2006; Eifert & Heffner, 2003; Levitt et al., 2004). These results suggest that the mechanism of action in exposures implemented by processes of acceptance, mindfulness, commitment and behavior-change can be conceptualized as attempts to increase psychological flexibility (Gloster, Klotsche, Chaker, Hummel, & Hoyer, 2011; Kashdan & Rottenberg, 2010). High psychological flexibility is assumed to empower the patient in tolerating negative thoughts, sensations and feelings and in reacting in a more flexible way to aversive stimuli. Whether ACT procedures really improve on exposure-based CBT, however, has not yet been adequately tested (Gloster, Hummel, Lyudmirskaya, Hauke, & Sonntag, 2012). Ensuring the effect of ACT interventions on treatment outcome requires the consideration of some sophisticated treatment integrity issues (Plumb & Vilardaga, 2010). Thus, it is well advised that treatment manuals using ACT should offer a high amount of flexibility (e.g. in case that a patient is initiating defusion during

ongoing treatment intervention, the therapist should be able to take this up by including the defusion process into the current exercise; Plumb & Vilardaga, 2010).

Although new treatment procedures are continuously being developed, numerous research trials still use treatment manuals, which deliver a step by step procedure only for the target disorder without helpful guidance for additional problems (Shafran et al., 2009). In consequence, a growing number of authors express criticism about the use of treatment manuals (e.g., Addis & Krasnow, 2000; Barlow, Levitt, & Bufka, 1999). Whereas some authors argue that a strict adherent implementation of symptoms-specific manuals reduces the usefulness for practitioners in routine clinical care (Kessler, Chiu, Demler, & Walters, 2005), others argue that the maximum possible level of treatment gains might not be achieved if individual characteristics of therapist and patient are not adequately considered (Hauke et al., 2013; 2014).

In summary, three final conclusions can be drawn from the studies described here: Firstly, optimized and commonly used therapeutic manuals should deliver a well-described flexible implementation of treatment components while maintaining the treatment structure over the course of therapy. Secondly, therapists applying the treatment should receive supervised education and training in both theory and functional application. And thirdly, further research in this area should focus on detecting core elements of mental disorders in order to support the development of treatment manuals that target specific (transdiagnostic) psychological dysfunctions instead of isolated disorders. Transferring these conclusions into clinical care and research might be a sensible alternative to the exclusive transfer of strict standardized treatment manuals as the only means for the dissemination of efficacious psychological treatments (Luborsky & DeRubeis, 1984).

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8

APPENDIX

Index: _____

BMBF Multicenter Randomized Treatment Outcome Study of Panic and Agoraphobia

Therapist Adherence and Competency Rating Scales

Sitzung 1 - Booster 2

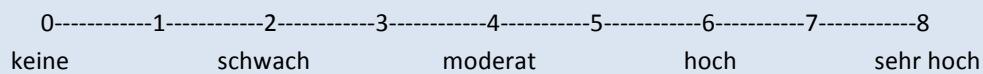
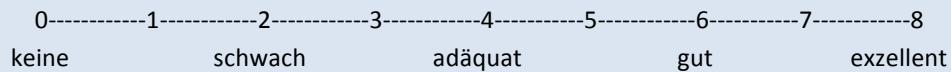
Sitzungsnummer: _____ Rater: _____

Therapeut: _____

Datum des Ratings: _____ Zeit für Rating: _____

Geschlecht des Therapeuten: _____

Geschlecht des Patienten: _____

1. ADHERENCE – wie hoch war die Gesamtmanualtreue des Therapeuten während der Sitzung?**2. COMPETENCY – Wie hoch war die Gesamtkompetenz des Therapeuten während der Sitzung?****3. ADDITIONAL SKILLS – Hat der Therapeut während der Sitzung irgendeine Technik/Fertigkeit verwendet, die nicht Bestandteil des Manuals ist?**

Ja _____ Nein _____ Unklar _____

Wenn Ja/ Unklar => bitte benennen: _____

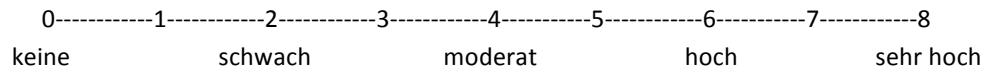
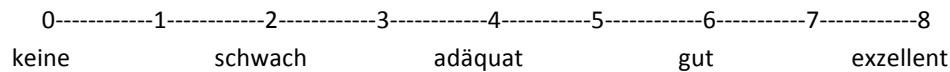
Zeitpunkt: _____

Bitte schätzen Sie bezüglich der jeweiligen Sitzung die folgenden Module getrennt für Adherence und Competency ein.Probleme bezüglich der Einschätzung:

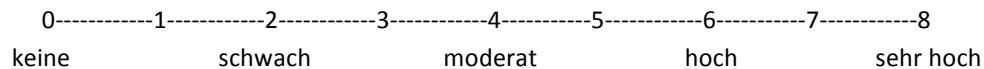
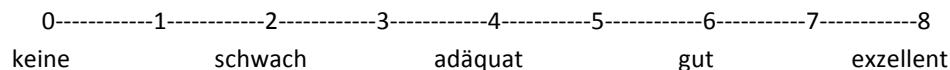
_____**A) ROLLE DER ANSPANNUNG (SITZUNG 1)**

A1) ADHERENCE**Der Therapeut:**

- erklärt, dass Anspannung über längere Zeit zu Körperreaktionen führt, die zu Panikanfall werden, da keine Erklärung für die Symptome vorhanden ist
- geht darauf ein, dass Anspannung normal ist, Daueranspannung jedoch zu Körperempfindungen führt
- beschreibt, dass Körperempfindungen ungefährlich sind und ein Hinweis auf Anspannung
- erklärt, dass die Auslösung einer Panikattacke zu weiterer Anspannung führt
- die Reduktion der Anspannung keine adäquate Behandlung der Panikstörung ist.

**A2) COMPETENCY – Wie kompetent hat der Therapeut das Anspannungsmodell vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)****B) TEUFELSKREIS - INDIVIDUELL (SITZUNG 1)****B1) ADHERENCE****Der Therapeut:**

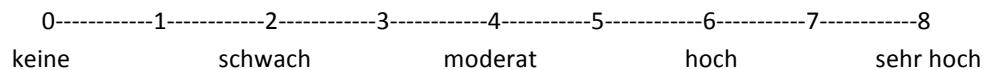
- erklärt zunächst den allgemeinen Ablauf einer Panikattacke
- lässt den Patienten einen frühen Angstanfall schildern
- trägt die Informationen des Patienten an der passenden Stelle im Teufelskreis ein
- exploriert nach, um Lücken zu schließen
- fasst den Teufelskreis gemeinsam mit dem Patienten zusammen
- beschreibt, dass Beruhigung den Ablauf des Kreislaufes unterstützt.

**B2) COMPETENCY – Wie kompetent hat der Therapeut den Teufelskreis vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)**

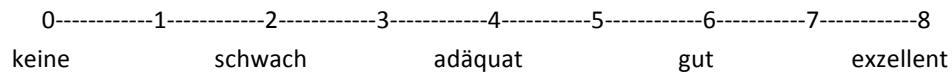
C) LEBENSLINIE (SITZUNG 2)**C 1) ADHERENCE**

Der Therapeut:

- lässt sich vom Patienten die Lebenslinie detailliert schildern
- exploriert insbesondere Faktoren, die bei der Entwicklung der Paniksymptomatik eine Rolle spielen
- achtet vor allem auf (exploriert dies):
 - den Umgang mit Krankheiten in der Familie
 - Tendenz, Körpersymptome als bedrohlich zu erleben
 - Umgang mit gefährlichen Situationen
- erfragt Belastungen im Jahr vorm Auftreten der ersten Attacken
- er fasst die wichtigen Faktoren am Ende zusammen

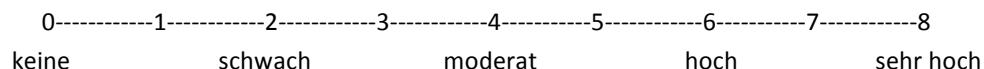


C2) COMPETENCY – Wie kompetent hat der Therapeut die Lebenslinie bearbeitet (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)

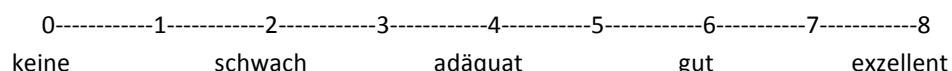
**D) ABLEITUNG DER ROLLE DER ANSPANNUNG (SITZUNG 2)****D1) ADHERENCE**

Der Therapeut:

- wiederholt die Entstehungsbedingungen pathologischer Angst
- fügt die vom Patienten genannten Faktoren (Vulnerabilitäts- und Belastungsfaktoren) an der entsprechenden Stelle ein
- weist darauf hin, dass diese Faktoren einen Einfluss auf die Wahrnehmungsschwelle haben
- fasst die Belastungsfaktoren zusammen und zeichnet diese als zunehmende Belastung in das individuelle Modell der Entstehung der Angststörung ein
- beschreibt, dass die erlebten Körperempfindungen durch die Vulnerabilitätsfaktoren als verunsichernd / bedrohlich wahrgenommen wurden und dies zur ersten Panikattacke führte
- grenzt die Entstehung der Störung von der Aufrechterhaltung ab



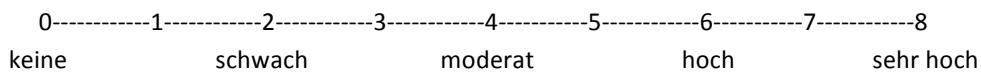
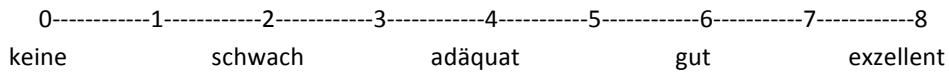
D2) COMPETENCY – Wie kompetent hat der Therapeut die Rolle der Anspannung vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)



E) ROLLE ÄNGSTIGENDER GEDANKEN (SITZUNG 3)**E 1) ADHERENCE**

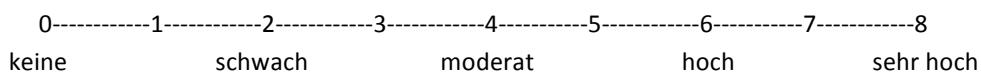
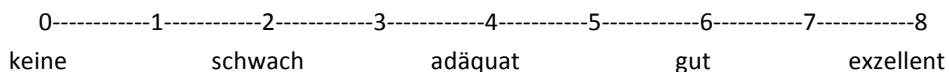
Der Therapeut:

- erklärt, dass Gedanken und Befürchtungen über Körpersymptome einen wesentlichen Einfluss auf das Angsterleben
- erklärt, dass Vermeidung dazu führt, dass die Annahme über das Körpersymptom weiter besteht
- bespricht mit dem Patienten anhand eines eigenen Beispiels die Wirkung der Gedanken auf das Angsterleben und sein Verhalten
- fragt nach der Lernerfahrung, die der Patienten dadurch macht
- erklärt, dass das Denken unter Angst häufig verzerrt ist und mit unrealistischen Vorstellungen einhergeht
- vermittelt, dass das wichtigste die Veränderung des Vermeidungsverhaltens ist und weniger die Änderung der dysfunktionalen Gedanken

**E2) COMPETENCY – Wie kompetent hat der Therapeut die Rolle ängstigender Gedanken vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)****F) ROLLE VON VERMEIDUNGSVERHALTEN (SITZUNG 3)****F1) ADHERENCE**

Der Therapeut:

- beschreibt Vermeidung als zentrale Komponente der Aufrechterhaltung der Angst
- beschreibt, dass Vermeidung dazu führt, dass korrigierende Erfahrungen verhindert werden
- bespricht mit dem Patienten typische Angstverläufe bei unterschiedlichen Formen von Vermeidung
- betont den typischen Angstverlauf bei kognitiver Vermeidung/Ablenkung (Wellenlinie)
- prüft gemeinsam mit dem Patienten, zu welchen kurz- und langfristigen Erfahrungen die Angstverläufe führen
- unterstützt den Patienten dabei, die richtigen Schlussfolgerungen zu ziehen
- korrigiert falsche Schlussfolgerungen
- lässt den Patienten die wichtigsten Schlussfolgerungen zusammenfassen

**F2) COMPETENCY – Wie kompetent hat der Therapeut die Rolle von Vermeidungsverhalten vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)**

G) ABLEITUNG DES BEHANDLUNGSRATIONALS (SITZUNG 5)**G1) ADHERENCE**

Der Therapeut:

- fragt den Patienten nach seinen Schlussfolgerungen aus dem Gedankenexperiment in Bezug auf die Behandlung
- verstärkt den Patienten wiederholt dabei, Bedenken / Zweifel zu äußern
- bespricht Zweifel/Bedenken mit dem Patienten im Sinne des Rationals
- fasst zusammen, dass es zur Behandlung der Angst vor Situationen darum geht, sich der Angst auszusetzen, bis diese von allein weggeht + dies wiederholt zu tun
- macht deutlich, dass Behandlung nur Sinn macht, wenn sich Patient klar dazu entscheidet, sich der Angst in Situationen auszusetzen

unbegleitet:

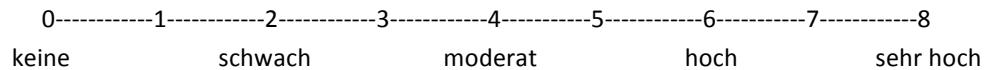
Der Therapeut:

- erklärt, dass die Vorbesprechung der Übungen eine notwendige Voraussetzung für den Behandlungserfolg darstellt
- führt ein, dass die Vorbesprechung der Übung als Hilfe zum Aufsuchen und für die richtige Durchführung (unterlassen jeglichen Vermeidungsverhaltens) dient
- erläutert die Struktur der Vorbesprechungen (Vorschlag von Übungssituationen, Angstverlaufskurven, Besprechung von Befürchtungen und Bedenken, Besprechung von Vermeidungsverhalten und dessen Unterbindung, Besprechung der Erleichterung des Aufsuchens der Situation, Nachbesprechung der Übung)
- erläutert die Aufgaben des Patienten in der Übungssituation
- erfragt das Verständnis des Patienten
- geht auf Fragen im Sinne des Rationals ein

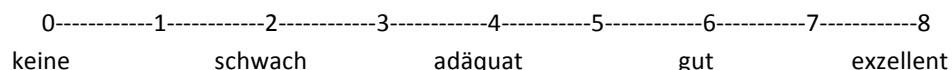
begleitet:

Der Therapeut:

- erklärt, dass das gemeinsame Aufsuchen der Situation eine notwendige Voraussetzung für den Behandlungserfolg darstellt
- führt ein, dass die Therapeutenbegleitung als Hilfe zum Aufsuchen und für die richtige Durchführung (Unterlassen jeglichen Vermeidungsverhaltens) dient
- erläutert die Struktur der Übungen (Hilfe beim Aufsuchen geben, Angst in der Situation steigern, nicht beruhigen, Vermeidungsverhalten identifizieren und modifizieren, Verbleib in der Situation bis Angstabfall)
- erläutert die Aufgaben des Patienten in der Übungssituation
- erfragt das Verständnis des Patienten
- geht auf Fragen im Sinne des Rationals ein



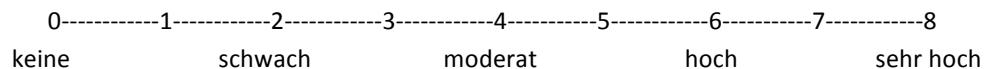
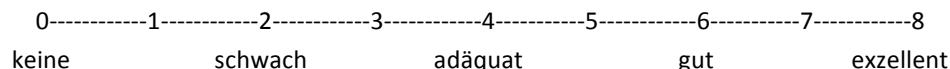
G2) COMPETENCY – Wie kompetent hat der Therapeut das Behandlungsrationale abgeleitet (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)



H) VERHALTENSANALYSE (SITZUNG 2)**H1) ADHERENCE**

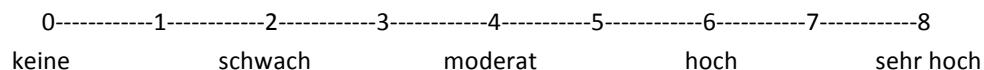
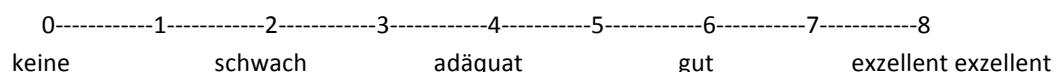
Der Therapeut:

- bittet den Patienten eine typische Angstsituation herauszusuchen
- exploriert bei der Verhaltensanalyse ausführlich die folgenden Punkte:
 - Auslösebedingungen und Situationen
 - Befürchtungen
 - Sicherheits- und Vermeidungsverhaltensweisen
- achtet darauf, dass die Befürchtungen des Patienten bis zu Ende gedacht werden (z.B. was heißt „verrückt werden“)
- exploriert besonders kognitive Vermeidungsstrategien nach
- exploriert dann Unterschiede zwischen den Panikanfällen und erhebt:
 - weitere typische Auslösersituationen und achtet auf gemeinsame Situationsmerkmale
 - Körperveränderungen und achtet auf besonders angstauslösende Symptome
 - Befürchtungen
 - Vermeidungs- und Sicherheitsstrategien und gibt dabei auch Beispiele

**H2) COMPETENCY – Wie kompetent hat der Therapeut die funktionelle Analyse vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)****J) ABLEITUNG DER THERAPIEZIELE (SITZUNG 3)****J1) ADHERENCE**

Der Therapeut:

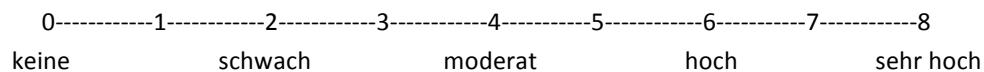
- benennt die Hauptprobleme des Patienten (Körpersymptome und Situationen = bedrohlich und angstzeugend, bei Angst wird vermieden, dadurch wird Erwartungsangst größer)
- lässt den Patienten anhand dieser Probleme Therapieziele ableiten
- erklärt das Vorgehen in der Therapie
- betont dabei die Wichtigkeit des Sicherheitsverhaltens
- fragt nach, ob Patient dieses Vorgehen nachvollziehen kann und ihm das beim Bewältigen seines Problems helfen kann
- geht auf Fragen und Zweifel im Sinne der bisher vermittelten Informationen ein

**J2) COMPETENCY - Wie kompetent hat der Therapeut die Ableitung der Therapieziele vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)**

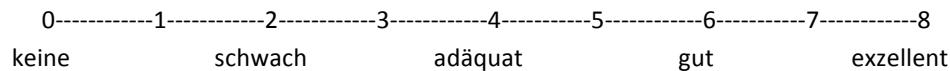
K) ENTSCHEIDUNG FÜR KONFRONTATION (SITZUNG 5-6)**K1) ADHERENCE**

Der Therapeut:

- betont die Wichtigkeit, der Entscheidung des Patienten für vs. gegen Exposition
- verdeutlicht, dass dies nicht bedeutet, dass er keine Angst davor hat, sondern sich mit/wegen seiner Angst entscheidet
- erklärt dem Patienten das Vier-Felder-Schema zur Entscheidung zur Exposition und gibt dies als Hausaufgabe
- klärt mit dem unentschiedenen Patienten in der Sitzung Zweifel und Bedenken
 - indem er sein Verständnis für die Zweifel des Patienten betont
 - indem er die Befürchtungen des Patienten anhand des Teufelskreises nachbespricht
- geht mit einem Patienten, der sich weigert vor, wie mit einem unentschiedenen Patienten und
 - betont die Konsequenzen der Entscheidung des Patienten
 - betont die Schwere der Entscheidung und die Anforderungen der Behandlung
- verweist auf Hausaufgabe und gibt bis zur nächsten Sitzung Bedenkezeit

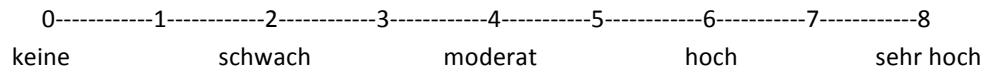


K2) COMPETENCY – Wie kompetent hat der Therapeut die Entscheidung für die Konfrontation vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)

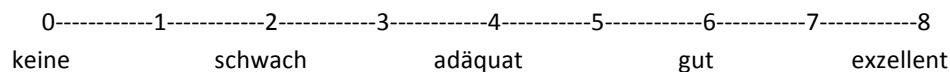
**L) INTEROZEPTIVE ÜBUNGEN - EINLEITUNG (SITZUNG 4)****L1) ADHERENCE**

Der Therapeut:

- benennt die ängstliche Bewertung der Körperveränderungen als zentralen Bestandteil der Angst
- wiederholt, wie Patient gewöhnlich mit Körperveränderungen umgeht und machen ihm den Unterschied zum jetzigen Vorgehen deutlich (keine Vermeidung, Körpersymptome und Angst sind erwünscht)



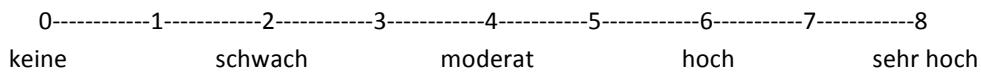
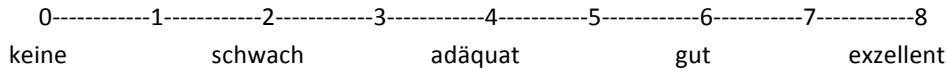
L2) COMPETENCY – Wie kompetent hat der Therapeut die Hausaufgabe der interozeptiven Übungen nachbesprochen (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)



M) INTEROZEPTIVE ÜBUNGEN – DURCHFÜHRUNG (SITZUNG 4 & 5)**M1) ADHERENCE**

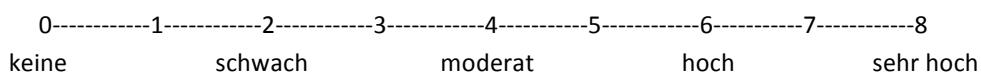
Der Therapeut:

- erläutert den Ablauf der Übungen
- führt Übungen gemeinsam mit dem Patienten zügig und ohne Pausen durch
- verstärkt den Patienten während der Übung durch Loben/Anfeuern; gibt kurze und konkrete Anweisungen zur Durchführung
- lässt nach jeder Übung eine Einschätzung zur Stärke des Symptoms, der erlebten Angst und zur Ähnlichkeit mit Panik machen
- diskutiert nicht während der Übung über Schlussfolgerungen mit Patienten (verweist auf Nachbesprechung)
- bespricht die Erfahrungen des Patienten mit ihm nach Abschluss der Übungen nach (bei Sitzung 5 im Vergleich zu Sitzung 4)
- fragt nach, beim Auftreten von Problemen (Übungen zaghaft, abgebrochen; keine Angst, keine Symptome bekommen ect.) + erarbeitet mit Pat. ggf. Lösungsmöglichkeiten im Sinne des Rational
- vergibt die drei Übungen, die am höchsten Angst ausgelöst haben als Hausaufgabe (bzw. wenn keine Angst, die am Ähnlichsten zur Panik)
- leitet den Patienten an, die Übungen bis zur Symptomprovokation auszudehnen und auftretende Symptome nicht zu beeinflussen + Wiederholung, bis Angst ggf. abnimmt

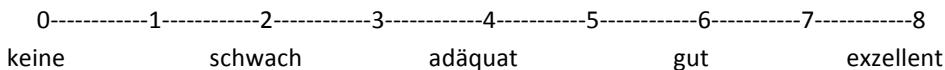
**M2) COMPETENCY – Wie kompetent hat der Therapeut die interozeptiven Übungen durchgeführt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)****N) INTEROZEPTIVE ÜBUNGEN – HA-BESPRECHUNG (SITZUNG 5 & 6)****N1) ADHERENCE**

Der Therapeut:

- fragt nach den Erfahrungen des Patienten bei der Durchführung der Übungen und seinen Schlussfolgerungen
- bespricht Anzeichen von Vermeidung und geäußerte Einstellungen, die dem Rational widersprechen
- bespricht mit dem Patienten Hindernisse, die eine erfolgreiche Übungsdurchführung behindert haben
- bespricht im Vergleich zum Ergebnis der letzten Übung Veränderungen in der Ausprägung von Symptomen und dem Auftreten von Angst im Sinne des Rational (Veränderungen der Angst durch Übung vs. Vermeidung)
- lässt den Patienten Schlussfolgerungen ziehen und korrigiert sie ggf. im Sinne des Rational



N2) COMPETENCY – Wie kompetent hat der Therapeut das Anspannungsmodell vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)

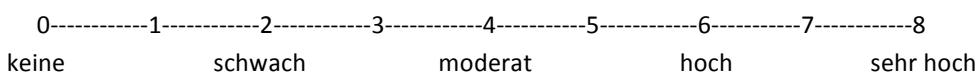


O) GEDANKENEXPERIMENT – DURCHFÜHRUNG (SITZUNG 5)

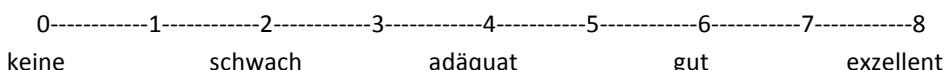
O1) ADHERENCE

Der Therapeut:

- wiederholt, die Rolle von Vermeidungsverhalten
- erklärt, dass es wichtig ist, die Vorstellungen des Patienten in Angstsituationen zu explorieren
- führt in das Experiment ein – keine Vermeidung/Ablenkung möglich; konkrete Beschreibung der schlimmsten Situation (beliebig ausdehnbar, geringe reale Gefährdung)
- achtet darauf, erleichternde Faktoren aus der Situation herauszunehmen und betont verschlimmernde Faktoren
- lässt Patienten den Angstverlauf einzeichnen, alles andere schreibt Therapeut
- fragt wiederholt nach Körperempfindungen und „was durch Kopf geht“
- fragt, was Patient glaubt, wie Angst weiter verläuft (zeigt Offenheit für den Verlauf, beeinflusst Patienten nicht, im Sinne eines Angstabfalls)
- macht im weiteren Verlauf immer wieder Anmerkungen zur Verschlimmerung der Angst
- erfasst Vermeidungsverhalten, stellt dieses als solches heraus und schließt es aus
- erfasst Annahmen, die zur Beendigung des Experiments führen und schließt diese ebenfalls aus, betont Bedeutung und verweist auf Nachbesprechung
- macht Zeitvorgaben zur Strukturierung des Experiments
- prüft angenommene Angstreduktion des Patienten im Sinne des Rationals und korrigiert ggf. im Sinne des Rationals
- beendet das Experiment erst, wenn Angst aufgrund von Gewöhnung/von selbst nachlässt (ggf. bei langer Zeitspanne [wenn absehbar, dass Patienten selbst nicht dorthinkommt (?)] = durch eigene Erklärung)
- bestätigt (bzw. nimmt vorweg), dass Angstreduktion durch Habituation erfolgt
- erklärt Habituation
- bespricht ausgeschlossene Ereignisse (z.B. Tod) nach
 - erklärt, dass dies häufig befürchtet wird, aber der Schutzfunktion der Angst widerspricht
 - versichert dem Patienten nicht, dass er nicht sterben kann (Unsicherheit wird aufrechterhalten)
- 2malige Wiederholung des Gedankenexperiments (gleiche Gegebenheiten + Erfahrung)



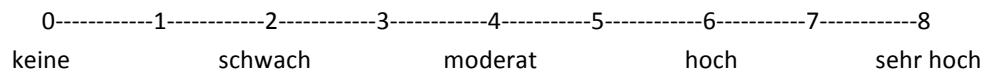
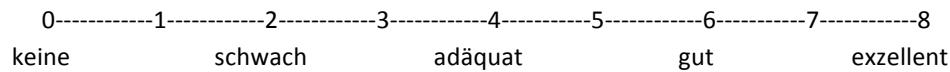
O2) COMPETENCY – Wie kompetent hat der Therapeut das Gedankenexperiment durchgeführt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)



P) VIER-FELDER-SCHEMA ZUR MOTIVATION (AB SITZUNG 6)**P1) ADHERENCE**

Der Therapeut:

- verwendet das Schema nur, wenn ein Patient ein Ereignis in der Zukunft vermutete, aber nicht sicher ist, ob es eintritt
- schreibt den vermuteten Ausgang (Befürchtung) und den anderen möglichen Ausgang in die erste Zeile und benennt den tatsächlichen Ausgang als unbekannt
- erarbeitet mit dem Patienten mögliche Verhaltensweisen für das Verhalten a) ich verhalte mich, als ob Befürchtung eintritt und b) als ob Befürchtung nicht eintritt konkret für den Patienten
- lässt den Patienten konkrete Vor- und Nachteile für die Verhaltensweisen in Abhängigkeit vom vermuteten Ausgang benennen
- lässt den Patienten zum Schluss eine Reihe (keine Zeile) wählen
- fragt nach den Schlussfolgerungen bzw. der Entscheidung des Patienten
- gibt Bedenkzeit bis zur nächsten Sitzung

**P2) COMPETENCY – Wie kompetent hat der Therapeut das Vier-Felder-Schema zur Motivation vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)**

Q) EXPOSITIONSSITZUNGEN –VORBESPRECHUNG (SITZUNG 6-11; BOOSTER)**Q1) ADHERENCE**

Der Therapeut:

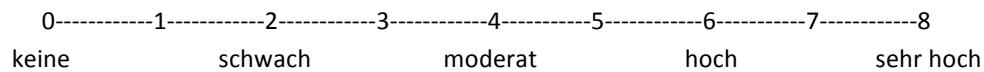
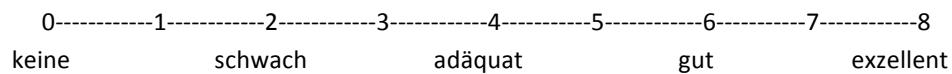
- benennt die Übung
- wiederholt, dass Situation ohne Sicherheits- und Vermeidungsverhalten aufgesucht werden soll
+ solange in der Situation bleiben, bis Angst von selbst reduziert
- beschreibt konkret die Übung und erfragt Bereitschaft zur Teilnahme
- lässt Erwartungsangst einschätzen, und exploriert Erwartungen des Patienten und lässt antizipierten Angstverlauf einzeichnen

ab Sitzung 9:

- wählt gemeinsam mit dem Patienten eine Übung aus
- achtet auf Schwierigkeit der Situation (fehlende Angstreduktion, Erwartungsangst)
- wiederholt gemeinsam mit dem Patienten die Absprachen für diese Übung
- fragt den Patienten, wie Übung durchzuführen wäre, damit Ziel der Angstreduktion möglich
- plant gemeinsam mit dem Patienten die Übung inkl. 2 Wiederholungen
- lässt Patienten zusammenfassen, wie Übung durchzuführen ist korrigiert ggf. die Aussagen des Patienten im Sinne des Rational

nur unbegleitet:

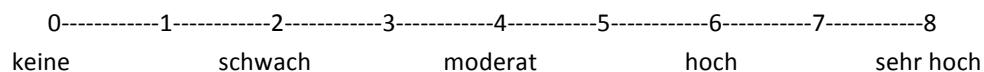
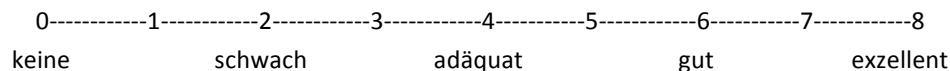
- exploriert Vermeidungsverhalten und meldet dies ggf. zurück, verdeutlicht die Wirkung des Verhaltens und bezieht dabei die Expositionsräume ein, erarbeitet gemeinsam mit dem Patienten Lösungsmöglichkeiten zur Verringerung des Vermeidungsverhaltens im Sinne des Rational
- betont die Möglichkeit interozeptiver Übungen zur Angststeigerung
- fragt nach Dingen, die Situation angenehmer machen und erarbeitet mit Patienten, was er ggf. dagegen tun könnte
- bespricht Umgang mit aufkommenden Gedanken und Körperempfindungen im Sinne des Rational (sind normal, nicht unterdrücken)
- erfragt nochmals Erwartungsangst und Bereitschaft, die Übung aufzusuchen
- keine Bereitschaft: exploriert Grund und zeigt Verständnis; ggf. wiederholt Entscheidung für Exposition und bespricht, unter welchen Umständen die Übung möglich war (immer in Bezug auf Rational) oder bearbeitet Zweifel des Patienten am Rational; ggf. wird eine Entscheidung für vs. gegen Behandlung herbeigeführt (inkl. Bedenkenzeit)
- bei Bereitschaft < 80: fragt nach, wie Bereitschaft zu steigern wäre; bespricht die Vorstellungen des Patienten bezogen auf das Rational, vergibt die Übung erst, wenn Bereitschaft bei 80%
- wiederholt zum Schluss den Umgang mit Sicherheits- und Vermeidungsverhalten
- gibt konkrete Hinweise zur Durchführung der Übung (wann?, wo?, wie?) und plant Möglichkeiten zur Unterstützung der Annäherung und zum Verbleibs in der Situation

**Q2) COMPETENCY – Wie kompetent hat der Therapeut die Expositionsübungen vorbesprochen (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)**

R) EXPOSITIONSSITZUNGEN –NACHBESPRECHUNG (SITZUNG 7-12; BOOSTER)**R1) ADHERECE (die Nachbesprechungen ist für begleitet kürzer – mit gleichem Inhalt)**

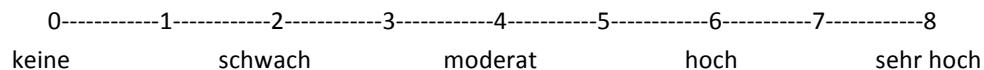
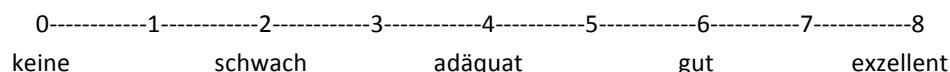
Der Therapeut:

- exploriert ggf. Gründe für die Nichtdurchführung der Übung(en) und bespricht dies im Sinne des Rationalen
- lässt sich Ablauf der Übung(en) schildern und fragt nach Problemen
- überprüft anhand der Schilderung des Patienten, ob er die Übung manualgetreu durchgeführt hat (kein Sicherheits-/Vermeidungsverhalten, solange in Situation bis Angst von selbst nachlässt)
- erfragt, ob Probleme beim nächsten Mal wieder erwartet werden und erarbeitet mit dem Patienten ggf. Lösungsmöglichkeiten
- bespricht Angstverlauf mit Schwerpunkt auf Vermeidungsverhalten nach
- erarbeitet mit Patienten Lösungsmöglichkeiten zur Aufgabe des Vermeidungsverhaltens
- fasst Übungsverlauf zusammen
- exploriert Schlussfolgerungen des Patienten und korrigiert diese ggf. im Sinne des Rationalen

**R2) COMPETENCY – Wie kompetent hat der Therapeut die Expositionsübungen nachbesprochen (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)****S) NACHBESPRECHUNG LERNERFAHRUNG (SITZUNG 9 & 12)****S1) ADHERENCE**

Der Therapeut:

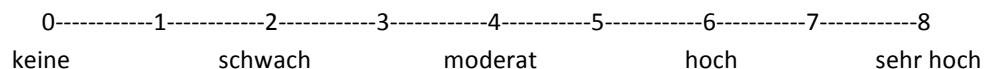
- vergleicht gemeinsam mit dem Patienten alle Angstverläufe der letzten Stunden (bei Sitzung 9: 6-8; bei Sitzung 12: 10 -11; Booster: Übungspläne)
- erfragt vom Patienten seine Erfahrungen und Schlussfolgerungen
- überprüft, ob Habituation stattgefunden hat und es einen Wiederholungseffekt gab
- ordnet die vom Patienten gemachten Erfahrungen und geäußerten Probleme ins Rational ein
- lässt Schlussfolgerungen formulieren, die für die weitere Therapie bedeutsam sein könnten
- erhebt gemeinsam mit dem Patienten die problematische Körperempfindungen und Gedanken und ordnet deren Bedeutung in den Teufelskreis ein; erarbeitet mit dem Patienten die Bedeutung dieser Symptome für weitere Übungen
- exploriert den Verlauf der Erwartungsangst, bespricht gemeinsam mit dem Patienten Probleme und deren Lösung im Sinne des Rationalen
- betont Bedeutung des wiederholten Aufsuchens von Situationen mit reduzierter Angst zur Reduktion der Erwartungsangst

**S2) COMPETENCY – Wie kompetent hat der Therapeut die Lernerfahrungen nachbesprochen (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)**

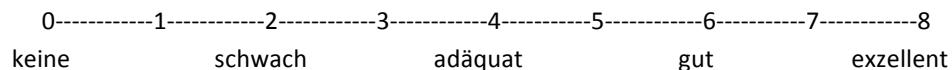
T) RISIKOSITUATIONEN (SITZUNG 12; BOOSTER 1-2)**T1) ADHERENCE**

Der Therapeut:

- erklärt die Normalität des Wiederauftretens von Angst und betont die Problematik des Vermeidungsverhaltens
- beschreibt/wiederholt Risikosituationen, die das Wiederauftreten fördern (Situationen mit Restsymptomen; Restsymptome selbst, selten aufgesuchte Situationen und Lebenssituationen mit erhöhter Stressbelastung)
- lässt den Patienten die Restsymptome und aktuelle/antizierte Belastungssituationen benennen
- erarbeitet mit dem Patienten gemeinsam konkrete Lösungsansätze und Handlungsstrategien bezogen auf den Umgang mit Restsymptomen und Belastungssituationen

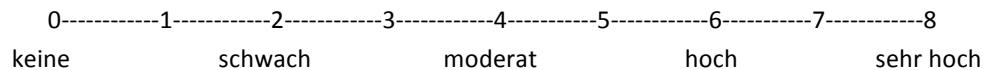


T2) COMPETENCY – Wie kompetent hat der Therapeut die Risikosituationen besprochen Anspannungsmodell vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)

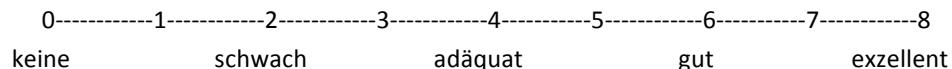
**U) ÜBUNGSPLAN (SITZUNG 12; BOOSTER 1-2)****U1) ADHERENCE**

Der Therapeut:

- lässt den Patienten festlegen, welche konkreten und verhaltensnahen Ziele er erreichen will inkl. der Schritte zur Zielerreichung
- plant konkrete Zeiten für die Übungen und achtet auf die Realisierbarkeit der Übungen
- bespricht gemeinsam mit dem Patienten den Umgang mit Hindernissen und Verzögerungen
- leitet den Patienten zur Fortführung des Übungsplanes an



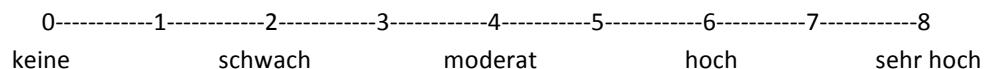
U2) COMPETENCY – Wie kompetent hat der Therapeut den Übungsplan besprochen vermittelt (z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)



V) FESTSTELLUNG ZIELERREICHUNG (BOOSTER 1 & 2)**V1) ADHERENCE**

Der Therapeut:

- bespricht gemeinsam mit dem Patienten die Erreichung der Ziele
- lobt Patienten für erreichte Ziele und verstärkt weitere Übung
- bespricht aufgetretene Probleme im Sinne des Rationals
- überlegt mit dem Patienten Modifikationen zur Sicherung der Zielerreichung
- hebt besonders Veränderungen in den Risikosituationen (Restsymptome, Belastungssituationen) hervor
- bespricht problematische Übungen im Sinne des Rationals nach und bespricht mit dem Patienten realisierbare Modifikationen

**V2) COMPETENCY – Wie kompetent hat der Therapeut die Zielerreichung besprochen**

(z.B. Umgang mit Fragen, Einbezug/ Wertschätzung des Patienten, Förderung der Motivation, ...)

