Therapist drift: Why well-meaning clinicians mess up therapy (and how not to)

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Outline

• Identify evidence of therapists drifting off protocol
  • and why it matters

• Why do we drift

• Ways of preventing therapist drift

• Questions
Therapy depends on three elements

- Leg 1 – the technology has to be good
- Leg 2 – the patient has to participate
Therapy depends on three elements

• Leg 1 – the technology has to be good
• Leg 2 – the patient has to participate
• Leg 3 – the therapist has to deliver the therapy

What is therapist drift?

• When we actively decide not to deliver key components of a therapy or passively avoid them
  • whatever the apparent justification
  • e.g., complex cases, patient not ready, treatment resistant, etc.

• When we ignore a therapy’s limitations and strengths
  • or fail to learn about them

• When we do a therapy because it is our favourite
  • the affiliation hypothesis
An example of therapist drift (Becker et al., 2004)

• Let’s imagine that I have PTSD, and I want to get treated...
  • you can be the therapists who I could access
  • all self-described experts in the field of treating PTSD

• What is the single best treatment method?
  • imaginal exposure

• How many of you will have heard of that method?
• And how many will feel comfortable using it with the patient?
• So, what is my chance of getting the best treatment from you lot?
• Are you reading my mind about what I would want? (Becker et al., 2009)

What is the best indicator of therapist drift?

• Our clinical outcomes in everyday practice
  • and they are not as stable as we might hope...

• Shapiro & Shapiro (1982) told us something very scary

Meta-Analysis of Comparative Therapy Outcome Studies: A Replication and Refinement

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The results are reported of a meta-analysis of 143 outcome studies, published over a 5-year period, in which two or more treatments were compared with a control group. Consistent with previous reviews, the mean of the 1,838 effect size measures obtained from the 414 treated groups approached one standard devia-
What is the best indicator of therapist drift?

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![Clinical outcomes vs. Number of years practicing graph]

The place of evidence in psychological therapies

• Why should we care about the numbers and evidence?

• Most importantly – because we care about our patients

• “Numbers in [health] are not an abstract academic game: they are made of flesh and blood, and they show us how to prevent unnecessary pain, suffering and death”
  • Goldacre (2014)
Psychotherapy in research settings

- Various reviews and meta-analyses have shown similar patterns of outcomes from psychotherapies in research settings

- Let’s use Hansen et al.’s (2002) figures
  - very similar to others
What happens in real life settings?

- Hansen et al. (2002) have been looking at just that question

- What happens is...

- And that can be with the same clinicians, working with similar problems
  - e.g., Beck et al. (2013)
  - one-third the effectiveness
Can you get good outcomes in the real world?

- Looking at the figures from the latest IAPT studies in the UK, something very weird happens
  - good, but weird...

- The mean pattern of outcomes is almost identical to the best clinical research trials
  - Clark (2017)

- So that would be a ‘yes’
  - explains why other countries are getting on board

But... (part 1)

- Services vary (Clark, 2017)
  - recovery rates from 23-75%

- Not explained by the nature of the patients being seen

- Services that do less well are:
  - less likely to use diagnosis/descriptors
  - more likely to share outcomes
  - more likely to discuss systems
But… (part 2)

• Individual clinicians vary just as widely
  • and we are not good at spotting it

• **Skills** (Brosan et al., 2007; de Jong, 2019; Walfish et al., 2012)
  • We think we are better than we are compared to others
  • We think that we do better CBT than we do

• **Outcomes** (de Jong, 2019; Walfish et al., 2012; Hannen et al., 2005)
  • We think that we get better outcomes than we do
  • We underestimate the number of patients who get worse

So why not just extend therapy until it works…?

• This is a very common pattern – increase the therapy dose
  • offer more therapy time,
  • expect/hope that the patient will get better with more time in therapy

• But remember that we are more likely to offer more therapy time when we are more anxious (Turner et al., 2014)
  • easier to offer another appointment than to stop therapy

• Danger that we train patients to expect that therapy is about coming to the sessions
  • therapy is more likely to be effective if it is 168 hours a week
Just give more therapy?

- Therapy dose-response is a topic where we have plenty of evidence
  - but we don’t always like the evidence
- Effects tail off after 6-10 sessions
  - whatever the therapy
- Same pattern in IAPT and non-IAPT services, and for different disorders

So start active therapy earlier?

- In general, this works very well
  - improves outcomes across disorders
    - Beard & Delgadillo (2019), Vall & Wade (2014)
- But there is a nasty little interaction with our skills base
  - Barkham (2019)
- So we need to push for change early AND be good at delivering therapy
How can we enhance our outcomes?

- **Empirically-supported treatments (EST)**
- Working from the manuals
- Appropriate flexibility to the individual

- **Evidence-based practice (EBP)**
- To improve our outcomes, this model tells us to combine:
  - the EST
  - professional expertise/judgement
  - patient values

The problem with the evidence-based practice model

- There is no evidence that EBP works

- Indeed, we are likely to make outcomes worse by bringing in clinicians’ judgement
  - Grove et al. (2000); Meehl (1954)

- And before everyone gets hopeful...
- ...our judgement does not get better with age, experience or profession
So let’s just do evidence-based therapy, and do the best for our patients (?)

- It would be lovely if we actually delivered ESTs
- We know that they can do well in real-life settings, after all
  - evidence from UK IAPT settings
- But that depends on us...
- This is where **therapist drift** happens

Two types of clinician (McHugh, 1994)

- ‘Romantics’
  - prioritise intuition and clinical judgement in reaching clinical decisions
- ‘Empiricists’
  - prioritise scientific evidence in reaching clinical decisions

The Cavaliers
“Wrong but Wromantic”
The Roundheads
“Right but Repulsive”
Formulating therapist drift: A CBT perspective

- Want to understand why well-meaning clinicians drift
  - assuming that we are not malevolent...

- To understand drift behaviours, we need to understand our:
  - Beliefs and attitudes
  - Emotions
  - Physiology/biology

- Some of the evidence for each

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Therapists’ beliefs and attitudes

- Warning: Some research findings that might upset you

- We rarely use manuals and we dislike them (Addis & Krasnow, 2000)
  - even though using them results in better outcomes for patients
  - many clinicians have no idea what a manual is

- We believe the therapeutic alliance will do lots of the work for us
  1. How much of the clinical outcome is associated with the alliance?
     - Clinician beliefs = 32% (Waller et al., 2020)
     - The evidence = 4-5% (Martin et al., 2000)
  2. Does the alliance drive therapy outcome?
     - Not in CBT (Tang & DeRubeis, 1999; Graves et al., 2017)
     - Important to focus on early behavioural change
Therapists’ beliefs and attitudes

• **We are up-to-date**
• Not really, as it can take 15-20 years for new research to filter into routine practice
• Take the example of modern approaches to exposure therapy
  • Institute of Health (2001)

• **We are skilled in our therapies**
• About 30% of therapists have never trained in the therapy that they claim to be delivering
  • Royal College of Psychiatrists (2011; 2013)

Therapists’ emotions

• There is evidence about a whole range of therapists’ emotions and how good our therapy is
  • e.g., boredom; depression
  • excitement at novelty – we do love a new therapy to collect...

• For today, I am going to focus on one therapist emotion - anxiety

• How does clinician anxiety cause drift?
The impact of our anxiety on CBT delivery

- If we are anxious then we:
  - Use behavioural activation less for depression
    - Simpson-Southward et al. (2019)
  - Avoid exposure and behavioural experiments in different disorders
    - Levita et al. (2016); van Minnen (2010); Waller et al. (2012)
  - Push for less weight gain in anorexia nervosa
    - Brown et al. (2013)

- Reduce the intensity of exposure work for anxiety
  - using outmoded methods, such as hierarchies
  - focus more on cognitive restructuring
    - Meyer et al. (2014)

- Rely more on the therapeutic alliance to generate change
  - Brown et al. (2013); Waller et al. (2020)
The problem with clinician anxiety:
Why being ‘well-meaning’ has its problems

*Long-term enhancement*  
Patient anxious at the prospect of change  
Short-term reduction  
Patient avoids change (e.g., does not do homework)

The problem with clinician anxiety:  
Our own safety behaviours

*Long-term enhancement*  
Patient anxious at the prospect of change  
Short-term reduction  
Patient avoids change (e.g., does not do homework)

*Long-term enhancement*  
Clinician anxiety at distressing the patient  
Short-term reduction  
Clinician avoids change (e.g., does not set homework)
The problem with clinician anxiety: Accommodation cycles get us stuck

- Patient anxious at the prospect of change
- Patient avoids change (e.g., does not do homework)
- Clinician anxiety at distressing the patient
- Clinician avoids change (e.g., does not set homework)

Therapists’ biology

- Greater cardiac reactivity indicate better tolerance of anxiety
  - contrasts with the biological ‘freeze’ response
- Clinicians who have greater cardiac reactivity are more likely to use exposure and other behavioural techniques
  - Levita et al. (2016)
- In other words, even our biology influences whether we drift or not...
So why does this matter?

- Therapy is not perfect
- But when we drift, we underperform on what it *could* deliver to our patients
  - and that means that people suffer
- What is the best thing that we could do right now?
  - develop new therapies?
  - deliver the existing ones appropriately?
  - let’s start with the red zone...

Psychotherapy outcomes from efficacy and effectiveness studies

Real life therapy outcomes in everyday practice (Hansen)
Let’s look at that red bit of bar in more detail...

- Those are the people who we let down when we drift
  - about 3 in every 10 who come to therapy

- Those are the people who suffer for much longer when we deliver sub-optimal therapy

- Those are the people who we should be ashamed to have let down...
  - and I include myself in that

Reducing therapist drift: A CBT approach

- We know that our drift behaviours are related to our:
  - beliefs and attitudes
  - emotions and safety behaviours
  - biology

- So what lessons should we be willing to learn from CBT, in order to improve our delivery of therapy?
What do we need in our CBT for drift?

• Identification that we drift, but not accepting it
  • do not expect age or experience to avert it

• Should we select therapists by personality, biology, etc.?
  • e.g., females less likely to adhere to protocols
    • Sprang et al. (2008)
    • probably unrealistic...definitely unnecessary

• Education and skills training
  • reading those manuals rather than just owning them
  • not just basic training or accreditation
  • this works surprisingly well to change attitudes
    • Deacon et al. (2014); Waller et al. (2016)

What do we need in our CBT for drift?

• Trying out the skills, and learning to tolerate our own anxiety
  • e.g., exposure for exposure therapists
    • Farrell et al. (2013); van Minnen et al. (2010)
    • behavioural activation for 'stuck', 'helpless' therapists

• Supervision(?)
  • but remember that supervisors drift, too (Dennhag et al., 2012)

• Supervision, focused on patient change
  • Ost et al. (2012)
  • patient outcomes matter
What do we need in our CBT for drift?

• Competence?
  • important, but not adequate
  • a driver’s license means that you were competent when you took your test, but are you as competent now?

• Adherence?
  • important, but extremely costly to monitor

• Outcomes/progress?
  • easiest way for individuals and services to improve
  • need to respond when outcomes are poor
  • progress needs to be discussed openly with the clinician, to improve our outcomes over time (Goldberg et al., 2016)

In conclusion

• We have some excellent therapy models
  • effective in real life settings

• We do not use evidence-based therapies when we could
  • therapist drift

• We understand the reasons why we do not use ESTs
  • emotional, cognitive, biological, personality, etc.

• We know what we need to do to get back on track

• So, I would like to finish on a simple question...
You will have noticed something today

• I have been deliberately pessimistic about our skills base

• However, this can also be seen as the pessimistic realism that we need to overcome our routine optimism
  • remember that clinicians are human, and hence positively biased

• If we are less inappropriately positive, then we might start to focus on getting better at delivering therapy

• And that means that we focus on the patient’s actual outcomes, rather than what we think their outcomes ought to be

Your question to think about...

• Now that we know all this...

  • **What will I do differently tomorrow?**

• Or will I choose to ignore all these factors in myself and my supervisees...
  • and let my patients continue to be in that red zone?

• And with that, it is all over to you

![Bar chart showing recovery rates]
- The dream – 100% recovery
- The possible – 60% recovery
- The reality – 20-30% recovery
References
