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

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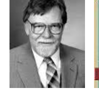
Origins of therapist drift

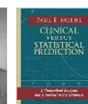
- Started out with my own experience as a trainer and supervisor
  - And a bit of grim realisation about my own practice
- Then a conversation with Terry Wilson, who encouraged me to get my thoughts and suggestions down on paper
  - I blame him
- Googling 'therap* drift' is now a bit scary
  - 780,000 hits
    - Including an acid track (by Dovetail)

2

The place of the nerd in psychological therapies

- Why should we all 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"
  - Ben Goldacre (2014)





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What is therapist drift?

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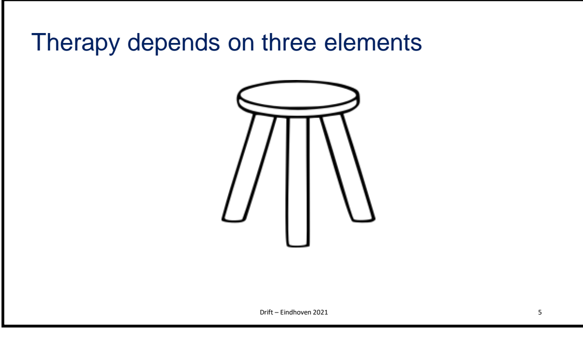
Therapy depends on three elements



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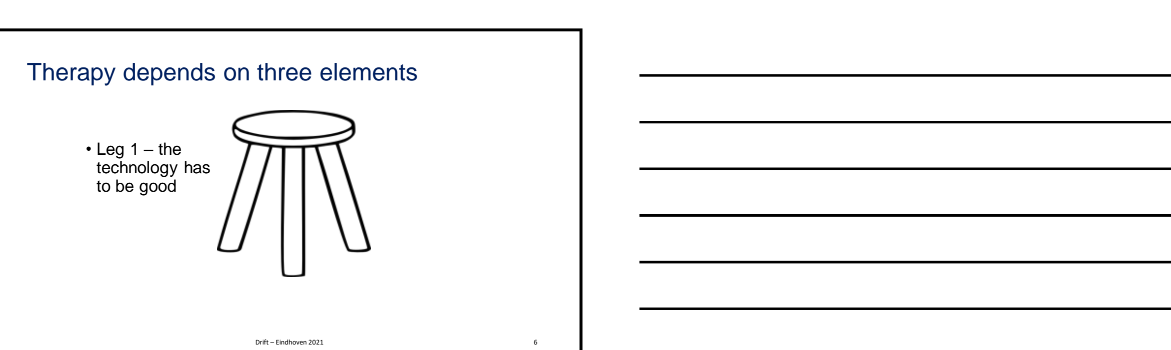

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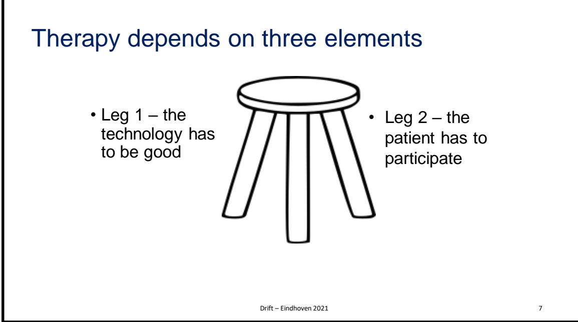

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Therapy depends on three elements

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

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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.
  - e.g., work with older adults, children, women, non-Caucasian groups
  - Meehl (1954) describes these as 'broken leg exceptions'
- 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

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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)

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Do we really miss key material in that way?

- What we should do, according to the books

100
80
60
40
20
0
Weighing patients
Food diaries
Cognitive restructuring
Exposure
Behavioural experiments
Surveys
Mindfulness
Schema therapy
Pre-therapy MET

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Do we really miss key material in that way?

- What we should do, according to the books
- What we report we actually do (Waller et al., 2012)

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What is the best indicator of therapist drift?

- Our clinical outcomes in everyday practice
- Shapiro & Shapiro (1982) told us something very scary

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

David A. Shapiro and Diana Shapiro
Medical Research Council/Social Science Research Council Social and Applied Psychology Unit
University of Sheffield, Sheffield, England

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 1,828 effect size measures obtained from the 414 treated groups approached one standard devia-

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Clinical outcomes

Number of years practicing

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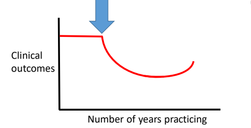

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In case you think I am being negative…

- Absolutely – but why?
- Because…Clinicians are human
  - We tend to interpret the world and our own actions too positively
  - The average clinician thinks that they are better than 80% of the rest, so what do we have to learn if that is true? (Walfish et al., 2015)
  - Which means that we fail to register what is not working
  - So we do not learn from our failures as well as we should
- I like to think of this as realistic pessimism
- But don't despair – we will get on to how we can overcome many of these problems

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What is the big problem here?

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Psychotherapy in research settings

- Various reviews and meta-analyses have shown the following pattern of outcomes from psychotherapies in research settings
- Let's use Hansen et al.'s (2002) figures
  - very similar to others

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Psychotherapy in research settings

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60
50
40
30
20
10
0
Recovered Improved Unchanged Deteriorated

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What happens in real life settings?

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

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What happens in real life settings?

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

Real life therapy outcomes in everyday practice (Hansen)

60
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20
10
0
Recovered Improved Unchanged Deteriorated
Routine practice

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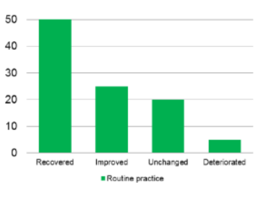
Can you get good outcomes in the real world?

- Looking at the figures from the latest IAPT studies, something very weird happens
  - good, but weird...
- The mean pattern of outcomes is almost identical to the best clinical research trials
  - Clark (2017)
- Not impacted by the COVID shifts to online working, etc.
  - Clark (2021)



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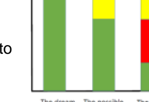
Imagine your next 1000 patients

- If our best therapies can get 50% recovery…then 500 should recover with your help
- If you don't do the therapies fully, then your likely recovery rate is one third of that…so only 150 recoveries
- So there will be 350 people out of the 1000 who fail to get better because of your drift
- We clearly need better therapies, if only 50% recover…
- …but we could be doing our job so much better if we just used the tools that we already have



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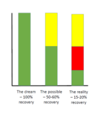
So why do we drift?



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Let's formulate…a set of interactive factors

- Knowledge and training
- Judgements/Attitudes
- Emotions
- Personality
- Behaviours
- Biology
- Environment

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- *There is way too much evidence for a brief webinar, so let's just play with a few examples*

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Personality: 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"

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Personality: some factors that can impair therapy

- Some characteristics are associated with positive outcomes
  - e.g., resilience ('unflappability') (Green et al., 2014)
- However, while we are all lovely people, beware of what can look like niceness…
- 'Openness to experience' and 'agreeableness'
  - Delgadillo et al. (2020)
  - Too much of these = we do not stick to anything = poorer outcomes
- Excessive empathy
  - Perera et al. (2016)
  - Poorer clinical outcomes

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Emotional factors

- Many have been suggested in the literature
  - boredom, anger, depression/low self-efficacy, shame
- But **anxiety** is the biggie
- Associated with poorer use of effective behavioural techniques across disorders and therapies
  - Meyer et al., 2014; Van Minnen et al., 2010; Waller et al., 2012
- Why?

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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)

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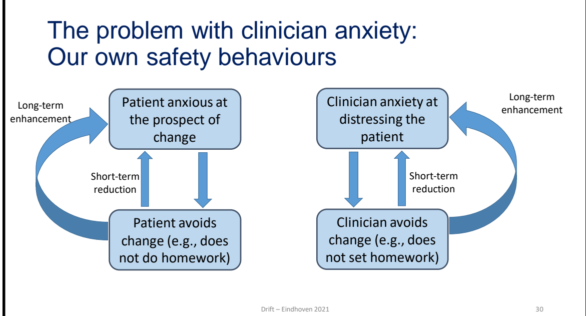
The problem with clinician anxiety: Our own safety behaviours



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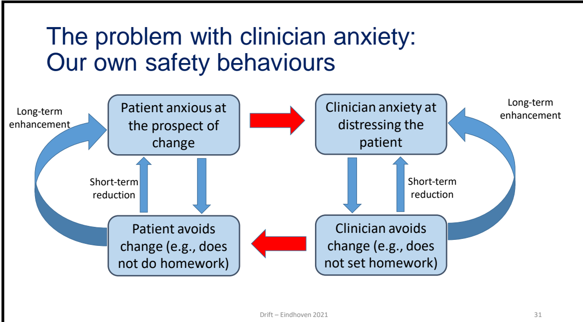

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As usual, Meehl (1973) put it best…

- "The spun glass theory of the mind"
- Our patients come to us needing help to change
- We worry that the patient is fragile
  - like a spun glass Xmas tree decoration
- We do not want to put any pressure on them, in case they break and it is our fault
- So we back off, the patient never has to change, and they never learn to become more resilient

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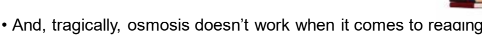
Judgement and attitudes

- Attitudes to evidence-based approaches/manuals
  - We rarely use manuals and we dislike them (Addis & Krasnow, 2000)
- Some clinicians have no idea what a manual or protocol is
- Many see them as clinically irrelevant
  - Not enough clinical examples
  - Designed for 'simple' cases
  - Getting in the way of our independence/artistry



- And, tragically, osmosis doesn't work when it comes to reading

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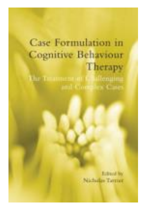
Alternative to manuals and protocols 1: Basing treatment on individual case formulation

- Common and rather tempting approach
  - Encouraged in clinical psychology training as a ‘unique’ professional skill
- Use individual formulation rather than diagnosis or disorder descriptors
- Base treatment on that formulation, rather than a protocol or manual
- But does it work?



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Does individual case formulation work?

- Schulte (1996; Schulte et al.,1992)
  - Better patient outcomes for anxiety disorders if we use the diagnosis/protocol than the formulation-based individualized approach
  - Even for more experienced therapists
- Eells et al. (1998) Most clinicians miss key information about causes and mechanisms
  - More descriptive than integrative
- Kuyken (2006) and Aston (2009) pointed out that the evidence is very weak for case formulation
  - Poor agreement and reliability
  - Clinicians disagree with each other

TAILOR-MADE VERSUS STANDARDIZED THERAPY OF PHOBIC PATIENTS*

What's in a Case Formulation?

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Alternative to manuals and protocols 2: Basing treatment on clinician judgement

- The Evidence-Based Practice model suggests that we should build on the research evidence, adding:
  - professional expertise/judgement
  - patient values
- Particular issue – no evidence for EBP…
  - but at least it can’t hurt, can it?

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That pesky 'clinician judgement' thing

- Unfortunately, we are likely to make outcomes <u>worse</u> by focusing on our clinical judgement
  - Grove et al. (2000); Meehl (1954)
- And before we get hopeful...
- ...our judgement does not get better with age, experience or profession
- So why do we cling to our judgement in our routine clinical practice?

Best Research Evidence
EBP
Professional Expertise
Client Values

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Comments by clinicians (all are real)

- "That research just does not apply here…"
- "If I had to do evidence-based work, it would stop me being the clinician that I feel I really am."
- "My clinical judgement transcends the research."
- "Evidence-based practice is too simple."
- "Evidence-based work is too complex."
- "Evidence-based practice is too demanding."
- "We don't use the c-word here."

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That old favourite

- "My work is art, not science"
- Just remember, there is a *lot* of bad art out there
  - Courtesy of the Museum of Bad Art
- So how do you guarantee that your 'artistic' therapist is not just as bad as those artist who produced this version of the Mona Lisa?
- Do bad artists know that they are bad artists?
- If not, why would bad therapists know that they are bad therapists?

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Beliefs: Our reverence for the role of the alliance

- What factors drive clinical outcomes?
- Lambert and Barley (2001) came out with this rather nifty summary
  - 15% of outcomes is due to techniques
  - 30% is due to 'common factors'
- But it got misinterpreted…

Techniques
Expectancy/ Placebo
Common factors
Extratherapeutic change

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Assumption that 'common factors = alliance'

- How much of clinical outcome is associated with the alliance?
  - Clinician beliefs = 32% (D'Souza Walsh et al., 2019)
  - That would mean that the alliance was twice as impactful as therapy techniques
- However, our beliefs are not always right…
  - The evidence for the relationship of the alliance with outcome = 4-7% (Martin et al., 2000)
- Therapist effects account for 6-7% (Saxon et al., 2018)

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Making the alliance a bit less impressive

- Lambert & Barley (2001)

Techniques
Expectancy/ Placebo
Common factors
Extratherapeutic change

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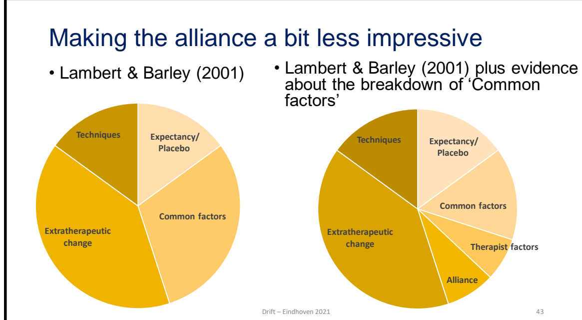
Making the alliance a bit less impressive

- Lambert & Barley (2001)
- Lambert & Barley (2001) plus evidence about the breakdown of 'Common factors'



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And just to make it worse…

- Does the alliance drive therapy outcome?
  - Not in therapies that are based on behavioural change
    - Tang & DeRubeis, 1999; Graves et al., 2017
- Behavioural change drives the development of a strong alliance
  - Our patients seem to like us better if we help them get well
- Important to focus on early behavioural change
- And remember that the alliance is not meant to be nice
  - The 'cactus' model
  - A prickly interplay of attachment bond and encouraging change

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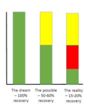
Having outlined some of the reasons that we drift…how do we reverse that drift?



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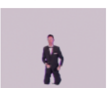
First – ask what works in therapy

- Then look at whether we are doing those things, and why not…
  - If not, then we are already drifting
- And remember that drifting can feel lovely
  - Ever done a shopping list in your head, or checked your emails during a session?
- Until we realise that we have gone a little out of our depth



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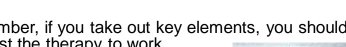
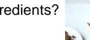
Time for some self-reflection…do I need to change?

- Follow the manual
  - Many brave clinicians and researchers have blazed the trail here, and left you a map
  - But remember to make the therapy flex to the patient
  - Don't try to make the patient fit the therapy
  - And don't expect the world to stay neat
  - So treat the manual/protocol like a map – if you need to take a diversion, you can use the map to get you back on track
- Remember, if you take out key elements, you should not trust the therapy to work
  - Baking a cake without key ingredients?





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The world is a messy place: Simplify

- Don't be deterred by comorbidity or complexity
  - Remember that complex is normal
    - COVID is just one example of that…adapt to thrive
  - Address one target really well
  - See what is left and address that
- Tackle therapy-interfering behaviours head-on
  - Name them and their impact on therapy's chances
  - Be prepared to stop the session very early (5-minute session)
    - With due warning and consultation with your supervisor
  - Cope with your own fear that this will drive the patient away
    - Even if it did, how does that worsen the situation?

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Therapeutic relationship ≠ being liked

- Understand the role of the alliance in therapy
  - Early change is your best way to develop it in the most effective therapies
  - Remember that 'prickly' aspect
  - Cope with not being liked sometimes
- My session 1 statement to all patients
  - "I'm going to be asking you to make changes, so that you get past your problems. That will probably mean that you hate my guts sometimes, and that is fine. I don't need you to like me – I need you to get well"
- Keeping the boundaries on the relationship
  - Firm empathy from the beginning (Wilson et al., 1997)

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Plan and monitor

- <u>Manage the session</u>
- Do you have an agenda ready at the start?
- Do you add patient material?
- Do you ever say: "Have a seat, tell me how your week was", while you try to remember what on earth you were planning for this session?
- <u>Measure, discuss and respond</u>
- Progress and Routine Outcome Measures (PROMS)
- Administer measures, but use them with the patient
  - Feedback, motivation, what to do next.
- Enhances outcomes (de Jong et al., 2021)

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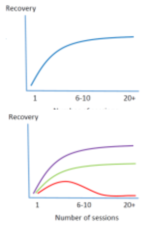
Behavioural change

- <u>Behavioural change</u> is key in our most effective therapies
- e.g., do we need the C in CBT for most disorders?
- Impact on mood, cognitions, quality of life, comorbid conditions
- <u>Early behavioural change</u> is even more critical
- Best predictor that we have of outcome
  - e.g., Beard & Delgadillo (2019)
- Don't just add more sessions, assuming that the treatment dose effect is linear



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Team working

- Supervision
- Needs to be case-focused and evidence-based
  - e.g., Ost et al. (2012)
- Not just profession-based/case management
- But that needs a supervisor who is up to date, too
  - And one who is able to deal with anxiety (their own and their supervisee's)

- Work as a team to plan and agree
- Open teams do best in patient outcomes (Clark, 2017)
- Discussing strategy and skills
- If your patient outcomes are better than mine, teach me

Clinical outcomes

Number of years practicing

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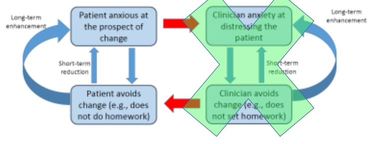
How are you going to be better next week?

- And finally, work on tolerating your own uncertainty
- Our job is to intervene here, for ourselves and our trainees



- Exposure for exposure therapists (Farrell et al., 2013)
  - Take the risks, and learn that your patient might be tougher than you think

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Key references

- Waller, G. (2009). Evidence-based treatment and therapist drift. *Behaviour Research and Therapy, 47,* 119-127.

- Waller, G., & Turner, H. (2016). Therapist drift redux: Why well-meaning clinicians fail to deliver evidence-based therapy, and how to get back on track. *Behaviour Research and Therapy, 77,* 129-137.

- And, of course:
- https://www.youtube.com/watch?v=tY5TsmDFMgk

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Questions?