Evidence-based treatment and therapist drift

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The traditional ‘make you jealous’ photo

• Because so many keynote speakers start by showing you their wonderful country...

• ...and because the UK is trying to stop all foreigners coming in...

• ...I want to start by showing you something that you will not be used to and might not see again

• We call these ‘hills’
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)
Empirically-supported treatments (EST)

• We have lots of treatments that are supported by strong evidence

• Strongest evidence is for CBT/BT
  • particular role for the behavioural elements

• Effective and efficacious
  • they work in the real world, as well as in the research setting
  • and with the same patients (complexity, etc.)
But beware...

Not every approach is evidence-based

Sometimes, books are published to make money...not to get people better

And not all articles should be trusted
CBT is not perfect

• According to the disorder, about 50-60% who start the treatment reach recovery
  • in well-conducted studies
  • efficacy and effectiveness

• So how might we improve our empirically-supported treatments?
Evidence-based practice (EBP)

• To improve our outcomes, this model tells us to combine:
  • the EST
  • professional expertise/judgement
  • patient values

• Some disagreement about the model
  • especially the ‘patient values’ part
  • originally – ‘ask the patient’s opinion’
  • became – ‘tell the patient what you are doing and why’
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 CBT, and do the best for our patients (?)

- It would be lovely if we actually delivered the EST version of CBT
- We know that it does well in real-life settings, after all
- But that depends on us...
- This is where **therapist drift** happens
- Alternative label: **therapist stampede**...
  - (with thanks to Terry Wilson)
Two types of clinician (McHugh, 1994)

• ‘Romantics’
  • prioritise intuition and clinical judgement in reaching clinical decisions

• ‘Empiricists’
  • prioritise scientific evidence in reaching clinical decisions
Two types of clinician (McHugh, 1994)

- Romantic or Empiricist...think about which one you are

- But worry more about all those clinicians out in the wild
  - who are not at this meeting
  - who never go to any meeting
  - who are not adequately trained
  - who do unproven therapies
  - etc.
CBT 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 CBT
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
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 Diane 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-
Formulating therapist drift: A CBT perspective

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

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

• Some of the evidence for each
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., in preparation)
    • The evidence = 4-5% (Martin et al., 2000)
  2. Does the alliance drive therapy outcome?
    • Not in CBT (Tang & DeRubeis, 1999; Graves et al., under consideration)
    • Important to focus on early behavioural change
Therapists’ beliefs and attitudes

- We are up-to-date
  - Institute of Health (2001)

- We are skilled in CBT
  - Royal College of Psychiatrists (2011; 2013)

- We are pretty good at delivering therapy
  - Brosan et al. (2007); Walfish et al. (2012)

And we think that our outcomes are much better than the evidence suggests is possible.

The mean self-rating of therapists is that we are better than about 80% of other therapists – so what do we have to learn if we are that good?

Average time from research to routine practice = 17 years

30% of psychotherapists are untrained in the therapy that we claim to be delivering.
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 and one therapeutic technique
  • anxiety and exposure

• How does clinician anxiety cause drift?
  • affecting our use of exposure-based techniques
The impact of our anxiety on CBT delivery

• If we are anxious then we:

• Use behavioural activation less for depression
  • Simpson-Southward et al. (in press)

• 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)
The impact of our anxiety on CBT delivery

• 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. (in preparation)
The problem with clinician anxiety: Our own safety behaviours

- Patient anxious at the prospect of change
- Patient avoids change (e.g., does not do homework)

Drift – Veldhoven 2016
The problem with clinician anxiety: Our own safety behaviours

<table>
<thead>
<tr>
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Meehl (1973) – The Spun Glass Theory of the Mind

Drift – Veldhoven 2016
The problem with clinician anxiety: Our own safety behaviours

- **Patient anxious at the prospect of change**
  - Short-term reduction
  - Long-term enhancement

- **Clinician anxiety at distressing the patient**
  - Short-term reduction
  - Long-term enhancement

- **Patient avoids change (e.g., does not do homework)**

- **Clinician avoids change (e.g., does not set homework)**

Drift – Veldhoven 2016
Therapist’s personalities

• Some personality traits predict better adherence and outcomes

1. Openness to experience (Peters-Scheffer et al., 2013)
2. Resilience, organisation and confidence (Green et al., 2014)
3. Resilience and mindfulness (Perera et al., 2016)
   • empathy had a negative association with outcomes

• More important to consider the combination of firmness and empathy
  • Wilson et al. (1997)
Therapist’s personalities

• One finding that might tell us why we choose specific CBTs
  • Freud & Waller (in preparation)

• Why do we opt for more traditional CBT or for ‘third wave’ variants of CBT?

• Remember – do not assume that empathy is a good thing in isolation (Perera et al., 2016)
Therapist’s 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?

Psychotherapy outcomes from efficacy and effectiveness studies

Real life therapy outcomes in everyday practice (Hansen)
So why does this matter?

• CBT 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...

Drift – Veldhoven 2016
Reducing therapist drift: A CBT approach

• We know that our drift is related to our:
  • beliefs and attitudes
  • emotions and safety behaviours
  • personality
  • biology

• And we could all be one of the tree-people...

• So what lessons should we be willing to learn from CBT, in order to improve our delivery of CBT?
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 CBT therapists by personality, biology, etc.?
  • e.g., females less likely to adhere to protocols
    • Sprang et al. (2008); Johnson & Waller (in preparation)
    • 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, focused on patient change
  • Ost et al. (2012)
  • but remember that supervisors drift, too (Dennhag et al., 2012)
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?
  • easiest way for individuals and services to improve
  • need benchmarks (what is good?)
  • need to respond when outcomes are poor

Drift – Veldhoven 2016
In conclusion

• In CBT, we have an excellent therapy model
  • effective in real life settings

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

• We understand the reasons why we do not use CBT
  • 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...
Your question to think about this weekend

• Now that we know all this...

• What will I do differently on Monday?

• 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 remember, we have existing patients as well as new ones, who deserve the best that we can give them.