Evidence-based treatment and therapist drift

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The University Of Sheffield.

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

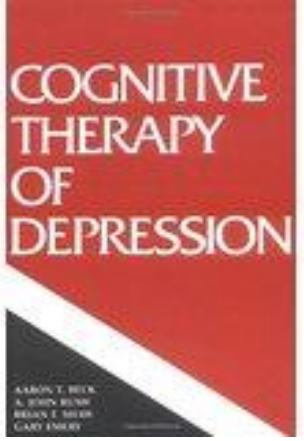
- We call these ‘hills’

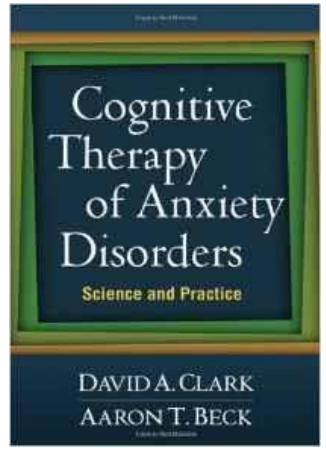
The place of evidence in psychological therapies

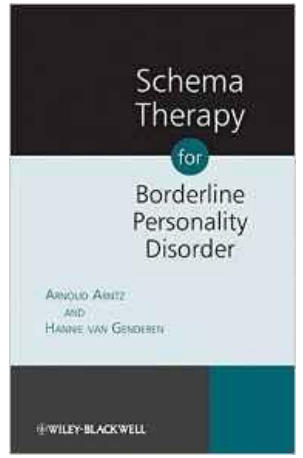
- Why should we care about the numbers and evidence?
- Most importantly – because we care about our patients
- “Numbers in [health] are not an abstract academic game: they are made of flesh and blood, and they show us how to prevent unnecessary pain, suffering and death”
  - Goldacre (2014)

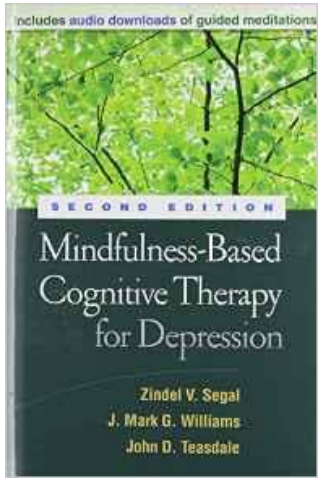
Empirically-supported treatments (EST)

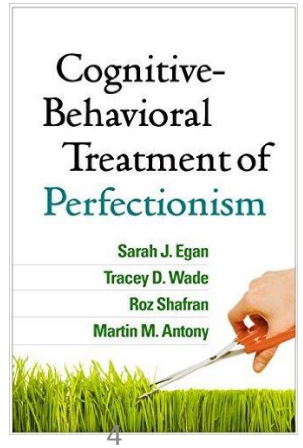
- We have lots of treatments that are supported by strong evidence
- Strongest evidence is for CBT/BT
  - particular role for the behavioural elements
- Effective and efficacious
  - they work in the real world, as well as in the research setting
  - and with the same patients (complexity, etc.)



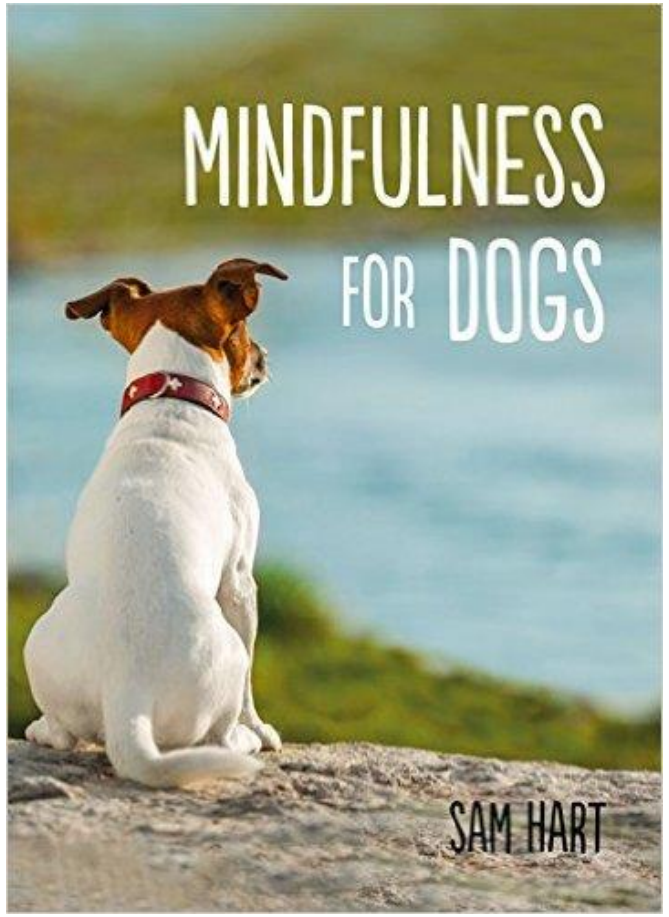








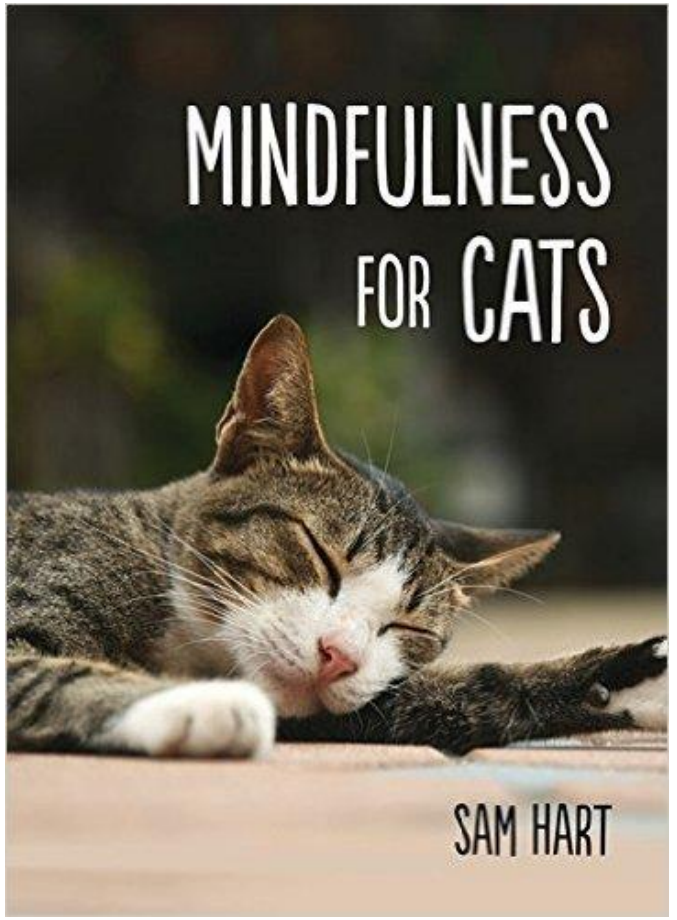
But beware...



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

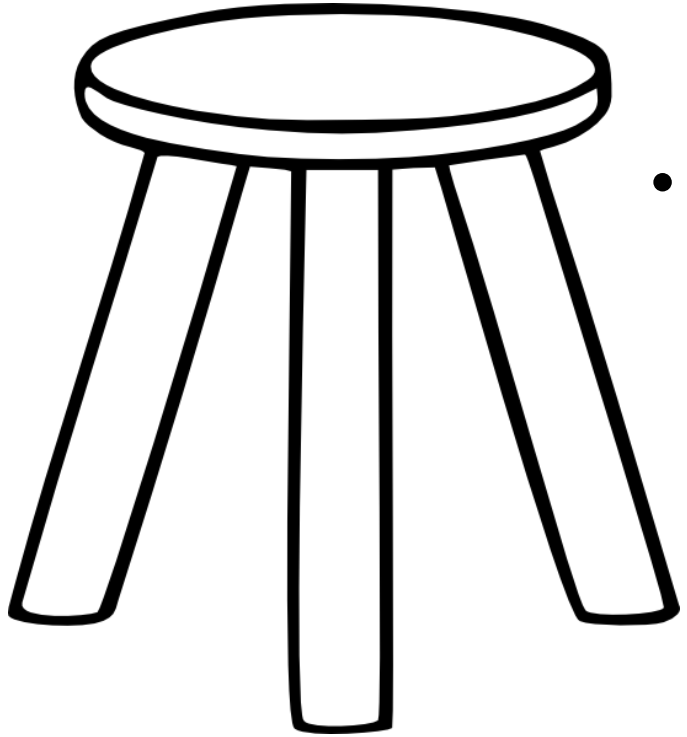
Two types of clinician (McHugh, 1994)

- 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

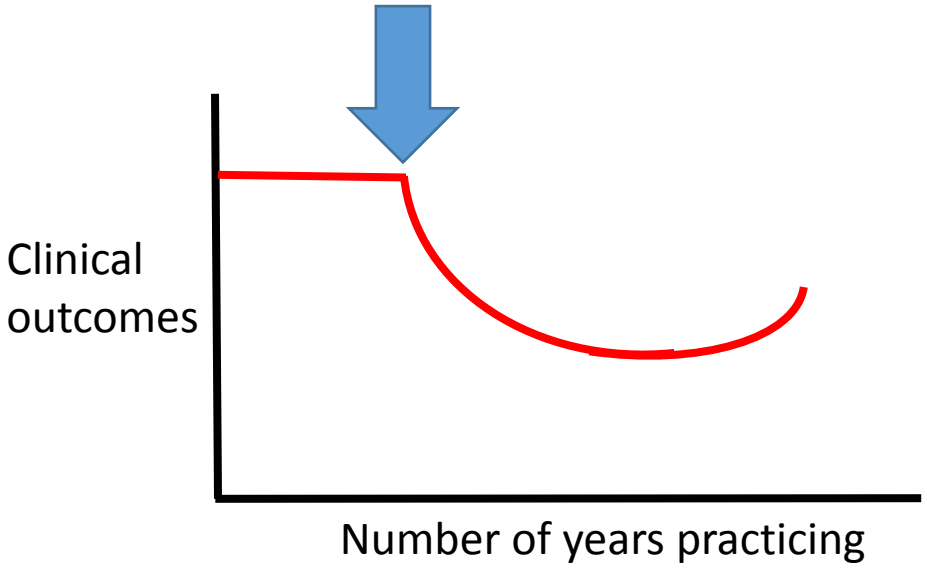
What is therapist drift?

- 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



Psychological Bulletin
1982, Vol. 92, No. 3, 581–604

0033-2909/82/9203-0581$00.75

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

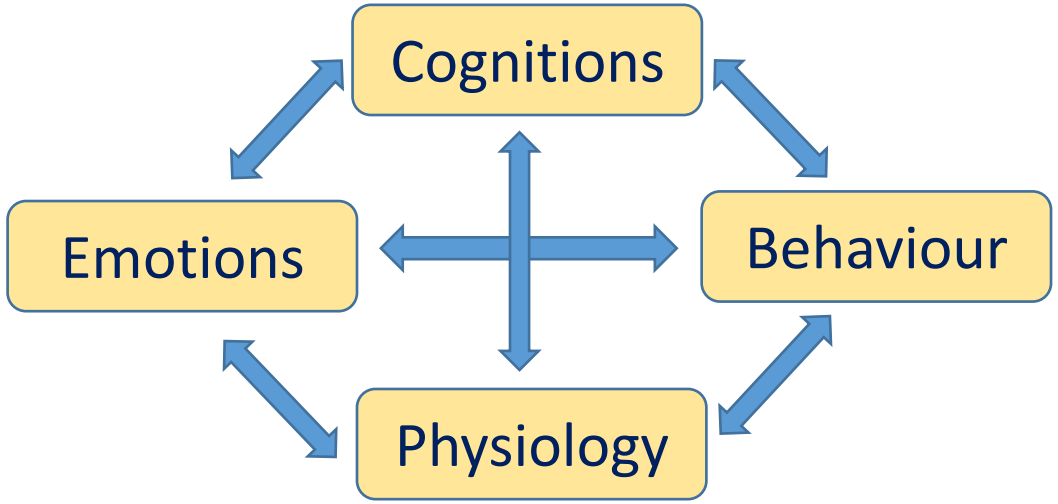
The results are reported of a meta-analysis of 143 outcome studies, published over a 5-year period, in which two or more treatments were compared with a control group. Consistent with previous reviews, the mean of the 1,828 effect size measures obtained from the 414 treated groups approached one standard devia-

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)

Average time from research to routine practice = 17 years

30% of psychotherapists are untrained in the therapy that we claim to be delivering

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?

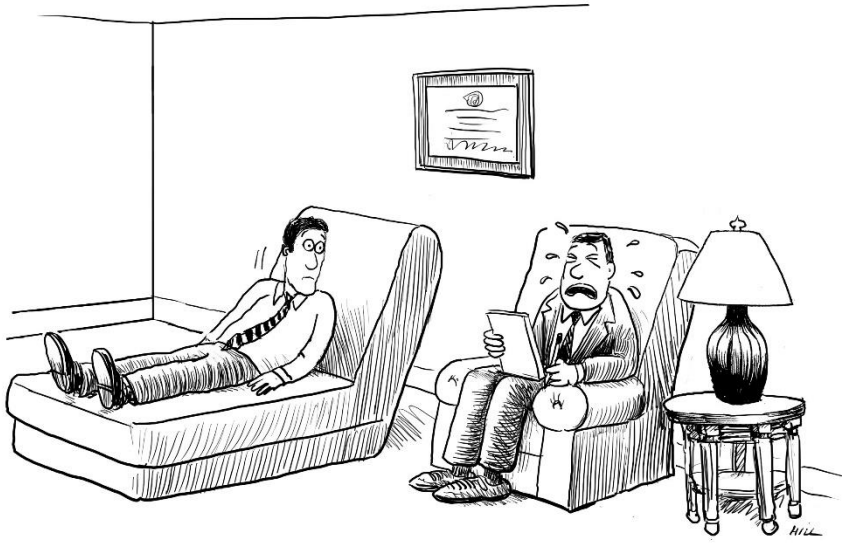
And we think that our outcomes are much better than the evidence suggests is possible

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)

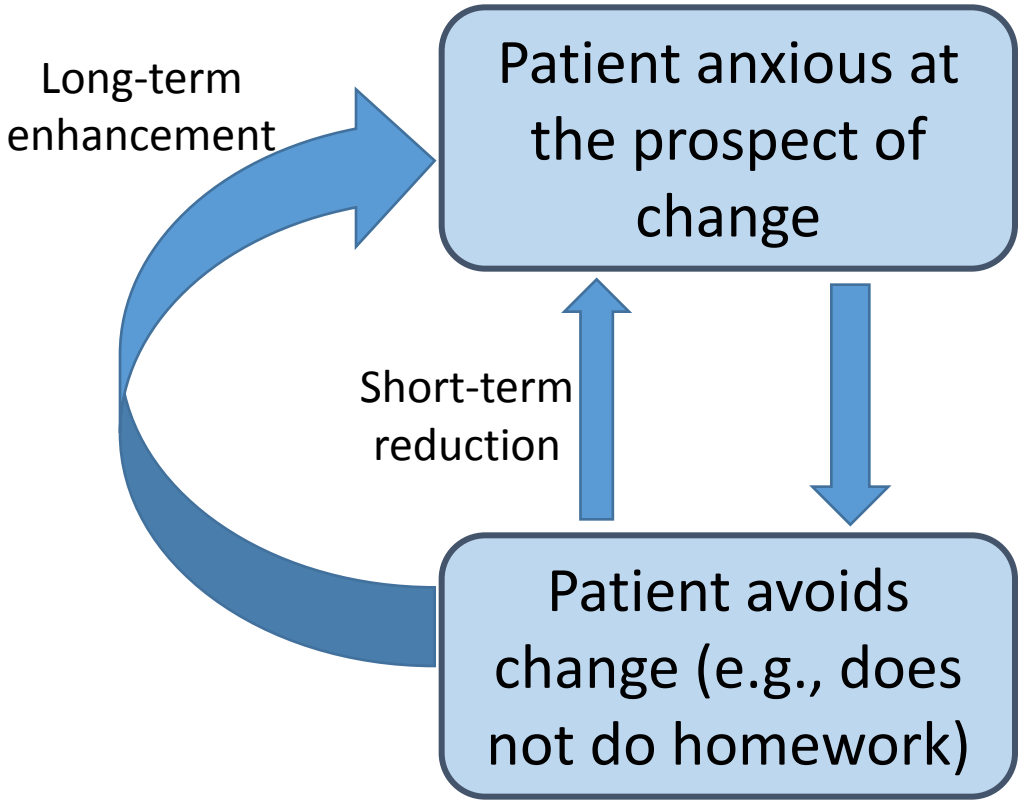
- Push for less weight gain in anorexia nervosa
  - Brown et al. (2013)

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



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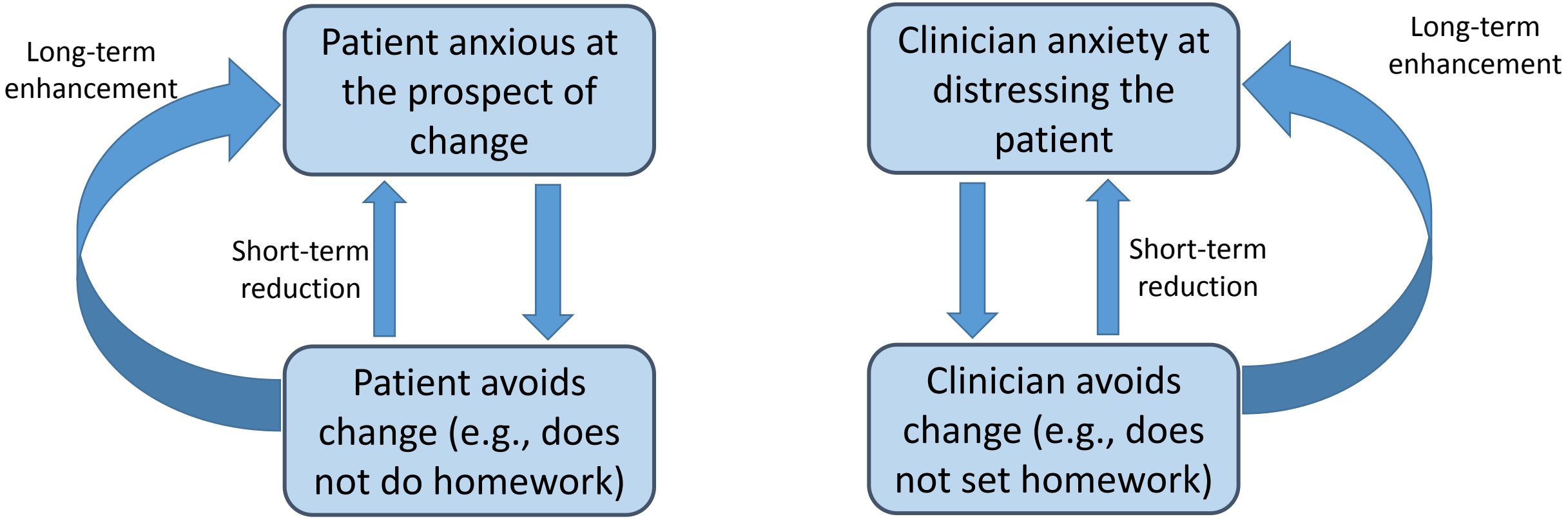
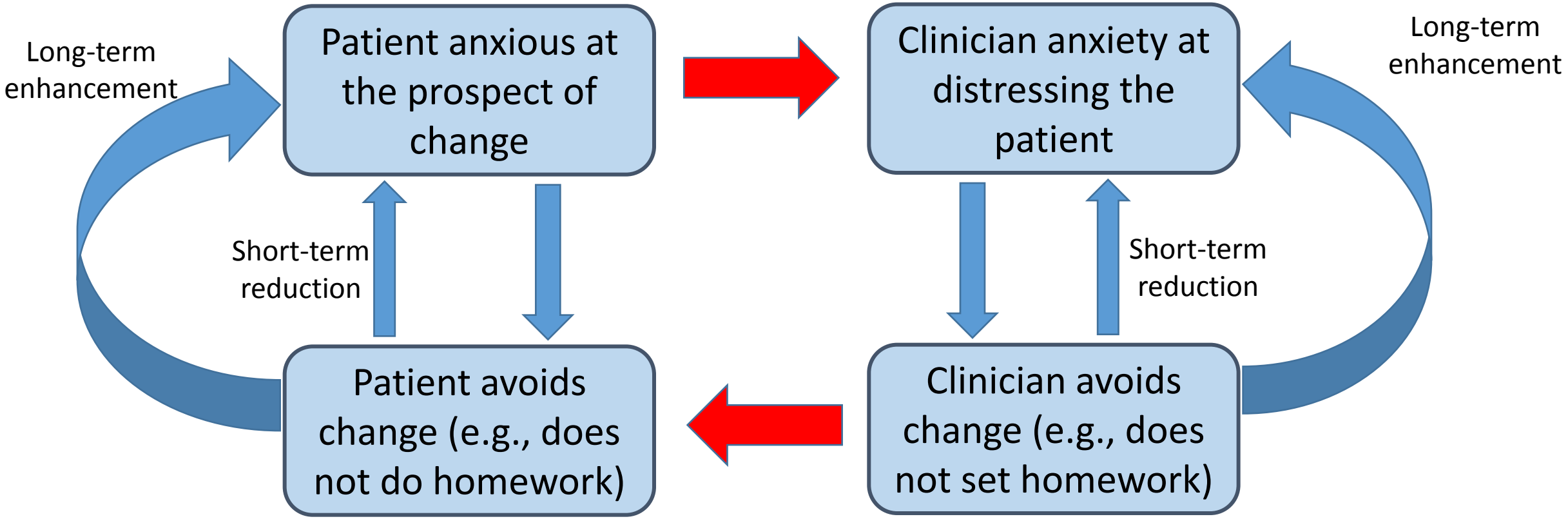


Meehl (1973) – The Spun Glass Theory of the Mind

The problem with clinician anxiety: Our own safety behaviours



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)

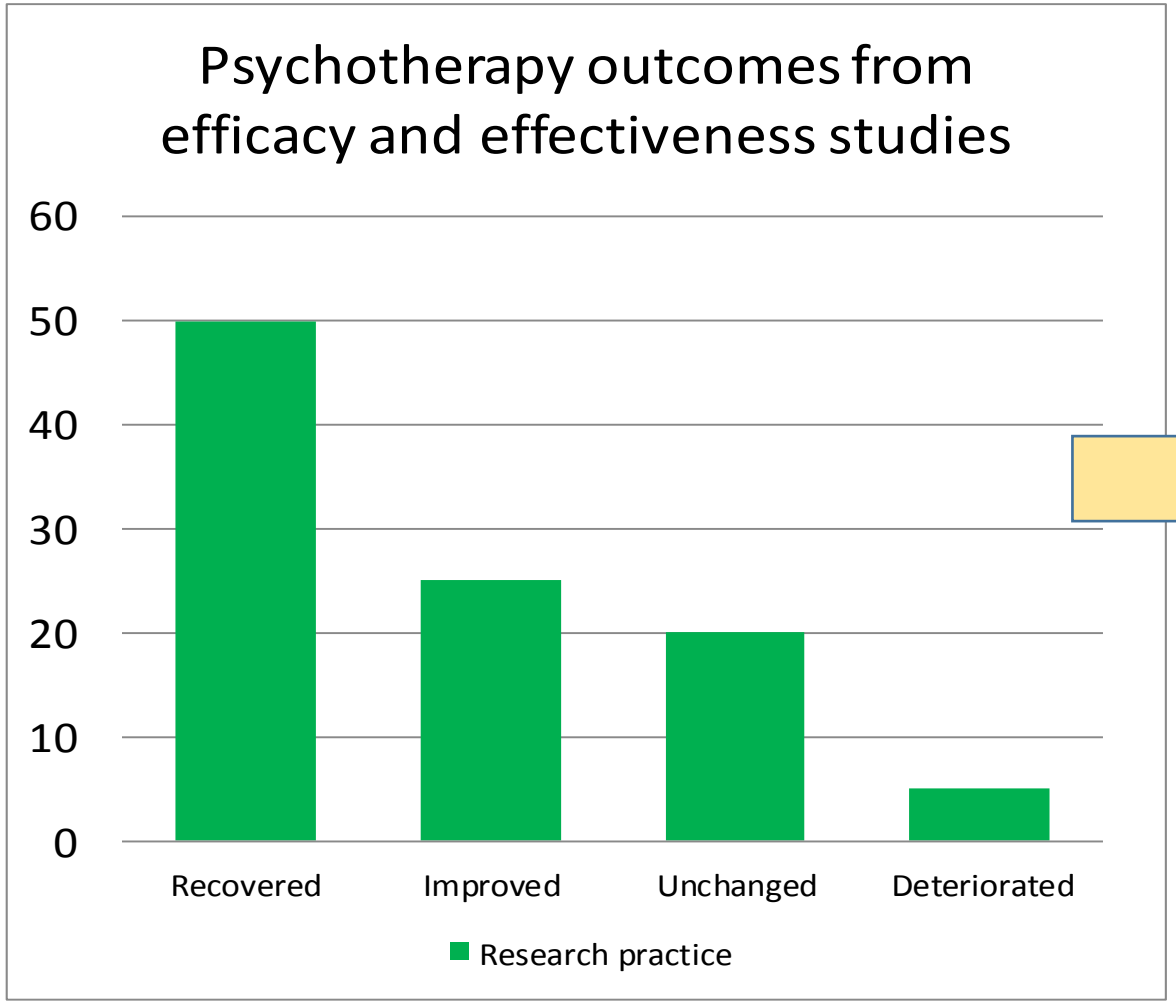
- Why do we opt for more traditional CBT or for 'third wave' variants of CBT?

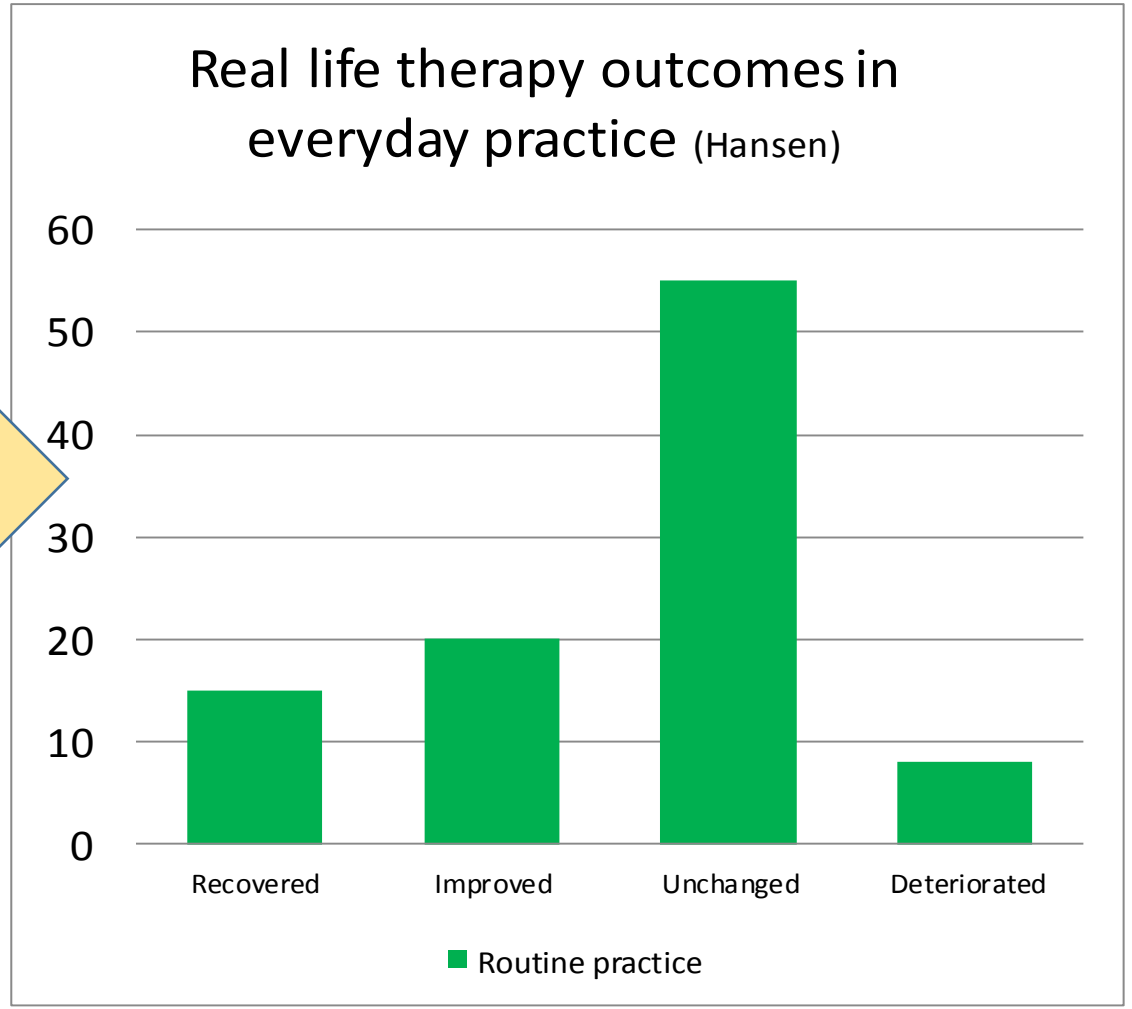
- Remember – do not assume that empathy is a good thing in isolation (Perera et al., 2016)

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...

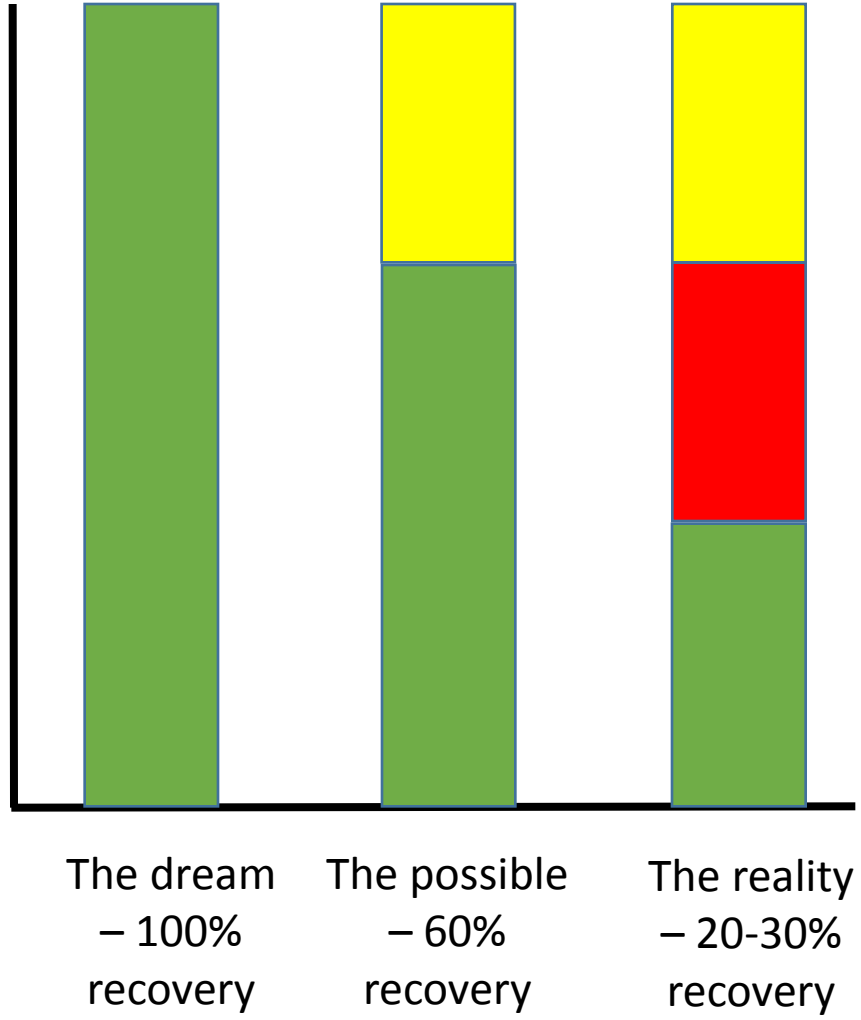
So why does this matter?





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...



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

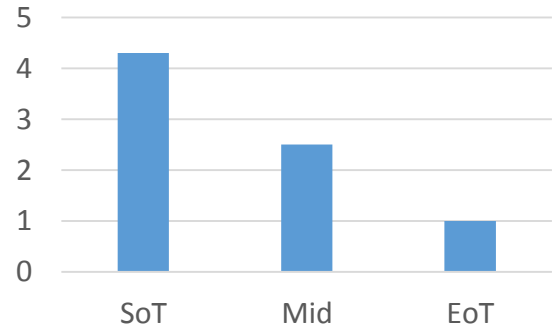
- Supervision, focused on patient change
  - Ost et al. (2012)
  - but remember that supervisors drift, too (Dennhag et al., 2012)

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



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