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Therapist drift redux: Why well-meaning clinicians fail to deliver evidence-based therapy, and how to get back on track

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therapy, and how to get back on track

Abstract

Therapist drift occurs when clinicians fail to deliver the optimum evidence-based treatment despite having the necessary tools, and is an important factor in why those therapies are commonly less effective than they should be in routine clinical practice. The research into this phenomenon has increased substantially over the past five years. This review considers the growing evidence of therapist drift. The reasons that we fail to implement evidence-based psychotherapies are considered, including our personalities, knowledge, emotions, beliefs, behaviors and social milieus. Finally, ideas are offered regarding how therapist drift might be halted, including a cognitive-behavioral approach for therapists that addresses the cognitions, emotions and behaviors that drive and maintain our avoidance of evidence-based treatments.

Therapist drift redux: Why well-meaning clinicians fail to deliver evidence-based

therapy, and how to get back on track

There are different reasons why evidence-based therapies might be delivered poorly, such as clinicians being inadequately trained in the therapy in question (e.g., Royal College of Psychiatrists, 2013) or working in a setting that does not permit the implementation of the necessary methods (e.g., not being permitted to provide the necessary number of sessions). Among those reasons is one that is centred in our own practice – therapist drift (Waller, 2009). Therapist drift can be conceptualised as our failure to deliver treatments that we have been trained to deliver, or failure to deliver them adequately, even where resources exist to allow us to do so. Such failure can be a consciously or an unconsciously-driven course of action. Regardless, it has the same consequence – the patient receives treatment that deviates significantly from the evidence-base, reducing their chances of improvement or recovery.

This paper will review the substantial recent evidence for therapist drift, the costs for patients, and the reasons why we drift. The focus will be largely on cognitive-behavioral therapy (CBT), simply because that is where most of the evidence has been generated. It will conclude by suggesting that we could benefit from applying the principles of CBT to ourselves, working to modify our own beliefs, emotions and behaviors.

Three key elements of effective therapy

Despite the evidence that therapy can be delivered effectively and economically (e.g., Layard & Clark. 2014), there is substantial evidence that it is not (as outlined below). Three conditions need to be in place.

The therapy has to work

First, there needs to be an effective set of therapeutic techniques, such as those that form the canon of CBT and other evidence-based therapies. These range from specific interventions to the more generic metacompetences, such as the ability to work with the

therapeutic alliance and the ability to respond to problems in the intervention. Research has resulted in a strong evidence base for protocol-based, manualised therapies (e.g., Addis & Waltz, 2002; Cukrowicz, Timmons, Sawyer, Caron, Gummelt & Joiner Jr, 2011; Guydish, Campbell, Manuel, Delucchi, Le, Peavy & McCarty, 2014; Hogue, Henderson, Dauber, Barajas, Fried, & Liddle, 2008; Hukkelberg & Ogden, 2013). Such results can be generalized to routine clinical settings if the therapy is implemented appropriately (Persons, Bostram & Bertagnolli, 1999; Persons, Roberts, Zalecki & Brechwald, 2006; van Ingen, Freiheit, Stacey & Vye, 2009), but not if it is delivered differently in routine practice (e.g., Gibbons, Stirman, Derubeis, Newman & Beck, 2013; Hansen, Lambert & Forman, 2002).

The patient has to engage in the therapy

Second, the patient needs to engage in the therapy, rather than simply attending sessions. As stated previously (Waller, 2009), it is always important to remember that CBT is most likely to be effective when it is a 168-hour-a-week therapy, where one hour is coaching by the therapist as to how to change and the other 167 hours are used to implement those lessons in the outside world. The danger is that the patient attends therapy sessions (for one hour a week) rather than undertaking the therapy fully (the remainder of the week), in the mistaken belief that attending sessions is the equivalent of 'doing therapy'. It is often the clinician's job to disabuse patients of that belief.

The clinician has to deliver the therapy

Finally, we need to know about and deliver those evidence-based therapies appropriately. This is the point where therapist drift has the potential to undermine therapeutic effectiveness. The evidence that we do drift and the reasons why require consideration.

Accumulating evidence of therapist drift

In recent years, there has been a substantial increase in the evidence of therapist drift. For example, there are substantial inter-therapist differences in how CBT is delivered across a range of disorders, even where the methods are widely available and well known

(e.g., McAleavey, Castonguay & Goldfried, 2014; Shafran, Clark, Fairburn, Arntz, Barlow, Ehlers Freeston, Garety, Hollon, Ost, Salkovskis, Williams & Wilson, 2009; Sinai, Gur & Lipsitz, 2012; Szkodny, Newman & Goldfried, 2014; Wang, Demler & Kessler, 2002; Wang, Lane, Olfson, Pincus, Wells & Kessler, 2005; Wolf & Goldfried, 2014). An issue here is that clinicians are unlikely to absorb new methods on their own merits (e.g., Cook, Schnurr, Biyanova & Coyne, 2009).

The use of exposure-based methods is a particular concern (e.g., Farrell, Deacon, Dixon & Lickel, 2013; Farrell, Deacon, Kemp, Dixon & Sy, 2013). For example, Hipol & Deacon (2013) have shown that our delivery of exposure techniques is comparatively rare and of dubious quality. In the field of posttraumatic stress disorder (PTSD), van Minnen, Hendriks and Olff (2010) have demonstrated that imaginal exposure is severely underutilised (e.g., Ehlers, Gene-Cos & Perrin, 2009; Russell & Silver, 2007). Therapists' decisions regarding its use are based not on its effectiveness and appropriateness, but on factors such as comorbidity, patient preferences, and their own gender and fears regarding negative outcomes.

In the field of eating disorders, clinicians show good levels of awareness of evidence-based therapies, but report using them relatively infrequently (Simmons, Milnes & Anderson, 2008; von Ranson, Wallace & Stevenson, 2013a; Waller, Stringer & Meyer, 2012), Taken as a whole, these findings remind us that simply labelling what one does as 'CBT' is no guarantee of what will be delivered or the ability of the therapist to deliver it.

There has been some advance in understanding the perspective of patients regarding what goes on in therapy, and whether it maps onto the evidence base. Research into the experience of patients who have been told that they received CBT is very compatible with the accounts of clinicians who state that they deliver that therapy, with substantial deviations from evidence-based approaches (e.g., Cowdrey & Waller, 2015; Stobie, Quigley, Ewing & Salkovskis, 2007). While it could be suggested that such deviations are due to patients rejecting the evidence-based approach, but the evidence seems to indicate otherwise, with patients appearing to be more positive about exposure-based methods than

their therapists (Becker et al., 2004, 2009).

Reasons for therapist drift

We know that we can deliver evidence-based treatments in to even complex cases in routine clinical settings (e.g., Long, Grubaugh, Elhai, Cusack, Knapp & Frueh, 2010), so why don't we? Meehl (1986) has addressed detailed some reasons for our failure to attend to evidence, many of which are reflected in more recent evidence regarding clinicians' knowledge, beliefs, behaviors, emotions and personalities

Our knowledge base

It might seem obvious that knowledge of the disorders that we work with is a prerequisite for successful treatment. However, even among clinicians who work in settings where they are routinely exposed to the necessary information or have it readily available, one cannot count on equivalent accessing of that knowledge. Despite the arguments in favour of the use of manuals and guidelines to enhance and maintain our knowledge and skills (e.g., Wilson, 1996), there is clear evidence that relatively few therapists use them (e.g., Addis & Krasnow, 2000; Tobin, Banker, Weisberg & Bowers, 2007; Wallace & von Ranson, 2011; Waller et al., 2012). This failure to access information that is readily available is not always a matter of simple omission. Many clinicians have negative attitudes to manuals (Addis & Krasnow, 2000; Waller, Mountford, Tatham, Turner, Gabriel & Webber, 2013), a point that will be addressed below.

Our beliefs and attitudes

It is important to consider the evidence that our beliefs and attitudes play a role in our delivery of treatment. For example, our negative beliefs about exposure-based methods makes us more cautious in implementing hierarchies when working with obsessive compulsive disorder and panic disorder (Deacon, Farrell, Kemp, Dixon, Sy, Zhang & McGrath, 2013; Deacon, Lickel. Farrell, Kemp & Hipol, 2013). As mentioned earlier, these beliefs and attitudes interact with our knowledge base, but they also play a profound role in shaping our emotions and behaviors when working in therapy.

Philosophical stance. It is common to hear the view that psychotherapy is either an art or a science, according to the view of the individual. In a related vein, McHugh (1994) describes clinicians as basing their practice on the incompatible personal philosophies of either 'romanticism' (prioritising intuition and clinical judgement in reaching clinical decisions) or 'empiricism' (who prioritising scientific evidence in reaching clinical decisions).

Self-belief. Lilienfeld, Ritschel, Lynn, Brown, Cautin & Latzman (2013) have detailed several biases in how we perceive our abilities and impact. Probably the most dramatic example is our self-assessment biases. Walfish, McAlister, O'Donnel & Lambert (2012) and Parker & Waller (2015) have shown that the great majority of psychological therapists believe that their skill level is well above the average, with very few seeing themselves as falling in the lower 50% of clinicians. Second, we report that our patients' recovery and improvement rates are far higher than one would expect from the evidence on routine clinical practice (e.g., Hansen et al., 2002). In short, we appear to have an over-inflated view of our own ability level, just as is found in other areas of human activity. The problem presented by such beliefs is clear – why would we try to improve as clinicians if we already believe that we are operating at a very high level?

Clinician judgement. Meehl (1954) and Grove, Zald, Lebow, Snitz & Nelson (2000) have reviewed and meta-analysed the available evidence, and demonstrated that clinician judgement is substantially less effective than protocol-driven approaches. Furthermore, there was no evidence that clinician judgement is more effective according to one's profession, level of training, or duration of experience (Grove et al., 2000). Indeed, there is some evidence that psychological therapists become less effective over the years following qualification (Shapiro & Shapiro, 1982). Therefore, we need to be aware that we are prone to ignoring evidence in an unjustified way, and that the scientific element should not be discounted on the grounds that 'we know best because of who we are'. Clinician judgement is essential for the flexible implementation of protocols (Wilson, 1996), but cannot substitute for those protocols.

The pros and cons of manualised treatments and protocols. The use of

evidence-based manuals results in lower costs of care and superior clinical outcomes than the use of unstructured approaches (e.g., Addis & Waltz, 2002; Cukrowicz et al., 2011), particularly among less experienced therapists (Crits-Christoph et al., 1991). However, we have a complicated relationship with treatment manuals, and one that can result in therapist drift.

Addis & Krasnow (2000) have determined that we can hold both positive views on the impact of such manuals on treatment outcome (e.g., 'can help keep therapists on track during therapy') and negative views on their impact on treatment process (e.g., 'undermines clinical creativity and artistry'). Those negative views are particularly important to understand, as there is some evidence that negative attitudes to manuals can predict poorer outcomes from CBT (Wiborg, Knoop, Wensing & Bleijenerg, 2012). Those attitudes to manuals are determined, in part, by our beliefs about what they contain. For example, if clinicians believe that manuals lack an emphasis on the therapeutic alliance then they are likely to have more negative attitudes to them, while if they believe that such manuals use case examples then their attitudes are more positive (Addis & Krasnow, 2000; Waller et al., 2013). Obviously, although both the working alliance and case examples are common topics in evidence-based manuals, if clinicians believes that this is not the case, they are unlikely to engage with those manuals or to have their beliefs challenged.

Our implementation of evidence-based protocols can be driven by unfounded beliefs and attitudes. For example, we are less likely to implement evidence-based treatment for a specific disorder where there is comorbidity present (Gielen, Krumeich, Havermans, Smeets & Jansen, in press; McAleavey et al., 2014; Meyer, Farrell, Kemp, Blakey & Deacon, 2014), even though the available evidence does not support such drift (e.g., Karačić, Wales, Arcelus, Palmer, Cooper & Fairburn, 2011). Broadly speaking, we routinely attribute our decisions to deviate from protocol-driven evidence-based practice to the patient (e.g., lack of motivation, resistance, severity of symptoms) or to the circumstances (e.g., logistical problems), rather than to ourselves (e.g., McAleavey et al., 2014; Szkodny et al., 2014; Wolf & Goldfried, 2014).

In general, how likely we are to implement these evidence-based therapies is driven at least in part by the information that we have about them and the attitudes that we hold towards them (Cahill, Foa, Hembree, Marshall & Nacash, 2006; Deacon, Farrell et al., 2013; Harned, Dimeff, Woodcock & Contreras, 2013; Meyer et al., 2014). For example, in an experimental study (Farrell, Deacon, Kemp et al., 2013), clinicians who were taught more about negative consequence of exposure work were likely to reduce the demands of such therapy and to engage in inappropriate calming of the patient.

How important is the therapeutic alliance? Beck, Rush, Shaw & Emery (1979) frame the alliance as necessary but not sufficient to ensure change, but place more emphasis on therapeutic technique as an agent of change. In contrast, many others present the alliance as a key agent of change (e.g., Gilbert & Leahy, 2007). The key question is whether we overvalue the therapeutic value of the alliance (Brown, Mountford & Waller, 2013a; Raykos, McEvoy, Erceg-Hurn, Byrne, Fursland & Nathan, 2014), permitting us to drift from delivering evidence-based therapies.

A common assumption is that the strength of the alliance predicts the level of therapeutic change. It is certainly well demonstrated that the two are correlated, though at a much lower level than is commonly assumed. The meta-analyses that have addressed this issue (Horvath & Symonds, 1991; Martin, Garske & Davis, 2000) have shown correlations of 0.22 and 0.26, which equate to only 5-6% of the variance in therapy outcomes. However, such correlations do not imply causal direction. Does the alliance drives therapeutic change or vice versa? Contrary to much received wisdom, longitudinal research (e.g., Brown, Mountford & Waller, 2013b; Crits-Cristoph et al. 2006; Tang & DeRubeis, 1999; Turner et al., 2015) have each demonstrated that early symptom change drives improvement in the alliance.

Our apparent faith in the power of the therapeutic alliance in CBT (e.g., Gilbert & Leahy, 2007) might be because it means that there is less of a need to learn or focus on evidence-based techniques. Our concerns about challenging or distressing our patients through the use of behavioural or cognitive change can result in our engaging in clinician

safety behaviours – not pushing patients to change, so that our self-identity as positive characters in their lives is not threatened. Meehl (1973) expressed this reluctance well when he described some clinicians as having a "spun-glass theory of the mind" – being fearful that they will somehow 'break' their 'fragile' patient if they ask them to undertake any change, despite the fact that the rest of the patient's week might be spent in extremely distressing circumstances.

Definitions of an effective working alliance need to be considered (e.g., Crits-Cristoph et al., 2006), such that we do not mistakenly believe that a consistently good relationship with our patients is the same thing as a good working alliance. Wilson, Fairburn & Agras (1997) stress the importance of balancing firmness and empathy in establishing a functional therapeutic alliance. We should also remember that our patients' views matter here. Fung, Elliott, Hays, Kahn, Kanouse, McGlynn, Spranca & Shekelle (2005) showed that patients who are given the choice are more likely to prioritize technical skills over interpersonal skills in a primary care physician. It is possible that we engage in erroneous mind-reading if we assume that our patients prefer us to downplay the use of evidence-based techniques.

Our emotions

Previously (Waller, 2009), it has been suggested that our emotional states are likely to lead us to drift from evidence-based practice, but there was little research to draw on at that time. That situation has changed substantially, with evidence that some of our emotional states are associated with therapy processes and outcomes. At a general level, Westra, Aviram, Connors & Kertes (2012) and Nissen-Lie, Monsen, Ulleberg & Rønnestad (2013) have shown that our emotional reactions to patients can facilitate or hinder therapy. For example, Beutler, Crago & Arizmendi (1986) have concluded that therapists who are lower in emotional disturbance have more consistent patient outcomes. Simply masking our emotions is unlikely to be effective. Deacon & Farrell (2013) argue cogently that: "Therapists who attempt to protect themselves from emotional distress during exposure run the risk of depriving clients from fully overcoming their pathological anxiety" (p.370).

The majority of the evidence from recent years relating clinicians' emotions to

therapist drift has stressed the role of our own anxiety. For example, anxious clinicians are less likely to employ evidence-based techniques when using CBT for depression (Simpson-Southward, Hardy & Waller, under consideration). Our own anxiety is particularly pertinent when understanding why we do or do not implement exposure-based methods. For example, Meyer et al. (2014) have shown that more anxious clinicians are likely to reduce the demands of exposure-based methods for patients. In the eating disorders, Waller et al. (2012) have shown that clinicians who report higher levels of anxiety are less likely to ask patients to undertake key CBT tasks (e.g., diary keeping, structured eating, behavioral experiments). Finally, in treating anorexia nervosa, more anxious CBT therapists report that their patients gain less weight, possibly because that anxiety is also associated with a belief that the early therapeutic alliance predicts outcome (Brown, Mountford & Waller, 2014).

Potentially underpinning the role of anxiety is the construct of intolerance of uncertainty, which Turner, Tatham, Lant, Mountford & Waller (2014) have shown to be associated with clinicians' concerns about delivering a range of elements of CBT. CBT is founded on neither clinician or patient knowing for certain what will happen when one implements change, but on both being willing to tolerate the uncertainty until the result is clear. However, if we are unable to tolerate anxiety, we are likely to edge into safety behaviors that mesh with those of the patient (see below). Of course, this conclusion resonates strongly with Meehl's (1973) "spun-glass theory of the mind" hypothesis, outlined above.

While anxiety is clearly worthy of further investigation, so is depressed mood. For example, Waller et al. (2013) have shown that therapists who report higher levels of depression are likely to hold more negative attitudes to manualised approaches to therapy. Similarly, Simpson-Southward et al. (under consideration) found that therapists with low self-esteem who do not implement evidence-based approaches have lower self-esteem than those who do. Obviously, the causality here could be circular – clinicians with lower self-efficacy levels are less likely to use evidence-based approaches, so are less likely to be effective in their work, and so are likely to develop lower self-esteem, and so on. Finally,

other mood states merit consideration when explaining why therapists drift off course, including anger and boredom (e.g., Morrant, 1984).

Our personalities

There is some early indication that our personalities are related to therapist drift. For example, Peters-Scheffer, Didden, Korzilius & Sturmey (2013) have shown that we are more likely to adhere to protocols if we have the trait of being open to experience. Similarly, Green, Barkham, Kellett & Saxon (2014) have shown that clinicians with higher levels of resilience, organisation and confidence have better outcomes when delivering brief, evidence-based interventions. This pattern needs further investigation, but suggests that the patterns of beliefs, behaviors and emotions detailed in this review might cluster in individual clinicians' personalities.

Our safety behaviors

In recent years, there has been more evidence to support the proposal that more anxious clinicians implement behavioral change less and are wary of implementing other central therapeutic techniques (e.g., Meyer et al., 2014; Turner et al., 2014; Waller et al., 2012). Such clinicians tend to focus on the role of the therapeutic alliance as an agent of change, and to prioritise its role over that of the therapeutic techniques that are supported by the evidence, even when doing so is associated with poorer outcomes (e.g., Brown et al., 2014). In short, we engage in safety behaviors to reduce our own level of anxiety in the short term, but run the risk of becoming less effective clinicians in the long term.

It is important to recognise that our safety behaviors are likely to interact with those of patients. The patient's anxiety can trigger anxiety in the therapist, and our own anxiety-reduction behaviors can encourage those of the patient. So, when we engage in behaviors that operate to reduce our own immediate anxiety by reducing the patient's immediate anxiety, our own escape behaviors act to encourage those of the patient. This process of accommodation is illustrated in Figure 1, as an example of how our good intentions (reduce the patient's anxiety about change in the session) can maintain the patient's disordered behaviors, emotions, etc.

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Insert Figure 1 about here

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Thus, we have two ways in which we can deviate from the most effective therapy. First, we can respond to the patient's anxiety (or feared anxiety) through reduction of the tasks of therapy, such as making the steps of an exposure hierarchy smaller and calming the patient (e.g., Farrell, Deacon, Kemp et al., 2013). Second, we can learn to avoid ever suggesting change. The likelihood is that the greater our characterological level of intolerance of uncertainty, the faster we will learn to avoid ever suggesting to patients that they should change. In short, it is possible to conclude that 'being nice' in the short term is a counterproductive venture if one wants the patient to do well, at least in some therapies (e.g., Nissen-Lie et al., 2010; 2013).

Our interpersonal milieu

Most of us operate as therapists in some sort of social context - informal relationships with our colleagues, or more formal power and supervisory structures (e.g., working for employers, reporting to referrers). As with any sphere of understanding human behavior, it is important to consider how that context might influence therapist drift.

Operating in teams and services. There are many ways in which working in teams and within service demands can impair our attention to best practice and positive outcomes – some institutional, some interpersonal. Among the obvious institutional examples are those services where there is not adequate support given to the delivery of a full course of treatment (e.g., a lack of necessary measures; inadequate training; short treatment slots). However, there is also evidence of institutional resistance to adopting evidence-based methods (e.g., Lowe et al., 2011), and that we do not communicate well across settings, even where that would be to the patient's advantage (e.g., Bambling et al., 2007).

Supervision. While it is hard to doubt that supervision is a positive asset in directing effective therapy (e.g., Öst, Karlstedt & Widén, 2012), it is important to note that the

evidence for such a conclusion is very limited. The research that does exist suggests that supervision per se is a positive influence in maintaining our skills and confidence (Mannix, Blackburn, Garland, Gracie, Moorey, Reid, Standart & Scott, 2006; Miller, Yahne, Moyers, Martinez & Pirritano, 2004), although the optimal focus of supervision is not clear (Bambling et al., 2007). Nor are all supervisees treated as equal. There is also evidence that supervisors treat male and female clinicians differently, according the clinicians' level of anxiety but regardless of the supervisor's own gender (Simpson-Southward, Waller & Hardy, in press).

What is more worrying is that there might also be a process of supervisory drift, where the supervisor becomes less challenging of the therapist, reducing the risk of any deterioration in the supervisor-supervisee relationship. For example, supervisors consistently overrate the abilities of their supervisees, relative to independent judges and even relative to the supervisees' own perceptions (Dennhag, Gibbons, Barber, Gallop & Crits-Christoph, 2012; McManus, Rakovshik, Kennerley, Fennell & Westbrook, 2012). Therefore, inflated ratings of clinician abilities are not confined to ourselves (Brosan, Reynolds & Moore, 2008; Parker & Waller, 2015; Walfish et al., 2012), but can also apply to those for whom we feel responsible, extending the reach of 'drift' within the therapy process.

Summary of reasons for therapist drift

It is clear from the evidence of recent years that our tendency to drift away from evidence-based practice is the product of a range of very human experiences and characteristics. These factors mean that we engage in safety behaviors in order to reduce our own anxiety about pushing for behavioral change. That range of reasons for drifting means that we are likely to need multi-faceted approaches to changing our own practice. So, what can we do to bring about such change, reducing the risk of therapist drift and improving the delivery of evidence-based treatments where they exist?

Reducing therapist drift

Given this understanding of the factors that underpin therapist drift, what can we

realistically do to reduce it? Changes in policy have only limited ability to regularise the adoption and delivery of therapies across clinicians (e.g., Beidas, Edmunds, Ditty, Watkins, Walsh, Marcus & Kendall, 2014; Franklin, Huppert, Garcia, Freeman, March & Foa, 2004). Rather, change can require active intervention to destabilise existing systems.

Systemic change

Uptake of clinical guidelines is notoriously slow and patchy, with an average of 17 years between the development of new knowledge via rigorous testing and its widespread clinical uptake (Institute of Medicine, 2001). Sprang et al. (2008) advocate more active means of dissemination, rather than the relatively passive means that predominate (e.g., circulation of guidelines). Shafran et al. (2009) have detailed ways in which evidence-based methods might be more effectively disseminated, including easy access to manuals, encouragement for clinicians to undertake training, and identifying mechanisms of action and outcome measures. Of their suggestions, the most relevant to therapist drift is that there should be greater exploration of therapist effects. Age and experience are not enough to ensure that we improve, and might be more closely related to drift from evidence-based methods and weaker patient outcomes (e.g., Grove et al., 2000; Shapiro & Shapiro, 1982). Therefore, other therapist and system effects on dissemination need to be considered.

Selection of therapists. This is an issue that is rarely discussed in an evidence-based context, but it is an important one to consider in future research – should personality or other markers (e.g., academic achievement) be used as a means of determining who is suitable to be trained to be a therapist? Are there particular individuals who are more suitable for delivering specific therapies? An example is the gender of therapists, where there is some evidence that female therapists are more likely to use unevidenced eclectic practice (Sprang et al., 2008). However, when delivering CBT itself, there is no difference between the genders in reported use of core techniques or attitudes to manuals (Waller et al., 2012; 2013). Therefore, if the personal, pre-training or pre-employment characteristics of the therapist lead to drift (or even outright rejection of the most effective treatment), then the possibility of selecting and 'streaming' therapists according to patients' needs should be

considered.

Training and maintenance of skills: Competence, adherence or outcomes?

While it would be hard to argue therapists should be delivering therapies that they have not had training in, exactly that scenario exists and has long been tolerated (Royal College of Psychiatrists, 2013). Authors have suggested that training should be improved (e.g., Sprang et al., 2008), including the need to take account of the therapist's own anxiety (e.g., Harned et al., 2013; van Minnen et al., 2013). However, what outcomes should we be hoping for?

Competence. One suggestion is that our emphasis should be on the development of therapist competence in delivery of therapies – can therapists accurately deliver therapeutic methods (e.g., Fairburn & Cooper, 2011; Koerner, 2013; Roth & Pilling, 2007)? This approach requires a high level of monitoring of expertise during training, and is therefore relatively costly. However, the issue of therapist drift is an important one here – if the individual therapist has a range if intrapersonal features (beliefs, emotions, etc.) that make them likely to depart from evidence-based treatments over time, then competence becomes much more difficult to use as a benchmark. Instead of simply determining that the therapist has *achieved* competence through training, there now needs to be long-term monitoring that the therapist has *maintained* competence. Such monitoring requires more expensive, time-consuming approaches (such as recording and objectively evaluating therapy sessions and the use of role plays – Fairburn & Cooper, 2011), and might need to be a career-long requirement to overcome the falling-off in outcomes that has been identified with time as a therapist (e.g., Shapiro & Shapiro, 1982). However, it would not be difficult to justify the expense in such cases if it resulted in better delivery of evidence-base treatments to patients.

Existing training methods are not ideal for clinicians to acquire competence (e.g., Sharpless & Barber, 2009). Fairburn & Cooper (2011) have suggested a staged approach to training, where internet-based resources are used to facilitate more comprehensive training than is normally available. But can we rely on individuals to monitor themselves or to monitor their supervisees in order to ensure the maintenance of competence? Given our perception

of our own abilities and those of our supervisees, the answer is that we probably cannot. Why should we be concerned about our abilities if we already believe that we (and our supervisees) are far better than the average clinician (e.g., Dennhag et al., 2012; Parker & Waller, 2015; Walfish et al, 2012)?

Adherence. If we cannot rely on the establishment and maintenance of competence due to therapist and supervisor drift, then one alternative might be to focus training on the importance of fidelity to models and adherence to treatment protocols (e.g., Perepletchikova, 2011). While competence and adherence undoubtedly share features, there is some evidence that they differ in their impact on outcomes (e.g., Guydish et al., 2014). Therapist adherence level is a better predictor of positive therapy outcomes than competence per se (e.g., Hogue et al., 2008). In short, what we *actually* do might be more important than what we *can* do. However, there are two issues with relying on adherence as a means of ensuring evidence-based therapy. First, our can personalities might impact on our treatment fidelity (Peters-Scheffer et al., 2013). Second, assessing adherence routinely is a highly intensive exercise, demand very high levels of resource.

Patient outcomes. There is one clear alternative to competence and adherence as best measures of dissemination and maintenance of skills – the measurement of patient outcomes. Fairburn & Cooper (2011) have described such a proposal as 'problematic', due to patient variation in responsiveness to the same treatment and the danger that services will be evaluated on too small a dataset. However, the alternative is to imagine an approach where the mechanical delivery of treatment is highly rated, even though the skill of flexible implementation (Wilson, 1996) is absent. Outcomes can be compared across services, in which case the concerns raised by Fairburn & Cooper (2011) are worthy of consideration, but the prevention of therapist drift requires intra-clinician comparison of outcomes – are we getting better or worse at getting our patients well? Using outcomes to acknowledge that some clinicians do poorly and some do better than the norm allows us to understand which clinicians might be exemplars of best practice, and hence models for enhanced delivery of evidence-based psychotherapies (e.g., Franklin et al., 2004; Green et al., 2014).

Summary. Obviously, the best approach to disseminating evidence-based practice in psychological therapies would be to ensure that individual clinicians are competent, adhere to the necessary techniques, and monitor and respond to feedback on their patients' outcomes. To discount the possibility of focusing at least partly on outcomes is to risk depriving us of the chance of learning from our mistakes, learning what works for whom, and learning from those who develop ways of enhancing the known impact of existing therapies. However, it is important to remember that feedback is helpful only if the clinician chooses to attend to it (De Jong, van Sluis, Nugter, Heiser & Spinhoven, 2012). Whatever we do, it seems that the goal has to include persuading clinicians to assimilate new evidence-based techniques.

A cognitive-behavioral approach for CBT (and other) clinicians to counter drift

In order to improve the delivery of evidence-based therapies, it seems to be necessary to change the characteristics and behaviors of therapists that result in therapist drift. If they are relevant to therapist drift, some characteristics (e.g., personality, age and gender) are a matter of selection and streaming, as outlined above. We also know that some apparent markers of quality are of dubious worth when it comes to delivering evidence-based therapies robustly, including our level of experience and accreditation (e.g., Brosan, Reynolds & Moore, 2006; Grove et al., 2000). However, there are other ways in which we can reduce our likelihood of drifting, using the principles that we already know are useful in helping our patients to change. In short, it is recommended that we adopt a CBT approach for therapists, to ensure that we operate at the maximal level of effectiveness.

Cognitive restructuring. First, we need psychoeducation - a good background understanding of the psychological principles underlying psychotherapy (e.g., Campbell et al., 2013; von Ranson et al., 2013b), as well as education about the specifics of how to address the pathology of the disorder in question (e.g., Farrell, Deacon, Dixon et al., 2013; Russell & Silver, 2007). An obvious issue is that evidence-based treatment manuals need to be read and used (rather than merely owned). Of course, it also matters that the manuals

are presented in ways that do not deter clinicians, so they need to be presented in ways that stress their clinical value for the patient, particularly focusing on case material (e.g., Addis, Wade & Hatgis, 1999; Stewart & Chambless, 2010). Furthermore, there is clear evidence that educational interventions and workshops can be used to modify clinicians' negative attitudes to exposure-based approaches (e.g., Deacon, Lickel, et al., 2013; Waller, D'Souza & Wright, in press).

Further elements of cognitive restructuring include learning from change and reduction of cognitive dissonance. Beyond the use of manuals, maintained discussion of new learning appears to be particularly beneficial in the implementation of exposure therapy (Harned et al., 2013). Farrell, Deacon, Dixon et al. (2013) suggest that clinicians should be provided with evidence at the levels of both empirical findings and case material (e.g., patient testimonials), to reduce dissonance between our cognitions and our affect.

Monitoring. As with all the monitoring that we ask our patients to undertake, it is vital to ensure that the therapist attends to the information that is generated, and responds appropriately. If a patient fails to complete a task on the first day after a therapy session, we have to stress that this needs to be corrected straight away, rather than waiting till the next therapy session. Similarly, as clinicians, we have to identify when we are letting our implementation slip, and deal with it immediately. For example, if the protocol indicates that we should be implementing exposure work but we are not doing so, then why not and how can we get back on track quickly? This process is helped by a focus on fidelity during supervision, but the therapist needs to be self-appraising between supervision sessions. This goal might be more easily achieved if we use disorder-specific rating scales to guide us in implementing evidence-based protocols (e.g., Hartley, Scarratt, Bucci, Kelly, Mulligan, Neil, Rivers, Taylor, Welford & Haddock, 2014). However, the key is that we should measure regularly and frequently, and respond to those outcomes. Outcome measurement should be seen as the hallmark of a collaborative approach to therapy, with therapist and patient working jointly to understand problems, determine the impact of treatment, and plan change.

Historical review. When we hear that the patient has experienced a therapy that

could be labelled as 'evidence-based', we should be wary of accepting that label. It is possible that the therapy was not the evidence-based version but a watered-down variant (e.g., Stobie et al., 2007; Cowdrey & Waller, 2015), where core tasks of therapy were omitted or changed to reduce the anxiety of both patient and therapist (e.g., Deacon & Farrell, 2013). Therefore, it is important to ask what happened in previous therapies, and to discuss why therapy might be expected to be very different in its demands this time.

Behavioral change. There are several aspects of behavioral change that we need to consider when planning to improve our skills in delivering evidence-based therapies. First, there is sometimes a need for ***behavioral activation***, to overcome the risk of the therapist simply waiting for change to happen spontaneously. Second, ***skills training*** is critical. Given that many clinicians have not been taught some of the basics of what they are meant to be implementing (e.g., Royal College of Psychiatrists, 2013), we need to engage in basic training for clinicians whose skills base is deficient. Finally, therapists need to be encouraged to build on their cognitive challenges (above) by carrying out ***behavioral experiments***, testing alternative beliefs about the outcome of acting in particular ways within therapy, and discovering which of their predictions do or do not come true (e.g., the patient valuing the alliance more or less strongly when pushed to change).

Exposure with response prevention. It has been suggested that we would help clinicians to deal with their own anxiety by undertaking exposure work (Farrell, Deacon, Dixon et al., 2013). This might include direct training with patients, but can also involve simulations and role-play exercises where we do not engage in therapist safety behaviors. Similar lessons might also apply to how supervisors could be encouraged to adopt a more accurate perspective on their supervisees' practice (e.g., directing the therapist to push the patient to make behavioural change), despite any fears that this will impair their working relationship with the supervisee.

Conclusion

This review has considered the developing evidence for the phenomenon of therapist

drift in recent years. Consistent themes have emerged:

- even when trained in them, we under-use evidence-based therapies;

- many of us do not deliver those interventions accurately when we say and believe that we are using them;

- it tends to be behavioral methods that we fail to use.

This evidence has been growing despite developing stress on evidence-based therapies and their dissemination (e.g., Layard & Clark, 2014; Shafran et al., 2009). We fail to deliver treatments effectively for a variety of interrelated reasons – our personalities, knowledge, beliefs and attitudes, emotions, interpersonal milieu and safety behaviors can all interact to ensure that we drift. Even supervision is no guarantee of effective therapy, as supervisory drift is just as possible as therapist drift.

How can we reduce therapist drift? Policy is a weak tool for influencing what happens in the therapy room. Competence and adherence are important to ensure, but to monitor them fully is resource intensive. Perhaps the best way of ensuring that clinicians stay on track is to monitor outcomes and respond when individual clinicians are less effective than others or show signs of worsening treatment results, checking adherence and adding training in response to those signs. However, a linked goal has to be ensuring that clinicians internalise the message about therapist drift. A cognitive-behavioral therapy approach has been proposed to help us to overcome therapist drift, addressing our knowledge base, our beliefs, our emotions and our safety behaviors.

There is still a clear need for further research into the phenomena of therapist drift and the reasons for it, covering a wider range of therapies, disorders and techniques. Most importantly, the impact of proposed interventions (e.g., Farrell, Deacon, Dixon et al., 2013; Shafran et al., 2009) needs to be considered. Without this work, it is highly likely that we will continue to fail to deliver evidence-based treatments effectively as we could, and that many patients who could benefit from our work will not do so.

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Figure 1 – <u>Interactive patient and clinician safety behaviors, and maintaining patterns of accommodation between those behaviors</u>