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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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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, behaviours and social milieus. Finally, ideas are offered regarding how therapist drift might be halted, including a cognitive-behavioural approach for therapists that addresses the cognitions, emotions and behaviours that drive and maintain our avoidance of evidence-based treatments.

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 behaviours.

1. 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.

1.1. 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 et al., 2014; Hogue et al., 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).

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1.2. 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-h-a-week therapy, where 1 h is coaching by the therapist as to how to change and the other 167 h are used to implement those lessons in the outside world. The danger is that the patient attends therapy sessions (for 1 h 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.

1.3. 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.

2. 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 et al., 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, 2013a; Farrell, Deacon, Kemp, Dixon, & Sy, 2013b). For example, Hipol and 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, Taylor, 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, Zayfert, & Anderson, 2004, Becker et al., 2009).

3. 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 et al., 2010), so why don't we? Meehl (1986) has addressed some reasons for our failure to attend to evidence, many of which are reflected in more recent evidence regarding clinicians' knowledge, beliefs, behaviours, emotions and personalities.

3.1. 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, 2012; 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 et al., 2013), a point that will be addressed below.

3.2. 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 et al., 2013a; Deacon, Lickel, Farrell, Kemp, & Hipol, 2013b). As mentioned earlier, these beliefs and attitudes interact with our knowledge base, but they also play a profound role in shaping our emotions and behaviours when working in therapy.

3.2.1. 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' (prioritising scientific evidence in reaching clinical decisions).

3.2.2. Self-belief

Lilienfeld et al. (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, and Lambert (2012) and Parker and 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?