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Factors related to psychotherapists' self-assessment when treating anxiety and other disorders

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ABSTRACT

The aim of the study was to replicate and extend recent findings regarding therapists' self-assessment biases. This study examined clinicians' estimates of their abilities when working with general clinical groups and with anxious patients, and of the recovery/improvement rates of their clients. It also considered what clinician personality traits and clinical practice elements were associated with such estimates. A total of 195 out 801 clinicians completed a survey regarding self-ratings, team ratings, therapy outcomes for their clients, and their own personality traits. The great majority of clinicians rated themselves and their teams as being better clinicians than their peers, though not to as extreme a level as in the previous study. They also reported exceptionally positive therapy outcomes. Due to the large proportion of non-responders, it is possible that these findings do not reflect actual self-assessment bias, but a greater willingness to participate among clinicians who are more skilled and with particular personality styles. However, the data suggest that perceptions of skill and therapy outcome might be associated with clinician personality characteristics, though not with other clinical practice variables. These interpretations should be treated with caution due to the limited response rate. Different possible explanations for these patterns of self-assessment are outlined, including conscious and unconscious processes. Methods for enhancing accurate skill perception are discussed, including self-monitoring and supervision.

Research has shown that the most efficacious psychological treatments for anxiety disorders come from the cognitive behavioural therapy (CBT) paradigm, either with or without psychopharmacology as a supplement (Bradley, Greene, Russ, Dutra, & Westen, 2005; Eddy, Dutra, Bradley, & Westen, 2004; Fedoroff & Taylor, 2001; Hofmann & Smits, 2008; Norton & Price, 2007; Otto, Pollack, & Maki, 2000; Westen & Morrison, 2001). While recovery rates across anxiety disorders are different across studies, they are all relatively high. For example, CBT treatment for post-traumatic stress disorder has a recovery rate of 67% of those who complete treatment (Bradley et al., 2005). Similarly high improvement rates (58%) have been reported for clients treated with CBT for generalised anxiety disorder (Butler, Chapman, Forman, & Beck, 2006). Across a wider range of disorders, Hansen, Lambert, and Forman (2002) report that over half of patients in such trials achieve recovery, while about two-thirds make clinically meaningful improvement. However, these data apply to efficacy and effectiveness studies rather than everyday clinical practice.

Despite these empirically supported treatments (ESTs) being available to clinicians, recovery and improvement rates are lower in everyday mental health practice. For example, Hansen et al. (2002) found a mean rate of recovery of 14%, a further 21% showing clinical improvement, 8% deteriorating and 57% showing little change. These figures are substantially less positive than those achieved in efficacy and effectiveness trials. Similarly, Westbrook and Kirk (2005, 2007) reported that approximately 33% of patients in routine care recovered, a further 15% showed reliable improvement, and 2–3% deteriorated, leaving approximately 48% unchanged. Chilvers et al.'s (2001) study of outcomes for depression showed a good outcome in approximately 30% of cases overall, with a further 30% improving, and 40% failing to improve. Better outcomes were shown by Schindler, Hiller, and Witthöft (2011), who found 48% recovery, 25% improvement, 2% deterioration and 25% remaining unchanged. However, despite the variation in outcomes between naturalistic studies, it is clear that there is a substantial

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gap in outcomes between more controlled studies and everyday practice. That effect might be due to the lower number of therapy sessions delivered in routine practice (Hansen et al., 2002), different patient profiles, or variations in delivery by the therapist.

There are many potential reasons for such variable delivery of therapies across therapists. One possible reason is that clinicians assume that their own clinical work is already of a high standard, both in relation to other clinicians and in terms of patient outcomes, and that consequently they do not need to focus on evidence-based methods. Such an assumption would mean that clinicians would perceive little reason to focus on monitoring, maintaining, and improving their skills and outcomes. Walfish, McAlister, O'Donnel, and Lambert (2012) found evidence to support this hypothesis. In a cohort of psychological therapists, the mean self-rated skill level relative to colleagues was high, with the mean rating being at the 80th centile (rather than the 50th, as should be the case). Indeed, no clinicians saw their skill level as being below the 50th centile, meaning that no-one saw themselves as being below the average level of skill. This overestimation of ability is found in a range of skills, such as driving and job performance (e.g., Anderson, Warner, & Spencer, 1984; Meyer, 1980), and is known as 'self-assessment bias'. Furthermore, when asking these clinicians about how many of their patients recovered or improved, Walfish et al. (2012) found that clinicians believe that most of their clients recover after therapy. In a similar vein, Brosan, Reynolds, and Moore (2008) found that, overall, therapists' self-ratings have no more than moderate agreement with independent ratings of their competence. Furthermore, they found that less objectively competent therapists over-rated their own abilities more than competent therapists did.

This early evidence of self-assessment biases among psychological therapists requires replication, but it will be equally important to elaborate on the reasons for those patterns of belief about skill level and therapy outcomes. One possible factor is the therapist's own personality. Research on psychodynamic therapists has found that personality style can affect the outcome of psychotherapy (Heinonen, Knekt, Jääskeläinen, & Lindfors, 2014; Heinonen, Lindfors, Laaksonen, & Knekt, 2012). For example, therapists who treated mood and anxiety disorders produced faster symptom reduction in short-term therapy if they were more extroverted, whereas more neutral and cautious therapists elicited better and longer-lasting results in long-term therapy. Furthermore, therapists who were less open and less extroverted had a difficult time establishing a lasting working relationship with clients. Finally, therapists' perceptions of treatment outcomes were unrelated to the outcomes reported by clients.

An alternative or additional possibility is that clinical variables are relevant to clinicians' beliefs about their ability and outcomes. Such variables are likely to include supervision and training. For example, Öst, Karlstedt, and Widén (2012) have shown that clinicians in training were able to perform at the same level as experienced clinicians as long as they received dedicated supervision. Similarly, additional post-qualification training might help clinicians to perceive their own abilities and limitations more realistically, as suggested by Brosan, Reynolds, and Moore (2006). These authors found that clinicians with additional training were more competent, but there was no comparable benefit of simple level of experience.

The first aim of this study is to replicate the work of Walfish et al. (2012), assessing at what relative level clinicians perceive their own abilities and those of their colleagues, and their judgements of how effective is the therapy that they deliver. This replication will be carried out in the UK, rather than in the US (Walfish et al., 2012). The second aim is to extend that work by determining factors that might influence this self-assessment, focusing on clinicians' personality traits and other clinical and demographic factors (e.g., age, supervision). There will be a particular focus on clinicians' own levels of emotional stability.

Methods

Ethics

The University of Sheffield Psychology Department Ethics Committee approved this study.

Design

This was a cross-sectional study of mental healthcare providers working with anxious clients. The study used a survey and self-report inventories. The data were analysed using mixed comparative and correlational methods.

Participants

A total of 801 mental health care providers were approached from an online database and via three workshops, and asked if they would complete this study. Six hundred twenty-eight therapists from the British Association for Behavioural and Cognitive Psychotherapies (BABCP) were emailed to ask if they would participate via an online survey. Each listed themselves on the BABCP therapist list as working with anxiety disorders or trauma. Of the 628 clinicians, 124 began and 93 completed the online survey. Of the 93, five gave partial information due to a technical error (ratings related to anxiety were not recorded). One of the 93 responses was deleted at the request of participant, due to an error in completion, and that person re-took the survey. The 30 remaining non-completed responses were unusable. Two participants listed that they worked with anxiety on the BABCP website, but reported in the study that they did not in fact work with anxiety. The rest of their usable data were still recorded and included. Thus, a total of 93 responses were used from the online survey.

The remaining 173 were therapists attending training workshops, who were asked to participate by completing a paper questionnaire. Of these 173 therapists, 103 started the study. However, one gave inadequate information, and therefore was eliminated from the study. Thus, 102 responses were used from workshops. Three participants incorrectly filled out the personality measure (discussed below), but the rest of their data were included. One gave multiple answers to the outcome scales for their general client group so those data were removed, but the rest of their answers were used. Another clinician did not report their skills and outcomes when working with a general client group, but the rest of their data were included.

Thus, a total of 227 responses were collected. Of these, 195 provided useable responses (32.8% male, 66.7% female, 0.5% preferred not to disclose). Their mean age was 46.5 years (SD = 9.99). Of the 195 participants, 32 reported being clinical psychologists (16.4%), 15 were counselling psychologists (7.7%), two were psychiatrists (1.0%), 47 were psychiatric nurses (24.1%), five were clinical social workers (2.6%), one was a marriage and family therapist (0.5%), 20 were licensed professional counsellors (10.3%), 72 were in another mental healthcare profession (36.9%), and one person (0.5%) did not report their profession. The mean years qualified was 11.3 (SD = 8.91). In terms of professional accreditation, 178 (91.3%) reported being accredited with a professional body, 14 (7.2%) reported no such accreditation, and three (1.5%) did not report their status.