Is Your Patient Treatment Resistant? Or is it YOU?

What to Do When Your Patient Doesn’t Respond to Treatment
Specific Protocols for Anxiety & Related Disorders

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Disclosures

• Nothing to disclose
Objectives

- Recognize when a patient is not responding to traditional CBT protocols
- Decipher whether the barriers to treatment gains are the result of the patient’s difficulties or the clinicians’ limitations
- Evaluate when & how to apply novel techniques from non-traditional CBT protocols in accordance with patient-specific needs
Traditional CBT

• CBT focuses on the relationship between thoughts, feelings & behaviors

• Classic CBT for anxiety & related disorders typically includes:
  – Thorough intake & diagnostic evaluation
  – Psychoeducation & treatment rationale
  – Cognitive appraisal & reappraisal
  – Behavior therapy (i.e. Exposure & Response Prevention)
  – Relapse Prevention
Review

- Intake information & diagnostic eval & behavioral analysis
- Psychoeducation re: CBT
- Psychoeducation re: specific Dx
- Treatment Rationale
Case Example

• Classic & positive response to CBT protocol
  – Case example: What if I’m Gay?!!
    • Pt misdiagnosed as having sexual identity issues
    • Pt’s response to misdiagnoses
    • Pt’s response to traditional CBT for OCD
Case Example

- Motivated pt non-responsive to traditional CBT
  - Student: “I’m never going to be myself again!”
  - Pt evaluated for meds & treated by psychiatrist
  - Pt referred for CBT by psychiatrist
  - Pt did NOT respond to traditional CBT!!!
Treatment

• Thorough intake & diagnostic eval
• Psychoeducation
• Cognitive appraisal/reappraisal
• Behavioral therapy
• Very little response
He Didn’t Respond!!!

- Continue to impose traditional CBT?
- Give up & refer as treatment refractory?
- Give up on your career? Explore a life of crime?
Thoughts

• What might be going on with this patient?
  – What “response” is the patient expecting and is it reasonable/achievable?

• Where would you go from here???
More Behavioral Analysis: What We Found

- Patient utilized therapy & psychiatric visits as reassurance
- Patient chronically sought reassurance from loving & well meaning parents who obliged
- Patient viewed CBT as a way to “feel better” & continually sought reassurance from therapist
- Patient never developed his own emotion regulation, and/or self-soothing strategies
- Patient learned to view emotions as “bad” & learned to live in the service of emotion management
What We Did

• Back to cognitive appraisal & reappraisal
• Back to psychoeducation re: maintenance of the anxiety cycle
• Emotion awareness exercises
• Distress tolerance & emotion regulation
• Family involvement
• Boundary setting
• Supportive therapy
Be a Detective

- It’s not creating your own or new treatment protocols.
- It is about “detecting” what might be getting in the way of the patients progress & treatment gains.
- It may be helpful to incorporate adjunctive approaches to traditional CBT based on individual need.
Classic Barriers

- Emotion regulation skills
- Low distress tolerance
- Family accommodations
- Motivational issues (subsequent depression)
- Intelligence-analyzing & figuring out if treatment was right, working, etc.
- Inappropriate medication plan
- Low insight
- Psychotic features
- Comorbid personality disorder
Mental Illness Stockholm Syndrome

• Explore resistance to getting better
• Fear of the unknown/comfort in the predictable
• Impending identity crisis (i.e. who am I without my symptoms?)
• Secondary gains of staying impaired (i.e. expectations to return to work/school/relationships)
• Don’t be afraid to ask about the pros and cons of getting better and what it means to “sell out” the disorder
Non-Traditional CBT Strategies & Techniques

- Motivational Interviewing
- Dialectical Behavior Therapy
- Acceptance & Commitment Therapy
- Other Mindfulness Based Strategies
- Transdiagnostic Approaches
Motivational Interviewing

• Overview:
  - Collaborative protocol b/t patient & therapist to address motivational issues when the patient either isn’t ready, willing or is ambivalent where the therapist evokes the person’s own innate motivation & resources for change (Miller & Rollnick)

• Questions:
  - What concerns does the patient have about CBT and its potential unwanted consequences?

• Helpful Techniques (based on Miller & Rollnick’s 4 general principles of MI):
  - Express empathy by normalizing ambivalence
  - Develop discrepancy b/t present behavior & important life goals & values from the patient’s perspective (decisional balance exercise)
  - Roll with resistance rather than falling into the trap of trying to persuade the patient to change (actively involve the patient in the problem solving process)
  - Support Self-Efficacy by eliciting the patient’s own innate motivation & resources for change & by reinforcing steps toward positive behavior change
Dialectical Behavior Therapy

• Overview:
  - A type of CBT designed, initially by Marsha Linehan to treat Borderline Personality Disorder designed to address:
    - Dysregulation & lability of emotions
    - Interpersonal dysregulation
    - Behavioral dysregulation
    - Dysregulation of the sense of self

• Questions:
  - What maladaptive strategies might your patient be utilizing?
Helpful DBT Strategies

- Mindfulness skills
- Interpersonal effectiveness skills
- Emotion regulation skills
- Distress tolerance skills

(Linehan)
Acceptance & Commitment Therapy

• Overview:
  - Approach that shifts the focus of treatment away from symptom reduction & anxiety management toward living a vital life.
  - Rather than waiting for negative internal experiences (intense emotions, thoughts, physical sensations, memories, etc.) to go away or improve, ACT is about getting the patient to engage in behaviors that will lead them toward living a life that is in accordance with the individuals personal values & life goals

• Case example: OCD/family values
Transdiagnostic Approaches

• Overview:
  - Protocol designed to address the commonalities & overlap of & between the major emotional disorders eliminating the need for multiple treatment specific manuals.
  - Helpful for patients w/multiple diagnoses
  - Helpful for clinicians with less experience
  - Utilizes traditional CBT, ERP, MI & ACT techniques in 8 treatment modules
  - Covers all bases

(Barlow, Farchione, et al)
Other Approaches & Novel Strategies

- The use of self-disclosure
- Traditional behavioral activation & incorporating structure, goals & schedules
- Reframing ERP in terms more likely to reach client
- Family/couples sessions
- Old fashioned alliance building
Classic Clinician Limitations

• Inexperience

• Forcing traditional protocols on all patients with similar disorders (excessively manualized treatment)

• Failing to see each patient as individual & unique despite diagnostic similarities

• Failing to tailor the treatment to the individual & relying on clinician familiarity & comfort with standard protocols
What If He’s Just Not That Into Me?

• Watch out for your own perfectionism!
• What are your expectations for “success” in your patient and are they reasonable?
• Acceptance that what works doesn’t always work
• Consult with colleagues
• Communicate with shared treatment providers (psychiatrist, talk therapist, etc)
Questions & Discussion
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