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TREATMENT FAILURES IN BEHAVIOR THERAPY

All clinicians experience treatment failures: The interventions are not successful, and the patient does not improve. Other times, some progress is made, but the patient continues to perform below the level of functioning he or she had prior to the onset of the problem. Therefore, it is important to try to understand the circumstances under which treatment is more likely to fail. Many of these parameters have been identified clinically and supported through research on predictors of treatment outcome for behavior therapy. There are a number of such predictors that elevate risk of poor treatment response, and various strategies are employed to enhance outcome in the face of such predictors. These can be divided into two main categories: patient characteristics and therapist characteristics.

PATIENT CHARACTERISTICS

There are a number of patient characteristics that are related to how well a patient will respond to behavior therapy. These factors include motivation, expectation, severity of symptoms, insight, and comorbidity. Oftentimes, several factors interact within an individual patient, but for clarity's sake, each one is considered separately here.

Motivation

Motivation is a key factor in determining how well a patient will respond to behavior therapy. Motivation is defined by (a) how interested the patient is in making changes in his or her life and (b) how much of an investment the patient is willing to make to make a change. If a patient is brought in by a family member because others are bothered by certain behaviors but the patient does not view the same behaviors as problems worth changing, then the patient will be less likely to engage in treatment and therapy is more likely to fail. More frequently, a patient is interested in changing but may not be willing to endure the distress that it takes to make changes (e.g., not willing to tolerate being anxious during exposure therapy). Thus, a patient who is not both interested in changing and is unwilling to endure the stress of change will more likely fail the treatment.

In behavior therapy for the treatment of anxiety disorders, unwillingness to tolerate the anxiety that accompanies therapy is more frequently the issue. A patient who is suffering from obsessive-compulsive disorder usually does not want to continue to experience the distress of the symptoms, but is sometimes not willing to endure the short-term distress it would take to successfully complete exposure and response prevention. Some researchers have started to examine whether motivational interviewing, a treatment strategy developed to help resistant patients engage in treatments for substance abuse, can assist the patient in deciding to invest in the short-term distress to achieve the long-term gain.

Expectation

Expectancy is defined as how much the patient believes that the therapy will work or how credible the treatment seems to the patient. If a patient believes that he or she is an exception and that behavior therapy will never work for him or her, then the patient is less likely to invest time and energy into the treatment and therefore less likely to improve significantly. Furthermore, if the patient really does not expect that the treatment will help, then motivation to conduct exposures or engage in other behaviors that can cause distress will be low or nonexistent. Depending on the patient, this can lead to either avoidance (e.g., not doing homework, not fully engaging in treatment such as exposures during the session, etc.) or conflict with the therapist (arguments about the treatment rationale, etc.). There are a number of methods that behavior therapists use beyond motivational interviewing to increase patient expectancy. First, because it is founded in empiricism, behavior therapists are able to discuss success rates with their patients. Many behavioral treatments for anxiety disorders suggest that at least 75% of patients will have at least a 50% reduction in their symptoms. This information plus the persuasion of a coherent model of treatment, a good

therapeutic alliance, and early change in treatment often help many patients acquire high expectancy of success when they engage in behavior therapy. When these things are not sufficient, the behavior therapist will often work with the patient to determine what factors contribute to low expectancy and attempt to remove the barriers by helping the patient to have positive experiences that are counter to his or her expectations.

Severity

Many patients who have extremely severe symptoms of anxiety or depression can recover through behavior therapy. The issue of severity appears to go beyond simple symptom manifestation to two separate domains: functional impairment (whether the patient is able to be productive in some area of life, such as family, social, work) and distress tolerance (how much the patient is able to cope with bothersome feelings, how likely he or she is to experience such feelings, or how sensitive or reactive he or she is and how easily he or she recovers from such feelings). These two areas may interact with one another but do not necessarily do so.

If a patient is not functioning in any area of life (e.g., unemployed, no social support, no family support, nothing to focus on but illness), it is harder to break him or her out of the maladaptive cycle of behaviors. Patients without any area of positive functioning often present as more demoralized and hopeless: They feel that change is impossible or that the investment needed to change will not be worthwhile. Such patients are less likely to engage fully in treatment (they are less motivated and have lower expectancies) and therefore less likely to improve. In some situations, the behavior therapist will work with the patient to establish specific goals to help gain better functioning in an area of life while simultaneously working on improving any symptoms that would interfere with such goals. This can help instill hope and confidence in the treatment. If the patient is able to engage in one area of functioning, then the therapist can use this to give the patient hope that by changing maladaptive behaviors, more energy can be put into having a more well-rounded, productive life.

If a patient has an extreme inability to tolerate distress, then behavior therapies that involve exposure to feared situations (e.g., exposure therapies for the anxiety disorders) are much more challenging to conduct. This can be addressed by first helping the patient to feel understood while he or she understands the rationale for treatment, and then to work slowly, helping the patient tolerate their experiences while encouraging the patient to experience more anxiety.

Insight

Insight is defined as having an awareness that one's thinking or beliefs are distorted or somehow inconsistent with others' views. Other terms for poor insight include *overvalued ideation, fixed beliefs, delusional thinking,* or *borderline psychotic thinking.* This difficulty is most frequently discussed in the context of obsessive-compulsive disorder, where a patient truly believes that touching doorknobs can cause AIDS despite strong contradictory evidence. In such a case, the patient will often state that other people are wrong to take risks like touching doorknobs and that they probably have AIDS and don't know it. Poor insight can be shown across the emotional disorders, with patients who have panic believing that they really will die from the next panic attack ("The next one is the big one, I know it"), socially anxious patients being sure that they really will be rejected by everyone in the world, and depressed patients being sure that they really will fail at anything they do. While patients on the severe end of poor insight are relatively rare, they are difficult to treat because they believe that they are right. Therefore, the therapist must be wrong to ask the patient to take risks to test a belief. Even though the therapist believes the risk to be low, the patient believes it to be high and too dangerous to test.

To manage poor insight, the therapist will try to find a smaller, related belief on the edge of the patient's fear or core issue that is less fixed (e.g., finding an exercise that the patient does not think is high risk for getting AIDS, but is somewhat concerned that it could lead to cancer) and starting by addressing this issue. Arguing with such patients is counterproductive. Most often, a motivational-interviewing style of reexploring what the patient wants out of treatment and how one might achieve his or her goals is a better approach. However, some patients expect treatment to help them make the world conform to their unrealistic beliefs rather than requiring them to make changes in their behaviors. At such times, treatment is unlikely to work, and waiting to conduct the treatment until the patient can no longer bear the consequences of living with the disorder is sometimes the best solution.

Comorbidity

Comorbidity, defined as co-occurrence of other symptoms or syndromes, can greatly influence treatment outcome. The co-occurrence of depression, panic attacks, personality disorders, and other psychiatric disorders can make treating the target disorder much more challenging. However, several studies have demonstrated that treatment of the primary disorder often leads to a substantial decrease in secondary, or less severe, co-occurring disorders. Therefore, one should not assume that co-occurrence immediately means that one needs to modify his or her treatment strategies. Presence of severe depression, borderline personality disorder, mania, acute psychosis, or a severe eating disorder usually requires stabilization of the syndrome prior to attempting to treat an anxiety or depressive disorder. More controversy surrounds the treatment of patients with comorbid substance dependence or abuse.

In addition, co-occurrence of another disorder should be carefully differentiated from the misdiagnosis of one disorder as another. A number of patients with disorders, such as schizophrenia, autism, and bipolar disorder, can display symptoms that appear to be an anxiety disorder or depression. A number of these patients do, in fact, seem to have co-occurring disorders. However, another group of patients engage in repetitive or ritualistic behaviors, have panic attacks, are socially anxious, are depressed, or are worried, though these symptoms are secondary to psychotic symptoms or other symptoms that characterize the primary disorder. In such cases, trying to treat the apparent anxiety or depressive disorder without careful monitoring of the primary disorder can cause destabilization of the patient. Such cases need to be monitored carefully and should be treated by therapists who are familiar with aspects of all of the disorders being treated.

THERAPIST CHARACTERISTICS

In addition to patient characteristics, the therapist's behaviors can clearly impact treatment outcome positively and negatively. There is less research about such characteristics; however, poor therapist conceptualization of the patient's problems, extreme rigidity or flexibility, criticism, and lack confidence in treatment all may detrimentally influence treatment outcome for behavior therapy.

Conceptualizing the Treatment

Part of the therapist's job in behavior therapy is to provide the patient with a coherent, individualized model of treatment based on theoretical understandings of treatment and how they apply to the individual patient's difficulties. Provision of an all-purpose, general model can make the patient feel as if they are not being listened to and that the therapist does not care about him or her as an individual. More important, without understanding the core fears of the individual patient, the therapist is unable to directly address the fears through treatment procedures such as imaginal and in vivo exposure. For example, if a therapist assumes that every patient with panic disorder has a fear of dying, the therapist may miss the patient's true fear of going crazy. Furthermore, if the therapist assumes that the patient's fear of going crazy means that he or she will be hearing voices, the therapist will not be able to address a patient's specific core fear (e.g., of being paralyzed, etc.). Similarly, in obsessive-compulsive disorder, if a patient reports ritualized hand washing and the therapist immediately assigns a task of putting one's hands in dirt, this may have no significance for the individual patient whose fears could range from a fear of bodily fluids to needing to wash "just right," having nothing to do with dirt. Therefore, it is essential that the therapist gain a clear, detailed understanding of a patient's difficulties in order to be able to effectively address the specific problems that a patient experiences. Furthermore, articulating the conceptualization of the patient's problems provides for a clear rationale for doing exposures and other exercises that may be seen as unusual and/or distressing. The patient is then more likely to feel understood, to be motivated to follow the therapist's treatment plan, and to be hopeful about treatment outcome.

Flexibility and Rigidity

Provision of good behavior therapy requires flexibility on the part of the therapist. If a therapist has a specific treatment plan for a patient and attempts to force the patient to follow it in an unwavering fashion, this would be considered extreme rigidity. Such inflexible execution of treatment will often lead the patient to feel misunderstood and mistreated. It will often evoke arguments, noncompliance, and possibly early termination of treatment by the patient. While

many behavior therapies today have been manualized and help the therapist to focus the treatment, a good behavior therapist uses the treatment manuals as a guideline instead of a mandated law for therapy. When patients misunderstand important concepts, have life crises, or are overly distressed by a plan (e.g., a specific exposure), it is important for the therapist to be understanding without losing sight of the treatment plan.

Conversely, some therapists are easily sidetracked, have difficulty in providing structure, and hesitate to pursue the difficult, distressing topics that may be the most beneficial for the patient. Imaginal exposure for posttraumatic stress disorder is a good example of this issue. Many therapists would prefer to provide a supportive environment for the patient and allow them to discuss problems as they arise. This is helpful for some patients, but many will benefit from a structured retelling of the trauma within the supportive environment. If a therapist allows a patient to continuously raise new issues in treatment that postpone exposures, this is ultimately to the patient's detriment and can end up leading the patient to feel that while supported, he or she is not making the desired changes. Thus, a careful balance of structure and flexibility in tailoring the treatment to the patient is necessary in effective behavior therapy.

Criticism

There are many ways for a therapist to provide corrective feedback to a patient. One factor that can undermine treatment is how critical the therapist is when he or she provides such feedback. If a therapist scolds a patient for doing an exercise incorrectly, uses a pejorative tone to discuss noncompliance, or is condescending to the patient when providing information, the patient can feel humiliated, ashamed, and/or angry.

A skilled behavior therapist provides feedback or encourages change through an empathic, unassuming authoritative tone. If a patient is not being compliant with homework, the therapist will inquire as to what barriers are interfering with the successful completion of homework instead of accusingly asking why the patient didn't do what was assigned. If an exercise was conducted incorrectly, the therapist assumes that either the assignment was not articulated clearly (i.e., the therapist's fault for the misunderstanding) or that there were legitimate reasons that interfered with comprehension and completion of the task. If it becomes apparent that the patient is not motivated to change, then this is openly discussed. Terms such as "laziness" should be replaced with phrases such as "the cost seems to currently outweigh the benefits."

Confidence in Treatment

Therapists can fall on either side of the confidence issue, being either too sure or too insecure. More frequently, it is insecurity that leads to treatment failures. If the therapist is not confident in his or her ability to help the patient, this will come across to the patient in both subtle and not subtle ways. Therapist confidence leads to patient confidence and positive expectations, while therapist insecurity in the treatment makes the patient insecure about the effectiveness of the treatment. The therapist need not only be confident in the treatment as a whole, but needs to project certainty that behavioral tasks assigned to the patient are consistent with the conceptual framework developed to address the patient's core issues. This will allow the therapist to help the patient endure the more distressing situations, such as imaginal exposures.

In contrast, some therapists can express themselves in an overly authoritarian tone, stating that he or she is the expert and that the patient needs to do what the therapist wants if the patient wants to improve. Such a stance can appear arrogant and nonconvincing, which leads to more reluctance to trust the therapist and unwillingness to comply with treatment recommendations.

THERAPEUTIC ALLIANCE

The therapeutic alliance, also known as the *patient-therapist relationship,* is neither a patient or therapist characteristic, but it may impact negatively on outcome. While the alliance has not received as much emphasis in behavior therapy as in some other modalities of therapy, it is clear that a good relationship between the therapist and the patient can facilitate compliance, enhance motivation, and improve treatment credibility. Moreover, a bad or negative relationship is likely to lead to many of the above-mentioned patient and therapist characteristics that lead to treatment failure. Finally, if patient and therapist factors are handled with skill, this may improve the alliance.

SUMMARY

Acknowledging and addressing treatment failures in behavior therapy is a little discussed but extremely

important aspect of behavior therapy. Patients' low motivation, low expectations, severity of symptoms, poor insight, and comorbidity and therapists' poor conceptualization of the patient's problems, extreme rigidity or flexibility, criticism, and lack of confidence in treatment are factors that have been identified as potential factors that can lead to treatment failures. By identifying predictors of treatment failure, we can begin to acknowledge limitations of treatment, while working simultaneously to learn new strategies to deal with these factors and further improve outcomes.

—Jonathan D. Huppert

See also: *Behavioral Approaches to Gambling (Vol. I); Corporal Punishment (Vol. III); Drug Abuse Prevention Strategies (Vol. II)*

Suggested Readings

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TURNER, SAMUEL M.

I was born in Macon, Georgia, to parents of a rural Georgia background, neither of whom was a college graduate. Although not well educated and not well-off financially, the family, like many southern African Americans, had a long history of land ownership and relatives in rural areas with substantial farmland. This background of land ownership and family stability provided an atmosphere that fostered independence and upward striving. I attended the segregated schools of the deep South during elementary and high school, schools that, although segregated, were made up of talented African American teachers who provided an unusual nurturing and supportive environment for learning. I did not go directly to college, but instead enlisted in the United States Air Force, where I spent 4 years, one of which was in Thailand during the Vietnam War. My military career did not end there, as I later served as an Army Reserve Officer.

My college career began during military service, and it was my experience with a psychologist who was a former military officer, a Bataan Death March survivor named Grover C. Richards, at a tiny midwestern university in Texas, that fostered my interest in psychology. This professor was a dynamic instructor and ardent behaviorist whose ability to link unusual experiences to behavioral principles and theories was particularly appealing to me. After completing my military obligation, I entered Georgia State University, where I completed the BA degree.

I then started my graduate work at the University of Georgia, a program heavily (but not entirely) influenced by behavioral theory, with a model of training firmly rooted in the scientist-practitioner tradition and a strong integration of clinical and research activities. Influential faculty members in the Georgia program included Rex Forehand, Karen Calhoun, Benjamin Lahey, and Henry Earl Adams, my primary mentor. As a comajor in social psychology, my mentor was Abraham Tesser.

I was fortunate enough to complete internship training at the Mississippi Medical Center, where I was influenced by a highly talented, productive, and influential group of faculty members, as well as trainees. Among the faculty were David H. Barlow, Edward B. Blanchard, Leonard Epstein, Gene Abel, and Richard Eisler. It was there also where I met and was supervised and mentored by Michel Hersen.

Following the successful defense of my dissertation, literally the next day, my family and I left for Pittsburgh, where I would begin my faculty career at what would become one of the most productive psychiatric facilities in the world: Western Psychiatric Institute and Clinic (WPIC) of the University of