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Strategies for handling treatment failure successfully

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Abstract

This paper addresses the topic of treatment failure in psychotherapy. We present some data supporting our assertions that failure is common, that it is rarely discussed, and that clinicians do not handle it well. We describe a hypothesis-testing mode of clinical work that provides a useful conceptual framework for handling treatment failure, and we use the framework to develop an algorithm for handling treatment failure. We illustrate the use of the algorithm to reverse the initially failing treatment of a hypochondriacal attorney. We conclude with a discussion of obstacles to utilizing the algorithm.

Treatment failure, although common, is rarely discussed. As a result, the literature provides psychotherapists with little guidance for handling failure successfully. We address this problem here.

We begin the paper with a brief discussion of failure itself, presenting some data to support our assertions that it is common, that it is rarely discussed, and that clinicians do not handle it well. Next, we describe an empirical, hypothesis-testing mode of clinical work that provides a useful conceptual framework for handling treatment failure and we present an algorithm for handling treatment failure that is based on the framework. We illustrate the successful use of the algorithm to reverse the initially failing treatment of a hypochondriacal attorney. We conclude with a discussion of obstacles to utilizing the algorithm.

Treatment Failure

Psychotherapy fails in many ways. Patients refuse treatment, drop out of treatment, fail to respond to treatment, or relapse following successful treatment (Emmelkamp & Foa, 1983). Patients sometimes deteriorate during treatment. We focus here on the phenomena of failure to respond to treatment and deterioration during treatment.

Failure to respond to treatment is unfortunately common. For example, depending on the measure of depressive symptoms used, only 36% to 56% of patients receiving active treatment in the NIMH Treatment of Depression Collaborative Research Program were rated as recovered at the termination of treatment (Elkin et al., 1989). Fisher and Durham (1999), in a review of randomized trials, reported that just under 40% of patients receiving psychosocial treatment for generalized anxiety disorder could be considered to be recovered following treatment. Deterioration during treatment appears to be rare but does occur. Ogles, Lambert, & Sawyer (1995) reported that 3% to 5% (depending on the outcome measure) of the patients who completed treatment in the National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH TDCRP; Elkin et al., 1989) showed reliable deterioration.

Treatment nonresponse and deterioration are rarely discussed in the literature. Exceptions include Foa and Emmelkamp's (1983) edited book, the practice guideline for treatment of major depression in primary care published by the Agency for Health Care Policy and Research (1993), and The Texas Medication Algorithm Project (Crismon et al., 1999); the latter two provide algorithms to guide decision-making when treating depressed patients. Nonresponse and deterioration are more frequently reported now that investigators have begun to report clinical significance of the outcome of randomized controlled trials (cf. Jacobson & Truax, 1991)

When treatment failure occurs, clinicians often lack the skills to handle it. Lambert (2000) hypothesized that clinicians "defend against" awareness of their patients' failure to progress. Consistent with that hypothesis, he and his colleagues showed that when they established a formal mechanism to notify clinicians of cases that were not making progress, outcome of those cases improved. Kendall, Kipnis, and Otto-Salaj (1992) found that 41% of clinicians surveyed about their management of patients who did not progress in treatment reported that they had not initiated any

change in the treatment plan or made any efforts to refer these patients to another provider.

The assertion that clinicians do not handle failure well is also supported by our own and others' experiences in case conferences. Meehl (1973) noted that clinicians in case conferences attempt to be "buddy-buddy," to behave as if they "believe all evidence is equally good," and to "reward everything--gold and garbage alike" (pp. 227-228). Clinicians frequently seize on small bits of data and use them to reassure the clinician who is presenting a failing case. For instance, a therapist discouraged by a child's increasing aggressive behavior at school is reassured by his colleagues that the child is improved, as evidenced by the fact that he "now plays with a single toy for an extended period of time instead of jumping from one toy to another during the therapy session." Similarly, clinicians often rely on the illogical observation: "The patient comes to therapy every week. She must be getting something out of it." These behaviors can block the investigation of causes for and solutions to treatment failure.

Identification of treatment failure is particularly important in these days of attention to the costs of care. One useful strategy for providing cost-effective care is stepped care, a method in which the clinician begins treatment with a low-cost intervention and moves to higher-cost intervention for patients who do not respond (Haaga, 2000). Effective implementation of stepped care, of course, requires prompt identification of treatment failures.

These observations suggest that clinicians are in need of guidelines and strategies for handling treatment failure.

An empirical approach to clinical work and its implications for handling treatment failure

A hypothesis-testing, empirical model of clinical work described by the behavior analysts (cf. Haynes & O'Brien, 2000), the program evaluation literature (cf. Bloom, Fischer, & Orme, 1995) and others (Hayes, Barlow, & Nelson-Gray, 1999; Kazdin, 1982) can help clinicians handle treatment failure successfully. Using this model, the treatment of every case is viewed as an experiment with an N = 1. The therapist begins by assessing the patient's problem and situation to obtain a diagnosis and formulation about the nature of the factors causing and maintaining the problems. The therapist proposes a treatment plan based on the diagnosis, the formulation, and the empirical literature. For example, a patient whose insomnia was hypothesized to result from worry would be treated with relaxation and other interventions, whereas a patient whose insomnia was hypothesized to be caused by his excessive use of caffeine would be advised to reduce his caffeine intake. Patient and therapist monitor the outcome and process of therapy frequently. If outcome is not optimal, the therapist returns to the assessment phase, collecting more information to evaluate whether the initial diagnostic and formulation hypotheses are inadequate or incorrect and whether new information might lead to new intervention proposals that might lead to a better outcome. The entire process is collaborative, with patient and therapist working together at all stages.

An algorithm for successfully handling treatment failure

We present an algorithm (see Figure 1) for clinical work based on the hypothesis-testing model just described. The algorithm specifies steps clinicians can take to prevent treatment failure, to identify it when it occurs, to overcome it, and, when necessary, to accept failure. We describe the steps of the algorithm in detail here.

Insert Figure 1 about here

Preventing failure

The first step to preventing treatment failure is to carry out a systematic and comprehensive assessment that yields information about diagnosis and an individualized case formulation. Diagnosis is important because the scientific literature, particularly the randomized controlled trials, is organized by diagnosis. Individualized case formulation is important because according to the conceptual model described immediately above, the treatment plan depends on the individualized case formulation.

Therapists can also reduce the probability of treatment failure by basing their initial case formulations and treatment plans on empirically-supported theories and protocols. For example, we recommend that the therapist treating a depressed patient base his or her idiographic formulation on a nomothetic theory of depression that has good empirical support, rather than on a novel theory of depression. Similarly, we recommend that the therapist base his or her individualized treatment plan on a protocol that has been shown to be effective in some type of controlled study, ideally a randomized controlled trial.

It is not always easy or even possible to base treatment plans on results from controlled studies for numerous reasons, including that many patients seek treatment for problems and disorders which have not been studied empirically. Moreover, the therapist's attempts to base treatment plans on both empirically-supported protocols and individualized case formulations may conflict at times, such as when the formulation of the individual case at hand does not appear to match the nomothetic formulation underpinning the empirically-supported protocol (Haynes, Kaholokula, & Nelson, 2000; Persons, 1999).

Therapists can also reduce the probability of treatment failure by not taking on cases outside their areas of expertise. There are limits to the degree to which therapist can follow this dictum, particularly in rural and other areas where providers are sometimes few and far between. In this case, it is important, of course, to inform the patient about the therapist's skill limits.

Treatment failure can also be prevented if therapists take care to work with patients to set realistic treatment goals that are mutually-agreed-upon.

Providing full informed consent for treatment can also reduce the chances of treatment failure. When patient and therapist agree about the nature of the patient's problems and the best approach to treating them, adherence and outcome are better than otherwise (Addis & Jacobson, 2000; see review in AHCPR, 1993).

Our algorithm includes one final step to prevent treatment failure that we believe is strikingly important, and that step is described in the box in Figure 1 that reads, "Can patient and therapist agree on a treatment plan?" We recommend that before beginning treatment, therapists offer patients a clearly described treatment plan and explicitly ask the patient whether he or she wishes to carry out it. This step can be surprisingly difficult to implement. Assessment can easily merge into treatment without an explicit boundary demarcating them, and therapists are not always fully aware at the beginning of treatment exactly what procedures will be required.

Nevertheless, asking patients to make an explicit commitment to the treatment plan is useful in preventing failure because it reduces the likelihood that patients will begin treatment without having made a firm commitment to carry it out. Without this firm commitment, patients may lack the motivation to get through the rough parts of the therapy. For this reason, protocols for tough-to-treat populations (cf. Linehan's (1993) for borderline personality disorder, Fordyce's (1976) for chronic pain and Steketee's (1993) for obsessive-compulsive disorder) invariably include a step in which the patient explicitly signs on to the treatment plan, often in writing.

This step of the algorithm also emphasizes to the therapist his or her responsibility to propose treatment plans that have a reasonable probability of success—or, at a minimum, to not agree to treatment plans which have little or no chance of success. We often find, when we examine our own failing cases, that we have, without being aware of doing so, signed onto a wimpy treatment plan that has little or no chance of success. We find this phenomenon to be particularly prevalent in child cases, where we often experience quite a bit of pressure from parents to accept treatment plans that are convenient but do not make good clinical sense. For example, some parents are eager to bring their child to the therapist's office for a weekly session but are reluctant to attend skills training sessions to learn to set appropriate limits to control their child's aggressive behaviors at home.

Asking patients to make an explicit commitment to a concrete treatment plan is also helpful because it sets the stage for the subsequent steps of the algorithm. It reminds the patient (and the therapist!) that treatment is goal-directed, outcome will be monitored, and treatment will be continued only if it is successful. This stance, made explicit at the outset, makes it easier for the therapist to carry out the difficult tasks of insisting on a change in the treatment plan or even discontinuing treatment if it fails.

Identifying failure

To handle failure successfully, the therapist must identify it when it occurs. Kendall et al. (1992) and Lambert (2000) assert that therapists frequently fail to identify failing cases. The reader may be surprised by this claim. However, we have found, and we believe that readers who examine their own caseloads will also find, a surprising number of patients who have been in treatment for a surprising length of time without making significant progress. Reasons for this are myriad. Many patients who are not making progress are quite happy to meet weekly with a supportive therapist whom they like and respect. And therapists find it rewarding to collect these patients' checks and find it easy to believe that since the process is so pleasant, something good must be happening. The algorithm prescribes several steps clinicians can follow to increase the probability that they will identify a treatment that is failing or deteriorating.

The first step to identifying failing treatments is to collect objective data to monitor progress at each therapy session (Kazdin, 1993). We recommend that the data be plotted, because a visual representation yields information about trends that is otherwise easily lost. We have observed that when we neglect to plot the scores, we find ourselves with a pile of papers in the chart but no clear sense of the progress of the therapy. We also recommend that the graphing process be done collaboratively with the patient, for several reasons. If two people are looking at the graph, the probability increases that treatment failure will be noted and addressed. Collaborative monitoring encourages the patient to play active role in the treatment, including any decision-

making about the direction of treatment. And if there is a major fluctuation in the graph, the patient and therapist can address it immediately.

In addition to monitoring outcome toward long-term treatment goals, it is useful to monitor intermediate outcomes and the process of therapy (Mash & Hunsley, 1993). For example, the therapist who is treating John, whose long-term goal is to hold a full-time job, can be more optimistic about reaching this goal if John has obtained an intermediate goal (holding a volunteer job) than if he has not. Similarly, the therapist can be more optimistic about success if the therapy process is good—that is, John and his therapist have a collaborative, trusting relationship, therapy sessions are productive, and John completes homework assignments reliably. To assist in monitoring therapy process, Burns (1998) has developed brief measures that can be used at each session to assess the patient's views of the helpfulness of the therapy session and the quality of the patient-therapist relationship.

In addition to monitoring outcome and process each session, our algorithm calls for a more global and substantial quarterly review of both process and outcome. At the San Francisco Bay Area Center for Cognitive Therapy we recommend that after 12 to 16 sessions the therapist initiate a collaborative review of progress with the patient. It is not unusual that, as a result of this exercise, the therapist notes aspects of the case that had not been apparent even when progress was monitored weekly. In part this is because weekly symptom monitoring using a self-report or other measure addresses only some of the treatment goals most patients set.

Finally, to identify failing treatments, it is necessary, as Mash and Hunsley (1993) point out, to set "agreed-on and specific indicators of when . . . goals are not being met (i.e., treatment is failing)." (p. 296). Without concrete indicators, even regular outcome monitoring can fail to ferret out a failing treatment. For example, one of us is treating Jane, whose goal is to improve her ability to manage her time effectively and meet deadlines. Jane and her therapist devised an idiographic measure of progress toward the goal that Jane completes weekly, which includes such items as "Paying all bills before the due date," and "going to bed before 1 a.m. Sunday through Thursday." On a 30-item scale of items of this sort, with items scored 0 or 1, Jane's scores at the beginning of treatment were 12, and she is now typically scoring 22 to 24. Certainly Jane's score reflects progress. Nevertheless, some of the failed items on the scale reflect the fact that Jane's electricity was recently nearly disconnected because she failed to pay the bill on time, and approximately twice a month she stays up as late as 4 a.m. in order to meet a work deadline. Thus, the question arises: Does a score of 22 reflect a treatment success or a treatment failure? To answer this question, Jane and her therapist will need to agree on a cutoff score that defines treatment failure.

Overcoming failure

The algorithm describes several steps the therapist can use to overcome a treatment failure. It is vital at all points in this process to discuss the situation with the patient in a collaborative, non-blaming, non-defensive, problem-solving way.

Sometimes, as in the example of Jane, the patient has shown a partial response. When this happens, as the algorithm notes, patient and therapist can ask themselves whether the partial response is sufficient or is likely to be the best outcome that can be obtained. If so, it makes sense to terminate the treatment (or to continue with a goal of maintaining the gains that have been achieved). Sometimes the decision that a partial

response is adequate involves shifting from a view of the patient's problem as an acute disorder that can be cured to that of a chronic one that is unlikely to remit completely (Scott, 1998).

When a partial response is not acceptable or when the treatment has failed completely, the algorithm recommends that therapists ask themselves the question: "Is the treatment plan that was devised actually being implemented?" If progress is not occurring, it may be because the therapist has, perhaps unwittingly, slipped into an inadequate treatment plan in response to pressures from the patient, exigencies of time and money, or other factors. If the agreed-upon treatment plan is not in place, the algorithm recommends that the therapist attempt to identify and remove obstacles to implementing it.

Other useful questions the therapist can ask him- or herself at this point are: "Is the treatment plan I would consider to be ideal for this patient being implemented? If not, how far is the current treatment plan from my ideal? Why?"

If the therapist cannot overcome obstacles to implementing a top-quality treatment plan, the algorithm recommends that the therapist return to the assessment phase to determine whether a diagnostic or other assessment error has been made and whether a revised diagnosis or formulation might lead to a revised treatment plan that might have more success. As part of this process, the therapist can seek information from the patient's significant others, consult with colleagues, or ask the patient to consult with another professional. Useful questions the therapist can ask him/herself at this point include:

- Are there any significant problems on the Problem List that I am not attending to?
- Is there a substance abuse problem that has not been identified or adequately treated?
- Is my hypothesis about the relationships among the presenting problems faulty?
- Are there contingencies that block the patient from improving (e.g., disability payments)?
- Are external factors, including significant others in the patient's life, undermining the treatment plan?
- Does the formulation of the case provide any account of why the treatment is failing to progress? For example, does the patient's beliefs that others are untrustworthy impede him from developing a productive collaborative working relationship with the therapist? If so, can this issue be addressed directly?
- Might a different conceptualization of the case (including perhaps a biological conceptualization) suggest a different treatment plan? Sometimes pharmacotherapy can alleviate symptoms sufficiently to allow a patient who was previously unable to work effectively in a psychosocial treatment to be able to comply with and benefit from that treatment.

Accepting failure

If after repeated efforts, the patient is not responding to treatment, it is, in most cases, ethically and professionally necessary to refer the patient to another provider (APA ethics code, 1992). In our experience, this step of the algorithm is one that therapists find particularly difficult to implement. In thinking about the difficult step of referring the patient to another professional, it is useful to remember that the process of attempting to overcome a treatment failure can appropriately require many weeks; it is

not a brief discussion that occurs in a single session. As the therapist moves through this process, he or she can prepare the patient (and him/herself!) for the need to refer the patient to another professional if treatment fails. Discontinuing treatment is often complicated by the fact that the failed therapies are often the ones in which therapists have invested the most. We find consultation with trusted colleagues to be invaluable in the difficult process of terminating treatment in these circumstances. The process of ending a failing treatment is complicated by the fact that many patients are not troubled by their lack of progress (this fact may account in part for the problem!) and would be quite happy to continue therapy indefinitely.

When the treatment is not progressing but the patient nevertheless wishes to continue to meet with the therapist, is it acceptable for the therapist to do so? We find this question to be a nettlesome one. We have concluded that it may be acceptable (but not desirable) to continue a failing treatment under certain conditions, including: the patient is fully informed, the patient is functioning at a reasonable level (treatment failure is not life-threatening, as in the case of a suicidally depressed person); no clearly superior treatment or therapist is available; progress is reviewed periodically. Continuing a failing treatment is risky, however, as it may block the patient from obtaining succcessful treatment. This question raises complex ethical and professional issues that deserve careful thought and that we cannot fully address here.

An illustration of the use of the algorithm: The case of George, the hypochondriacal attorney

The treatment of a young man complaining of hypochondriasis illustrates the application of the algorithm depicted in Figure 1 for handling treatment nonresponse. We use **bold typeface** to highlight the steps of the algorithm the therapist used.

George was a 37-year-old white attorney who lived with his wife and two children in Berkeley. He sought treatment from one of the authors (J. B. P.) for distressing bouts of fear about his health.

The therapist began with **an assessment of George's problems to obtain a diagnosis and formulation**. George was quite distressed by fears about his health that arose approximately twice a week. When he noticed a bruise on his body or experienced low energy or any other sign of malaise, he had the thought, "I might have cancer" or "It could be leukemia," and he became extremely anxious for several hours to days, often obtaining relief by asking his wife for reassurance that he was not seriously ill or by telephoning or visiting his physician. George also experienced quite a lot of anxiety and stress in his work, but he minimized this problem, presenting it as a natural consequence of the fact that he was a senior partner in a large firm, worked long hours, and handled quite a lot of responsibility. He reported he drank 1 to 2 beers nightly and more on weekends in an effort to alleviate his work stress. He denied other significant problems. Diagnostically, George met criteria for hypochondriasis (APA, 1994).

The therapist had limited expertise in treating hypochondriasis; she had previously treated only a handful of cases. Nevertheless, she went forward with the process of developing a formulation and offering George a treatment plan rather than referring him to another professional for two reasons. First, there was not, in the San Francisco Bay Area, another professional available who had clearly superior expertise in treating hypochondriasis. Second, although little was known about treatment of hypochondriasis, what was known utilized the cognitive-behavioral conceptualizations

and interventions used for treatment of panic and obsessive-compulsive disorder, with which she did have considerable experience.

George had suffered fears about his health on and off since he was a child. Health fears had flared up about 6 weeks prior to his seeking treatment, when he had noted blood in his urine, a discovery that led to the diagnosis of a "borderline cancerous" bladder tumor which had been excised in an outpatient surgical procedure three weeks previously. Except for this event, George had had no significant medical problems. He noted, "I have a medical file this thick, but it's all due to stress and anxiety." His anxiety had been treated unsuccessfully with multiple medications, including stelazine.

George had a family history of anxiety; he described his mother as someone who always expected the worst, continually cautioned her children not to take risks, and feared "doing the wrong thing" and attracting negative opinions from others in the community. George's father had been distant and disengaged from his children, focusing all his time and energy on the successful family business. George had two brothers; both were successful businessmen, and one suffered from anxiety.

The therapist **developed a case formulation** and a **treatment plan** for George's health fears based on the cognitive-behavioral (CB) model developed by Paul Salkovskis (1989). The therapist modelled her formulation and treatment plan on the Salkovskis one because, upon **reviewing the efficacy literature**, she found no controlled studies of treatment for hypochondriasis. However, she did find a report demonstrating effectiveness of the CB treatment in two cases (Visser & Bouman, 1992) and she saw that Salkovskis modelled his conceptualization and treatment of hypochondriasis on conceptualizations and treatments for anxiety disorders that had been shown effective in numerous randomized controlled trials. (Subsequent to George's treatment, a series of 17 cases (Bouman & Visser, 1998) and a randomized trial (Warwick, Clark, Cobb, & Salkovskis, 1996) demonstrating the efficacy of CBT were published.)

The cognitive-behavioral formulation proposed that George had learned from his mother that the world was a dangerous place (catastrophic things could happen at any moment), and that he was vulnerable and unable to cope with any negative events. Because negative life events could not be handled, they must be prevented at all costs via hypervigilance, avoidance, and worry. These beliefs had been activated by George's recent bout with cancer. Now, any mention of cancer or any ambiguous physical symptom activated his fears of cancer. George avoided many situations that he anticipated might cause distress; he avoided all newspaper articles and TV programs about cancer, for example. He also engaged in extensive health-related rituals, checking shampoo labels carefully so he could avoid those he feared contained toxins, installing a water filter system in his home to screen out potentially dangerous substances, and similar. When his fear became activated, George sought to relieve his distress by obtaining reassurance from his wife or physician. George's avoidance behaviors, reassurance-seeking, and hypervigilant behaviors increased his preoccupation with his body and his tendency to interpret ambiguous or novel bodily symptoms as due to cancer. The formulation proposed that although the avoidance and reassurance strategies and other health-related rituals temporarily relieved George's

anxiety, in the long term they contributed to the maintenance of his fears because they prevented George from confronting the fears and learning that they were irrational.

The treatment plan flowing from the formulation called for George to systematically expose himself to situations that activated his health fears while abstaining from seeking reassurance or any other behavior that would neutralize his fears. Cognitive restructuring would be also be used to modify George's irrational perceptions of danger and his ability to cope with adversity.

The therapist explained the formulation and intervention strategy to George, who accepted it. The therapist provided full **informed consent for treatment**, outlining treatment options, the limited database underpinning the proposed treatment, and the details of exactly what would be required in treatment. George **accepted the treatment plan** and elected to **proceed with the recommended treatment.**

George and his therapist **set the following measurable, realistic and mutually agreed upon treatment goals:**

- To reduce hypochondriacal fears to no more than one brief bout per week.
- To stop asking his wife and physician for reassurance about his health.
- To reduce alcohol intake to none during the week (Sunday through Thursday) and a maximum of two drinks per day on Friday and Saturday.

Although George's therapist made every effort to carry out all the steps of the algorithm designed to prevent treatment failure, she made a diagnostic error and developed an inadequate formulation, and these (as the algorithm proposes), contributed to an initial treatment failure, as described next. Fortunately, the use of effective strategies to identify failure and a strong collaborative problem-solving patient-therapist relationship allowed them to recover from the initial treatment failure, as we show.

To **monitor outcome each session**, the therapist asked George at the beginning of each session how many episodes of health fears he had had the previous week. When he began treatment, George reported he was having about 2 hypochondriacal episodes weekly (see Table 1).

Insert Table 1 about here

George began his treatment by making an immediate sharp reduction in his alcohol intake after the therapist pointed out to him that his alcohol use was probably not helping his anxiety and might be worsening it. Subsequently, therapy sessions focused on strategies to reduce the hypochondriasis, as this was George's top priority treatment goal.

George and his therapist embarked on exposure and response prevention methods for treating his hypochondriasis. They developed a hierarchy of George's health fears, which included items such as reading articles about cancer in newspapers and medical books, and George began approaching the items on his hierarchy. The therapist also conducted an imaginal exposure session in which George imagined contracting and dying a painful death from cancer; George listened to the tape of the session repeatedly until it did not frighten him. George also agreed to begin dropping out some of his health-related rituals--leaving the shampoo on his head longer and using the same brand repeatedly, for example. George was asked to refrain from asking his wife and

physician for reassurance about his health. Cognitive restructuring was also used to address George's catastrophic interpretations ("I have cancer") of ambiguous spots on his body.

In a belated (after 26 sessions) **quarterly progress assessment,** George and his therapist reviewed both the process and outcome of treatment. They reviewed George's goals for treatment, which clearly stated **criteria for treatment success**. George stated that he was pleased to have met his goal to reduce his drinking. However, he and the therapist agreed that little progress had been made in alleviating George's hypochondriasis: his health fears were less intense but they were not less frequent, and he was still seeking reassurance from his doctor and his wife when he felt anxious about his health.

The fact that George was still seeking reassurance from his wife and doctor could have been seen as an **adherence** problem or as a **failure to fully implement the treatment**, and the therapist might have focused on **identifying obstacles to implementing the treatment plan and worked to overcome them.** However, the therapist elected to view the problem as a treatment failure, and (following the arrow in the algorithm back to the assessment point at the beginning of the algorithm) she initiated a process of **additional assessment and formulation in an effort to arrive at some new intervention ideas.**

In the process of collecting additional assessment data, George's therapist learned that George had significant performance anxiety and he met criteria for social phobia. George had a hard-driving, anxious style of functioning at work in which he was hypervigilant at all times, fearing making any type of mistake; he particularly feared public speaking situations. A major source of George's work stress was the chronic fear that he would be asked to give a talk to a large group. Two years previously, on his way to the podium to give an important talk to an audience of 400 people, George had stumbled and dropped his papers, and had felt acutely embarrassed. He described this as "the worst experience in my entire life" and he had fully expected to lose his annual bonus as a result. George tied his performance anxiety to some very painful experiences as a child in which he was teased and scapegoated by peers.

In the course of these discussions, George astutely observed that he still used hair dye despite his fears that it was carcinogenic; this fact conveyed to him that he was more afraid of rejection than of cancer. In addition, George completed a Thought Record that showed the relationship between his hypochondriasis and his performance anxiety. The activating situation was that a co-worker had said to George, who had a cold, "Oh, you're sick again." This comment activated, in George, the following stream of automatic thoughts: "I am sick a little more often; It could be leukemia; I'll miss work; I'll be put on a program to speak to 300 people but I won't find out about it until too late to prevent it; Work will pile up; Something important will get by me; I'll get fired; I'll end up with a lower-status job; Others will think I'm inferior; I'll be inferior." This Thought Record clearly indicated that one of George's major feared consequences of being ill was a loss of status in his eyes and those of others. This information fits neatly in the Salkovskis (1989) formulation of hypochondriasis, but the therapist had missed this piece of the puzzle in her initial formulation of the case.

Thus, George and his therapist developed a new **diagnosis and formulation of his hypochondriasis. The new formulation led to a new treatment plan** which

utilized **empirically-supported** (Heimberg, Liebowitz, Hope, & Schneier, 1995) **treatment of George's performance anxiety.** George and his therapist developed a hierarchy of public speaking situations and George began practicing the situations as often as he could. Cognitive restructuring interventions focused on helping George reduce his irrational fears in speaking situations and other social situations in which he feared embarrassing himself. The new treatment plan also addressed George's tendency to monitor his body and to attribute any unusual sensation to serious illness. The therapist proposed to George that he suffered chronic performance anxiety but that he was not very aware of this. Thus, when he was particularly anxious—often about fears of humiliation in social situations—he did not attribute his anxiety to social anxiety, but instead tended to hyperfocus on his body and to attribute any unusual feelings to a catastrophic medical disorder. The therapist suggested that George ask himself, when health fears arose, whether he was having performance anxiety and if so, to focus on managing that.

George and his therapist set a **new treatment goal** of reducing performance anxiety, both because George elected to work on this goal for its own sake, and because the new formulation suggested that work on this goal would also be likely to help with the goal of reducing hypochondriasis. George's **criterion for success** was to be able to speak in any professional setting with minimal anxiety. George and his therapist **monitored progress toward the treatment goals** by periodically re-rating the items on George's public speaking hierarchy and by counting hypochondriacal episodes, as before (see Table 1).

At a subsequent **progress review**, George reported that, as predicted, the treatment of his public speaking anxiety had significantly reduced both his public speaking anxiety and his hypochondriacal symptoms (see Tables 1 and 2). Medical records kept by George's primary care physician confirmed the decrease in his hypochondriasis. Before treatment began, George made 3 to 4 visits annually to his physician in order to get reassurance about his health fears. In the six months prior to beginning treatment for hypochondriasis, George had three "reassurance" visits to his primary care physician (double the usual number), and he also had three "reassurance" visits during the six months of treatment that was focused on hypochondriasis. After the focus of therapy shifted to his performance anxiety, George visited his physician for reassurance only once or twice a year.

At post-treatment, George reported that he was substantially less afraid of cancer, no longer noticed spots on his body, and felt comfortable wearing shorts, which he had previously avoided due to fears of getting skin cancer. He reported that he had 2 to 3 days every 6 months in which he was troubled at all by health concerns, and he managed those fears easily. George's performance anxiety was not completely gone, but it was significantly reduced (see Table 2). George stated: "In the past I lived in fear of giving a talk or even being asked a question in a meeting. Now I can come to work and not be afraid of anything. The big turning point was learning you could do public speaking and not be perfect."

Insert Table 2 about here

Thus, after an initial failure, George's treatment was ultimately a success. His case illustrates the use of the algorithm depicted in Figure 1 for preventing, identifying, and overcoming treatment failure. Even the initial failure in George's case demonstrates the utility of the algorithm. The initial poor outcome was due in part to the therapist's failure to obtain an accurate diagnosis and a complete formulation. However, the fact that outcome was monitored systematically allowed the therapist to identify the failure, and the fact that the therapist and patient worked together collaboratively to collect additional assessment data that yielded a new formulation and treatment plan led to an ultimate treatment success.

Obstacles to implementing the algorithm

Although the algorithm presented here is logical and straightforward, we recognize that, in practice, it is often difficult to implement. We describe here several obstacles to implementing the algorithm and some suggestions for overcoming them.

Obstacles commonly arise in the "Preventing Failure" stage because conducting a thorough assessment, reviewing the literature to devise an empirically-supported treatment plan, setting treatment goals, and discussing measurement of progress take substantial skill, effort, and time. Both patients and therapists may grow impatient with the process, especially if a managed care health plan limits the number of sessions. We remind therapists that, as in the example of George's case, errors in the initial assessment can be costly later on.

Additionally, emotional pressures may make it difficult for therapists to insist on treatment plans that have a reasonable chance of success. Therapists may find themselves agreeing to weak treatment plans because of fears that if they propose an aggressive treatment plan the patient will choose to work with another therapist. Therapists may agree to weak treatment plans because they fear being an excessively demanding taskmaster who is unsupportive to a distressed person. The best answer we can give to these concerns is to suggest to therapists that even if some patients leave treatment because they are not willing to agree to assertive treatment plans, those who stay are likely to do well in treatment, and these positive outcomes will, in the long run, redound to the patient's interest and the therapist's credit. Similarly, it is not overly demanding to refuse to move forward with treatment plans that are unlikely to be helpful.

In the "Identifying Failure" stage, other obstacles arise. Monitoring progress can be threatening to both therapists and patients, perhaps in part because therapists fear learning that they are not helpful and patients fear learning that they are not recovering. When this happens, therapists can feel incompetent, and patients can feel they are "bad patients." In support of this notion, Kendall and colleagues (1992) found a positive correlation between the percentage of failing cases in a therapist's caseload and the therapist's tendency to rate him/herself low on professional ability. Therapists may also be reluctant to monitor progress systematically because it takes time and effort and can seem cold and impersonal. Without monitoring, however, treatment failure cannot be identified and addressed.

The therapist must overcome his/her reservations about monitoring in order to carry it out successfully. If the therapist is not clear and confident that monitoring is a good idea, the patient is likely to have difficulty getting on board with it. We recommend that therapists examine their reservations carefully in an effort to resolve them. If the

therapist believes that patients will feel that monitoring is cold and impersonal, we recommend that therapists experiment with and test out their hypothesis, perhaps by trying monitoring with an "easy" patient and then asking the patient for feedback about it. We also recommend that the therapist take time to discuss monitoring and the rationale for it carefully with the patient--rather than simply handing the patient a piece of paper and asking him to fill it out. We find that when we present monitoring carefully, most patients find it easy to use it and do not complain that it is cold and impersonal. If the patient clearly understands and has accepted the rationale for monitoring, s/he is more likely to comply.

The "Overcoming Failure" stage requires patients and therapists to use problem-solving skills to resolve troubles arising in the original treatment plan or to generate new treatment plan. This process, again, is quite a lot of work and can be uncomfortable. It can be easier to simply continue using the original methods (even if those methods aren't working). It's easier for the therapist to tell himself "the patient must be getting something out of it if she's still coming," even if this stance does nothing for the patient in the long run. To assist with problem-solving and hypothesis generation, we find consultation with colleagues to be invaluable.

Finally, the "Accepting Failure" stage can be particularly tough. It is our impression that accepting treatment failure is the most difficult stage of the algorithm. We find that it is extremely difficult to conclude we have not been helpful and to refer a case to another provider. Financial contingencies often discourage this. If a therapist ends the treatment, she loses money. Therapists may also fear that terminating treatment may cause patients to feel rejected or to be harmed in some other way, or may expose the therapist to a malpractice lawsuit on grounds of abandonment. Therapists may have difficulty terminating failing treatments because of their belief that "at least the patient has a solid relationship with me and can come to talk to me every week; if she doesn't have that, she'll have nothing." We find consultation with trusted peers to be invaluable in helping us let go of failing treatments. We recommend that more attention be paid to helping therapists learn to accept failure as an inevitable aspect of top quality evidence-based clinical work.

Finally, we believe the following points may be helpful to overcoming obstacles in all phases of the algorithm:

(1) Identifying and addressing treatment failure, even if it means referring to another provider, really is in the best interest of the patient.
(2) Following the algorithm in fact suggests that the therapist cares about the patient and his well-being, or else the therapist could simply keep taking his money even if he is not improving.
(3) Referring a patient to another provider is a reflection that the therapist has hope for the patient to get better; the therapist has hope that another professional can help this patient.
(4) No therapist helps every patient, every time.

Conclusion

We present here an algorithm that therapists can use to prevent, identify, overcome, and accept treatment failure. The algorithm is a work in progress. Whether the algorithm leads to improved clinical care is of course an empirical question.

We encourage readers to experiment with the algorithm to evaluate whether it is helpful in their clinical work. Fundamental philosophical differences related to theoretical orientation among therapists about how knowledge is obtained and how change occurs (cf. Messer & Winokur, 1984) may influence whether therapists find this algorithm useful. To offer just one example, if therapists believe that patient progress can not be meaningfully measured by a rating scale or by discrete, quantifiable criteria, the algorithm described here will not help them manage treatment failure.

We recognize that the steps of the algorithm are difficult to implement and that it represents an ideal, a level of practice to aspire to, rather than one that is easily implemented. We also recognize that the algorithm is oversimplified in the sense that it does not fully capture the dynamic process of hypothesis formation and revision that happens throughout treatment.

Author Note

We thank our patient for giving permission to report his case here, and we thank his primary care physician for his contributions. Please send reprint requests to Jacqueline B. Persons, San Francisco Bay Area Center for Cognitive Therapy, 5435 College Avenue, Oakland, CA 94618, jbp@sfbacct.com.

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Figure 1: Empirical approach to clinical work that facilitates effective handling of treatment failure

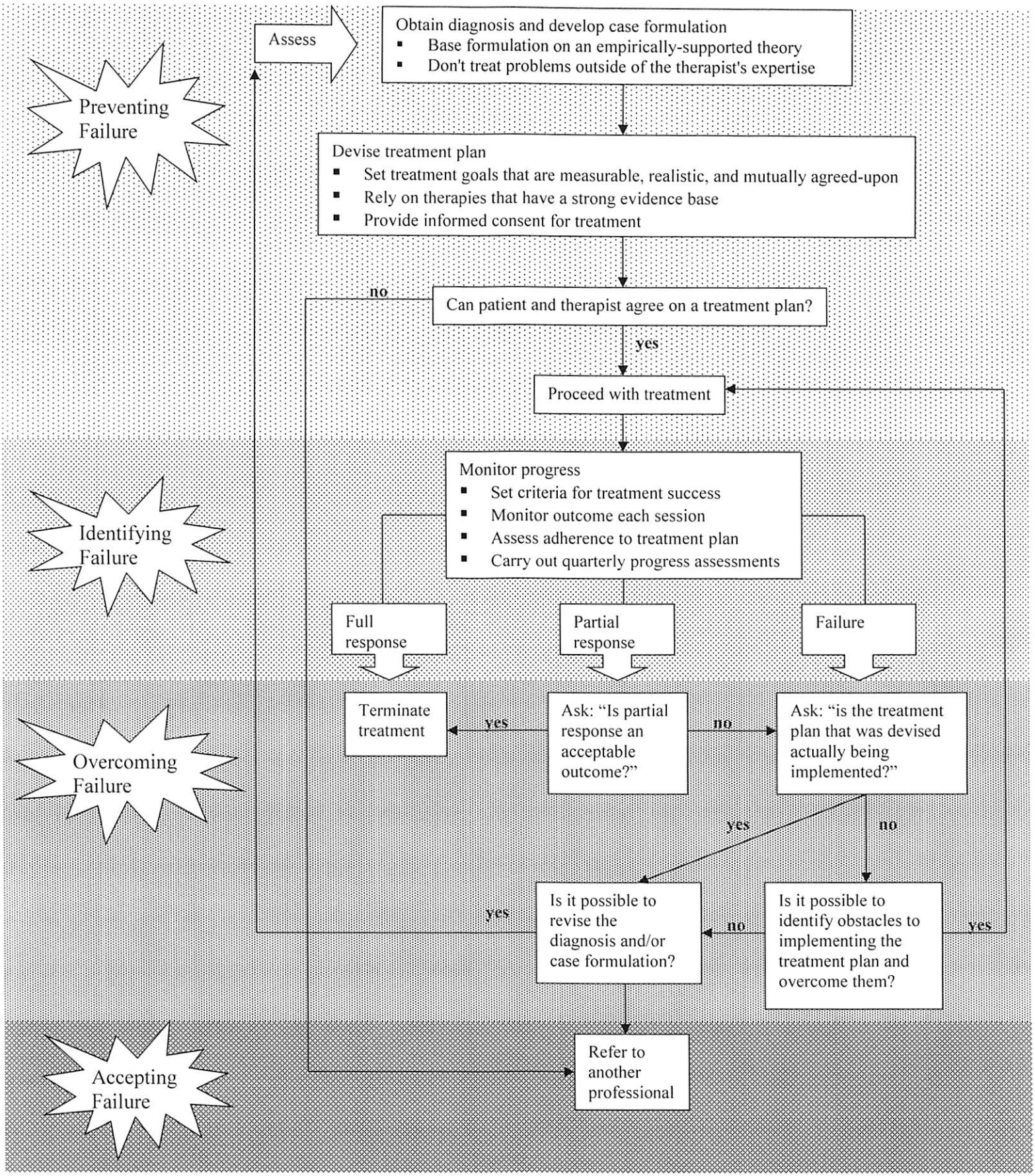

Table 1

Hypochondriachal episodes during interventions focussing on hypochondriasis and on public speaking

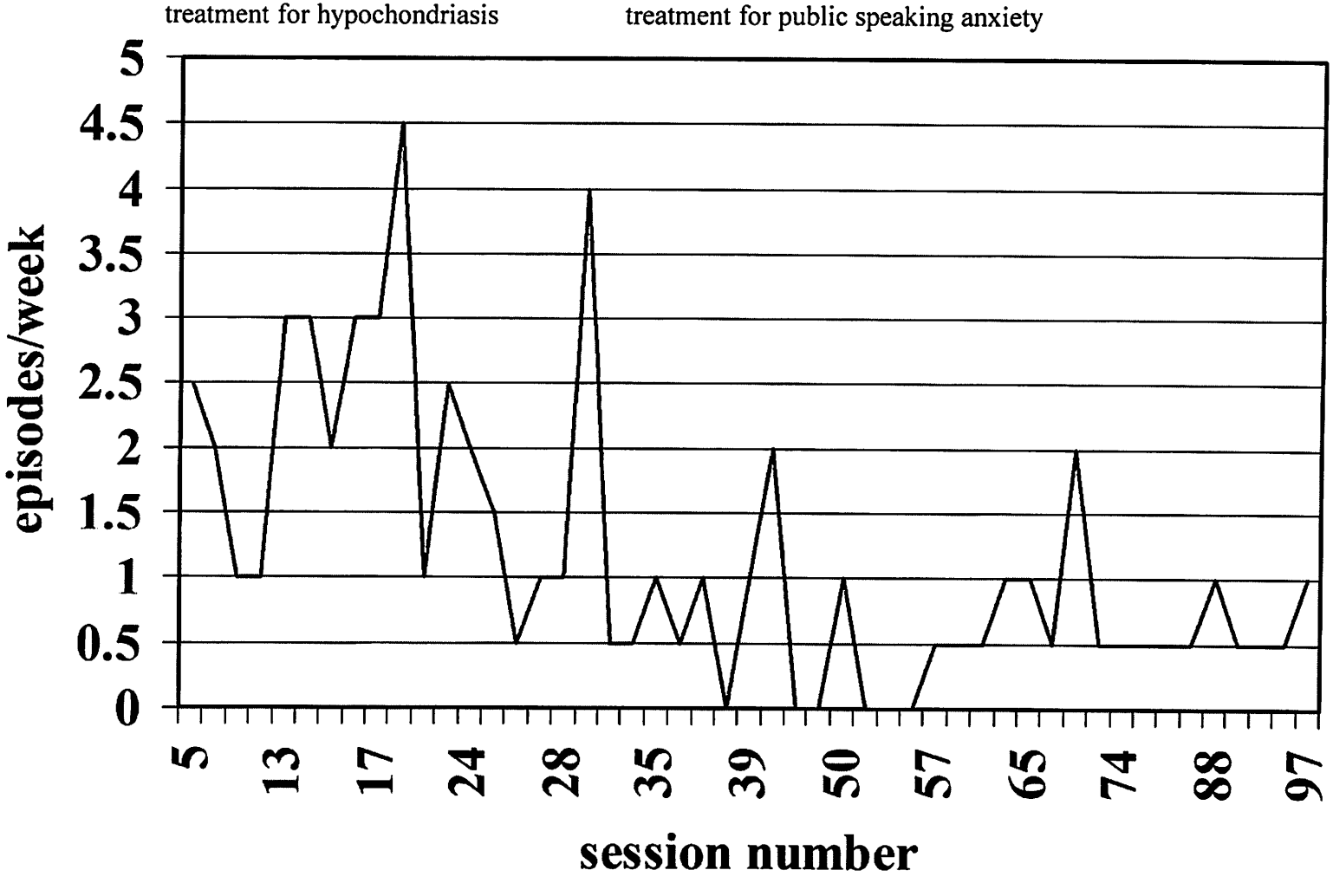

Table 2

Self-report anxiety ratings of public speaking hierarchy items at four time points