Causes and Management of Treatment-Resistant Panic Disorder and Agoraphobia: A Survey of Expert Therapists

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Cognitive behavior therapy (CBT) is recognized as an effective psychological treatment for panic disorder (PD). Despite its efficacy, some clients do not respond optimally to this treatment. Unfortunately, literatures on the prediction, prevention, and management of suboptimal response are not well developed. Considering this lack of empirical guidance, we decided that it would be useful to survey expert cognitive behavioral therapists about what they have found in their practices to contribute to a poor treatment response and what strategies they have found helpful in preventing or managing these problems. Ten factors associated with suboptimal responding emerged. Listed in order of reported frequency, they were as follows: lack of engagement in behavioral experiments, noncompliance, comorbidity, inadequate case formulation/misdiagnosis, secondary gain, problems with cognitive restructuring, presence of other negative life events, medication complications, poor delivery of treatment, and therapeutic relationship barriers. The current paper discusses these factors and details treatment suggestions to improve outcome provided by the survey participants.

PANIC DISORDER (PD) is a distressing and disabling anxiety disorder characterized by an onset of recurrent unexpected panic attacks. Panic attacks involve a sudden rush of intense fear that is accompanied by a variety of physical (e.g., palpitations, dizziness, sweating) and cognitive (i.e., fear of dying, losing control, or going crazy) symptoms (American Psychiatric Association, 2000). Clients with PD fear subsequent attacks and become preoccupied with potential "catastrophic" consequences of panic attacks (e.g., the panic attack will cause a heart attack, stroke, fainting, loss of control). Many clients suffering from PD develop agoraphobia, which refers to fear and/or avoidance of activities or situations that they believe will provoke an attack, where escape may be difficult (e.g., airplanes, elevators, trains), or where help may be unavailable in the event of a panic attack (e.g., being at home alone, in an airplane, far from home). The severity of panic attacks and agoraphobia can range from multiple daily attacks and house-boundness to infrequent attacks and endurance of feared situations with discomfort, respectively.

Cognitive behavior therapy (CBT) is well established as an effective psychological treatment for PD. It is a first-line treatment option according to guidelines of best practice (cf. American Psychiatric Association, 1998). Although there are several different CBT "packages" for PD

(cf. Margraf, Barlow, Clark, & Telch, 1993), most CBT treatments include the following components:

- psychoeducation about PD and CBT;
- panic management strategies such as relaxation and breathing;
- cognitive restructuring of fear-based thought content and processes;
- exposure to feared bodily sensations (interoceptive exposure);
- exposure to feared situations (exteroceptive exposure)

For most clients undergoing treatment, CBT has been shown to reduce panic attacks, generalized anxiety, agoraphobic avoidance, and depression (e.g., Barlow, Gorman, Shear, & Woods, 2000). Although results across studies vary slightly, most show that CBT results in a panic-free rate of approximately 75% to 90% (Barlow, Raffa, & Cohen, 2002).

Despite the efficacy of CBT for PD, some clients show a suboptimal response to it in that they either do not respond or respond only partially (Rosenbaum, Pollack, & Pollack, 1996). The literatures on the prediction, prevention, and management of suboptimal treatment response are not advanced. Studies of factors associated with poor outcome were recently reviewed by McCabe and Antony (2005), who identified three factors with consistent support: symptom severity, comorbid depression, and a comorbid personality disorder. Although this information is useful to the practicing clinician in

anticipating potential challenges in treatment, empirical guidance on the types of problems commonly encountered that lead to suboptimal response and how they might be prevented or managed is lacking. In the absence of this guidance, we decided that it would be useful to ask expert clinicians what they have found to contribute to poor treatment outcome and what strategies they have found to be useful in the prevention and management of the problems they see. A similar method was employed by Scott, Pollack, Otto, Simon, & Worthington (1999) to evaluate psychiatrists' response to treatment-refractory PD when using pharmacological interventions.

Method

Participants

Participants were members of the Association for Behavioral and Cognitive Therapies (ABCT) who were selected and invited by the authors to complete an on-line survey, and who volunteered to participate. Participants were aware that they would be acknowledged in the manuscript. To identify experts, both authors independently reviewed the membership list of ABCT and identified individuals who made significant contributions to the study or application of CBT for panic disorder. The authors compared their lists and only individuals who were identified by both authors were included. Of 30 members who were invited, 20 participated (see the Appendix for a list of participants).

Procedure

The survey involved two questions to which participants were asked to produce brief answers. Specifically, invited members were emailed the following message:

We have been invited to write a paper on cognitive behavioral approaches to treatment resistant panic disorder. As part of this effort, we are conducting a brief survey of identified experts in the field. We hope you agree that empirically informed clinicians, such as the readership of this journal, will value the opinion of experts in this area, where direct empirical guidance is lacking. We are asking if you would give us a few minutes of your time to answer two brief questions about how you have come to approach the problem. We will identify and acknowledge the assistance of all contributing experts.

By "treatment resistant," we generally mean a client who, in response to conventional CBT for panic disorder (i.e., psychoeducation, relaxation, breathing retraining, cognitive restructuring, sensation and situation exposure), continues to exhibit clinically distressing or disabling features of the disorder (e.g., panic attacks, agoraphobic avoidance, concern over future attacks, change in activities, avoidance of physical sensations), or otherwise shows incomplete progress. We are interested in what your experience with treatment resistance has been, and how you have come to approach it.
1. In your experience, what have been the primary reasons that some clients have had incomplete responses to conventional CBT for panic disorder (top 3 reasons or fewer)?
2. Would you please briefly explain how you believe each of the above problems is best approached therapeutically?

In some literatures (e.g., treatment of infectious disease), the term "treatment resistance" has been defined more narrowly than we did for this survey. The more narrow definition refers to instances in which treatment is delivered as intended (i.e., with good treatment fidelity), received by the client (i.e., compliance is confirmed), but nonetheless results in a poorer-than-expected response. We intentionally broadened the definition to include any factor that the survey taker thought accounted for a poorer-then-expected response. We did this to get a sense of what experienced therapists commonly encounter in their day-to-day practices. Although this broader definition is also termed "treatment resistance," we use the terms "suboptimal" or "incomplete response" interchangeably because they may more accurately reflect what we assessed.

Analyses

Question 1: In your experience, what have been the primary reasons that some clients have had incomplete responses to conventional CBT for panic disorder (top 3 reasons or fewer)? Answers to Question 1 were listed verbatim for each participant along with their ranking. The authors then categorized answers independently. One of us identified 10 categories. The other identified 11 categories, 10 of which overlapped with the other author's 10. The remaining category was integrated into an existing one (i.e., "Problems With Cognitive Restructuring"), leaving 10 categories of cited reasons for treatment resistance. The categories were then ranked as follows: A category ranked "1" by an author received 3 points, a rank of "2" received 2 points, and a rank of "3" received 1 point. Ranks were summed for each category across respondents. Categories were then ranked from highest to lowest total points. Alternative methods of ranking did not change the order.

Question 2: Would you please briefly explain how you believe each of the above problems is best approached therapeutically? For each cause of treatment resistance cited, participants were