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Haverkampf, C. J. (2023). Treatment-Resistant Anxiety: Reassessment, Sequencing, and Collaborative Care. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):31-40

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Treatment-Resistant Anxiety: Reassessment, Sequencing, and Collaborative Care

Narrative Clinical Review

Abstract—Persistent anxiety after treatment is common, but "treatment-resistant anxiety" does not describe a uniform disorder or outcome. It may reflect inadequate treatment, intolerance, nonresponse, partial response, relapse, persistent avoidance, or functional nonrecovery across generalized anxiety, panic, agoraphobia, and social anxiety disorders. This narrative review synthesizes evidence and guidance available through 30 May 2023. Before escalation, clinicians should conduct a resistance audit that confirms diagnosis, risk, comorbidity, medical and substance-related differentials, context, treatment adequacy, implementation, tolerability, psychotherapy fidelity, safety behaviors, and measured outcomes. First-line care remains adequately delivered disorder-specific cognitive behavioral therapy, including exposure where indicated, and/or an evidence-supported antidepressant selected through shared decision making. After limited response, clinicians may optimize an incomplete but beneficial treatment, add missing active procedures, switch after verified nonresponse or intolerance, combine modalities, or seek specialist review. Pharmacologic augmentation has a narrower evidence base and requires a defined target, monitoring plan, review date, and stopping rule. Long-term benzodiazepine use is generally not preferred, and abrupt withdrawal may be dangerous. Communication-focused formulation is presented as an author-developed adjunct rather than a substitute for established care. The principal conclusion is that resistance is a provisional classification of a treatment episode, not a fixed patient attribute.

***Index Terms*—**treatment-resistant anxiety, generalized anxiety disorder, panic disorder, social anxiety disorder, cognitive behavioral therapy, pharmacotherapy, reassessment

I. INTRODUCTION

Anxiety may persist despite careful treatment and sustained effort. Repeated failures can leave patients feeling blamed and clinicians uncertain whether to repeat, intensify, or replace an intervention. The label "treatment-resistant anxiety" is useful only when it prompts a structured account of what was treated, how it was delivered, and what outcome occurred.

Earlier JPPC articles addressed severe anxiety, Communication-Focused Therapy for anxiety and panic, and treatment-resistant anxiety (Haverkampf, 2012; Haverkampf, 2017a, 2017b). Building on their emphasis on individual formulation and communication, this review distinguishes diagnostic uncertainty, treatment inadequacy, poor fidelity, implementation difficulties, intolerance, nonresponse, partial response, relapse, and functional nonrecovery. It then places optimization, switching, combination, and augmentation within a guideline-informed sequence.

Treatment resistance should be defined within a specific disorder rather than anxiety as a single category. GAD, panic disorder, agoraphobia, and social anxiety disorder share distress and avoidance but differ in feared outcomes, maintaining processes, and evidence-supported interventions. OCD and PTSD require related but distinct pathways. Apparent resistance may instead reflect co-occurring syndromes, continuing threat, or an unrecognized primary condition.

Core clinical propositions

- Resistance reflects disorder, treatment, person, and context—not a fixed patient trait.
- Escalation should follow an audit of diagnosis, adequacy, fidelity, implementation, tolerability, and outcomes.
- Inadequate treatment, intolerance, nonresponse, partial response, relapse, and functional nonrecovery require different decisions.
- Psychotherapy adequacy depends on active disorder-specific procedures, not attendance alone.
- Augmentation requires partial benefit, a defined target, monitoring, and a stop rule.
- Measure symptoms, functioning, approach behavior, and quality of life.

II. SCOPE AND METHOD

This narrative review draws on guidelines, systematic reviews, meta-analyses, randomized studies, and influential clinical reviews available through 30 May 2023. Search concepts included treatment-resistant anxiety, GAD, panic disorder, social anxiety disorder, CBT, exposure, pharmacotherapy, switching, combination, augmentation, pregabalin, antipsychotics, and benzodiazepines. Priority was

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given to NICE guidance, major professional recommendations, and quantitative syntheses. Relevant earlier JPPC publications were included. The literature search was purposive rather than systematic and did not formally grade risk of bias. This is not a prescribing protocol; drug selection, dosing, tapering, interactions, reproductive considerations, and monitoring require individualized care.

Unless otherwise stated, all tables and boxed frameworks in this article are author-developed clinical syntheses intended to organize assessment and discussion; they are not validated instruments or substitutes for clinical judgment.

III. DEFINING THE OUTCOME PROBLEM

No single definition of treatment-resistant anxiety is accepted across disorders. Some reviews define resistant GAD after one adequate antidepressant trial, whereas specialist practice may reserve the term for failure of more than one pharmacologic and psychotherapeutic intervention (Ansara, 2020; Patterson & Van Ameringen, 2016). The chosen threshold materially affects reported prevalence and limits comparison across studies.

Outcome states must be distinguished. Nonresponse is little clinically important improvement in the intended target after an adequate trial. Partial response is meaningful improvement with substantial residual symptoms or impairment. Remission denotes symptoms below a specified threshold but not necessarily restored functioning. Relapse is clinically important worsening after response or remission. Intolerance is not nonresponse because adverse effects may prevent an adequate trial.

Residual behavior can be more informative than a summary score. Panic attacks may lessen while agoraphobic avoidance persists; worry may decrease while reassurance seeking occupies hours; social anxiety may improve in sessions while work or intimacy remains restricted. Outcome review should identify which symptoms, behaviors, and functions changed and whether the original target was correct.

Table 1. Distinct explanations and outcomes in apparent treatment resistance

Term	Operational meaning	Clinical implication
Inadequate trial	Dose, duration, exposure, or active psychotherapy procedures were insufficient	Correct delivery before declaring resistance
Nonadherence	Medication use or practice differed from the agreed plan, for reasons requiring exploration	Address barriers, understanding, adverse effects, access, and preference
Intolerance	Adverse effects prevent an adequate trial	Reassess benefit–risk and choose another option
Nonresponse	Adequate treatment produces little clinically important target improvement	Switch modality or agent; reconsider formulation
Partial response	Meaningful improvement with substantial residual symptoms or impairment	Optimize, add a targeted component, or consolidate
Relapse	Symptoms recur after response or remission	Restore effective components and review maintenance
Functional nonrecovery	Symptoms improve, but functioning remains restricted	Target avoidance, practical barriers, and rehabilitation
Diagnostic revision	Evidence supports a different or additional condition	Revise formulation and treatment

IV. PSEUDORESISTANCE

“Pseudoresistance” denotes apparent treatment failure that does not establish failure of an adequately matched and delivered intervention. It does not imply that symptoms are exaggerated or voluntary. Cost, waiting lists, cognitive burden, adverse effects, fear, cultural mismatch, disability, and a weak alliance can all prevent an adequate trial. The term should describe the treatment episode without blaming the patient.

Diagnosis and target.

Reassess the feared outcome, triggers, time course, avoidance, safety behaviors, bodily symptoms, and functional impairment. Panic-like episodes may reflect arrhythmia, endocrine or respiratory disease, medication effects, or substance withdrawal. Intrusive thoughts accompanied by rituals suggest OCD; trauma cues and re-experiencing suggest PTSD. Illness anxiety disorder, body dysmorphic disorder, eating disorders, depression, bipolar disorder, psychosis, autism, and ADHD may also shape or account for the presenting anxiety.

A diagnosis may be correct but incomplete. Depression can limit exposure; alcohol may facilitate social situations while worsening next-day anxiety; insomnia can heighten arousal; chronic pain or the menopausal transition can alter bodily sensations. Realistic danger, discrimination, insecure housing, and relationship violence require practical or safeguarding responses, not treatment solely as distorted threat appraisal.

Pharmacotherapy adequacy.

Verify the medication, dose, time at a therapeutic dose, missed doses, timing, adverse effects, interactions, and outcome. Patient recall may differ from records. An apparent six-month trial may contain only a brief period at a tolerated therapeutic dose. Early activation may prompt discontinuation

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before benefit, whereas persistent adverse effects may make continuation inappropriate.

Questions about implementation should be nonjudgmental and specific. A neutral inquiry—"Many people miss or alter doses when adverse effects are difficult; what did medication use look like in a typical week?"—is more informative than a question that presupposes full adherence. Cost, pharmacy supply, pregnancy concerns, sexual adverse effects, and fear of dependence may all influence use.

Psychotherapy adequacy and fidelity.

A course described as CBT may have consisted mainly of supportive discussion. Adequacy depends on disorder-specific active procedures. Panic treatment commonly includes psychoeducation, cognitive methods, interoceptive and situational exposure, and reduction of safety behaviors. Social anxiety treatment may include attention training, behavioral experiments, feedback, and reduction of self-protective behavior. GAD treatment may target worry, intolerance of uncertainty, avoidance, and problem solving. A 2023 meta-analysis found large post-treatment reductions in intolerance of uncertainty and a short-term advantage for directly targeted interventions that was not maintained at follow-up (Wilson et al., 2023).

Exposure must be delivered, not merely recommended. Review the hierarchy, frequency, duration, predicted outcome, safety behaviors, and learning. An exercise completed with repeated reassurance or guaranteed escape may not test the feared prediction. Exposure imposed without a shared rationale, appropriate pacing, and continuing consent is neither good technique nor evidence of fidelity.

Therapist competence, accessibility, and fit also matter. A patient may attend every session yet receive an intervention that is diffuse, culturally mismatched, inaccessible, or insufficiently adapted to comorbidity. Completion of a scheduled course is therefore an administrative endpoint, not proof that an adequate therapeutic trial occurred.

Outcome measurement.

Use a disorder-specific symptom measure alongside functional outcomes and patient-selected goals. The GAD-7 can screen and monitor generalized anxiety symptoms but cannot distinguish among all anxiety disorders. Panic frequency, avoided situations, reassurance seeking, work attendance, relationship participation, sleep, and quality of life may show changes that a total symptom score misses.

Measurement should be timed to the intervention. A transient rise in anxiety during exposure is not treatment failure, and rapid relief from sedation may not represent durable recovery. Baseline assessment, repeated measurement, and follow-up reveal a trajectory. Before designating resistance, reconfirm diagnostic criteria, course, impairment, and the intended target; prevalence estimates and a screening score cannot substitute for clinical reassessment (American Psychiatric Association, 2022; Bandelow & Michaelis, 2015; Spitzer et al., 2006).

The resistance audit

- Confirm diagnosis, comorbidity, medical and substance differential, risk, and realistic threat.
- Reconstruct each intervention: target, dose or procedure, duration, implementation, adverse effects, and outcome.
- Determine whether psychotherapy delivered disorder-specific active procedures and between-session practice.
- Identify residual avoidance and safety behaviors, including reassurance, escape, substances, and accommodation.
- Review rationale, understanding, preferences, access, culture, disability, and reasons for stopping.
- Measure symptoms, functioning, and at least one approach behavior against baseline.
- Classify the episode before selecting the next treatment.

V. FIRST-LINE TREATMENT AS THE FOUNDATION

Guidelines recommend stepped care according to severity, impairment, preference, and prior response. For GAD and panic disorder, NICE includes high-intensity psychological treatment—CBT or applied relaxation for GAD and CBT for panic—and recommends an SSRI when medication is chosen, followed by sequencing according to response and tolerability (National Institute for Health and Care Excellence, 2020). Recommendations and licensed indications differ by country and disorder.

Meta-analysis of placebo-controlled trials supports CBT for anxiety and related disorders, although effect sizes vary across diagnoses and studies (Carpenter et al., 2018). Pharmacologic evidence supports several antidepressants and, in GAD, other agents; however, comparative rankings are sensitive to study quality, tolerability, and publication patterns (Slee et al., 2019). Adequate first-line care may require careful titration, repeated exposure, and a period of consolidation rather than a brief trial.

Shared decision making should address expected benefits, common and serious harms, likely onset, discontinuation effects, reproductive considerations where relevant, interactions, treatment availability, and the patient's previous experience. Population-level rankings should be presented as evidence about average outcomes, not as guarantees for an individual patient.

VI. A SEQUENCED REASSESSMENT PLAN

Step 1: Stabilize urgent problems.

Assess suicidal thinking, severe self-neglect, dangerous intoxication or withdrawal, psychosis, mania, violence, and acute medical symptoms. Severe anxiety may coexist with each. Immediate safety, medical, or crisis care takes precedence over long-term optimization.

Step 2: Select the primary current target.

Comorbidity can obscure treatment order. Select the syndrome or behavior causing greatest immediate risk or

Haverkampf, C. J. (2023). Treatment-Resistant Anxiety: Reassessment, Sequencing, and Collaborative Care. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):31-40

preventing progress while retaining a map of co-occurring problems. The target may change over time. Alcohol dependence, for example, may require coordinated treatment before exposure is safe.

Step 3: Decide whether to optimize.

Optimization is appropriate when treatment is tolerated, has produced at least some benefit, and was not fully delivered. It may involve completing the recommended duration, cautiously adjusting dose within guidance, strengthening implementation support, increasing CBT practice, adding a missing exposure component, or reducing safety behaviors. Simply extending an ineffective and burdensome intervention does not constitute optimization.

Step 4: Switch or combine.

After verified nonresponse or intolerance, options include switching within a recommended medication class, moving to another evidence-supported class, or changing modality according to diagnosis, guidance, and preference. CBT and pharmacotherapy may be combined when one modality is insufficient or combination is preferred. Evidence for combination and long-term sequencing varies across anxiety disorders.

Step 5: Obtain specialist review.

Multiple adequate treatment failures, diagnostic uncertainty, severe comorbidity, complex polypharmacy, pregnancy, significant medical disease, or high risk warrant specialist review. A multidisciplinary reassessment can revisit diagnosis, medication interactions, psychotherapy fidelity, sleep, substance use, and social context before augmentation is considered.

Table 2. Clinical decisions after an initial treatment trial

Finding	Next question	Potential action
Clear benefit with residual symptoms	Is treatment tolerated but incomplete?	Consolidate or optimize; target residual avoidance
No benefit after an inadequate trial	Why were dose, duration, or active procedures insufficient?	Correct the barrier and deliver an adequate trial
No benefit after an adequate trial	Are diagnosis and target still supported?	Switch modality or agent; obtain specialist review
Benefit with intolerable effects	Which effect, timing, risk, and alternatives?	Adjust, switch, or discontinue safely with supervision
Early worsening	Expected transient change, wrong target, mood switch, adverse effect, or risk?	Review promptly; do not assume persistence is required
Repeated relapse	Was treatment stopped, maintenance absent, or context changed?	Restore effective care; review triggers and maintenance
Functional restriction despite symptom change	Which avoidance or environmental barrier remains?	Use exposure, rehabilitation, relational, or practical intervention

VII. PSYCHOTHERAPY AFTER LIMITED RESPONSE

Further psychotherapy should not reproduce an inadequately specified intervention under a new label. Review the original formulation, active procedures, practice dose, alliance, and learning. When exposure was absent or consistently buffered by safety behaviors, a high-fidelity course of disorder-specific CBT remains foundational treatment rather than a salvage intervention.

When CBT was adequately delivered but the response remains incomplete, options include a focused extension, greater practice, a different delivery mode, or another evidence-based approach. For GAD, meta-analysis supports psychological treatment, although effects vary by intervention and comparator (Carl et al., 2020). Remote formats may widen access, but complex comorbidity, risk, or marked impairment may still require face-to-face or specialist care.

Acceptance-based methods may be useful when attempts to suppress internal experience dominate, provided treatment remains linked to observable behavior. If psychodynamic psychotherapy is considered because relational patterns and meaning are central or the patient prefers it, clinicians should discuss its more limited disorder-specific evidence and continue outcome monitoring. No modality should be exempt from outcome evaluation.

Limited response to exposure requires a detailed procedural review. Was the feared prediction explicit? Was the task safe, relevant, and collaboratively chosen? Was there sufficient opportunity to observe the outcome? Did reassurance, distraction, medication timing, or the presence of a companion function as a safety signal? Were tasks varied across contexts and generalized? A correction at any of these points may restore learning. Mechanism-informed review can consider whether treatment engaged exposure and inhibitory learning, responses to uncertain anticipation, and the distinction between defensive responses and conscious anxious experience (Craske et al., 2014; Craske et al., 2017; Grupe & Nitschke, 2013; LeDoux & Pine, 2016).

VIII. PHARMACOTHERAPY AFTER LIMITED RESPONSE

Medication decisions should be based on the specific disorder, licensed indications, previous trials, comorbidity, interactions, adverse effects, and patient preference. General anxiety algorithms should not be used to support unsupervised medication changes. NICE provides a sequence for GAD and panic disorder and advises against routine long-term benzodiazepine use and against antipsychotics for GAD in primary care (National Institute for Health and Care Excellence, 2020). Other guidelines differ in detail (Baldwin et al., 2014; Katzman et al., 2014).

Haverkampf, C. J. (2023). Treatment-Resistant Anxiety: Reassessment, Sequencing, and Collaborative Care. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):31-40

Optimize or switch antidepressant treatment.

If an SSRI has produced a tolerable partial response, confirm dose, duration, and implementation before switching. With verified nonresponse or unacceptable adverse effects, another SSRI or an SNRI may be considered according to the disorder and relevant guidance. Previous discontinuation symptoms, overdose toxicity, drug interactions, blood pressure, sexual adverse effects, bleeding risk, and individual vulnerabilities may influence selection.

Some guidelines include pregabalin for GAD when SSRIs or SNRIs are not tolerated. Evidence also exists for its use as augmentation in resistant GAD, but this evidence should not be generalized to every anxiety disorder. Sedation, dizziness, edema, weight gain, respiratory risk when combined with other depressants, renal dosing, misuse, dependence, and withdrawal require attention. Current regulatory warnings and controlled-drug status should be checked at the point of prescribing.

Tricyclic antidepressants and monoamine oxidase inhibitors have evidence in selected anxiety disorders but greater burdens of toxicity, interaction, dietary restriction, monitoring, or tolerability. Their use is usually individualized and specialist-led. Historical efficacy does not by itself make an agent the appropriate next treatment.

Augmentation.

Augmentation adds an agent to a treatment that has produced a useful but incomplete response. Its rationale is strongest when the existing benefit is worth preserving and the added intervention addresses a defined residual target. Reviews of treatment-resistant GAD include studies of pregabalin and atypical antipsychotic augmentation, but trials are few, definitions vary, and long-term evidence remains limited (Ansara, 2020; Patterson & Van Ameringen, 2016).

Atypical antipsychotics carry potential metabolic, extrapyramidal, cardiovascular, endocrine, and sedative harms. In nonpsychotic anxiety, modest symptom change may not outweigh these risks. Any trial requires baseline and follow-up monitoring, a defined threshold for meaningful benefit, and a stopping plan. Treatment should not continue indefinitely in the absence of demonstrable functional gain.

Buspirone, hydroxyzine, and other agents appear in some guidelines or clinical practices, but evidence varies by disorder and treatment stage. Adding several weakly supported agents simultaneously obscures attribution of benefit and increases interaction burden. Where feasible, one major change should be made at a time, with a specified target and review date.

Benzodiazepines.

Benzodiazepines can reduce acute anxiety rapidly and may have limited short-term indications, but they are not generally preferred as a routine response to chronic treatment resistance. Risks include sedation, falls, cognitive and psychomotor impairment, tolerance, dependence, withdrawal, interactions with alcohol and opioids, and a possible concern about interference with exposure-based learning, for which the clinical evidence is limited and context-dependent. Patients receiving long-term prescriptions require individualized review; abrupt discontinuation is unsafe.

After regular use, abrupt discontinuation can cause severe withdrawal, including seizures. Tapering should be gradual, individualized, and medically supervised. Anxiety during taper may reflect withdrawal, recurrence, expectancy, or several processes. A nonjudgmental approach reduces concealment and risk.

Principles for an augmentation trial

- Confirm diagnosis, adequate foundational treatment, and a partial response worth preserving.
- Specify the residual symptom or functional target and evaluation period.
- Discuss evidence, off-label status, alternatives, interactions, reproductive considerations, and preference.
- Record baseline measures and required monitoring.
- Change one major variable at a time where feasible.
- Define benefit, unacceptable harm, and the stopping or tapering plan in advance.
- Reassess whether the added drug improves functioning rather than only sedation or a score.

IX. COMORBIDITY AND CONTEXT

Depression and bipolarity.

Depression may intensify avoidance, hopelessness, sleep disturbance, and cognitive burden. Both disorders may require treatment, but antidepressant escalation should be preceded by assessment for previous mania or hypomania. A reduced need for sleep, episodic activation, grandiosity, or antidepressant-associated mood elevation changes the formulation and risk assessment.

Suicidal thoughts should be assessed directly. Marked anxiety accompanied by agitation and insomnia can carry substantial risk even without prominent depressed mood. Medication quantities, activation, substance use, and access to means may require specific management.

Substance use.

Alcohol, cannabis, sedatives, stimulants, caffeine, nicotine, and withdrawal states may precipitate, maintain, or mask anxiety. A substance may also function as a safety behavior in social or panic situations. Abrupt removal without appropriate support can increase acute risk or undermine exposure; coordinated treatment of substance use and anxiety is preferable.

Sleep.

Chronic insomnia can impair emotional regulation and engagement with treatment. Obstructive sleep apnea, restless legs syndrome, circadian disorders, and medication effects require separate assessment. CBT for insomnia can be coordinated with anxiety treatment. Sedating polypharmacy should not substitute for a sleep diagnosis.

Haverkampf, C. J. (2023). Treatment-Resistant Anxiety: Reassessment, Sequencing, and Collaborative Care. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):31-40

Neurodevelopmental and cognitive factors.

Autism and ADHD may alter sensory load, uncertainty, social interpretation, and treatment implementation. CBT may require concrete language, visual structure, adjusted pacing, and executive-function support. Such adaptation preserves the active treatment. Cognitive impairment, learning difficulty, and limited language access may also be mistaken for poor adherence.

Relationships and accommodation.

Partners may provide repeated reassurance, accompany all travel, speak for the patient, or reorganize daily life around feared outcomes. Such support may be necessary and compassionate, yet it can also maintain avoidance. With consent, selected partner involvement can distinguish supportive assistance from inadvertent reinforcement and allow a graded transfer of action. Where violence or coercive control is possible, safety assessment takes precedence and joint work may be inappropriate.

Social adversity.

Poverty, insecure housing, racism, immigration threat, unsafe work, caregiving demands, and medical uncertainty may sustain realistic anxiety. Treatment should distinguish controllable from uncontrollable threats and incorporate practical action where possible. Describing anxiety as resistant while the environment remains dangerous misattributes the source of persistence. Cumulative stress physiology and sleep disturbance may further sustain symptoms and disability; sleep therefore warrants direct assessment rather than being treated only as a secondary marker of anxiety (McEwen, 2007; Cox & Olatunji, 2020).

X. COMMUNICATION, ALLIANCE, AND EXPECTATIONS

Haverkampf (2017a) described Communication-Focused Therapy (CFT) as an author-developed formulation for anxiety and panic. It examines how internal sensations, thoughts, and interpersonal messages are interpreted, communicated, and revised. CFT does not have an outcome literature comparable to that supporting established CBT and medication strategies; it should therefore be presented transparently as a supplementary framework.

Communication analysis may reveal interpretive mismatches. A patient may hear "exposure" as dismissal of danger, while the clinician interprets missed practice as unwillingness. A medication adverse effect may go unreported because stopping feels disobedient. Partner reassurance may express care while confirming threat. Making these meanings explicit generates testable hypotheses about alliance, implementation, and interpersonal maintenance.

The formulation can trace one episode: event, internal signal, interpretation, message, response, immediate effect, and delayed effect. Each link is a hypothesis rather than an established cause. If clearer communication or a changed response does not alter the cycle, revise the formulation.

The framework may also clarify the functional outcome that gives treatment personal significance. A patient may wish to travel, parent independently, work, date, or sleep alone. Naming that valued destination provides a concrete criterion by which exposure, medication, and accommodation can be evaluated.

Repeated treatment failure alters expectations. Patients may approach another intervention with guardedness, while clinicians may become either overly optimistic or subtly pessimistic. These reactions merit direct discussion. A credible rationale acknowledges uncertainty: "This treatment is supported for your presentation; the earlier course did not include its central procedure; and we will review progress after a defined period."

Hope is most credible when attached to a transparent process rather than a promised outcome. A well-specified trial can improve assessment, fidelity, and learning even if it does not produce the desired response. Therapeutic nihilism is unwarranted, but so is an indefinite sequence of unmeasured interventions.

Expectancy and nocebo effects may influence experience, but they should never be used to dismiss reported adverse effects. Patients need accurate information in proportionate language and a clear route for early review. Collaborative decisions improve the interpretability and acceptability of a treatment trial, although they cannot guarantee implementation or response.

XI. DEPRESCRIBING, POLYPHARMACY, AND SETTING OF CARE

In persistent anxiety, medications often accumulate over time: an antidepressant, benzodiazepine, hypnotic, antipsychotic, antihistamine, analgesic, stimulant, or supplement. Each may have had an initial rationale. In combination, however, they may produce sedation, activation, cognitive effects, interactions, withdrawal cycles, and uncertainty about which treatment is beneficial.

A medication map records each agent's indication, start date, target, benefit, adverse effects, missed-dose effects, and prescriber. Its purpose is to identify agents without a current rationale and combinations requiring monitoring, not to promote indiscriminate discontinuation. Coordination among prescribers reduces contradictory changes.

Deprescribing is itself a treatment process. Benzodiazepines and several antidepressants can cause substantial withdrawal symptoms if reduced too rapidly. The schedule depends on the agent, duration, dose, symptoms, medical risk, and individual history. Recurrence, withdrawal, and anticipatory anxiety may overlap; changing one major variable at a time improves safety and interpretation.

Supplements and nonprescription products should be included in the medication map because product quality, pharmacologic effects, and interactions vary. Disclosure is more likely when clinicians ask neutrally and without ridicule.

Haverkampf, C. J. (2023). Treatment-Resistant Anxiety: Reassessment, Sequencing, and Collaborative Care. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):31-40

Weekly outpatient treatment is not the only appropriate format. More frequent sessions, intensive outpatient programs, day treatment, home-based exposure, or inpatient care may be considered according to severity, risk, access, and diagnosis. Greater intensity should increase delivery of the active intervention, not merely the amount of clinical contact.

Inpatient admission can provide safety and stabilization but may also remove ordinary triggers and reduce autonomy. Discharge planning should therefore transfer learning into the home and community environment. Residential or other intensive exposure programs may be considered for severe avoidance where clinically indicated and available; evidence, applicability, fidelity, generalization, and follow-up vary.

Telehealth can increase access and permit exposure in relevant environments, but it also requires privacy, reliable technology, emergency planning, and adaptation for digital fatigue. Keeping video off may reflect privacy, technology, cultural preference, disability, or a safety behavior; its function should be explored rather than assumed.

Primary care remains central to monitoring, continuity, and the physical differential diagnosis, while specialist services add diagnostic and pharmacologic expertise. Responsibilities for prescribing, physical monitoring, crisis care, and follow-up should be documented to avoid conflicting advice.

XII. SPECIAL POPULATIONS

Older adults.

Older adults may present differently and have greater medical burden, falls risk, cognitive change, bereavement, and polypharmacy. Benzodiazepine and other sedative harms require particular attention. CBT can be adapted in pace, examples, and memory supports without presuming reduced capacity. New-onset anxiety warrants medical and medication review.

Pregnancy and postpartum.

Untreated severe anxiety carries risks, while medication exposure also requires careful consideration. Decisions should use current perinatal guidance, previous response, gestational timing, breastfeeding plans, and patient preference. Abrupt medication discontinuation after pregnancy is discovered may produce withdrawal and relapse. Postpartum anxiety, OCD, depression, and psychosis require careful differentiation.

Physical illness.

Cardiovascular, respiratory, endocrine, neurological, vestibular, and inflammatory conditions may mimic or amplify anxiety. Assessment should not force a false choice between medical and psychological explanations. A clear plan identifies who will investigate new symptoms and how familiar anxiety responses will be managed.

Neurodiversity and disability.

Autistic people may experience sensory overload, social uncertainty, and anxiety related to change, requiring environmental adaptation as well as psychological work. ADHD may impair planning and treatment implementation, and physical disability may make standard exposure tasks inaccessible. Goals and methods should be co-designed; accommodation is not, by definition, avoidance.

Cultural and linguistic context.

Idioms of distress, family roles, medication beliefs, and preferred help vary across cultural and linguistic contexts. Professional interpreters, culturally informed examples, and attention to racism and migration-related threat can improve assessment. Adaptation should preserve the active ingredients of evidence-based treatment.

XIII. RESIDUAL SYMPTOMS, LONG-TERM CARE, AND RELAPSE

Some patients remain symptomatic after several adequate treatments. Continuing care may still reduce risk and improve daily life. Goals include fewer crisis presentations, shorter exacerbations, more independent travel, stable work, better sleep, or lower medication burden. Partial recovery is a legitimate outcome.

Acceptance of residual symptoms is distinct from resignation. Treatment may help the patient act without requiring anxiety to disappear first, while clinicians continue to review reasonable options. Rehabilitation, occupational support, relationship work, and appropriate accommodation can coexist with active symptom-focused care.

Repeated treatment can itself become burdensome. Appointments, adverse effects, exposure assignments, and constant monitoring may consume time and attention that recovery is intended to restore. A planned consolidation period can allow practice and observation before another change, provided risk remains adequately managed.

For some patients, care shifts toward long-term self-management of a recurrent or chronic condition. A named coordinator, crisis plan, periodic specialist review, and accurate medication history reduce fragmentation. Goals include adaptive capacity, participation, quality of life, and possible further symptom improvement.

A specialist case-conference agenda

- State the current primary diagnosis, alternatives, comorbidity, risk, and realistic environmental threats.
- Present a chronological treatment table covering adequacy, fidelity, implementation, harms, and outcome.
- Identify the strongest evidence for true resistance and the strongest competing explanation.
- Review medication interactions and agents without a current measured indication.
- Review psychotherapy formulation, exposure quality, alliance, culture, disability, and access.
- Define one next intervention, target, duration, monitoring plan, and stopping rule.
- Name the functional goal that matters to the patient.
- Assign responsibility for follow-up, physical monitoring, crisis care, and communication among clinicians.

Haverkampf, C. J. (2023). Treatment-Resistant Anxiety: Reassessment, Sequencing, and Collaborative Care. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):31-40

Anxiety disorders may be chronic or recurrent. Maintenance decisions depend on relapse history, severity, residual symptoms, adverse effects, and preference. Medication should not be stopped abruptly because discontinuation may resemble relapse. Maintenance planning can emphasize continued approach behavior and reduced safety behavior; indefinite attendance need not be assumed.

A relapse plan records early signs, the first effective response, relevant contacts, and thresholds for urgent assessment. It distinguishes a lapse from a sustained recurrence. Sleep disruption, substance use, major transitions, and renewed accommodation may be early indicators. Ordinary life goals should remain in the plan so that care is not organized solely around symptom surveillance.

For patients with repeated partial responses, rehabilitation and accommodation may accompany continued treatment. Assistive support, a modified role, or residual anxiety does not negate recovery. The clinically relevant question is whether the person has greater agency, participation, and quality of life.

XIV. MAKING THE NEXT DECISION WITH THE PATIENT

After the audit, several reasonable options may remain. A concise decision aid can compare continuation, optimization, switching, combination, and a pause for further assessment. For each option, the clinician should describe disorder-specific evidence, likely burden, common and serious harms, uncertainty, review timing, and the plan if it proves ineffective. The patient identifies the outcomes and adverse effects that carry greatest weight.

Previous treatment experience should shape the decision. Illustratively, a patient who experienced severe discontinuation symptoms may prioritize a slowly reversible plan; someone whose work involves driving may place particular weight on sedation; and a patient who waited a year for psychotherapy may prefer to optimize it before changing medication. These are author-developed examples for eliciting preferences rather than findings from comparative preference studies. Preferences remain clinically relevant variables rather than deviations from evidence-based care.

The next intervention should be documented as a time-limited, testable treatment trial. The record specifies the target, baseline, dose or psychotherapy procedure, minimum duration, measures of implementation and fidelity, adverse-effect monitoring, review date, threshold for success, and stopping or tapering plan. This structure supports both therapeutic optimism and restraint.

When patient and clinician prefer different options, the disagreement should be documented and discussed. The clinician explains evidence and safety limits; the patient explains values, previous burden, and acceptable trade-offs. A second opinion may be useful after multiple failures. Except in lawful emergency frameworks for acute risk, coercion is poorly suited to the sustained collaboration required in long-term anxiety care.

Table 3. Shared comparison of next-step options

Option	Best-supported rationale	Main uncertainty or burden
Optimize current treatment	Partial response with an incomplete but tolerable dose or procedure	Additional burden without further benefit
Switch medication	Verified nonresponse, intolerance, or a better-matched evidence-supported agent	Discontinuation, new adverse effects, and delayed onset
Switch or intensify psychotherapy	Missing active procedure, poor fit, or preference for psychological treatment	Access, practice burden, and variable provider fidelity
Combine modalities	Residual impairment after one modality or a strong patient preference	Greater complexity and uncertain contribution of each component
Augment pharmacotherapy	Meaningful partial response after adequate foundational care	Narrower evidence base and added interaction or long-term harm
Specialist diagnostic review	Multiple failures, complexity, risk, or diagnostic uncertainty	Delay and limited access, but possible prevention of inappropriate escalation

XV. SAFETY AND EARLY DETERIORATION

New chest pain, syncope, severe breathlessness, neurological change, or other acute physical symptoms should not automatically be attributed to anxiety. Suicidal intent, severe self-neglect, psychosis, mania, dangerous intoxication or withdrawal, and escalating violence require prompt assessment. Initiating, switching, or tapering medication may alter risk and should be accompanied by accessible follow-up.

Serotonergic or sedative combinations, overdose toxicity, pregnancy, older age, falls, organ impairment, and driving or occupational demands may alter the medication plan. This review cannot substitute for a prescriber who knows the patient and current product information.

Deterioration after a treatment change should be characterized rather than automatically normalized. Establish what changed, when it changed, its relation to dose or session, and whether the symptoms are familiar. Increased anticipatory anxiety before exposure may occur; new suicidal thinking, severe agitation, mood elevation, allergic symptoms, syncope, or neurological change requires prompt review.

Antidepressants may cause early nausea, sleep disturbance, activation, sexual adverse effects, or other symptoms. Some effects diminish, some persist, and some make treatment unacceptable. Whether to continue, adjust, switch, or stop

Haverkampf, C. J. (2023). Treatment-Resistant Anxiety: Reassessment, Sequencing, and Collaborative Care. J Psychiatry Psychotherapy Communication, 2023 Jun 30;12(2):31-40

depends on severity, risk, expected benefit, and patient preference. Advice to "give it time" is inadequate without a defined safety and follow-up plan.

Exposure can be inadequately dosed. A temporary rise in distress may accompany approach, but sustained deterioration may indicate an overwhelming task, undisclosed trauma, actual danger, covert safety behavior, or alliance rupture. Review the exercise and formulation, and re-establish collaborative consent. Fidelity does not require inflexibility.

Activation accompanied by reduced need for sleep, increased goal-directed activity, impulsivity, grandiosity, or unusual confidence raises concern for mania or hypomania and changes the treatment plan. Akathisia may be experienced as severe internal agitation and mistaken for anxiety. Both require timely clinical assessment.

A written contact plan should specify whom to call, which service covers urgent changes, and which symptoms require emergency assessment. Timely review is part of safe prescribing and exposure-based care. Patients should not have to decide alone whether a new symptom reflects expected discomfort, an adverse effect, or deterioration.

Table 4. Interpreting early deterioration

Observed change	Possible interpretation	Response
Familiar anxiety before planned exposure	Anticipatory threat associated with approach	Review rationale, task size, consent, and safety behaviors
Persistent functional decline across sessions	Excessive task dose, wrong target, comorbidity, or alliance rupture	Pause escalation and reassess formulation and risk
Agitation after a medication change	Activation, akathisia, anxiety, withdrawal, or mood switch	Prompt prescriber assessment and symptom characterization
Reduced sleep with increased energy and risky plans	Possible hypomania or mania	Urgent psychiatric assessment
New suicidal thinking or severe self-neglect	Deterioration requiring direct risk assessment	Activate the safety and crisis pathway
New chest pain, syncope, severe breathlessness, or neurological signs	Possible medical condition rather than familiar anxiety	Appropriate urgent medical evaluation

XVI. LIMITATIONS AND RESEARCH NEEDS

Definitions vary, and trials often concentrate on GAD. Augmentation studies are generally small, brief, and heterogeneous; network meta-analysis allows indirect comparison but inherits differences among trials. Complex comorbidity and social adversity are underrepresented. As a narrative review, study identification was not exhaustive and risk of bias was not formally graded.

Sequencing studies should compare optimization, switching, combination, and augmentation using functional outcomes, long-term follow-up, and adverse-effect reporting. Psychotherapy research should report fidelity, exposure dose, safety behaviors, adaptations, and implementation. Communication-focused hypotheses require prospective testing before efficacy can be inferred.

XVII. CONCLUSION

Treatment-resistant anxiety is best understood as a provisional classification of a treatment episode, not an enduring patient attribute. Before escalation, clinicians should confirm the target disorder, risk, comorbidity, context, and the adequacy, fidelity, tolerability, and implementation of previous treatment. A resistance audit distinguishes inadequate delivery, intolerance, partial response, relapse, functional nonrecovery, and true nonresponse—states requiring different decisions. Disorder-specific CBT and evidence-supported pharmacotherapy remain foundational. Optimization, switching, combination, or specialist augmentation should then be selected according to observed response, with predefined targets, monitoring, review points, and stopping rules. Communication and relationship processes can enrich formulation but should not displace established care. Outcomes should include approach behavior, functioning, participation, and agency as well as symptom reduction.

XVIII. DISCLOSURES

Conflicts of interest—The author developed Communication-Focused Therapy and has published related work. In this review, it is identified as an author-developed supplementary framework and is not presented as a replacement for established evidence-based treatment. No other conflicts of interest were reported.

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