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Premature termination of psychological treatment for anxiety disorders in a clinical setting

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Abstract

Background: Empirically supported psychological treatments (ESTs) have demonstrated their effectiveness and clinical utility for the treatment of anxiety disorders (AD) but few studies have assessed the factors associated with premature termination in ESTs for AD. **Method:** The goals of this study, which involved 291 patients with a diagnosis of anxiety who had received outpatient psychological care, consisted of examining premature termination of treatment (PTT), comparing the individual characteristics of the patients who successfully completed treatment with those who terminate it prematurely, and analyzing the predictors of PTT. **Results:** Of the sample, 8.2% refused to start treatment, 28.5% dropped out before completing it, and 63.2% successfully completed treatment. In 50% of the cases, PTT occurred during the first 7 sessions, and in 80%, before the 15th session. Alternatively, 76.4% of the patients who complete treatment successfully do so before session 20. We found that patients with PTT attended a significantly lower number of treatment sessions and attended the sessions more irregularly and unpunctually. Presenting a generalized anxiety disorder (GAD), problems with punctuality and with task performance were predictors of failure to complete treatment. **Conclusions:** These findings suggest the need to reinforce early adherence to treatments to help patients remain in treatment.

Keywords: Anxiety disorders, psychological treatment, dropout, rejection, premature termination.

Resumen

Terminación prematura del tratamiento psicológico para los trastornos de ansiedad en el contexto clínico. **Antecedentes:** los tratamientos psicológicos empíricamente apoyados (TEAs) han demostrado utilidad clínica para el abordaje de los trastornos de ansiedad (TA), pero pocos estudios han evaluado los factores asociados a la terminación prematura (TPT). **Método:** se examinaron las tasas de TPT, sus predictores y las características de aquellos pacientes que terminaron prematuramente frente a los que completan, en una muestra de 291 pacientes, en atención ambulatoria y diagnosticados de algún trastorno de ansiedad. **Resultados:** el 8,2% de los participantes rechazaron comenzar el tratamiento, el 28,5% abandonaron antes de completarlo y el 63,2% completaron con éxito. El 50% de los casos de TPT se produce durante las 7 primeras sesiones y en el 80% antes de la sesión 15. El 76,4% de los pacientes que finalizan con éxito su tratamiento lo hacen antes de la sesión 20. El grupo TPT acudió a un número significativamente menor de sesiones y asistieron de manera más irregular e impuntual. Resultaron predictores de no completar el tratamiento presentar un Trastorno de Ansiedad Generalizada, problemas de puntualidad y en la ejecución de tareas. **Conclusiones:** los resultados apuntan la necesidad de reforzar la adhesión temprana a los tratamientos para ayudar a los pacientes a mantenerse en los mismos.

Palabras clave: trastornos de ansiedad, tratamiento psicológico, abandono, rechazo, terminación prematura.

Empirically supported psychological treatments (ESTs) for anxiety disorders (AD) have shown their efficacy and clinical utility, although the scope and impact of these ESTs are often negatively affected by premature termination of treatment (PTT) (Chambless & Ollendick, 2001).

Some authors propose distinguishing dropping out of treatment (DT) from refusing treatment (RT) (Hatchett & Park, 2003; Swift & Greenberg, 2012). DT refers to PTT after having begun treatment when the patient fails to appear without having reached the preset goal (according to the therapist's judgment or to objective measures of clinical significance; Hatchett & Park, 2003), or because the proposed goals were not achieved after a certain number of sessions (following the dose-response guidelines) (Bados, Balaguer, & Saldana, 2007a; Lambert, 2007; Lambert, Hansen, & Finch, 2001). RT refers to PTT without having started treatment (Swift & Greenberg, 2012).

Swift and Greenberg (2012) report a 19.7% of PTT for psychological treatments, compared with the 47% indicated in the work of Wierzbicki and Pekarik (1993) or the 43.8% of Bados et al. (2007a), referring to dropping out in the clinical context. An important point is that DT rates were higher in effectiveness studies (compared with efficacy studies) and if the DT was defined by the therapist´s criteria (Swift & Greenberg, 2012).

In AD, the rates and variables involved in PTT vary depending on the studies consulted. For example, Swift and Greenberg (2012), without distinguishing between type of study and definition of PTT, indicate dropout rates of 16.2%. Issakidis and Andrews (2004), in

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a sample of patients diagnosed with AD in a clinical context, found that RT is more common (30.4% of patients do not start treatment) than DT (10.3% of patients drop out after starting). These results contrast with the 33.3% of PTT in patients with diagnoses of anxiety in a clinical setting, indicated by Bados, Balaguer and Saldaña (2007b), considering both RT and DT.

There are also important differences in outcomes and variables associated with PTT across studies. Some point out that, in AD, there is a greater likelihood of dropout than in depressive problems, especially if there is comorbidity between the two disorders (Issakidis & Andrews, 2004; Lamers et al., 2012; Pinto-Meza et al., 2011), whereas in other studies, AD dropout rates are lower than in other disorders (Bados et al., 2007a).

According to the type of diagnosis of AD, Issakidis and Andrews (2004) indicate a greater percentage of dropouts in patients diagnosed with Social phobia (30.4%), Panic with agoraphobia (27.9%), and generalised anxiety disorder (GAD) (34%) compared to the average of the sample.

However, there is some consensus that age (lower age in dropouts) and the existence of comorbidity (particularly with depressive symptomatology) are relevant factors for PTT in AD (Aderka et al., 2011; Issakidis & Andrews, 2004; Lamers et al., 2012). Lastly, in contrast to the above, several authors underline the difficulty of identifying predictors of PTT in AD (Eskildsen, Hougaard, & Rosenberg, 2010; González, Weersing, Warnick, Scahill, & Woolston, 2011).

In summary, the variables associated with PTT in the psychological treatment of AD are confusing. In accordance with this, the goals of this study are: 1) to evaluate PTT for AD in a clinical context; (2) to compare the demographic, clinical, and treatment variables of patients who successfully complete treatment compared with those who terminate prematurely and finally; (3) to identify clinically useful predictors of completing or not completing treatment.

Method

Participants

The sample consists of 291 patients, who had been treated at the University Psychology Clinic of the Universidad Complutense de Madrid (CUP-UCM), and who presented at least one diagnosis of anxiety according to the criteria of the *Diagnostic and Statistical Manual of Mental Disorders-IV TR* (American Psychiatric Association [APA], 2000). Participants, aged 18 or older, had completed their contact with the CUP-XX, either due to therapeutic discharge (successful completion of treatment) or to PTT (including DT and RT).

Instruments

Sociodemographic variables: sex, age, civil status, educational level, and work situation were obtained by means of an ad hoc questionnaire at the beginning of the intervention.

Clinical variables: diagnosis (*DSM-IV-TR*), comorbidity and duration of the problem, and the existence of previous treatments were obtained through the clinical interview conducted by the therapist, and the diagnostic instruments appropriate to each case; for example: the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988; Sanz & Navarro, 2003), the Mobility Inventory for Agoraphobia (Chambless, Caputo, Jasin, Gracely, & Williams, 1985), the Penn State Worry Questionnaire (Meyer, Miller, Metzger, & Borkovec, 1990), the Fear of Negative Evaluation Scale (Watson & Friend, 1969), the Maudsley Obsessive -Compulsive Inventory (Hodgson, 1977) or the Fear Questionnaire (Mathews, Gelder, & Johnston, 1981/1986).

Treatment variables: number of assessment and treatment sessions, the level of task performance (considered adequate if successfully completing at least 75% of the tasks assigned by the therapist), adequate session attendance (if at least 75% of the sessions were attended punctually) were obtained from the final treatment report made by the therapist.

Premature termination of treatment: single category of PTT included patients who began the assessment but refused to start treatment (RT) or who left before completing the treatment (DT). This information was obtained from the final treatment report made by the therapist

Procedure

The study was conducted at the CUP-UCM, an outpatient health care center, considering only cases with at least one diagnosis of AD as the primary disorder. The characteristics of the clinic and therapists are described in Labrador, Estupiñá and García-Vera (2010).

In the CUP-UCM, patients are assigned to a therapist who, after an individualized assessment in which instruments of clinical utility (interviews, questionnaires, and self-registers) are used, establishes the formal diagnosis according to the *DSM IV-TR* (APA, 2000) requirements and designs an individualized treatment plan, based on the clinical case formulation and the ESTs for ADs.

The treatment, carried out in weekly 1-hour sessions, had a variable duration, and concluded either due to therapeutic discharge or dropout. The use of techniques based on ESTs for AD was homogeneous; the most frequent were psychoeducation, deactivation techniques, exposure, cognitive techniques, and techniques to control internal dialogue (used in 80% of the cases, on average). Techniques such as problem-solving and social skills training were used fewer (around 50% of cases).

Data analysis

Descriptive and frequency analyses were conducted to obtain the sociodemographic, clinical, and treatment characteristics of the sample of the study.

In order to analyze significant differences in these variables between the two groups of patients , we used χ^2 tests for categorical variables, *t*-tests for continuous variables, and Mann-Whitney *U* tests and Fisher's Exact Test (*FET*) for the variables that did not meet the assumption of normality. In addition, frequency analyses were performed to calculate the moment at which the treatment was completed or prematurely terminated.

Finally, we performed binary logistic regression analysis to examine the predictors of completing or not completing a treatment. We included the sociodemographic, clinical, and therapeutic variables that the literature has suggested are relevant (age, sex, marital status, social support, employment status, diagnosis, comorbidity, duration of the problem, and adequate punctuality and task performance).

All data were analyzed using the statistical package SPSS19.

Results

Percentages of patients who complete, reject, and drop out of treatment

Out of the 291 participants of the sample, 184 (63.2%) completed the treatment, and 107 (36.8%) terminated it prematurely. Of the latter, 24 patients (22.4%) refused to start treatment, and 83 (77.6%) dropped out after having started.

Comparison of patients who complete and who prematurely terminate treatment

As seen in Table 1, no statistically significant differences were observed in the sociodemographic variables examined between patients who completed and those did not complete treatment.

Regarding the clinical and treatment variables (Table 2), patients who completed treatment received significantly more treatment sessions (14.8) than those who did not complete treatment (8.5) (U = 5434, p<.001); in addition, the percentage of those who attended regularly and punctually was higher (90.6% compared to 72.2%; FET = 15.4, p<.001).

Table 3 shows the percentages of patients who completed and who did not complete treatment according to diagnosis. Panic disorder with agoraphobia was the diagnosis that obtained the highest percentage of patients who completed treatment (79.5%), and GAD obtained the lowest (53.8%). However, there were no significant differences between the group of patients who completed and those who did not complete the treatment as a function of the diagnosis.

Period in which treatment is abandoned or completed

Table 4 shows that 28.4% of the patients who dropped out of treatment did so before Session 5, and 75.3% did so before Session 15. In the sample of completers, 76.4% of the patients who successfully completed treatment did so before Session 20.

Predictors of PTT

Table 5 shows a logistic regression model that includes the variables that the literature points to as possible factors involved in treatment completion or dropout. The significant predictors of failure to complete treatment—that is, rejecting treatment or dropping out—were not performing the tasks adequately and systematically (B = - 1.33, p = .01), presenting a diagnosis of GAD (B = 2.06, p = .02), and not adequately and punctually attending treatment sessions (B = - 2.18, p<.001).

Table 1
Sociodemographic characteristics of the two groups of patients

	N = 291		p†
	Complete *n* = 184	**Do not complete *n* = 107**	
Age (*M* ± *SD*)	29.8 ± 10.6	29.2 ± 11.1	.52
Sex (%)			
Males	26.6	29.9	.54
Females	73.4	70.1	
Civil status (%)			
Without a partner	71.2	78.5	.17
Married/partner	28.8	21.5	
Studies (%)			
Non-University	38.8	49.5	.07
University studies	61.2	50.5	
Work situation (%)			
Active	42.4	37.4	.43
Students	45.7	53.3	
Other	12	9.3	

† level of statistical significance of the χ^2 tests in the case of categorical variables and *t*-tests for continuous variables. For variables that did not fulfill the assumption of normality, we used Mann-Whitney *U* or Fisher's Exact Test (FET) if χ^2 could not be used
* p<.05; ** p<.01; *** p<.001

Discussion

This work was conducted in clinical setting and its design was descriptive and retrospective. We found that 36.8% of the

Table 2
Clinical and therapeutic characteristics of the two groups of patients

	N = 291		p†
	Complete *n* = 184	**Do not complete *n* = 107**	
Duration (months) of the problem (*M* ± *SD*)	38.3 ± 55.9	43.9 ± 46.3	.56
Comorbidity (%)	20.1	27.1	.17
Prior treatments (%)	54.4	54.3	.97
Nr. of assessment sessions (*M* ± *SD*)	3.3 (1.2)	3.5 (1.2)	.20
Nr. of treatment sessions (*M* ± *SD*)	14.8 (10.5)	8.5 (9.1)	<.01**
Adequate session attendance (%) (appropriate attendance and punctuality in at least 75% of sessions)	90.6	72.2	<.001***
Level of tasks performance (%) (performs correctly at least 75% of the tasks)	80.4	71.2	.08
Consumption of psychoactive drugs (%)	18.8	14.7	.40
Nr. of treatment goals (*M* ± *SD*)	7 ± 3.7	6.5 ± 4.1	.52

† level of statistical significance of the χ^2 tests in the case of categorical variables and t-tests for continuous variables. For variables that did not fulfill the assumption of normality, we used Mann-Whitney *U* or Fisher's Exact Test (FET) if χ^2 could not be used
* p<.05; ** p<.01; *** p<.001

Table 3
Diagnosis of the two groups of patients

	***N* = 291**		
	Complete *n* = 184	**Do not complete *n* = 107**	**p†**
Panic disorder with agoraphobia (%) *n* = 39	79.5	20.5	
Social phobia (%) *n* = 59	61	39	
Specific phobia (%) *n* = 20	55	45	
Panic disorder without agoraphobia (%) *n* = 39	69.2	30.8	
Generalized anxiety disorder (%) *n* = 26	53.8	46.2	34
Non-specific anxiety disorder (%) *n* = 57	63.2	36.8	
Obsessive-Compulsive Disorder (%) *n* = 33	54.5	45.5	
Posttraumatic stress disorder (%) *n* = 18	61.1	38.9	

† level of statistical significance of χ^2 or Fisher's Exact Test (FET)
* *p*<.05; ** *p*<.0; *** *p*<.001

Table 4
Treatment period in which dropout and discharge from treatment take place

Treatment session at which patients who began treatment drop out n = 83			
	n	**Percentage**	**Accumulated percentage**
Session 0-1	7	8.6	8.6
Session 2	2	2.5	11.1
Session 3	7	8.6	19.7
Session 4	7	8.6	28.4
Session 5	7	8.6	37
Session 6	4	4.9	42
Session 7	7	8.6	50.6
Session 8	5	6.2	56.8
Session 9	4	4.9	61.7
Session 10	2	2.5	64.2
Session 11	3	3.7	67.9
Session 12	-	-	67.9
Session 13	4	4.9	72.8
Session 14	2	2.5	75.3
Session 15	3	3.7	79
Session 16	4	4.9	84
Session 17	2	2.5	86.5
Session 18	-	-	86.5
Session 19	1	1.2	87.7
Session 20	1	1.2	88.9
More than 20 sessions	9	11.1	100

Accumulated percentage	**Session at which treatment is completed (n = 184). Range (3-66)**				
	Session				
	1-5	6-10	11-15	16-20	20-...
	17.8	38	59.6	76.4	100

Table 5
Regression analysis on predictors of premature termination of treatment (PTT)

Predictors of PTT				
	B	**P**	**Exp (B)**	**R^2**
Adequate task performance (correctly performs at least 75% of the tasks)	-1.33	<.001	0.26	.20
Presenting a diagnosis of GAD	2.06	.02	7.86	
Punctual session attendance (adequate attendance and punctuality in at least 75% of sessions)	-2.18	.01	8.88	

Note: the variables included in the model were age, sex, marital status, social support, work status, diagnosis, comorbidity, duration of the problem, and level of adequate punctuality and task performance

patients in the study did not complete the treatment, which is higher than reported in some studies focusing on AD. It is nearly 20 points higher than found in the meta-analysis of Swift and Greenberg (2012), although in this study, various types of studies and definitions of PTT are mixed. We note that the definition of PTT adopted is decisive when calculating its percentages. For example, in the work of Issakidis and Andrews (2004), the 10.3% of dropouts reported must be changed significantly to 40.7%, if we consider the definition of PTT adopted in this work, because 30.4% of the patients refused to start treatment. In Spain, Bados et al. (2007b), in an assistential health care context and with a similar definition of PTT (including rejections and dropouts from treatment), although less dependent on the therapist's criterion and based more on quantitative and dose-response criteria, found 33.3% of PTT, very similar to that obtained in this work.

In summary, PTT rates in AD vary considerably according to the criteria used to define PTT, but when both rejections and dropouts from treatment are included, as in this study, the percentages seem to range around 35%. This aspect should be highlighted when comparing the outcomes because, in many works, usually referring to pharmacological interventions, the calculations of efficacy or effectiveness only take into account patients who complete their protocols (analysis of *completers*), so their efficacy or effectiveness is probably overestimated by excluding those who refuse to start or drop out of treatment. If these data are compared with those provided by studies in which patients who refuse to begin treatment or who drop out of treatment (*intention to treat*) are taken into account (Bados et al., 2007b), the apparent effectiveness of psychological treatments for AD would be penalized despite having repeatedly shown their effectiveness (Chambless & Ollendick, 2001).

Of the PTT, 77.6% (28.5% of the total) drop out after starting treatment. These percentages reveal the appropriateness of any action aimed at improving adherence to and/or acceptance of treatments, regardless of their technical aspects. Also, 22.4% of the patients with PTT (8.24% of the total) refused to begin treatment. That is, we must attend those aspects that increase early adherence to psychological treatments, such as therapeutic alliance, psychoeducational or motivational aspects (Keller, Zoellner, & Feeny, 2010). In fact, some studies underscore the importance of the first sessions: (1) as an adhesion factor because the patient begins to perceive improvements or (2) as a facilitator of PTT in the absence of perceived improvements or of satisfaction with the obtained results (Bados et al., 2007a; Cahill et al., 2003; Howard, Kopta, Krause, & Orlinsky, 1986).

No sociodemographic differences between patients who completed treatment and those who did not were observed, which contrasts with studies finding that patients with PTT are younger or have a lower educational level (Lamers et al., 2012).

As expected, the number of treatment sessions of patients who completed their treatment was higher. More relevant is the fact that patients who did not complete their treatments attended the sessions more irregularly and unpunctually. This may be of particular relevance, it may prematurely inform the therapist about the risk of therapeutic dropout, indicating the appropriateness of taking corrective action, such as reviewing the reasons for or justification of the interventions, reducing the demands, or resorting more to psychoeducational and motivational techniques.

Although at the level of task performance, no significant differences were found, a trend was evident (p = .08), showing higher percentages of adequate task performance in patients who completed treatment (80.4%) versus those who did not (71.2%). Consequently, this value of adequate task performance, although not as clearly as adequate attendance, can also serve as an alarm signal about treatment progress, revealing the need to adapt the interventions. In fact, despite the benefits of applying contrasting ESTs, their rigid and little adapted application can be seen as impersonal and unappealing, facilitating reaching PTT to a greater extent than less structured treatments (based on common factors), as reported by some studies (Farrell & Deacon, 2016; Swan & Heesacker, 2013; Swift & Callahan, 2010). It seems clear that the care of the therapeutic alliance and the relational and motivational aspects must complement the technical aspects, in order to improve the impact and scope of ESTs.

Although comorbidity has been frequently identified as a factor associated with PTT (Issakidis & Andrews, 2004; Lamers et al., 2012; Pinto-Meza et al., 2011), no significant differences appeared between groups. Perhaps the small percentage of patients with comorbidity can partly explain this outcome and, moreover, in this work, some of the patients included in the group of non-comorbidity might have been included in the comorbidity group with another form of diagnosis. As indicated in other works (Bernaldo de Quirós et al., 2012), the percentages of comorbidity are lower when the diagnosis is established from a clinical interview (Rettew, Lynch, Achenbach, Dumenci, & Ivanova, 2009).

No significant differences were found as a function of the diagnosis between the two groups of patients. The low percentage of completed treatments by patients presenting specific phobia (55%) is noteworthy, as this disorder achieves high success rates in "laboratory" settings (Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008). The nuclearity of exposure and its "aversive" nature for patients (Olatunji, Deacon, & Abramowitz, 2009), and, especially, the low functional limitation that these problems usually exert in the patients' lives may explain its high rate of PTT. In contrast, treatment of AD with Agoraphobia, also based on exposure, showed the highest percentage of completed treatments. Perhaps the important functional limitation that this problem usually produces and its effect on the patients' motivation to change explain their greater adherence to treatment.

Once the treatment has started, 50% of the patients with PTT drop out in the first 7 sessions, and 80% before the 15thsession. As considered above, it appears that the first treatment sessions play a fundamental role in adherence. Alternatively, 76.4% of the patients who successfully complete treatment do so before session 20, similar percentage as proposed by Turner, Beidel, Spaulding and Brown (1995) or Lambert, et al. (2001) for the first 14 sessions. These data support the thesis of dose-response, indicating a certain asymptotic value of the impact of psychological treatment beyond a certain number of sessions.

Finally, it is important to note that the regression model shows that GAD is a predictor of not completing treatment, in accordance with the findings of some studies (Issakidis & Andrews, 2004). GAD could imply greater "chronicity" and a more diffuse nature of the problem compared to other AD, which ultimately might interfere with the course of treatment. Both appropriate punctuality (arriving adequately and punctually to at least 75% of the sessions) and successful task completion (at least 75%) were found to be significant predictors of treatment. These data confirm the issues raised previously about the importance of attending to those factors that could forewarn about PTT.

Among the limitations of the study is that, despite its clinical value and having been carried out in a health care context, it is a retrospective and descriptive study, something which limits the scope of the results. Methodologically structured designs could answer some questions that remain open, such as the patients' reasons underlying the therapeutic abandonment or the role of the different (more or less structured) therapeutic components in the PPT. Furthermore, we grouped patients who refused treatment (RT) and those who dropped out (DT) into a single category (PTT) due to reduced sample size; therefore, we could not analyze separately the differences between the two PTT profiles. Future research should address this distinction, its specific features and implications in clinical practice (e.g., misapplied treatments or excessively long assessment sessions).

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