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FACTORS INTERFERING WITH THE COURSE OF TREATMENT FOR ANXIETY DISORDERS: PROLONGATION AND PREMATURE TERMINATION OF TREATMENT

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El tratamiento de los trastornos de ansiedad ha demostrado su eficacia y efectividad. Sin embargo, no siempre se consiguen los resultados deseados. Estudiar aquellos factores que interfieren en el curso natural del tratamiento contribuirá a tomar medidas oportunas. Dos de estos factores son la prolongación innecesaria de los tratamientos y el fenómeno de la terminación prematura. Como es esperable, la duración del tratamiento depende de la naturaleza del problema y de la existencia de problemas comórbidos, pero también de planificaciones demasiado ambiciosas (exceso de técnicas) o la combinación con psicofármacos (con incrementos de hasta un 21% de sesiones). La terminación prematura se sitúa entorno al 30-35% y los pacientes "anuncian el desenlace" con peor ejecución de tareas y asistencias más irregulares desde el principio. Aproximadamente 50% de los abandonos ocurren antes de la sesión 8 y entorno al 80% de los tratamientos completados exitosamente concluyen antes de la sesión 20.
Palabras clave: *Trastornos de ansiedad, Prolongación, Terminación prematura, Psicoterapia.*

The efficacy and the effectiveness of anxiety disorder treatments have been proven. However, the desired results are not always achieved. Studying the factors that interfere with the natural course of the treatments could help to correct and to adapt them. Two of these factors are the unnecessary prolongation of treatments and their premature termination. As expected, the duration of the treatment depends on the nature of the problem and the existence of comorbid problems, however treatments that are too ambitious (an excess of techniques) or combined with pharmacological treatments (increasing sessions by up to 21%) also have a longer duration. Premature termination is around 30-35% and patients "announce" the dropout by displaying poorer task performance and more irregular attendance from the beginning. More than 50% of the therapeutic dropout occurs before the eighth session and 80% of successful treatments are completed before the 20th session.
Key words: *Anxiety disorders, Prolongation, Premature termination, Psychotherapy.*

Anxiety problems are the most frequent reason for psychology consultations and the important functional limitation they generate is well-known (Haro et al., 2006; Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Somers, Goldner, Waraich, & Hsu, 2006).

Fortunately, there are more and more psychological interventions to address anxiety problems that have empirical support, and they are firmly recommended in clinical guidelines (Chambless & Ollendick, 2001; Stewart & Chambless, 2009). However, daily practice does not reflect the "privileged" and deserved position of psychological treatments for anxiety disorders (AD). Although one of the reasons could be due to the "subculture" of the pharmacological approach established both in health systems and in the population, it is necessary to deepen the analysis of the factors that could harm or threaten the applicability of the psychological treatments of AD. The difference between the characteristics of clinical trials (where internal validity prevails) and the characteristics of the applied field where the internal validity suffers "tensions" and ecological value prevails is well-known, which may compromise the results of the interventions (Kazdin, 2008; Westbrook & Kirk, 2007). In other words, the patients are not chosen and protocols cannot be rigid. The adaptation of these protocols that originate from research is essential, as it is essential in understanding the factors that interfere in their application and functioning.

Analyzing these factors involves, for example,

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examining the factors that **prolong the treatments unnecessarily** and therefore threaten their "competitiveness". Another related phenomenon that impacts more directly on the scope of the treatments is their **premature termination** by the patient. There are implications not only in terms of efficiency but also of effectiveness if the study of the treatment utility is carried out under the honest paradigm of "intention to treat", little used in pharmacological trials.

The analysis and discussion of these two phenomena and the associated factors are precisely the objective of this work.

FACTORS THAT INFLUENCE THE PROLONGATION OF TREATMENTS FOR AD

When a treatment is prolonged it can have an impact in different areas. The most logical one is related to efficiency. This unbalances the cost-benefit balance regardless of the context of the intervention. Evidently, a treatment must have the duration that is necessary, but we must also try to extend it as little as possible. Psychotherapy, as a profession, should aim to be as competitive as possible, without undermining the care of the patient (logically). Less obvious is the impact that very long treatments can have on the effectiveness of the interventions; they can end up losing the starting point and therefore the direction. In other words, they could end up creating the effect of "going around in circles".

The factors that can influence the prolongation of treatments for AD are diverse. However, the studies that have attempted to identify factors or sociodemographic profiles that may be associated with longer treatments are scarce and inconclusive. Barnow, Linden & Schaub (1997) found that being a woman, over 46 years old, and widowed or divorced was related to a prolongation of the treatment.

Although there is an approach that advocates transversal transdiagnostic treatments with very promising results (Newby, McKinnon, Kuyken, Gilbody, & Dalgleish, 2015), AD are heterogeneous, so it is difficult for their approach to always be the same, and therefore the duration of the intervention will vary. Clinical guidelines indicate that it is suitable for generalized anxiety disorder (GAD), obsessive compulsive disorder (OCD), or posttraumatic stress disorder (PTSD) treatment protocols that vary between 12 and 20 sessions (APA, 2006; NICE, 2004). This contrasts with much shorter treatments such as those recommended, for example, for specific phobia (APA, 2006). In any case, although the duration varies, the protocols recommended by the clinical guidelines for ADs do not usually exceed 20 treatment sessions.

Another factor that is traditionally related to the duration of treatments is comorbidity (Lamers et al., 2011). ADs are related (and sometimes even mixed) with depressive problems. The existence of this binomial has frequently been related to less effective and longer treatments (Deveney & Otto, 2010), partly because the ADs in clinical practice do not correspond directly with those of the samples used to validate the treatment protocols. In fact, many anxiety problems occur in the context of other more structural and general functioning problems, such as personality problems. The presence of these types of difficulties, logically, requires the therapist to attend to them and therefore may compromise the optimal course of treatment.

An expected and logical factor is the nature of the treatment itself as a predictor of a longer duration. More complex treatments that include more techniques have been associated with longer durations, without identifying any specific technique as being mainly responsible for this prolongation (Bernaldo-de-Quiros et al., 2015). Specifically, the authors indicated that the accumulation of techniques and the presence of an obsessive-compulsive anxiety problem (according to DSM IV-TR) were related to longer treatments.

Another factor that has traditionally been associated with the prolongation of treatments is the influence of having received previous psychological and pharmacological treatments (Lin, 1998). It seems logical that patients who have histories of previous treatments, which obviously failed, present more chronic problems or ones with a longer duration, and therefore require longer treatments. The possible effect that these previous treatments can exert on a new treatment (for example, less motivation due to an accumulation of therapeutic learning) deserves reflection.

The combination of psychological and pharmacological treatments for AD requires separate mention. The contribution that psychological treatments make to pharmacological treatments is known, as it has been shown that they contribute to reduce relapses, dropouts and improve the maintenance of the achievements (Otto, Smits, & Reese, 2005). More controversial is the debate

on the contribution of pharmacological treatments to psychological treatments in the approach to AD, since some studies indicate a synergistic effect (Norberg, Krystal, & Tolin, 2008) and others, on the contrary, suggest that pharmacological treatment can interfere in the therapeutic processes of AD (Franklin, Abramowitz, Bux, Zoellner, & Feeny, 2002; Otto, McHugh, & Kantak, 2010). In this regard, our research group conducted a study precisely to examine the contribution of adding pharmacological therapy (anxiolytics, antidepressants, or a combination) to the psychological treatment of AD, in comparison with psychological treatment applied in an isolated manner in an outpatient care setting (Fernandez-Arias et al., 2013). The results indicated that there were no significant differences between the two groups, except for a longer duration of the problem and in age-related factors (marital status and profession), which in both cases was higher in the combined group. No differences were detected in adherence to psychological treatment or greater severity of pretreatment anxious symptomatology in one group over another. In fact, the results of the treatment of the combined group compared to that of psychological therapy alone were similar, with no significant differences being able to be identified between the two, either in recovery rates (72.2% recovered versus 69.3% recovered, respectively), or in the magnitude of the change (d = 1.46 compared with d = 1.32, respectively). However, the most important fact is that the treatment of the combined group was significantly longer than that of the psychological treatment group (specifically, 21.4% more). In other words, adding pharmacological treatments to psychological treatment for AD significantly extended the treatment duration without significantly increasing its effectiveness.

FACTORS THAT INFLUENCE THE PREMATURE TERMINATION OF TREATMENTS

Traditionally, premature termination of treatments (PTT) has been considered as the opposite of completing them although there is some controversy surrounding the definition (Swift & Greenberg, 2012). Some authors propose to differentiate between treatment abandonment (TA) and treatment rejection (TR) (Hatchett & Park, 2003; Swift & Greenberg, 2012). TA is the premature termination of a treatment once it has been started, whereas TR is not starting it, so premature termination would be in the evaluation phase. Identifying these phenomena differentially may allow us to adapt corrective measures to avoid them. In the context of anxiety problems, the premature termination of treatments is, naturally, a challenge with important implications for the patient (since there is no treatment, therefore, no effects are expected) and for the professional practice itself (the scope and impact of the treatment are reduced and, therefore, its position is penalized in the clinical guidelines or in the review works). Rates of PTT in ADs vary substantially depending on the work consulted, due to differences in the definition of a PTT or even in the identification criteria (objective criteria as opposed to "therapist's opinion", for example). Swift and Greenberg (2012) reported in their meta-analysis on therapeutic abandonment, rates of 19.7% that contrast with 47% found by Wierzbicki and Pekarik (1993) or 43.8% by Bados, Balaguer and Saldana (2007), data obtained in clinical assistance contexts in both studies. It seems obvious that the different conception of the phenomenon may be influencing the very different figures found in the literature, but also, the context in which the study is conducted may be decisive as well. As in the case of the prolongation of the treatments, the patients cared for in daily practice do not necessarily fit the "ideal patient", which may compromise the course of the treatment itself leading to its premature termination if the necessary measures are not put in place (for example the adaptation of the treatment protocol). Understanding precisely the factors that could be behind the PTT of anxiety problems, is an important objective in optimizing the scope and impact of anxiety problems. There is also controversy on this matter. On the other hand, there is some consensus that age (younger in patients who drop out) and the existence of comorbidity (especially with depressive symptomatology) are relevant factors for PTT in AD (Aderka et al., 2011; Issakidis & Andrews, 2004). Finally, contrary to the above, several authors stress the difficulty of identifying predictors of PTT in AD (Eskildsen, Hougaard, & Rosenberg, 2010; Gonzalez, Weersing, Warnick, Scahill, & Woolston, 2011; Pina, Silverman, Weems, Kurtines, & Goldman, 2003).

Our research team carried out a study that aimed to examine the PTT rates, distinguishing between the rejection of the treatments and their abandonment once commenced (Fernandez-Arias et al., 2016). The results revealed that 36.8% of the patients with an anxiety problem diagnosis finished their treatments prematurely.

Of these, 22.7% did not even start it. No differences were found regarding the characteristics of the patients who rejected the treatments in comparison with those who did not, but it was evidenced that, significantly, from the beginning, they performed worse on the tasks set by the therapist and attended more unpunctually and irregularly than those who completed their treatments. There were no significant differences in the percentage of treatments completed or abandoned with regards to the different problems, although panic disorders with and without agoraphobia had the highest percentages of completed treatments (79% and 69.2%, respectively), while the highest rates of abandonment were for generalized anxiety disorder (46.2%), obsessive compulsive disorder (45.4%), and specific phobia (45%). A subsequent analysis confirmed that the poor execution of tasks and having a diagnosis of generalized anxiety disorder were predictors of premature termination of treatments. The presence of a comorbid diagnosis was also a predictor.

When examining the moment in which the premature termination occurs, (see Figure 1), it can be observed that in approximately 50% of times the abandonment occurs before session 8.

Additionally, in Figure 2, the session in which the treatments are completed is shown. It can be seen that approximately 80% of the cases that complete their treatment do so before the 20th session.

FIGURE 1
SESSION IN WHICH THE ABANDONMENT OF TREATMENT OCCURS

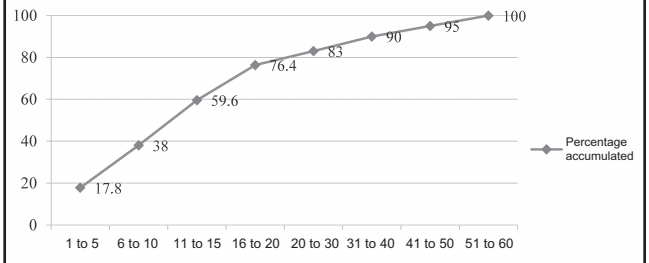
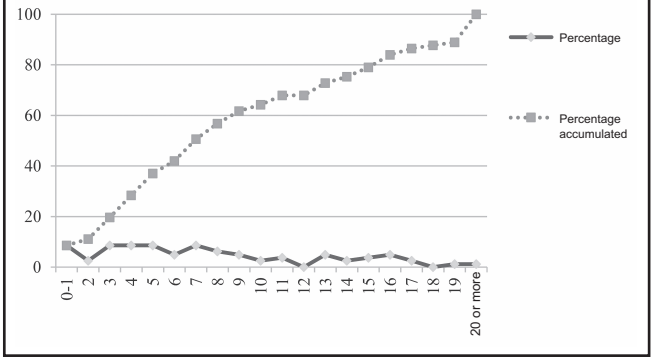


FIGURE 2
SESSION IN WHICH THE TREATMENT IS COMPLETED



DISCUSSION AND CONCLUSIONS

The psychotherapeutic approach to anxiety disorders is an efficacious and effective reality. Around 60-70% of cases succeed in benefitting from these treatments (Bados et al., 2007; Stewart & Chambless, 2009). However, there is still a percentage of patients on whom the psychotherapeutic approach has no impact or to whom it does not reach. The premature termination of the treatments, as well as their unnecessary prolongation, constitute serious threats to the course and therefore to the usefulness of the treatments.

The data suggest that no specific technique is associated with longer treatments or with premature terminations. This data contrasts with some studies that suggest that the use of exposure techniques is extremely aversive and, therefore, facilitates therapeutic abandonment.

Comorbidity is a key factor. The complexity of the problems has also traditionally been associated with longer and less successful treatments (Deveney & Otto, 2010; Lamers et al., 2011). In addition, it is known that this is a frequent reality in anxiety disorders, especially in the anxiety-depression binomial (Morrison, Bradley, & Westen, 2003). It seems clear that psychotherapeutic approaches must take into account these factors of comorbidity that could interfere in their course of treatment. However, the data suggest that the accumulation of techniques and the design of complex treatments are associated with longer, but not necessarily more effective, treatments (Bernaldo-de-Quiros et al., 2015). It seems logical that treatments that include a greater number of techniques are longer. The question is whether the accumulation of techniques is necessary to address clear and simple processes such as those that underlie anxiety problems.

In fact, the accumulation of treatments is not necessarily more effective nor does it result in shorter treatments. When comparing groups of patients with isolated psychological treatment versus those who followed a similar treatment but in combination with psychotropic drugs, no differences were observed regarding the

severity of symptoms or success rates. However, the combined treatment reported 3.5 more sessions of treatment (a 21.4% increase over the mean of the group of psychological treatment alone). The practical implications of these data are clear. Psychotherapeutic treatments for anxiety problems are efficacious and effective by themselves (as indicated in the main guidelines) and the contribution of pharmacological treatments is not clear and may even sometimes be negative (Fernandez-Arias et al., 2013).

However, not all anxiety problems are the same. Specifically, obsessive compulsive disorder was a predictor of longer treatments (Bernaldo-de-Quiros et al., 2015), as suggested in the clinical guidelines, with protocol recommendations that extend to 16-20 sessions (APA, 2006). On the other hand, generalized anxiety disorder predicted premature terminations of treatment. It seems clear that problems that generate significant disruption are more likely to interfere with the course of treatment. However, simple problems such as specific phobia also showed high rates of premature termination. It is worth considering the possibility that motivation factors, the "aversiveness of the treatment" and the low interference of this type of problem in the life of the subjects may influence the high dropout rates observed (Fernández-Arias et al, 2016). This data contrasts with the high efficacy detected for the treatments of these problems (Wolitzky-Taylor, Horowitz, Powers, & Telch, 2008). The hypothesis that the interference of the problem in the daily life of the subjects is a key factor, in the progress of the treatments, gains particular force when one observes the high rates of treatments successfully completed for problems related to panic with or without agoraphobia (Fernández-Arias et al., 2016), which in principle are associated with a greater functional limitation.

The patients who rejected or abandoned their treatments performed, from the beginning, worse in the tasks set and they also went to consultation more irregularly (lack of punctuality and unexcused absences). This fact allows professionals to carefully observe a predicted end and offers the opportunity to take corrective measures such as the adaptation of tasks or reframing the treatment. In fact, in the study by Fernández-Arias et al. (2016) it was observed that half of the abandonments are observed before the eighth session, which emphasizes the importance of the first sessions.

Finally, it should be noted that 76.2% of the treatments completed successfully are completed before the 20th session. This data is consistent with the studies that indicate a negatively accelerated dose-response relationship from a given session (Lambert, Hansen, & Finch, 2001). However, there are alternative explanations for this phenomenon that it would be desirable to study in the future, such as the hypothesis of the progressive loss of effectiveness of the sessions (Kopta, Howard, & Lowry, 1994) or the search by patients of a subjective and sufficient level of functioning (Barkham et al., 2006).

CONFLICT OF INTERESTS

There is no conflict of interests.

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