



## Characteristics of demand and psychological treatments in a university clinic



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### ABSTRACT

The objectives of this study are to describe the most common characteristics of patients receiving psychological treatment and the treatments administered. We analyzed a sample of 856 patients at the University Psychology Clinic of the Complutense University of Madrid. Five diagnostic categories accounted for 78.4% of demand: anxiety disorders (31.9%), no diagnosis (15.4%), other problems requiring clinical attention (14.2%), mood disorders (9.5%) and adaptive disorders (7.4%). A total of 17.7% presented a comorbid diagnosis and 49.3% had received treatment previously. The mean of assessment and treatment sessions was 3.5 and 12.7, respectively. The most commonly applied techniques included psychoeducation (95.1%), cognitive restructuring (74.8%), relaxation (74.4%), and control of internal dialogue (68.1%). Of the patients that had finished contact with the clinic, 68.3% were a therapeutic success. We discuss the generalization of the results and the implications for the profession and clinical practice.

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### Características de la demanda y de los tratamientos psicológicos en una clínica universitaria

#### RESUMEN

Los objetivos del estudio son describir las características de los pacientes que acuden a tratamiento psicológico y de los tratamientos aplicados. Se analiza una muestra de 856 pacientes de la Clínica Universitaria de Psicología de la Universidad Complutense. Cinco categorías diagnósticas cubren el 78.4% de la demanda: trastornos de ansiedad (31.9%), sin diagnóstico (15.4%), otros problemas objeto de atención clínica (14.2%), trastornos del estado de ánimo (9.5%) y trastornos adaptativos (7.4%). El 17.7% presentaba un diagnóstico comórbido y el 49.3% habían recibido un tratamiento previo. La media de sesiones de evaluación fue de 3.5 y 12.7, respectivamente. Las técnicas más utilizadas fueron psicoeducación (95.1%), reestructuración cognitiva (74.8%), relajación (74.4%) y control del diálogo interno (68.1%). De los pacientes que habían finalizado el contacto con el centro el 68.3% obtuvo el alta terapéutica. Se discute la generalización de los resultados e implicaciones para la profesión y la práctica clínica.

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The professional activity of psychologists is socially perceived as positive and the practice of clinical psychology is considered useful and effective, and their clients generally express satisfaction (Buela-Casal et al., 2005). However, information on how clinical psychology actually works is scarce, especially in the healthcare context as opposed to the research context (Kazdin, 2008).

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Thus, there are numerous studies on the professional activity of clinical psychologists in the research field, generally yielding highly positive results, even though few studies have addressed the subject of psychological work and its efficacy in care contexts (effectiveness studies) (Gaston, Abbot, Rapee, & Neary, 2006; Labrador & Ballesteros, 2011; Mastrocinque, De Wet, & Fagioloni, 2013; Peeters et al., 2013). Hence, there are scarcely any data on the type of patients attended or on the treatments applied and their results.

The empirical evidence suggests high levels of efficacy of some psychological treatments, the so-called empirically supported treatments (EST), which tend to be brief and focused on the specific characteristics of each problem. But there is scarcely any evidence of treatment effectiveness (clinical utility) and efficiency (cost/benefit ratio) (Hunsley & Lee, 2007; Szkodny, Newman, & Goldfried, 2014). There is indeed some research highlighting the similarity between practice in care settings and research trials (Nathan, Stuart, & Dolan, 2000; Stirman, DeRubeis, Crits-Christoph, & Rothman, 2005) but, on the other hand, there is some degree of suspicion about whether the application of ESTs in everyday professional practice might lead to a reduction in the percentages of improvement and an increase in the duration of treatments with respect to those achieved in the research context (Chambless, & Ollendick, 2001; Gonzales, Ringeisen, & Chambers, 2002).

Nevertheless, precise knowledge about healthcare practice in clinical psychology is of the utmost interest, since it would permit us to identify the type of problem for which psychological attention is sought, the treatments available and those actually used, their principal characteristics (assessment sessions, treatment sessions, techniques used, etc.) and, especially, the results obtained by each of them. Moreover, it would allow us to observe the extent to which developments and advances in research are appropriate for everyday clinical practice, and whether they are actually applied – that is, to check whether ESTs are employed in healthcare practice and whether the results obtained are similar to those yielded by research work (Chambless, & Ollendick, 2001; Nathan, & Gorman, 2007; Wampold et al., 2011).

Nonetheless, this type of research is not without its difficulties, given that it requires having information available on large samples of patients, psychological problems, and psychotherapists within the context of clinical psychology professional practice. Bearing in mind that the professionals who provide this care are somewhat reluctant to make such data available, an excellent alternative would be to look at the work of university psychology clinics, which offer attention to patients (Bados, Balaguer, & Saldaña, 2007; Borkovec, 2004; Labrador, Estupiñá, & García-Vera, 2010; Minami et al., 2009; Vallejo et al., 2008). Specifically in our country in a review of psychological services within the universities (Saúl, López-González, & Bermejo, 2009), it is stated that 36% of Spanish universities have a service of psychological intervention with a total of 59 psychological services, of which 22 are carried out jointly with the psycho-educational services and 37 are exclusively psychological. In addition to counseling, in almost 60% of mental health services, psychotherapy is also provided and most services are not defined by a unique psychotherapy reference model. In this regard, more than half of the psychological therapy services are available to the general public, whereas the remaining ones are offered in exclusive to the university community. Therefore, there are variations in the cost of services. It seems important to frame this work in clinical care services in the university context with Spanish population to increase awareness about the demands and processes applied in these contexts.

In order to make progress in this direction, we designed the present study, whose goals, all in the context of a university psychology clinic, were: a) to describe the demand for psychological attention; b) to describe the characteristics of treatment and

the results obtained; and c) to assess the costs of psychological treatments.

## Method

### Participants

*Facility description.* The University Psychology Clinic of the Complutense University in Madrid (Clínica Universitaria de Psicología de la Universidad Complutense) (CUP-UCM) has been recognized as a health care facility by the Madrid regional government since 1998. The facility fulfils a number of functions, including the provision of outpatient psychological services based on criteria of quality, efficacy, and efficiency. The CUP-UCM is open to the general public and accepts all types of patients seeking treatment there, as long as they do not require hospitalization. Market prices are applied.

There are normally 14 psychologists working at the CUP-UCM. Two of these are supervisors/coordinators, while the other twelve are resident psychologists on two-year terms, the majority of whom are women, with an age range of 25–28. All have a psychology degree (minimum of 5 years' study), with at least one Masters (minimum of two years' extra study) accrediting their specialization in assessment, diagnosis, and treatment of psychological disorders. The postgraduate qualification most commonly held is Masters in Clinical and Health Psychology at the UCM. They get training in Cognitive-Behavioral therapy and between two and three years of supervised clinical practice prior to their starting to work at the Psychology Clinic of the Complutense University (CUP). Therapists are in charge of designing treatments to match patients' needs within an evidence based practice framework (APA Presidential Task Force on Evidence-Based Practice, 2006) and complying with ESTs guidelines. Therapist work at the CUP is supervised by scholars in clinical psychology and/or psychiatry. Supervision and standardization of treatment materials ensure homogeneity.

*Patients.* The initial sample was made up of all patients in the general database of the CUP-UCM ( $N = 1,325$ ) since its inauguration in June 1999 and up to February 2008. Of these, we excluded those who had not completed the assessment process ( $n = 344$ ), due to the difficulties for assigning a diagnosis or collecting information on the variables of interest to the study. Patients divide into the following groups: patients whose clinical records lacked values of the variables relevant for the study and for which the omissions could not be rectified; patients classified as “dropout” (after making an appointment they failed to attend the first session), “in pre-treatment assessment process” (their assessment process was still ongoing at the moment of the study), or “intervention in crisis” (patients who attend in emergency situations such as sudden losses, panic attacks, psychotic symptoms, and receive very brief interventions). The final sample comprised 856 patients, of whom 199 were currently in treatment or follow-up and 657 had already concluded their relation with the clinic. Patients still in either treatment or follow-up session were not considered in the analysis of treatment results. All patients were made aware of, and gave consent to, the use of their clinical records for research purposes at the beginning of their relationship with the center.

### Design and Variables

The present work constitutes a retrospective and archival study that collects the results of an intentional sample of psychological treatments that took place in a natural setting, which were followed up in a longitudinal fashion.

Data was collected through different questionnaires and semi-structured interviews. The tool most used was the “Pauta de

entrevista clínica para adultos” [Clinical interview schedule for adults] (Muñoz, 1998).

**Sociodemographic variables:** sex, age, marital status, profession, employment situation, and educational level. These are assessed by means of an ad hoc questionnaire applied at the beginning of the intervention.

**Clinical variables:** diagnostic group (according to DSM-IV-TR criteria; APA, 2000), comorbidity (presence of a second diagnosis), and having received treatment previously. These are assessed by the therapists by means of semi-structured interview and self-recording procedures. In addition, semi-structured interviews and self-recording procedures were completed with validated questionnaires for that purpose. The comorbidity variable was dichotomized according to whether or not there was a second diagnosis.

**Therapeutic variables:** number of assessment and treatment sessions; number and type of intervention techniques applied, according to the guidelines provided in empirically supported treatment manuals, such as Beck’s cognitive therapy of depression (cf. Nathan & Gorman, 2007); treatment results (premature discontinuation or therapeutic discharge by agreement of both patient and therapist) were based on the final treatment report made by the clinician, and were not considered in those patients who are still undergoing treatment.

**Economic variables:** economic and time costs of the psychological intervention.

#### Procedure

Data was stripped of any personal cues and included in the center’s database by each therapist as a part of their regular duty. Therapists included data, through a standardized form developed by the center, with clear descriptors for each variable. At the start of the study, the authors checked the database and completed missing data with the clinical record file of each patient when it was necessary.

## Results

### Sociodemographic Variables

As can be seen in Table 1, the majority of people seeking psychological help are women (65.2%), and single (67.3%). Approximately half are employed (49%), the other approximate half being students (45.8%). Mean age is 29.7 years (range 3–77).

### Clinical Variables

Table 2 shows the distribution of diagnostic groups. As can be seen, *anxiety disorders* is the group with the highest prevalence (31.9%), followed by *no diagnosis* (15.4%), *other problems requiring clinical attention* (14.2%), *mood disorders* (9.5%), and *adaptive disorders* (7.4%). That is, five diagnostic categories, including that of patients without a precise diagnosis, account for almost four fifths of the demand (78.4%). For 17.7% of the patients ( $n = 152$ ) at least a second diagnosis was issued, and in 50.7% ( $n = 434$ ) of cases participants had not previously been in treatment.

### Treatment Variables

Table 3 shows treatment variables. There was a mean of 3 assessment sessions and 13 treatment sessions, even though the number of treatment sessions was highly variable ( $SD = 11.04$ ). A mean of 6–7 intervention techniques were applied, the techniques most widely applied being psychoeducation (95.1%), cognitive

**Table 1**  
Sociodemographic characteristics.

	Total sample $N = 856$	Therapeutic success $N = 449$	Dropouts $N = 208$
Age $M (SD)$	29.7 (13.2)	29.2 (13.1)	29.1 (12.3)
Sex $n (%)$			
Men	298 (34.8)	143 (31.8)	81 (27.2)
Women	558 (65.2)	306 (68.2)	127 (72.8)
Marital status $n (%)$			
Single	576 (67.3)	305 (67.9)	142 (68.3)
Married	216 (25.2)	119 (26.5)	53 (25.5)
Separated/divorced/ widowed	64 (10.1)	25 (5.6)	13 (6.2)
Educational level $n (%)$			
Incomplete primary	81 (9.5)	43 (9.6)	21 (10.1)
Complete primary	85 (9.9)	43 (9.6)	23 (11.1)
Secondary	259 (30.3)	132 (29.4)	60 (28.8)
University diploma	156 (18.2)	89 (19.8)	38 (18.3)
University degree	275 (32.1)	142 (31.6)	66 (31.7)
Profession/employment situation $n (%)$			
Student	392 (45.8)	204 (45.4)	106 (51.0)
Employed	419 (49.0)	209 (46.5)	90 (43.3)
Unemployed/retired	45 (5.3)	24 (5.3)	10 (4.8)
Housewife	18 (2.1)	12 (2.8)	2 (0.9)

restructuring (74.8%), relaxation techniques (74.4%), and techniques for the control of internal dialogue (68.1%).

Table 4 shows the total number of patients who had finished contact with the clinic ( $n = 657$ ); 68.3% ( $n = 449$ ) had obtained therapeutic success and 31.7% ( $n = 208$ ) had dropped out of the treatment. The diagnostic groups with the highest rates of therapeutic success were psychotic disorders (87.5%), substance use disorders (83.3%), somatoform disorders (80%), dissociative disorders (75%), and anxiety disorders (74.1%). The groups with the highest dropout rates were sleep disorders (66.6%) and eating disorders (60%).

As Table 5 shows, the diagnostic group that received the largest number of treatment sessions was that of eating disorders, with a mean of 24 sessions, while the group receiving the fewest sessions was the “no diagnosis” group, with a mean of 8 sessions. Likewise, eating disorders and dissociative disorders were those that received the largest number of assessment sessions, with means of 4. Patients who had at least a second diagnosis received a larger number of sessions (mean of 17), as so did patients who had received previous treatment (mean of 15), though there was great variability.

### Economic and Time Cost Variables

Although there were substantial differences between the psychological treatments, their average costs should be considered. Thus, taking into account the 48€ fee per session (the minimum fees recommended until 2009 by the Spanish Psychological Association [Colegio Oficial de Psicólogos]), the average fee of assessment is 144€; the average cost of treatment (13 sessions) is 624€; and the average cost of follow-up is 48€. Consequently, the total cost of intervention is 816€. Average duration of treatment (excluding follow-up) is 4 months (16 sessions, one per week).

## Discussion

It is important to bear in mind, first of all, that the CUP-UCM has some special characteristics, given that it is a university clinic – though any clinic studied will have certain characteristics that delimit the potential for generalizing the data. In any case, as far as the data on patients and problems from the CUP-UCM are concerned, the clinic is open to all people and to any type of problem

**Table 2**  
Clinical characteristics, N (%).

	Total sample N = 856	Therapeutic success N = 449	Dropouts N = 208
<i>Diagnostic group n (%)</i>			
Anxiety disorders	273 (31.9)	146 (32.5)	51 (24.5)
No diagnosis or reserved diagnosis	132 (15.4)	76 (16.9)	30 (14.4)
Other problems requiring clinical attention	122 (14.2)	62 (13.8)	35 (16.8)
Mood disorders	81 (9.5)	40 (8.9)	20 (9.6)
Adaptive disorders	63 (7.4)	33 (7.3)	20 (9.6)
Personality disorders	47 (5.5)	19 (4.2)	17 (8.2)
Infancy, childhood or adolescence disorders	31 (3.5)	24 (5.3)	9 (4.3)
Eating disorders	25 (2.9)	6 (1.3)	9 (4.3)
Impulse control disorders	19 (2.2)	11 (2.4)	5 (2.4)
Somatoform disorders	15 (1.7)	8 (1.8)	3 (1.4)
Sexual disorders	13 (1.5)	7 (1.7)	2 (0.9)
Psychotic disorders	10 (1.2)	7 (1.5)	1 (0.5)
Substance use disorders	7 (0.8)	5 (1.1)	1 (0.5)
Sleep disorders	6 (0.7)	2 (0.4)	4 (1.9)
Dissociative disorders	5 (0.6)	3 (0.6)	1 (0.5)
<i>Comorbidity n (%)</i>			
No	704 (82.3)	375 (83.5)	160 (76.9)
Yes	152 (17.7)	74 (16.5)	48 (23.1)
<i>Previous treatments n (%)</i>			
No	434 (50.7)	238 (53.0)	105 (50.5)
Yes	422 (49.3)	211 (47.0)	103 (49.5)

that can be treated in an outpatient context, so that it probably represents the reality of the demand for psychological attention in Spain, especially outside the National Health System. In any case, it seems very important to access the data on the psychological intervention on a large sample of patients and therapists from the context of health in order to characterize the current state of professional clinical psychology in general and in the university psychology clinics in Spain in particular.

**Table 3**  
Treatment variables.

	Total sample N = 856	Therapeutic success N = 449
<i>Number of assessment sessions M (SD)</i>	3.5 (1.48)	3.1 (1.4)
<i>Number of treatment sessions M (SD)</i>	12.7 (11.01)	12.8 (10.7)
<i>Number of techniques applied M (SD)</i>	6.7 (2.47)	6.3 (2.8)
<i>Type of technique n (%)</i>		
Psychoeducation	814 (95.1)	421 (93.8)
Cognitive restructuring	640 (74.8)	347 (77.3)
Relaxation	637 (74.4)	340 (75.7)
Control of internal dialogue	583 (68.1)	312 (69.5)
Other specific techniques	554 (64.7)	291 (64.8)
Problem-solving	450 (52.6)	262 (58.4)
Social skills	398 (46.5)	221 (49.2)
Exposure techniques	340 (39.7)	203 (45.2)
Operant acquisition techniques	295 (34.5)	143 (31.8)
Operant elimination techniques	203 (23.7)	100 (22.3)
Behavioral contract	185 (21.6)	82 (18.3)
Modeling	174 (20.3)	81 (18.0)
Token economy	45 (5.3)	18 (4.0)
Biofeedback	22 (2.6)	13 (2.9)
Aversive techniques	14 (1.6)	7 (1.6)

### Patients

The typical patient would be a woman aged around 30, single, employed or a student, and with at least a secondary education. It is noteworthy that 2/3 patients are women, a similar figure being found in other studies (MSC, 2008; Valero & Ruiz, 2003; Vallejo et al., 2008). Various explanations can be suggested for this finding. One is that women present more psychological problems than men, as reflected in epidemiological data on anxiety and depression, though this imbalance is not so evident in other problems; women are also clearly less represented in problems such as addictions. Another explanation would be that men are more reluctant to seek psychological help. In any case, the reality is that twice as many women as men demand psychological help and the clinical psychologist must face this reality.

Also to remark is the high educational level of patients (50% have a university education), which may be reflecting the difference between the demand for private healthcare and the demand for National Health Service care. Thus, Vallejo et al. (2008) also found that 50% of users had a university education, although it is important to clarify that it is an online service with particular characteristics compared to just 5.4% of Valero and Ruiz's (2003) sample recruited at a mental health clinic of the National Health Service in Málaga. Data from the government's mental health policy document (Estrategia de Salud Mental [Mental Health Strategy]) point to a balance between the three categories of education: primary, secondary and university (MSC, 2008). The low mean age (30 years), as well as the high percentage of single people (67%), probably reflects a high representation of students (45.85%) because it is a university clinic. In this regard, a significant number of university psychological services offering psychological therapy are specific to the

**Table 4**Patients who have finished their contact with the clinic, *N* (%).

	Therapeutic success 449 (68.3)	Dropout 208 (31.7)	Total <i>N</i> = 657
<i>Diagnostic group</i>			
Anxiety disorders	146 (74.1)	51 (25.9)	197
No diagnosis or reserved diagnosis	76 (71.7)	30 (28.3)	106
Other problems requiring clinical attention	62 (63.9)	35 (36.1)	97
Mood disorders	40 (66.8)	20 (33.2)	60
Adaptive disorders	33 (62.3)	20 (37.7)	53
Personality disorders	19 (52.8)	17 (47.2)	36
Infancy, childhood or adolescence disorders	24 (72.7)	9 (27.3)	33
Eating disorders	6 (40.0)	9 (60.0)	15
Impulse control disorders	11 (68.8)	5 (31.2)	16
Somatoform disorders	8 (80.0)	2 (20.0)	10
Sexual disorders	7 (70.0)	3 (30.0)	10
Psychotic disorders	7 (87.5)	1 (12.5)	8
Substance use disorders	5 (83.3)	1 (16.7)	6
Sleep disorders	2 (33.3)	4 (66.6)	6
Dissociative disorders	3 (75.0)	1 (25.0)	4
<i>Comorbidity</i>			
No	375 (70.1)	160 (29.9)	535
Yes	74 (62.2)	45 (37.8)	119
<i>Previous treatments</i>			
No	238 (69.4)	105 (30.6)	343
Yes	211 (67.2)	103 (32.8)	314

university community (a total of 16), although there are services (a total of 20) such as the CUP-UCM that also extend to the general population (Saúl et al., 2009).

### Clinical Problems

There is only a small number of problems for which people seek psychological assistance. The majority of demand (61%) is accounted for by three diagnostic groups: anxiety disorders, no diagnosis, and other problems requiring clinical attention (basically relationship problems). If we add two more diagnoses, depressive disorders and adaptive disorders, 78.4% of demand is accounted for. These results do not appear to differ greatly from those obtained at public health care centres, since the data from Valero and Ruiz (2003), or from the Ministry of Health and Consumer Affairs (MSC, 2008) also indicate that anxiety and mood problems are the most common. In addition, it also corresponds to the type of demand for psychological services within the universities (Saúl et al., 2009) where the most common problems treated are anxiety disorders, mood disorders, maladjustment, lack of self-esteem or social skills, test anxiety, interpersonal relationship problems, etc.

It is worth pointing out that help is sought for very few problems among all that are supposed to be within the field of activity of psychologists. This may indicate that, at least in Spain, the psychologist is not associated with this type of problem (e.g., sexual dysfunction, sleep disorders, pathological gambling, somatoform disorders or dissociative disorders), despite the high prevalence of such problems according to epidemiological studies. Alternatively, these data may suggest that psychological treatments are not considered effective or appropriate for these problems. Nevertheless, studies on the efficacy and effectiveness of such treatments leave no doubts about their worth (Chambless & Ollendick, 2001; Gaston,

Abbot, Rapee, & Neary, 2006; Labrador & Ballesteros, 2011). This reveals the need to provide information on and “publicize” – for the general public and especially for those responsible for health services – the availability of psychological treatments and their efficacy, effectiveness, and efficiency in these areas, as endorsed by a substantial body of empirical data (Fisher & O’Donohue, 2006; Labrador & Crespo, 2012; Nathan & Gorman, 2007).

Also of note is the high percentage of patients without diagnosis or with reserved diagnosis (15.4%), which calls into question the true value of the nosological classifications of the demand for psychological help. In many cases people seek psychological help for problems that have nothing to do with the diagnoses included in psychopathological classifications.

Moreover, it is interesting that just 17.7% have more than one diagnosis, a result which fails to support the claim that in clinical care it is usual to find high levels of comorbidity. The percentages are below those reported in other studies, probably because the use of structured interviews as a method of diagnosis tends to generate more comorbid diagnoses than would be found in the case of more thorough assessments carried out by clinical psychologists (Rettew, Lynch, Achenbach, Dumenenci, & Ivanova, 2009). Although the absence of more than one diagnosis does not mean that a person’s problem is unique or isolated, it certainly indicates that treatments which have proved effective in research, commonly in patients with diagnoses of just one disorder, may often be generalizable to clinical care practice.

### Treatment Characteristics

The average of 3.5 assessment sessions implies a substantial problem for the practice of clinical psychology, since on the one hand it means that it takes a long time before an intervention

**Table 5**  
Assessment and treatment sessions in patients that have completed their treatment successfully ( $N = 449$ ),  $M$  ( $SD$ ).

	$N$ Assessment sessions	$N$ Treatment sessions
<i>Diagnostic group</i>		
Anxiety disorders	3.2 (1.2)	13.5 (9.9)
No diagnosis or reserved diagnosis	2.7 (2.0)	8.0 (10.4)
Other problems requiring clinical attention	2.9 (1.2)	11.6 (9.1)
Mood disorders	3.4 (1.3)	17.2 (13.2)
Adaptive disorders	2.7 (1.1)	11.9 (9.3)
Personality disorders	3.9 (1.4)	14.2 (8.3)
Infancy, childhood or adolescence disorders	3.4 (1.9)	10.2 (9.2)
Eating disorders	4.0 (1.4)	24.2 (10.6)
Impulse control disorders	3.3 (0.6)	17.4 (16.0)
Somatoform disorders	3.0 (0.9)	19.9 (9.2)
Sexual disorders	2.4 (1.1)	12.5 (9.0)
Psychotic disorders	2.7 (0.9)	19.0 (16.7)
Substance use disorders	3.2 (1.3)	13.6 (8.4)
Sleep disorders	2.5 (0.7)	13.0 (5.6)
Dissociative disorders	4.0 (1.0)	13.6 (2.8)
<i>Comorbidity</i>		
No	3.0 (1.4)	11.9 (3.5)
Yes	3.5 (1.1)	17.5 (10.5)
<i>Previous treatments</i>		
No	2.9 (1.4)	10.7 (9.5)
Yes	3.2 (1.4)	15.1 (11.4)

begins – a month since the help is sought, at a rate of one session per week (provided that the first appointment is arranged immediately after being requested); on the other hand, this average of assessment sessions means a 27% increase in the total length of the treatment. A shorter assessment period is necessary so as to make the work of the clinical psychologist more competitive with respect to that of other professionals. In this line, it would seem important to develop «assessment protocols» that facilitate a quicker and accurate assessment (Hunsley & Mash, 2008).

As regards duration of the treatments, the average of 12.8 sessions for successful completion of treatment is quite short, and indicates that psychological treatments using EST are limited in time. Specifically, using weekly sessions, the mean length of intervention is 3 months (4 including the assessment sessions), despite its not being an easy sample, as reflected in the fact that nearly 50% come from a previous unsuccessful treatment.

The percentages of dropouts (31.7% of those who had finished their contact with the clinic) are high. The diagnostic groups with the highest dropout rates were sleep disorders (66.6%) and eating disorders (60%), even though it is true that these are not the groups most frequently attending treatment at private clinics, intending to seek help from specialists in these problems. Dropout is sometimes the result of unavoidable factors, such as changes of residence or financial problems, but in other cases they are probably due to dissatisfaction with treatment or the patients' considering that they have already made sufficient progress. This means that some of these patients drop out after achieving substantial therapeutic improvement, even if in the therapist's view their treatment is not complete. In any case, this is an aspect for improvement, since even the best treatment is not efficacious if the patient drops out. Identifying the variables responsible for these dropouts goes beyond the limits of this work, but research in this area could make an important contribution to the practice of clinical psychology.

Of special relevance are the therapeutic results. Of those patients who had already finished their contact with the clinic, it is noteworthy that more than two thirds achieved therapeutic success (68.34%) – that is, cases in which “all” the therapeutic goals had been fulfilled. It is true that there are variations depending on the diagnosis, but the average amount of therapeutic success is high in all cases. It must be said that the diagnostic groups with the highest rates of therapeutic success – psychotic disorders (87.5%), substance use disorders (83.3%), somatoform disorders (80%), and dissociative disorders (75%) – all have low frequencies, so that they could be “special cases” in which the therapy focused on particular objectives, since in some of them, such as psychotic disorders and substance use disorders, the patients tend to seek help from specialist professionals. Nevertheless, anxiety disorders, the main group demanding treatment, have a high percentage of success (74.1%). On the most negative side are the treatments of personality disorders, eating disorders, and sleep disorders, with dropout rates similar to or even higher than success rates (Swift & Greenberg, 2012).

Moreover, these results were obtained with limited financial costs, since the average cost of a psychological intervention is 816€. Nonetheless, this estimation of direct costs should be taken with caution due to the impact of indirect, non-measurable costs and the lack of a direct cost comparison with other interventions. For example the comparisons of costs with other university psychological clinics in Spain extended to general population are complicated by their variability: in most services there is a differentiation of rates (reduced/standard) according to the type of population (internal/external users), other services are free, whereas in other cases the service cost is reduced and in the CUP-UCM, normal rates follow the recommendations by the Spanish Psychological Association [Colegio Oficial de Psicólogos].

These results are even more significant in view of the fact that almost 50% of the patients attend the clinic after a failed treatment,

which probably indicates that these are cases more resistant to treatment and likely to become chronic. Other studies have already noted that the absence of previous treatments optimizes the likelihood of completing a treatment (Fenger, Mortensen, Poulsen, & Lau, 2011; López-Goñi, Fernández-Montalvo, Illescas, Landa, & Lorea, 2008). A history of therapeutic failures can be regarded as an indication of greater difficulties resulting either from the characteristics of the problem or from the characteristics of the patient and his or her environment; the therapist should face this with a careful and detailed assessment in order to identify the causes of the previous failure and proceed accordingly. Patients who had received previous treatment did not present higher success or failure rates, though it does appear in these cases to be necessary a larger number of treatment sessions, as was reported elsewhere (Labrador, Bernaldo de Quirós, & Estupiñá, 2011).

As regards the type of techniques employed, psychoeducation was the most frequently used (95.1%), which involves explaining the problem to the patients, the treatment to be applied, and the work they will need to do. This would seem to be a core aspect of psychological intervention. Given that every psychological treatment is an educational process in which patients are taught to act differently, to perform new behaviors instead of usual behaviors, it would seem crucial for them to know what they should learn and what they should get rid of from their repertoire.

The extensive use of techniques for cognitive restructuring, relaxation, and control of internal dialogue suggests that these techniques are perhaps used in a uniform fashion, regardless of the specific diagnosis (Mansell, Harvey, Watkins, & Shafran, 2009; McEvoy, Nathan, & Norton, 2009). Also, it is striking that even though anxiety disorders are the most prevalent group, exposure techniques are not among the most widely used (39.7%), despite their recommendation as techniques with strong empirical support in the main national and international guidelines of reference (APA, 2006; MSC, 2008; NICE, 2011). In any case, this 39% appears to cover the cases with diagnosis of anxiety (31.9%). Also it is noteworthy that this percentage increases in the group of therapeutic success (45%).

Research limitations stem from: a) the type of study, a retrospective and archival study which does not allow considering process variables such as therapeutic variables, therapeutic alliance, etc. and b) the context of the clinic in which the study was carried out. Therefore, it would be important to develop prospective studies and offer results from psychology clinics, with a view to continuing the work of describing and improving psychological attention in the healthcare setting.

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## Conflict of Interest

The authors of this article declare no conflict of interest.

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