**End of Treatment Outcomes for Patients with Anxiety Disorders: Detailed Report**

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**Description of the Sample**

This analysis includes all patients with a primary diagnosis of an anxiety disorder who have participated in an evaluation followed by a minimum of one therapy session with me, and who are not currently in treatment with me. All of these patients entered treatment with me at some point between 2009 (when I began my private practice) and 2017. Given that this is an analysis of end of treatment outcomes, patients who are currently in treatment with me were not included in this sample.

This sample includes 16 patients, all female, who presented with a primary diagnosis of an anxiety disorder. These patients ranged in age from 10 – 42 years old, with a median age of 20. Duration of illness before beginning treatment ranged from 2 weeks to 25 years. The median duration of illness at intake was 12 months. Thirty-eight percent of these patients (n = 6) found my practice through their own on-line research, 31% (n = 5) were referred by their psychiatrist, 25% (n = 4) were referred via word of mouth by a friend, colleague, or relative who had previously sought my services, and one patient was referred by her pediatrician.

Patients’ primary diagnoses included Unspecified Anxiety Disorder (n = 5), Panic Disorder with Agoraphobia (n = 3), Generalized Anxiety Disorder (n = 2), Acute Stress Disorder (n = 2), Panic Disorder without Agoraphobia (n = 1), Illness Anxiety Disorder (previously known as Hypochondriasis; n = 1), OCD (n = 1), and Social Anxiety Disorder (n = 1).

Fifty-six percent of patients in this sample (n = 9) did not have any comorbid diagnoses. Forty-four percent of the patients (n = 7) presented with a secondary diagnosis. Secondary diagnoses included depressive disorders (n = 3), Binge Eating Disorder (n = 1), Other Specified Feeding or Eating Disorder (n = 1), Body Dysmorphic Disorder (n = 1), and Social Anxiety Disorder (n = 1).

**Description of the Treatment**

Three quarters of these patients (n = 12) were treated with Cognitive-Behavioral Therapy (CBT), while one quarter (n = 4) was treated with client-centered or supportive psychotherapy. Fourth-four percent of these patients (n = 7) paid full rate for their therapy sessions, while the remaining 56% (n = 9) paid a reduced rate due to financial need.

Length of treatment ranged from two weeks to 5.6 years, although the vast majority of patients were in treatment for somewhere between 2- 19 months. The median treatment duration was 4.5 months. Number of sessions attended ranged from 1 to 160, although the majority of patients (75%) attended between 3-17 sessions. Median number of sessions attended was 12.

Degree of family involvement varied based on the age of the patient, her living circumstances, the nature of her symptoms, and her personal preferences. Thirty-one percent of patients had a high level of family involvement (meaning that parents participated actively in the evaluation, treatment planning, and most, if not all, of the therapy sessions), 19% of patients had a moderate level of family involvement (meaning that parents participated in the evaluation and treatment planning and maintained regular two-way communication with me throughout the course of treatment), 31% had a low level of family involvement (meaning that parents or other family members participated in the evaluation or treatment planning, or attended at least one therapy session, or had some phone contact with me), and 13% had no family involvement (meaning that I had no contact with any family members throughout the course of treatment).

All patients under age 18 had at least a moderate level of family involvement, and 83% of patients under age 18 had a high level of family involvement.

All patients of college age (18-22) had low to moderate levels of family involvement.

Among adult patients in their 30’s and 40’s, 60% had no family involvement, 20% had a low level of family involvement, and 20% had a moderate level of family involvement.

**Treatment Completion and Recovery Rates**

Of all 16 patients who began treatment with me for anxiety disorders, 44% percent of patients (n = 7) recovered completely from their anxiety disorder, while 38% (n = 6) made significant progress in terms of reduction of symptoms and improvement in functioning, and 19% (n = 3) made some progress towards recovery.

Half of the patients (n = 8) completed a full course of treatment. A “full course of treatment” means that termination of treatment was mutual and planned, as the patient, her family (when family was involved), and I collaboratively agreed that she was functioning well, not showing any symptoms, had met all of her treatment goals, and was no longer in need of any treatment. The number of sessions required to complete a full course of treatment varied from 3 – 25 sessions, with a median of 4 sessions. The duration of treatment for those who completed a full course of treatment ranged from 1-19 months, with a median duration of 3 months. Of those who completed a full course of treatment, 88% (n = 7) had achieved full recovery and 12% (n = 1) had made significant progress since starting treatment.

Thirty-one percent (n = 5) of patients quit treatment prematurely, 13% (n = 2) moved to another geographic location before completing treatment and were transferred to therapists close to their new homes, and 6% (n = 1) was referred to another clinician who could better meet her needs. Among those who did not complete a full course of treatment for any of the above reasons, 63% (n = 5) had made significant progress in their recovery at the time they left treatment with me, and the remaining 37% (n = 3) had made some progress.

Recovery rates for patients receiving CBT were similar to those receiving supportive counseling (42% vs. 50%, respectively). However, patients receiving CBT were more likely to discontinue treatment prematurely compared with patients receiving supportive counseling. This is most likely due to the reality that CBT is a more directive approach which requires patients to approach their fears. Confronting one’s anxiety raises considerable discomfort, and individuals without strong family support may be more likely to avoid treatment altogether. Notably, none of the patients who had high levels of family involvement in treatment dropped out of CBT prematurely.

**Predictors of Successful Treatment**

Family involvement in treatment was a significant predictor of treatment completion and of full recovery. All of the patients whose family members were highly involved in their treatment (n = 5) completed treatment and recovered fully from their anxiety disorder. Patients with low family involvement, or no family involvement, were more likely to discontinue treatment prematurely and less likely to achieve full recovery compared to patients with high levels of family involvement. However, there were two individuals – both adults – who recovered fully from their anxiety disorders with no family involvement in treatment.

Patients without a secondary diagnosis were almost twice as likely to achieve full recovery (55%) than patients with a secondary diagnosis (29%). This is not surprising, as individuals with two or more disorders tend to have more symptoms, more distress, more functional impairment, and more life challenges than those who have only one disorder.

Forty-four percent of patients took psychotropic medication during their treatment. Patients who took medication during their treatment were much less likely to achieve full recovery (14%) than those who did not take medication during their treatment (67%). This finding should be interpreted with caution, as it is unlikely that medication actually caused patients to do worse in their treatment. It is more likely that taking medication is a marker for some other variable, or several other variables, and it is those other variable(s) which are directly responsible for worsening treatment outcome. For example, patients who took medication during their treatment were more likely to have a secondary diagnosis (57%) than those who did not take medication during their treatment (33%), and we know that having a comorbid diagnosis complicates treatment and makes full recovery more challenging. Additionally, patients who took psychotropic medication were, on average, older than those who did not take medication and had a much longer duration of illness. Of those taking medication, 86% were over the age of 18, and 71% had been struggling with their anxiety and other disorders for at least 2 years prior to beginning treatment with me. Of those not taking medication, only 45% were over age 18, and 88% had been struggling with anxiety for one year or less.

Finally, it is important to note that the majority of patients who took medication during treatment (71%) were referred to my practice by their psychiatrists and were already taking medication when they began treatment with me. Patients who were referred to me by their psychiatrist may differ in some important way from those who were self-referred or from those who were referred through word of mouth. For example, the type of patient who seeks medication as a first line of treatment for their anxiety disorder (i.e., those who saw a psychiatrist and began taking medication first, then were referred to me for therapy later) may have more severe symptoms than those who seek psychological services first. It is also possible that those who seek medication first may be less willing to participate in therapy or less motivated to engage in the behavioral changes, lifestyle modifications, cognitive restructuring, and self-reflection that psychological treatment for anxiety entails.

The way that patients arrived at my practice was a predictor of treatment completion and treatment outcome. Among patients who found my practice through their own online search or through word of mouth, 70% (n=7) completed treatment and 60% (n = 6) achieved full recovery. Among the patients who were referred to me by a physician (either their psychiatrist or their pediatrician), only 16% completed treatment and recovered (n = 1).

Paying full rate for services was a significant predictor of good attendance at sessions, treatment completion, and recovery. Those who paid full rate were nearly three times as likely to complete treatment (71%) than those who paid a reduced rate (33%). Those who paid full rate were also more likely to achieve full recovery (57%) than those who paid reduced rate (33%). Sixty-seven percent of patients who paid a reduced rate no-showed for at least one appointment (and often for multiple appointments), compared to only 29% of patients who paid full-rate.

I have several hypotheses that may explain these statistics involving rate paid for services. One hypothesis is that patients who paid a reduced rate had poorer attendance and worse outcomes due to the life stressors and logistical challenges associated with having a lower income and being of a lower socio-economic status. Another hypothesis is that those who paid less money for their sessions were less invested in their treatment, which made them more likely to no-show and more likely to quit prematurely, and thus less likely to recover. Yet another hypothesis is that reduced rate patients did not have the finances to remain in treatment until they recovered. This hypothesis is less somewhat likely, though, as I am open with patients about my flexibility with fees and my willing ness to lower their rate when their financial circumstances change.

It is important to note that most of the predictors of positive outcome are correlated with one another. In other words, individuals who presented for treatment at younger ages were more likely to have high levels of family involvement, more likely to attend all of their sessions and complete their treatment, more likely to have a shorter duration of illness, less likely to be on psychotropic medication, more likely to pay full rate for services (as their parents had good incomes), and more likely to be self-referred (as their parents were typically proactive in searching for effective treatment).

The predictors of less favorable treatment outcome were also correlated with one another. Patients who were older at the time they entered treatment with me were less likely to have family involvement (because they lived alone), more likely to have been referred to me by their psychiatrist and to be on medication at the time they started treatment, more likely to have a comorbid diagnosis, more likely to have a longer duration of illness, more likely to discontinue treatment prematurely, and less likely to be able to pay full rate for services.

In sum, it may not be one factor that predicts positive treatment outcome, but rather a constellation of factors that tend to co-occur. Additionally, it may not be one particular factor that makes treatment more challenging, but rather the sum total of many factors that frequently occur together.