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Relevant factors in treatment adherence: A case study

Ricardo de Pascual-Verdú*, Miriam Rocha-Díaz, Gala Almazán-Antón

Instituto Terapéutico de Madrid, Spain

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ABSTRACT

In this paper, a case study is presented. The client had been in therapy before, and had abandoned all previous treatments before any significant improvement had taken place. In the treatment reported here, she committed to the therapy and made progress. Possible reasons for this change in adherence are discussed.

Factores importantes en la adhesión al tratamiento: un estudio de casos

Palabras clave:
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RESUMEN

En este estudio se presenta un caso. La cliente había estado ya en terapia, abandonando todos los tratamientos previos antes de que su problema hubiera mejorado significativamente. En el tratamiento reseñado aquí finalmente se comprometió con la terapia y mejoró. Se discuten posibles explicaciones para este cambio en la adhesión terapéutica.

In this paper, a case of non-compliance and therapeutic abandon is presented. After three failed treatments conducted by different therapists from the same clinic, who worked under the same theoretical and clinical approach, finally the client commits to a treatment and follows it to its conclusion. We will analyze here some possible factors that may have contributed to the client's improvement but, mainly, to her commitment with a therapy that was fundamentally identical to those she had previously abandoned.

The question of where to find the factors that might account for the change in the client's behavior towards her commitment with the clinical process is undoubtedly mediated by the theoretical model from which we look at the clinical setting. In our case, as behavioral therapists and behavior analysts, we necessarily will look for these factors in the client's environmental contingencies and the different interaction styles of the therapists. For a better understanding of this approach based in the analysis of the therapist's and client's verbal behavior in session, we recommend reading Froján, Calero, Montaño, and Ruiz (2011).

One of the main concerns of any clinician is the client's adherence to the treatment, both as compliance with specific instructions as, on a broader level, commitment to the treatment and the changes that are needed in order for it to progress in the adequate way towards the clinical targets that were set. Talking about this commitment of the client to change, which is a prerequisite for the achievement of the therapy's targets, forces us to refer to some topics that are related to each other and to clinical change itself: from the therapeutic relationship as a climate that will, if properly created, stimulate the client's compliance and improvement to motivation in therapy and the most adequate way to give instructions.

* Corresponding author. Instituto Terapéutico de Madrid. C/ Castelló 24, esc. 2, 4° dcha. 28001 Madrid.
E-mail address: r.pascual.verdu@gmail.com (R. de Pascual-Verdú).

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Regarding the therapeutic relationship, consistently found to be one of the main factors that account for clinical success (Andrews, 2000; Castonguay, Constantino, & Grosse, 2006; Lambert, 1992), we consider it very fruitful and clinically useful for it to be thought of as the product of a clinical interaction that is shaped and directed by the therapist through his/her behavior during the clinical session (Froján *et al*., 2011), and which plays, or might play, a dispositional role in improving the odds of the client following the therapist's instructions. This is to say that the way in which the therapist interacts with his/her client has an effect in the way in which they commit to the clinical process and follows instructions or advances towards the clinical targets (Callaghan, Summers, & Weidman, 2003; Karpiak & Benjamin, 2004; Truax, 1966).

The content of these therapist's utterances that will more frequently help making the client commit to change is a topic generally researched as part of the field of motivation in therapy. When asked about what motivating in therapy is, experts will give a wide variety of answers, such as verbally anticipating positive consequences of change (Newman, 1994; Ruiz, 1994, 1998), remarking about those that were already obtained in the past (Cormier & Cormier, 1994), alluding to other clients' improvement (Ruiz, 1998), psychoeducation (Froján & Santacreu, 1999; Gavino, 2002; Newman, 1994), verbally anticipating problems that may appear should the client remain in his/her current state (Blume, Schmaling, & Marlatt, 2006; Hall, Weinman, & Marteau, 2004; Kanfer, 1992; Meichenbaum & Turk, 1991), explaining their problem to them in terms of causal relations and how to modify them (Meichenbaum & Turk, 1991; Ruiz, 1998), or underlining the relation between the expected changes and the client's values (Meichenbaum & Turk, 1991; Ruiz, 1998). What all these possible ways to motivate have in common is the fact that they are ways to verbally specify a contingency of the "if you do X, Y will happen" kind, X being a more or less complex, complete detailing of the client's homework issued by the therapist. It seems, then, that according to experts, the best way to help the client commit to change is through the highlighting of the consequences on his/her life in general and his/her problem in particular that are to be expected from his/her actions.

As for adherence, we agree with Martin Alfonso (2004) in their notion that the therapist's in-session behavior, which is fundamentally verbal, has or may have an effect on the odds of the client following instructions or not. We also believe it is fundamental for the client's adherence and compliance to be considered as a behavioral factor encompassing the client's behavior but also his/her interaction with the therapist. This interaction between the therapist's and the client's behavior in relation to compliance might be mediated by the way in which the clinician issues the instructions (Marchena-Giráldez, Calero-Elvira, & Galván-Domínguez, 2013).

Occasionally, researchers delving into this phenomenon of the same client being involved in several clinical failures followed by a success invoke as an explanation the idea that the client was not in the right "motivational stage" to commit to change, a description in line with the considerably popular Transtheoretical Model of Change (TMC) proposed by Prochaska and DiClemente (Prochaska & DiClemente, 1983; Prochaska, diClemente, & Norcross, 1992), which assumes that the process of clinical change of a client will go through given phases or stages. Following this model, the fact that the client did not commit to previous treatments would be explained, according to these authors, by her not being in the right motivational stage. The fact that she eventually committed to another treatment would be explained by her being in a stage of commitment to change. However, and in line with what Froján, Alpañés, Calero, and Vargas (2010) point out, the TMC has considerable problems both in its theory and its practice: the stages' definition and order are arbitrary, with no noticeable difference in clinical outcome that can be attributed to adapting interventions or treatments to the stage through which the client is supposedly going through in a given moment. What is more: should this theory be used to explain the clinical changes or lack thereof in the case we here present, we would be incurring in a circular reasoning that we deem inappropriate. Hence, we will focus on the analysis of clinical interaction in the different treatments as a source of possible explanations for the difference in outcome between said treatments.

Description of Previous Treatments

The client (henceforth E.) started attending therapy in the summer of 2008, when she was 27, to try and solve her anxiety problems, which were mostly related to her job as a speech therapist in a school. Her first contact with psychological therapy, however, happened one year before, in the form of a single session in which she was given some guidelines regarding anxiety and how to control it.

Two years later, in the winter of 2010, she came back to the same clinic, with the same problem. She was now treated by a different therapist. In that moment she felt unable to go to work or leave her home, and had trouble interacting with other people, along with doubts concerning her (at the time) impending wedding. She was on a 4-day sick leave authorized by her doctor, who had also prescribed Transilium (benzodiacepine) and Rexer (anti-depressant). The client feared she was having another depressive episode, since she had had two of these before (in 2001 and 2007), also while she was medicated.

This second psychological treatment (henceforth Treatment 2) consisted of 3 assessment sessions (using interviews with the client and her relatives as an assessment tools, along with homework that consisted mainly in the client having to take notes about her thoughts in difficult situations and pleasurable situations) and 4 treatment sessions, one of which consisted mainly of the explanation of the functional analysis (that will be detailed later, since it is broadly the same in all interventions underwent by the client). In this intervention phase, several clinical targets were proposed. These will also be detailed later, because they were mostly the same throughout all of the client's treatments. This treatment was interrupted by the client citing her wedding as a reason, even though it had not yet been considered complete.

After Treatment 2, the client was medicated with antidepressants for 10 months, experimenting a slight improvement of her symptoms due to her adaptation to her new marital life and also to convenient changes in her job (a new Head of Studies had been appointed, and she was in charge of what she perceived to be an "easier group" of children). She kept her good mood until she had to take care of a group of children with learning difficulties (which meant a slower progression and being exposed to more responsibilities and critics). Through several months, the anxiety responses had been increasing, and her mood getting worse even while being treated with Transilium. She decided to start a new psychological therapy in the summer of 2012 (henceforth Treatment 3) with a different therapist. She complained of a low mood, high anxiety, and a general dissatisfaction with her life. She had lost a lot of weight, she did not rest enough at night and she had a very negative speech about her job, her skills, her marital relationship and her vital situation. She was also very worried about this recurrence of her problems. In this occasion, she was trying not to take a sick leave, and also to keep active and discuss with herself her negative thoughts in an effort to refute them.

Treatment 3 consisted of 6 sessions: 3 assessment sessions and 3 treatment sessions, one of which was mostly dedicated to the explanation of the functional analysis of her problem. The last two sessions took place after the treatment was interrupted for a month.