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A Study of Patients who go to a Psychology Clinic Seeking Treatment

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In order to characterize a typical clinical context, as opposed to an academic or research context, this article will analyze the sociodemographic and clinical characteristics of patients who turn to a psychology clinic in need of professional help. This study was conducted using an initial sample of 1,305 patients at the *Universidad Complutense de Madrid* (UCM) Clínica Universitaria de Psicología. Of the sociodemographic characteristics studied, it is noteworthy that the majority of patients were women (65%) and relatively young (the average age is 29.7 years-old). The disorders for which psychological help was most often needed were anxiety and mood disorders and relationship problems, which together made up 50% of cases. In 17.70% of cases, patients had at least one comorbid disorder in addition to the one that brought them to the clinic. The generalizability and implications of the results are discussed.
Keywords: descriptive study, clinical characteristics, demographic characteristics, psychology users, request for psychological treatment.

Con el objetivo de caracterizar el contexto clínico habitual, en contraposición al contexto académico o de investigación, se analizan las características sociodemográficas y clínicas de los pacientes que acuden a una clínica de psicología en demanda de ayuda profesional. El trabajo se ha realizado a partir de una muestra inicial de 1305 pacientes de la Clínica de Psicología de la Universidad Complutense de Madrid. De las características sociodemográficas destaca que la mayoría de los pacientes son mujeres (65%), relativamente jóvenes (edad media de 29,7 años). Los trastornos por los que más frecuentemente se demanda ayuda psicológica son los trastornos de ansiedad, trastornos del estado de ánimo y problemas de relación, que constituyen alrededor del 50% de los casos. En un 17,70% de los casos hay uno o más trastornos comórbidos a aquel por el que se acude a consulta. Se discuten la generalización de los resultados y las implicaciones de los mismos.
Palabras clave: estudio descriptivo, características clínicas, características demográficas, usuarios de psicología, demanda de atención psicológica.

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In recent years, an abundance of studies and opinions have elucidated the positive social perception of the practice of clinical psychology, both abroad and in Spain (Berenguer & Quintanilla, 1994; Buela-Casal, 2005; Consumer Reports, 1995; Labrador, Echeburúa, & Becoña, 2000). The general opinion is that psychologists' work is useful and effective, people seek out their services, and clients are generally satisfied with them (Berenguer & Quintanilla, 1994; Consumer Reports, 1995, Seligman, 1996). Mental Health Services in the public sector offer data about the requests they receive (e.g., Belloso & Espín, 2007; Valero & Ruiz, 2003), suggesting that in Spain, depressive and anxiety disorders are quite prominent, major depressive episodes having an annual prevalence of 13.96%, specific phobias 3.60%, alcohol dependence disorders 0.69%, anxiety or panic disorders 0.60%, and social phobias 0.60% (Haro et al., 2006). However, data on this prevalence in the general population, or the type of disorders for which help is requested in the public sector, is one thing; to quantify the requests made at centers that are not part of the public health system is another matter entirely.

In Spain, Santolaya, Berdullas, and Fernández (2001) have suggested that in normal clinical practice, the profile of Spanish clinical psychologists is generally young (22.5% are under 30) and the majority are women (70%) and work primarily in private practices (73%), either alone or in tandem with other professionals. Nevertheless, representative data is not available about the patients treated or the type of psychological treatment they received (problems, characteristics and duration of the intervention, results, etc.). Thus, we are at a loss for studies that describe the treatment reality of private clinical psychology practice, which constitutes the majority in Spain (Santolaya et al., 2001), with its diversity of therapists, patients and their issues. In other words, how does the "clinical context" compare to the "research context"? The latter is a source of the standards for clinical practice and there is generally more information available about it (Seligman, 1995; Shadish et al., 1997; Weisz, Weiss, & Donenberg, 1992; Weisz, Weiss, Han, Granger, & Morton, 1995), though that information remains quite scarce in Spain. These two contexts, though they should theoretically be similar, have important differential characteristics.

The Clínica Universitaria de Psicología resembles centers within the clinical context in every aspect discussed above, except that there is a system of supervision, which was created to lend support, not to monitor clinical performance as in the case of supervising controlled clinical trials. Note that while the Clínica Universitaria de Psicología foments research activities, those are independent of its treatment functions, which proceed independently of the research except for when clinical data is of a useful format to research. Finally, keep in mind that this center's cognitive behavioral approach is the most common in Spain (Santolaya et al., 2001).

Few studies have described normal clinical practice or even questioned the validity of these characterizations (Gaston, Abbot, Rapee, & Neary, 1996; Nathan, Stuart, & Dolan, 2000; Stirman, DeRubeis, Crits-Christoph, & Rothman, 2005). However, a precise understanding of the "typical clinical" reality is of the utmost importance because it would allow us to identify the type of problems for which psychological treatment is sought. It would also be desirable to be able to identify the kinds of treatments available (that are most accessible), the types of treatments actually used, and the results yielded by each. In that vein, it has been suggested that university psychology services and centers are exceptional for performing applied research on various aspects of clinical practice, and under conditions of high ecological validity at that (Borkovec, 2004). Services with these characteristics

Table 1
Contrasting the Characteristics of Therapy in Clinical and Research Contexts

Research Context	Clinical Context
Treatment is offered; patients with a certain level of severity are selected.	Patients ranging from slight to considerable severity seek and choose treatment.
Random assignment and the presence of a control group.	Non-randomized assignment, absence of a control group.
Homogeneous groups.	Heterogeneous groups.
Treatment in the laboratory, academic context.	Treatment in private clinics or hospitals.
Treated by researchers or their assistants with a limited caseload.	Treated mostly by psychologists with a heavy caseload.
Intervention that is limited in time and done by the manual.	Self-corrective intervention of variable duration.
Supervision and confirmed adherence to the manual.	Without the manual and without supervision over clinical performance.
Essentially cognitive-behavioral interventions	Interventions are eclectic as well as cognitive-behavioral.
Discrete objectives (symptoms and diagnosis).	Broad objectives (general functioning)

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Table 2
Psychology Clinic Therapists' Characteristics

Variable	Therapists
Number	N=37
Sex	72.88% women
Age at which they joined the center	Mean: 25.35 years-old; SD: 1.22 years
Intervention's approach	Cognitive - Behavioral.
Clinical Training (in years)	Median: 7 years (undergraduate, two years of postgraduate); range 5.5-8 years
Supervision and controls	Access to supervision for cases in assessment, treatment and follow up.
Caseload[a] and Full vs. Part-time	Median: 23 cases; range 12-38 Full-time

[a] calculated according to currently active cases and therapists (*n* therapists = 12; *n* active cases = 283)

have developed in the last 25 years in Spain (Saúl, López, & Bermejo, 2009), though they vary widely in terms of performance, objectives and approach. Of these, 20 offer clinical psychological services both within and beyond the sphere of the university community, functioning as private clinics without profit goals, or as authorized health centers, and they have published data about their patients and requests for treatment (Ávila–Espada, Herrero, & Fernández, 2009; Botella et al., 2009; García-Vera & Sanz, 2009 Gutiérrez, 2009; Martorell & Carrasco., 2009; Saldaña, Bados, García-Grau, Balaguer, & Fusté, 2009). One such center is the UCM Clínica Universitaria de Psicología.

In light of the above, the present study's objective is to identify and characterize the types of people and problems for which psychological assistance is requested at a psychology clinic, to contextualize them using information available about other, similar centers, and to describe their peculiarities in order to generalize about them.

Methods

Participants

Description of the Center. The Clínica Universitaria de Psicología at UCM has been recognized by the Comunidad Autónoma de Madrid as a *Health Center* since 1998. Its main objectives are: a) to provide ongoing, quality psychological treatment services, b) to promote the continuing education of clinical psychology and health professionals, and c) to create an environment that furthers the clinical psychological activities (treatment and research) of the UCM Psychology Department.

Description of the Therapists. The Clínica Universitaria de Psicología currently employs a team of twelve psychologists in a treatment capacity. Two are permanent UCM employees and are in charge of supervision and coordination functions. The other ten serve as interns-residents for a two-year period. All are licensed in psychology with a post-graduate degree at least at the master's level accrediting their specialization in assessment, diagnosis and treatment of psychological disorders, the most common being the Master en Psicología Clínica y de la Salud at UCM. They also completed a wide array of courses and educational workshops, many of them given by the Clínica Universitaria de Psicología itself. The therapists, typically between the ages of 24 and 27, had a primarily Cognitive-behavioral background and between one and three years of supervised clinical practice upon joining the Clínica Universitaria de Psicología. Their interventions may have been supervised by well-reputed professionals in the fields of clinical and health psychology, and/or psychiatry.

Description of the Patients. The Clínica Universitaria de Psicología is a center open to the general public that accepts all types of patients at their own request with no exclusion criteria. It collects information about its patients in the service of both clinical and research aims, which patients are notified of when they begin therapy. Data about the cases, stripped of any personal information except for a case number, is archived in compliance with the requirements of the Ley Orgánica 15/1999 de protección de datos de carácter personal.

Therapists. 37 therapists that have worked at the Clínica Universitaria de Psicología were included; their characteristics are displayed in Table 2.

Patients. Initially, all patients included in the Clínica Universitaria de Psicología. general database (N = 1305) between the time it was created in June, 1999, and February, 2008, were considered for participation. This database does not include patients that take part in research programs at the Clínica Universitaria de Psicología.

Patients were divided into the following categories:

Patients Who Refuse Treatment (n = 266). Cases in which a request for clinical attention is made, but treatment never begins.

Patients Currently in Assessment, Treatment or Follow-up (n = 263). Of these, 51 were in pre-treatment assessment,

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168 in treatment, 38 in follow-up, and 6 in post-treatment evaluation.

Patients in Crisis Situation Intervention (n = 27). This refers to cases in which the intervention was carried out at the request of either the patient or the academic authorities, in an emergency situation.

Diagnosed Patients that have Concluded Their Relationship with the Clinic (n = 749).

Exclusion Criteria in the Study

After the first distribution analysis of patients, the following filter was applied to the data in keeping with the study's objectives:

We excluded patient histories that were not of value in terms of the variables relevant to this study, or in which omissions could not be rectified (n = 105).

Patients classified as "refusing treatment," "in pre-treatment assessment" and "in crisis intervention" were excluded from our analysis. This was due to difficulty assigning them a diagnosis or gathering information about the variables of interest in those patients who had not completed the assessment process (n = 344).

The final sample was comprised of 856 patients.

Variables

The following were selected from the variables described:

Therapist Variables. Relevant demographic characteristics (sex, age), training in Clinical Psychology, workload, whether they worked full or part-time, level of specialized training in therapies, and supervision of clinical performance.

Patient Variables.

Demographic Characteristics. Sex, age, civil status, occupational situation, level of education, avenue of recruitment into the sample.

Clinical Characteristics. Diagnosis, comorbidity, evolution of the problem, history of previous treatments, use of pharmacological treatments.

Instruments

The clinical and sociodemographic data collected when treatment began were coded by therapists into a database created ad hoc, and were later transferred into a data file generated using the SPSS statistical package. Data were taken directly from the center's clinical patient histories, which were conserved in physical form and included records of patient data as well as the center's formal reports, and the instruments, interviews and observations taken into consideration by the therapist.

In order to reach a diagnosis, therapists selected evaluation instruments based on clinical interviews, whether or not those instruments had adequate psychometric properties, and whether or not they are considered representative within the body of literature pertaining to each disorder. Each therapist reached a diagnosis through an individualized assessment process with each patient.

Procedure

Data Analysis

In order to characterize the patient sample, frequency analysis was applied to the data collected, which was coded into an SPSS file.

Results

The resulting sample of cases, 856 patients, yielded the following results:

Demographic Variables (n = 856)

Sex. 34.8% were male (n = 298) and 65.2% were female (n = 558).

Age. The patients' average age was 29.74 years-old (with a standard deviation of 13.25 years and ages ranging from 3 to 77 years-old). 13.1% (n = 112) were under 18 when they started treatment (see Figure 1).

Civil Status. 67.3% (n = 576) of subjects reported being single and 25.2% (n = 216) said they were married or cohabitating with a stable partner. 6.1% (n = 52) were separated or divorced and 1.4% (n = 12) were widows or widowers.

Occupational Situation. Almost half of patients (46,8%) were employed in various sectors and 45.8% were students (see Table 3). Of those employed, professionals or technicians (17.2%) and administrative services personnel (15.2%) were prominent.

Level of Education. The distribution according to level of education appears in Table 3. Note that 50.35% had a college degree, divided into 18.2% with associate degrees and 32.1% with bachelor's degrees. Meanwhile, 9.5% of

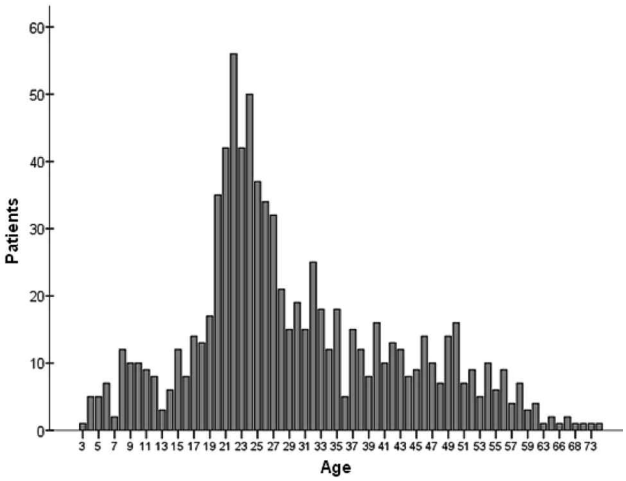

Figure 1. Sample Distribution by Age.

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Table 3
Sociodemographic Characteristics of the Sample (n = 856)

Variable	Frequency	Percentage
Civil Status		
Single	576	67.3
Married or cohabitating with a stable partner	216	25.2
Separated/divorced	52	6.1
Widow/widower	12	1.4
Level of Education		
Did not complete primary school	81	9.5
Completed primary school	85	9.9
Secondary	259	30.3
Associate college degree	156	18.2
Bachelor's college degree	275	32.1
Occupational Situation		
Students	392	45.8
Professional /technician	146	17.1
Other	130	15.2
Administrators	94	11.0
Service sector	49	5.7
Unemployed	33	3.9
Homemaker	18	2.1
Retired	12	1.4
Avenue of Access to the Center		
UCM staff or student	481	56.2
Unknown	152	17.8
Information from other patients	69	8.1
Through another professional	64	7.5
Other	53	6.2
Press/publicity	37	4.3
Number of prior treatments		
0	434	50.7
1	265	31.0
2	101	11.8
3 or more	56	6.5
Type of previous treatment		
No treatment	434	50.7
Pharmacological treatment	159	18.5
Behavioral therapy	63	7.3
Other	33	3.8
Psychodynamic therapy	21	2.4
Systemic therapy	1	0.1
Several of the above	148	17.2

the sample had not completed primary education, 1.8% (n = 15) over the age of 18.

Avenues of Clinic Access. Around half of the patients (56.2%; n = 481) had gone to the clinic either because they were UCM staff or students, or had been referred by UCM staff or students (see Table 3). In a high percentage of cases (17.8%), no precise information was available about how the patient had access to the clinic, making it impossible to determine the source of the cases.

Clinical Variables (n = 856)

Diagnosis. We took into account each patient's diagnosis according to their therapist, which they reached in accordance

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Table 4
Distribution of the Patient Sample According to Diagnostic Categories (n = 856)

DSM – IV – TR Diagnostic Categories	Frequency	Percentage
Anxiety Disorders	**273**	**31.89**
No Diagnosis	**127**	**14.84**
Mood Disorders	**81**	**9.46**
Relationship Problems	**84**	**9.81**
Adjustment Disorders	63	7.36
Personality Disorders	47	5.49
Other Clinical Conditions That May Be the Focus of Clinical Attention	34	3.97
Eating Disorders	25	2.92
Impulse Control Disorders	19	2.22
Attention Deficit and Disruptive Behavior Disorders	16	1.87
Somatoform Disorders	15	1.75
Sexual Disorders	13	1.52
Psychotic Disorders	10	1.17
Learning Disorders	7	0.82
Sleep Disorders	6	0.7
Elimination Disorders	6	0.7
Dissociative Disorders	5	0.58
Deferred Diagnosis or Status	5	0.58
Psychological Factors Affecting Medical Illness	4	0.47
Alcohol-related Disorders	4	0.47
Other Disorders of Early Childhood or Adolescence	3	0.35
Tic Disorders	3	0.35
Cannabis-related Disorders	2	0.24
Cocaine-related Disorders	1	0.12
Mental Retardation	1	0.12
Communication Disorders	1	0.12
Child Abuse	1	0.12

with the criteria described in the DSM – IV and the DSM – IV TR (APA, 1995, 2000). Diagnoses were established through a series of clinical interviews and were supported by questionnaires and behavior checklists. Table 4 includes the distribution of diagnoses, with the most prevalent ones highlighted in bold.

The clinical areas with greatest prevalence were: Anxiety Disorders: 31.89% (n = 273); Relationship Problems: 9.81% (n = 84); and Mood Disorders: 9.46% (n = 81).

The most prominent diagnoses were: [F32.x – F33.x] Major Depressive Disorder, with its different specifiers regarding course, severity and recurrence: 6.40% (n = 55); [F40.1] Social Phobia: 6.29% (n = 54); [F41.9] Generalized Anxiety Disorder: 5.70% (n = 49) and [F40.01] Panic Disorder with Agoraphobia: 4.54% (n = 39). 14.84% (n = 127) did not receive a diagnosis (in the majority of cases, because they did not meet the DSM criteria for a particular diagnosis).

Comorbidity of Diagnoses. 17.7% of patients (n = 152) were given one or more additional diagnoses, as Table 5 conveys. The most prevalent comorbid diagnoses are indicated in bold.

The Problem's Duration. 32.9% (n = 282) reported having "always" had the problem or not being able to pinpoint when symptoms began because they evolved slowly and insidiously. As for the remaining 67.2% of subjects who were able to identify a concrete beginning to their symptoms (n = 575), the problem's average duration was 38.3 months with a standard deviation of 55.1 months. This duration ranged from 1 to 550 months. In the sample's data, there are peaks at 12, 24, 36, 48 months, etc., suggesting patients often describe their problems' duration in years (see Figure 2).

Previous Treatment. It is worth mentioning that the majority of patients (50.7%; n = 434) had not been in treatment previously; then again, in some cases, patients had received up to 10 previous treatments (see Table 3).

Types of Previous Treatment. The most frequent of patients' previous treatments were pharmacological. Table 3 includes the distribution of patients according to type of previous treatment received.

Taking Medication. A total of 21.4% (n = 183) of patients had been prescribed medication due to their problem at the

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Table 5
Distribution of the Sample According to Comorbid Diagnostic Categories (n = 152)

DSM – IV – TR Diagnostic Categories	Frequency	Percentage
Anxiety Disorders	**40**	**26.32**
Relationship Problems	**28**	**18.42**
Mood Disorders	**23**	**15.13**
Personality Disorders	**16**	**10.53**
Other Clinical Conditions That May Be the Focus of Clinical Attention	13	8.55
Eating Disorders	7	4.61
Learning Disorders	4	2.63
Adjustment Disorders	3	1.97
Somatoform Disorders	3	1.97
Communication Disorders	2	1.32
Elimination Disorders	2	1.32
Alcohol-related Disorders	2	1.32
Impulse Control Disorders	2	1.32
Other Cognitive Disorders	1	0.66
Dissociative Disorders	1	0.66
Psychotic Disorders	1	0.66
Cannabis-related Disorders	1	0.66
Cocaine-related Disorders	1	0.66
Sexual Disorders	1	0.66
Sleep Disorders	1	0.66

time they sought out therapy. The pharmacological therapy prescribed for 41.0% (n = 75) of medicated patients was a combination of various psychopharmaceuticals, followed by anti-anxiety medications with 32.8% (n = 60), antidepressants at 14.2% (n = 26), antipsychotics at 4.9% (n = 9) and other medications (mood stabilizers, homeopathic preparations, other non-psychotropic medications) accounted for the remaining 7.1% (n = 13).

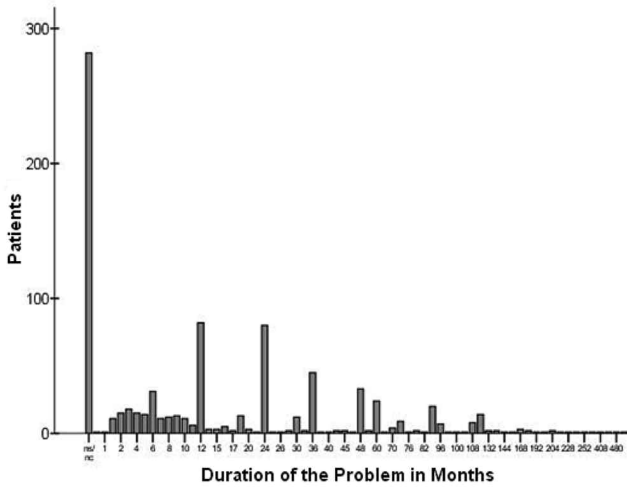

Figure 2. Distribution of Patient Sample According to the Problem's Duration.

Discussion

These data from a broad sample of patients and therapists, collected in everyday clinical psychology practice situations, may serve to empirically describe the reality of requests for psychological intervention.

Surely, there are certain aspects of the sample that could introduce bias into the data, such as the fact that it is a university clinic, or that the avenue for accessing treatment, as well as its institutional and physical location, encourage the presence of UCM staff, which may have been a determining factor in the fact that over 50% had a college degree. By the same token, the therapists were homogeneous to a certain extent in terms of training and because they prioritized using empirically-supported therapies. Clearly, whatever the sample, there will always be limitations or bias. Bearing those in mind, however, and despite the university-centric clinic (Borkovec, 2004; Shadish et al., 1997, 2000), we consider these data to be representative of a psychology clinic working in "everyday practice," and relevant and useful to guiding the work of clinical psychologists.

Patients

With regards to the patients, since the clinic is open to anyone and all types of issues, they are probably representative. The female majority (65.2%), however, stands out; two in every three patients were women. These data

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have been supported by the findings of other studies in suggesting women are the primary seekers of psychological or psychiatric attention (Martorell & Carrasco, 2009; Saldaña et al, 2009; Vallejo et al., 2008; Valero & Ruiz, 2003).

It being a university clinic, students and employees at the university are highly represented in the data (approximately 56.2% were, or were their relatives). This bias probably makes the sample less descriptive of the patients that usually request psychological attention. Similarly, the patients' average age is noteworthy, with a clear hyper-representation of people between the ages of 19 and 27, which also influences their occupational situation (45.8% students) and civil status (67.3% single). Furthermore, note the sample's high average level of education, 50% having earned a college degree. Although this percentage is not representative of the Spanish population (43.5% to 12.9%, depending on sex and age; INE, 2009), it is unclear whether or not it might be representative of the population that seeks out psychological treatment, especially psychological treatment in a clinic where patients pay, outside of the National Health System (Vallejo et al., 2008; Valero & Ruiz, 2003). Nevertheless, this patient profile is similar to the one reported by other university centers that provide psychological attention to the general and university communities, which report around 60% of external patients, with a high percentage of women and students (Ávila–Espada, et al., 2009; Botella et al., 2009; Gutiérrez, 2009; Martorell & Carrasco., 2009; Saldaña et al., 2009).

Clinical Problems

As for the clinical variables, the disorders for which help was most frequently requested were anxiety problems (31.89%), without a doubt the most common psychological challenge, and perhaps one of the areas in which psychologists' performance is most highly rated. A total of 51.16% of the problems treated fell into one of these three categories: anxiety disorders, mood disorders and adjustment disorders, which are all highly related and frequently occur with comorbidity. Of the other disorders, only the relationship problems subgroup (9.81%) was striking. These data are again similar to those of other university centers, in which anxiety, mood and adjustment disorders are typically predominant as the main diagnoses (Ávila–Espada, et al., 2009; Botella et al., 2009; Gutiérrez, 2009; Martorell & Carrasco., 2009; Saldaña et al., 2009).

Other problems did appear in lower percentages of requests, but it is beyond the scope of this study to establish whether or not this was due to low frequency in the population (e.g., eating disorders had less than a 4% prevalence, CFR APA, 2000). Multiple hypotheses could be made to try and explain this situation, among them that perhaps the Spanish population does not associate psychologists with this type of problem (sexual dysfunction, sleep disorder, any problem within the field of health psychology, etc.), so Spaniards would not come to the clinic seeking this kind of help. It is also possible that psychological treatments are not considered effective or suitable for these problems. In any case, we need to inform and help the general population and health services administrators come to understand (*publicize*) that there are psychological treatments available to address these issues. Also, these treatments have systematically demonstrated themselves to be effective and are substantiated by considerable empirical support (Chambless & Hollon, 1998; Labrador et al., 2000, Pérez, Fernández, Fernández, & Amigo, 2003).

It is also of note that 14.81% of people who solicited psychological help did not fit into the diagnostic categories described in the DSM-IV-TR, a rate to which we ought to add the 3.97% corresponding to "other clinical conditions that may be the focus of clinical attention." These rates seem to reflect a relatively frequent need (18.78%) to address requests that do not deal with psychopathological disorders alone. They also bring into relief the limitations of categorical diagnostic systems like the DSM. There is no doubt that clinical psychologists' interventions should be geared toward, in addition to overcoming disorders, improving one's everyday abilities and living conditions. This probably implies that in some or many cases, intervention involves giving advice and guidance, in addition to or instead of clinical help (Norcross, 2002).

These data, on the other hand, are especially relevant in that they indicate the types of problems clinical psychologists will most frequently face. This is particularly important in educating future clinical psychologists to deal with these most common issues for which help is required.

On the subject of comorbidity, it is usually estimated that in contrast to treatments in the research sphere that focus on "pure" issues (only one diagnosis), it is more frequent in everyday clinical practice for various problems to occur at once (Goldfried & Wolfe, 1996; Seligman, 1995), though this tendency varies widely across different diagnostic categories and demographic profiles (Alonso et al., 2004). In our sample, the incidence of dual-diagnoses was low (17.7%), but keep in mind that just because there is only one formal diagnosis, that is not to say there is only one problem or that other important concomitant factors are not in play; it simply means they do not meet the criteria for another diagnosis. This has to do, in part, with the directives of the DSM-IV-TR itself and its multi-axial system, which in many cases suggests not including a diagnosis if another is already available that encompasses the problem (APA, 2000, pp. 6-7). Furthermore, we believe these data could be especially relevant to changing certain clinical psychologists' suspicions about the value to normal, professional practice of therapies developed within the research sphere. The data also attest to the value of developing specific psychological intervention protocols for specific disorders. All in all, as was to be expected, the most

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prominent disorders also turned out to be the ones most frequently comorbid (anxiety, depression, relationship problems…).

As for problems' duration, note that a third of patients (32.9%) reported having this problem all their lives, which supports the statement that people do not identify the help that psychological treatment can provide in a timely fashion. It is accepted or assumed that one has to live with the problem, and they attempt to do so for a long time. Yet the suffering continues and at some point, fortunately, one comes to consider the possibility of psychological help. The fact that the average duration of the problems that bring patients to the clinic, when identifiable, is 38 months, points to the same conclusion. In addition, when a problem goes on a long time, it is not innocuous: when an issue becomes chronic, people change their lives in important ways to adapt to it, which necessitates a broader intervention to manage not only the initial, problematic behaviors, but also the ones subsequently derived from those.

Approximately 50% of patients had received treatment before, pharmacological being the most frequent, but evidently, with little success given that they returned in need of help. On the one hand, the fact that 50% come from a prior therapeutic failure reflects the seriousness of these cases. On the other, the data reflect a great diversity in the treatments that had been received previously (as many as 10 in some cases). This begs the question of to what point this high recurrence is due to applying inadequate treatments, and to what extent other clinical variables (inadequate assessment, patient characteristics, etc.) are involved. If the first is true, it would reinforce the importance of having lists of, and guides to, the "empirically-supported treatments" available. Treatments could be grouped according to problem, and direct professionals toward a therapy to apply, and patients as to what to ask for. It is highly probable that this would serve to increase interventions' effectiveness by suggesting the most convenient one in each case, thereby avoiding a situation where some patients pilgrimage through different treatments, or where unhappiness leads them to go without adequate psychological help.

Conclusions

The results of our analysis of the sample of therapists, patients and treatments allow us to conclude that:

At a center for psychological attention paid for by the patient that maintains an essentially clinical structure and is recognized by the Autonomous Community of Madrid as a health center, patients are treated per their own request.

Patients are treated by young, predominately female therapists trained for at least 7 years in cognitive-behavioral therapy and with access to supervised practice, who manage these cases on a full-time basis.

Patients have a wide range of profiles in terms of the variables studied; nevertheless, we find remarkable: the (2:1) female-male ratio, the sample's high level of education, the sample's relative youth (average age of 29.71 years-old), and the preponderance of in the sample of singles (67.3%) and students (45.8%).

The problems for which the most requests for psychological help were made are anxiety disorders, relationship problems and mood disorders, major depression and social phobia being the most common diagnoses.

14.84% (n = 127) of patients did not meet the criteria for being diagnosed with any disorder according to the DSM-IV-TR, a rate which is high yet similar to the data collected by other psychological services (Botella et al., 2009).

Problems have a long history (mean 3 years).

The majority do not present with other problems (82.3%).

50% had already received another treatment previously, largely pharmacological.

In summary, the present study takes one step along a path it appears we need to follow, that of characterizing the professional work of clinical psychologists. These data certainly may reflect the bias of the clinic where they were collected, but bias will always be present depending on the clinic where data are gathered. However, there is no doubting the importance of presenting precise, quantifiable data obtained by means of valid, reliable, representative instruments that allow for comparisons of the greatest possible breadth. This was the present study's objective, applied to the reality of clinical psychological practice at the Clínica Universitaria de Psicología.

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