

**Short-term psychodynamic psychotherapy and cognitive-behavioral therapy in  
generalized anxiety disorder: a randomized controlled trial<sup>1</sup>**

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**Objective:** While several studies have shown that cognitive-behavioral therapy is an efficacious treatment for Generalized Anxiety Disorder, few studies have addressed the outcome of short-term psychodynamic psychotherapy, even though this treatment is widely used. The aim of this study was to compare short-term psychodynamic psychotherapy and cognitive-behavioral therapy with regard to treatment outcome in Generalized Anxiety Disorder.

**Method:** Patients with Generalized Anxiety Disorder according to DSM-IV were randomly assigned to receive either cognitive-behavioral therapy (N=29) or short-term psychodynamic psychotherapy (N=28). Treatments were carried out according to treatment manuals and included up to 30 weekly sessions. As the primary outcome measure, the Hamilton Anxiety Rating Scale was used which was applied by trained raters blind to the treatment conditions. Assessments were carried out at the completion of treatment and 6 months afterwards.

**Results:** Both cognitive-behavioral therapy and short-term psychodynamic psychotherapy yielded significant, large, and stable improvements with regard to symptoms of anxiety and depression. No significant differences in outcome were found between treatments in regard to the primary outcome measure. These results were corroborated by two self-report measures of anxiety. In measures of trait anxiety, worry and depression, however, cognitive-behavioral therapy was found to be superior.

**Conclusions:** The results suggest that the applied methods of cognitive-behavioral therapy and short-term psychodynamic psychotherapy are beneficial for patients with Generalized Anxiety Disorder. In future research, large-scale multi-center studies should examine more subtle differences between treatments including the question which patients benefit most from which form of therapy.

Generalized Anxiety Disorder is characterized by chronic, pervasive and uncontrollable worry and is associated with somatic complaints (1). The disorder has a lifetime prevalence estimated at 5.7% (2) and is associated with high rates of comorbidity (3).

As shown in several studies and meta-analyses, cognitive-behavioral therapy is an efficacious and specific treatment for Generalized Anxiety Disorder (4-7), according to the definition by Chambless and Hollon (8).

Few studies have assessed the outcome of short-term psychodynamic psychotherapy on Generalized Anxiety Disorder. Durham and colleagues (9) compared short-term psychodynamic psychotherapy and cognitive-behavioral therapy in the treatment of Generalized Anxiety Disorder. In that study, however, short-term psychodynamic psychotherapy and cognitive-behavioral therapy were not equally carefully implemented. In contrast to the cognitive-behavioral therapists, for example, the therapists applying short-term psychodynamic psychotherapy were not specifically trained in their treatment model. Treatment manuals were used only for cognitive-behavioral therapy. Adherence to the treatment model and competent delivery was not checked for short-term psychodynamic psychotherapy. In this study, short-term psychodynamic psychotherapy served as a kind of "strawman" as Smith, Glass and Miller (10) put it. In an open manual-guided study Crits-Christoph and colleagues (11) examined supportive-expressive therapy, as described by Luborsky (12), which was specifically adapted to Generalized Anxiety Disorder (13). Crits-Christoph et al. (11) reported significant improvements for patients with Generalized Anxiety Disorder after treatment. The within-group effect sizes for improvements in anxiety were large (16) and of the same size as they were previously reported for cognitive-behavioral therapy (17). In a randomized controlled feasibility study, supportive-expressive therapy adapted to the treatment of Generalized Anxiety Disorder was as effective as a supportive therapy with regard to continuous measures of anxiety, but significantly superior with regard to symptomatic remission rates (18). However, the sample sizes of that study were relatively

small (N=15 vs. N=16), and the study was not sufficiently powered to detect more possible differences between treatments.

In sum, there is a need to study the effects of short-term psychodynamic psychotherapy in Generalized Anxiety Disorder in a more rigorous way. In this article, we shall present a study of short-term psychodynamic psychotherapy based on supportive-expressive therapy. In a randomized controlled trial manual-guided short-term psychodynamic psychotherapy was compared to manual-guided cognitive-behavioral therapy in Generalized Anxiety Disorder.

Insert Figure 1 about here

## METHODS

This study was carried out in the Department of Psychosomatic Medicine and Psychotherapy at the University of Goettingen between May 2001 and June 2007. It was approved by the ethical committee of the Medical Faculty of Georg-August-University Goettingen. After providing their informed consent, patients were randomly allocated to one of the two treatment groups.

An investigator allegiance effect was controlled for by including representatives of both short-term psychodynamic psychotherapy (FL, SS) and cognitive-behavioral therapy (EL, CW) in the trial.

Inclusion and exclusion criteria: Patients between 18 and 65 years of age for whom Generalized Anxiety Disorder was the primary diagnosis were included in this study. Primary diagnosis was defined as the most severe mental disorder according to the Anxiety Disorders Interview Schedule-Revised (19). The following exclusion criteria were applied: (A) the presence of any acute, unstable, or severe Axis III medical disorder that might interfere with the successful completion of treatment; (B) any current or past history of schizophrenic disorder, bipolar disorder, or Cluster A or B Axis II disorders; (C) any current or past

neurological disorder; (D) criteria indicative of alcohol or substance dependency or abuse, an eating disorder, or major depression in the previous 12 months; (E) patients currently receiving concomitant psychotherapeutic or psychopharmacological treatments.

### *Participants*

The patients were recruited by referrals of psychotherapists and physicians in private practices as well as by advertisements and information about the study presented in mass media. All patients were diagnosed by use of the Structured Clinical Interviews (SCID I, II) (20) for DSM-IV (21). All interviews were carried out by an experienced and trained master's degree-level clinical psychologist. Diagnoses were made by the consensus of at least two experienced clinical psychologists. A total of 231 patients were screened. Fifty-seven patients fulfilled the inclusion criteria and did not meet any of the exclusion criteria (see Figure 1).

Insert Table 1 about here

Five patients did not complete their treatment; one patient dropped out due to problems in the therapeutic relationship, whereas the others moved to another city (cognitive-behavioral therapy: 2; short-term psychodynamic psychotherapy: 3). At the 6-month follow-up, three additional patients dropped out. Further psychotherapeutic treatment was required by two of these patients (one cognitive-behavioral therapy and one short-term psychodynamic psychotherapy patient). The third patient (short-term psychodynamic psychotherapy) developed a severe somatic disease (breast cancer) and, therefore, was unable to pass the follow-up examination. During the six-month follow-up period, the remaining forty-nine patients received no psychotherapeutic or psychopharmacological treatment. According to our inclusion criteria, this was true for all patients during the treatment period as well.

The mean age of the intention-to-treat sample was 42.49 years (SD=12.33). Eighty-one percent of the sample were female. Seventy-nine percent of the patients were in a permanent partnership. For sixteen patients, Generalized Anxiety Disorder was the only mental disorder diagnosis (28%), while 41 patients showed one or more comorbid mental disorder (72%). Of the comorbid disorders, other anxiety disorders (35%) and depressive disorders (26%) were most prominent. Some patients showed adjustment disorders (19 %), obsessive-compulsive disorders (12%), and somatoform disorders (5.3%). Nearly half of the patients (46%) had undergone psychotherapeutic treatment in the past.

### *Treatments and Therapists*

Both cognitive-behavioral therapy and short-term psychodynamic psychotherapy included up to 30 (50-minute) sessions and were carried out according to treatment manuals. The applied form of cognitive-behavioral therapy is described in a treatment manual (22). Apart from general strategies of cognitive-behavioral therapy the applied treatment includes the following interventions: relaxation training, problem solving, planning of recreational activities, and homework. The focus of the treatment is on changing and controlling worrying (including worry exposure) and catastrophizing anticipations. Thus, the applied manual of cognitive-behavioral therapy combines different techniques as they are also used, for example, by Borkovec and Ruscio (23) and Brown, O’Leary and Barlow (24).

The applied method of short-term psychodynamic psychotherapy was based on Luborsky’s (12) supportive-expressive therapy, which has been specifically adapted to the treatment of Generalized Anxiety Disorder by Crits-Christoph et al. (13). For this study, the Generalized Anxiety Disorder treatment manual by Crits-Christoph et al. (13) was adapted to a 30-session treatment (25). The short-term psychodynamic treatment carried out in this study may differ in some ways from supportive-expressive therapy as it is usually carried out in US studies (11, 18). It can best be described as short-term psychodynamic psychotherapy based

on supportive-expressive therapy (12). The treatment used in this study focuses on the Core Conflictual Relationship Theme associated with the symptoms of Generalized Anxiety Disorder. Emphasis is put on a positive therapeutic alliance. As patients with Generalized Anxiety Disorder are hypothesized to suffer from insecure attachment, a positive therapeutic alliance provides a corrective emotional experience and allows the patient to approach feared situations, both psychologically and behaviorally (13,25). Within a positive therapeutic alliance therapists are recommended to encourage new behaviors including approaching feared situations which is consistent with Freud's (26) recommendations for the treatment of phobia. The experiences the patient makes when approaching feared situations are used to work on the Core Conflictual Relationship Theme, e.g. modify the expected responses from others. Thus, although the cognitive-behavioral therapy and short-term psychodynamic psychotherapy approach are clearly different regarding the therapeutic procedures, the patient is encouraged in both forms of psychotherapy to approach feared situations, however, for different reasons (changing catastrophizing anticipations vs. changing Core Conflictual Relationship Theme).

The mean number of sessions for those that completed the cognitive-behavioral therapy treatment was 28.81 (3.44) and for short-term psychodynamic psychotherapy 29.12 (3.06). The treatments were carried out by nine licensed psychotherapists in private practice who regularly apply either cognitive-behavioral therapy or psychodynamic therapy. Three of the nine psychotherapists were women. Mean age of the therapists at the beginning of the study was  $M=47.9$  years. Their average professional experience as psychotherapists was 18.7 years (range from 12 to 30 years) for the cognitive-behavioral therapists and 16.3 years (range from 4 to 26 years) for the psychodynamic therapists. In contrast to the psychodynamic therapists the cognitive-behavioral therapists were in general familiar with the use of treatment manuals. For the time of their professional experience (mean: 18.7 years) they were experienced in the use of the specific interventions included in the applied CBT manual. All

therapists were specifically trained in the use of the respective treatment manuals by the developers of the German versions of the manuals (FL, EL).

Implementation of the treatment manuals, including adherence to the manuals and competent delivery of interventions, was ensured for each group of therapists by continuous group supervision, which was carried out every month by supervisors who were highly experienced in cognitive-behavioral therapy or psychodynamic therapy and highly familiar with the respective treatment manual. The supervision included reading and discussing the manual and discussion of audio-taped cases or special treatment situations.

All of the sessions were audio-taped. From each treatment included, one treatment session was randomly selected and rated by nine independent raters who were provided with extensive information about the two treatment manuals, including their specific treatment elements. Each of the selected sessions was rated blindly by 3 to 8 raters with regard to the type of treatment that was applied. The raters identified 26 of 29 cognitive-behavioral therapy treatments correctly as the form of cognitive-behavioral therapy described in the respective cognitive-behavioral therapy manual (89.7%) and 24 of 28 short-term psychodynamic psychotherapy treatments (85.7%) correctly as the form of short-term psychodynamic psychotherapy described in the respective short-term psychodynamic psychotherapy manual (overall rate of correct identification: 87.7%). A closer look at the misidentified treatment sessions showed, that in these sessions both cognitive-behavioral therapy and short-term psychodynamic psychotherapy therapists encouraged the patient to approach feared situations. As described above, both approaches address feared situations, but use a different rationale. The agreement beyond chance was  $\kappa=0.76$  (27), which can be considered as an excellent agreement beyond chance (28). These results suggest that the treatments were carried out in good accordance with the respective manuals.

### *Assessment and Measures*



Patients were assessed at baseline, at the end of treatment, and 6 and 12 months after end of the treatment. Results of the 12-month follow-up will be reported in a subsequent publication after they become available.

As the primary outcome measure, the Hamilton Anxiety Rating Scale (29) was used. It includes 14 items that are rated on a five-point scale. The scale was rated by three specifically trained, independent, and blinded raters. In the case of divergent ratings, consensus ratings were required.

In addition, several self-report measures for which reliability and validity have been demonstrated were applied. Worry was assessed by the Penn State Worry Questionnaire (30). Trait anxiety was assessed by the State-Trait-Anxiety Inventory (31). For other measures of anxiety, we used the Beck Anxiety Inventory (32) and the anxiety scale of the Hospital Anxiety and Depression Scale (33). Severity of depression was assessed by the Beck Depression Inventory (34). Interpersonal problems were assessed using the Inventory of Interpersonal Problems (35).

### *Data Analysis*

Data were analyzed using SPSS Version 16.0. The baseline clinical and demographic variables of the two treatment groups were compared by  $\chi^2$ -tests for dichotomous variables or t-tests for continuous variables. Differences between the two treatment groups at baseline in Hamilton Anxiety Rating Scale, Penn State Worry Questionnaire, State-Trait-Anxiety Inventory, Beck Anxiety Inventory, Hospital Anxiety and Depression Scale -Anxiety, Beck Depression Inventory, and Inventory of Interpersonal Problems scores were examined by one-way analyses of variance (ANOVAs).

Outcome of cognitive-behavioral therapy and short-term psychodynamic psychotherapy was examined by repeated measures ANOVAs. In the case of a significant group-by-time-interaction, post hoc t-tests were applied. Analyses were performed for post-

treatment and follow-up assessments. Intention-to-treat analysis (N=57) was employed by the last observation carried forward method. In addition, we conducted a completer analysis (N=52) for all patients who completed their psychotherapy as expected. For the primary outcome measure specified a priori (Hamilton Anxiety Rating Scale), alpha was not adjusted. For Hamilton Anxiety Rating Scale, a two-tailed alpha level of 0.05 was used for statistical tests. For the secondary outcome measures, alpha was set to 0.01 (0.05/5) in order to protect against type I error inflation.

Within-group effect sizes were assessed by dividing the difference between the pre-treatment and the post-treatment or follow-up score by the pooled standard deviation at baseline (16).

## RESULTS

No significant differences were found in clinical or demographic variables between the two treatment groups at baseline (see Table 1). Furthermore, the two treatment conditions did not differ significantly with regard to drop out rates during treatment ( $\chi^2(1) = 0.01$ ,  $p = 0.91$ ). In Table 2, means and standard deviations of the outcome measures are presented for the intention-to-treat sample.

Insert Table 2 about here

One-way ANOVAs showed no significant differences between the two treatment groups at baseline (Hamilton Anxiety Rating Scale ( $F(1,55) = 0.44$ ,  $p = .51$ ); Penn State Worry Questionnaire ( $F(1,55) = 5.21$ ,  $p = .03$ ); State-Trait-Anxiety Inventory ( $F(1,55) = 2.01$ ,  $p = .16$ ); Beck Anxiety Inventory ( $F(1,55) = 0.02$ ,  $p = .89$ ); Hospital Anxiety and Depression Scale - Anxiety ( $F(1,55) = 0.48$ ,  $p = .49$ ); Beck Depression Inventory ( $F(1,55) = 0.62$ ,  $p = .44$ ); Inventory of Interpersonal Problems ( $F(1,55) = 0.04$ ,  $p = .84$ ).

Insert Table 3 about here

The outcome of the two treatments was compared by repeated measures ANOVAs (see Table 3). For the post-treatment data significant effects of TIME were found for all outcome measures indicating significant improvements (Hamilton Anxiety Rating Scale ( $F(1,55)= 160.86, p<.01$ ); Penn State Worry Questionnaire ( $F(1,55)= 69.47, p<.01$ ); State-Trait-Anxiety Inventory-T ( $F(1,55)= 91.89, p<.01$ ); Beck Anxiety Inventory ( $F(1,55)= 77.09, p<.01$ ); Hospital Anxiety and Depression Scale -Anxiety ( $F(1,55)= 133.88, p<.01$ ); Beck Depression Inventory ( $F(1,55)= 87.50, p<.01$ ); Inventory of Interpersonal Problems ( $F(1,55)= 24.91, p<.01$ )). This was also true for all outcome measures at 6-month follow-up indicating significant improvements (Hamilton Anxiety Rating Scale ( $F(1,55)=154.83, p<.01$ ); Penn State Worry Questionnaire ( $F(1,55)=78.86, p<.01$ ); State-Trait-Anxiety Inventory-T ( $F(1,55)=82.34, p<.01$ ); Beck Anxiety Inventory ( $F(1,55)=66.45, p<.01$ ); Hospital Anxiety and Depression Scale -Anxiety ( $F(1,55)= 93.56, p<.01$ ); Beck Depression Inventory ( $F(1,55)=82.87, p<.01$ ); Inventory of Interpersonal Problems ( $F(1,55)= 23.01, p<.01$ )). Examination of the completer sample yielded no divergent results.

TIME x GROUP interactions at post-assessment were not significant for the Hamilton Anxiety Rating Scale ( $F(1,55)=1.66, p=.20$ ), the Beck Anxiety Inventory ( $F(1,55)=1.31, p=.26$ ), the Hospital Anxiety and Depression Scale -Anxiety ( $F(1,55)=2.79, p=.10$ ), and the Inventory of Interpersonal Problems ( $F(1,55)=0.20, p=.66$ ) indicating no differences in treatment outcome between cognitive-behavioral therapy and short-term psychodynamic psychotherapy. Significant TIME x GROUP interactions emerged for the Penn State Worry Questionnaire ( $F(1,55)=10.08, p<.01$ ), the State-Trait-Anxiety Inventory-T ( $F(1,55)=7.68, p<.01$ ), and the Beck Depression Inventory ( $F(1,55)=6.86, p=.01$ ). At the 6-month follow-up, no significant TIME x GROUP interaction was found for the Hamilton Anxiety Rating Scale

( $F(1,55)=3.01$ ,  $p=.09$ ), the Beck Anxiety Inventory ( $F(1,55)=1.58$ ,  $p=.22$ ), the Hospital Anxiety and Depression Scale -Anxiety ( $F(1,55)=2.65$ ,  $p=.11$ ), the Beck Depression Inventory ( $F(1,55)=4.38$ ,  $p=.04$ ) or the Inventory of Interpersonal Problems ( $F(1,55)=.08$ ,  $p=.77$ ). Significant TIME x GROUP interactions emerged for the State-Trait-Anxiety Inventory-T ( $F(1,55)=9.11$ ,  $p<.01$ ) and the Penn State Worry Questionnaire ( $F(1,55)=14.70$ ,  $p<.01$ ). Analyses of the completer sample yielded no divergent results.

The results of the post hoc two-tailed t-tests indicated that cognitive-behavioral therapy yielded significantly larger treatment effects for Penn State Worry Questionnaire, State-Trait-Anxiety Inventory-T, and Beck Depression Inventory after treatment (Penn State Worry Questionnaire:  $t(52)=3.19$ ,  $p<.01$ ; State-Trait-Anxiety Inventory-T:  $t(52)=2.78$ ,  $p<.01$ ; Beck Depression Inventory :  $t(52)=2.63$ ,  $p=.01$ ). This was true for the Penn State Worry Questionnaire and State-Trait-Anxiety Inventory-T also at the 6-month follow-up (Penn State Worry Questionnaire:  $t(51)=3.86$ ,  $p<.01$ ; State-Trait-Anxiety Inventory-T:  $t(54)=3.03$ ,  $p<.01$ ). Superiority of cognitive-behavioral therapy in these measures was associated with large between-group effect sizes in favor of cognitive-behavioral therapy (see Table 4).

Repeated-measures ANOVAs testing for differences between post-therapy and follow-up scores did not reveal significant main effects of TIME or significant TIME x GROUP interactions ( $p>.24$ ).

All within-group effect sizes for measures of anxiety and depression were large ( $\geq 0.80$ ) according to Cohen (16), except for Penn State Worry Questionnaire in short-term psychodynamic psychotherapy at follow-up (0.68, Table 4). For the Inventory of Interpersonal Problems the effect sizes were medium in both treatments. At the 6-month follow-up, the treatment effects were maintained.

Insert Table 4 about here

## DISCUSSION

In a randomized controlled trial, short-term psychodynamic psychotherapy and cognitive-behavioral therapy were compared in the treatment of Generalized Anxiety Disorder.

With regard to the severity of symptoms of anxiety at baseline, the patients included in this study were comparable to those of other treatment studies, for example, Hamilton Anxiety Rating Scale ranging from 23.21 to 25.83 (15) or from 21.8 to 26.8 pre-treatment (36) and State-Trait-Anxiety Inventory ranging from 57.34 to 58.43 (15) or from 49.8 to 52.2 pre-treatment (36).

Both treatments were associated with significant improvements in measures of anxiety and depression. For both methods the within-group effect sizes were comparable or even larger than those reported by several other studies (11,15,17,36). For the primary outcome measure (Hamilton Anxiety Rating Scale) as well as for two measures of anxiety (Beck Anxiety Inventory and Hospital Anxiety and Depression Scale –Anxiety) and for interpersonal problems (Inventory of Interpersonal Problems), no significant differences in outcome between the two treatments were found. However, cognitive-behavioral therapy was superior in measures of trait-anxiety (State-Trait-Anxiety Inventory), worrying (Penn State Worry Questionnaire), and depression (Beck Depression Inventory). With regard to descriptive statistics, the between-group effect sizes are in favor of cognitive-behavioral therapy. Thus, it is possible that more differences between the two treatment conditions exist, but the sample sizes were not large enough to permit detection. This is a limitation of our study. As in many studies of psychotherapy research, this was due to limitations in funding. Future randomized controlled trials comparing the outcome of psychodynamic psychotherapy with that of other active forms of psychotherapy should be carried out using larger patient samples.

Contrary to short-term psychodynamic psychotherapy, a core element in the applied method of cognitive-behavioral therapy is a modification of worrying. This specific difference between the treatments may explain the superiority of cognitive-behavioral therapy in the Penn State Worry Questionnaire and in part also in State-Trait-Anxiety Inventory-T - the latter also contains several items related to worrying. The results presented here may suggest that the outcome of short-term psychodynamic psychotherapy in Generalized Anxiety Disorder may be further optimized by employing a stronger focus on the process of worrying. In psychodynamic psychotherapy worrying can be conceptualized as a mechanism of defense that protects the subject from fantasies or feelings that are even more threatening than the contents of his or her worries (14).

As cognitive-behavioral therapy focuses explicitly on changing cognitive processes such as worrying or automatic thoughts, using the Penn State Worry Questionnaire as an outcome measure may tailor outcome measurement specifically to the effects of cognitive-behavioral therapy. In this context, it is of interest that the Penn State Worry Questionnaire did not show significant correlations to the Hamilton Anxiety Rating Scale ( $r=0.16$ ) or to the Beck Anxiety Inventory ( $r=0.16$ ) in this sample of patients with Generalized Anxiety Disorder ( $N=57$ ). In contrast, the Penn State Worry Questionnaire correlated significantly with the State-Trait-Anxiety Inventory ( $r=0.66$ ,  $p < 0.0001$ ). – As noted above several items of the State-Trait-Anxiety Inventory-T are related to worry. These correlations suggest that the Penn State Worry Questionnaire and in part the State-Trait-Anxiety Inventory-T tap other, more cognitive aspects of anxiety than the Hamilton Anxiety Rating Scale or to the Beck Anxiety Inventory. The items of the Hamilton Anxiety Rating Scale and the Beck Anxiety Inventory items suggest that these two instruments tap more somatic aspects of anxiety. In these two measures of anxiety, the treatments did not differ significantly.

The specificity of pathological worry in Generalized Anxiety Disorder has been questioned by several authors (37). Thus, the superiority of cognitive-behavioral therapy to

short-term psychodynamic psychotherapy regarding comorbid depression (Beck Depression Inventory) found at post-assessment may reflect the affinity of anxiety and depression in terms of worrying and rumination (38). As noted above, these cognitive aspects are typically addressed by cognitive-behavioral therapy.

It is common practice in psychotherapy research to use the Inventory of Interpersonal Problems Total Score. However, even in homogenous diagnostic groups different interpersonal subtypes can be found (39). These subtypes do not differ in levels of symptom severity or comorbid diagnoses, but exhibit differences in their improvement of interpersonal problems (40). Thus, studying changes using the Inventory of Interpersonal Problems Total Score provides only limited information. Thus, differences between the two treatments regarding improvements in interpersonal problems may exist. Furthermore, the treatments may be able to yield more than only medium improvements in interpersonal problems.

For cognitive-behavioral therapy a long tradition of treating anxiety disorders by manual-guided therapy exists. A large number of randomized controlled trials on cognitive-behavioral therapy for anxiety disorders including Generalized Anxiety Disorder have been carried out. For short-term psychodynamic psychotherapy we presented the first randomized controlled trial in Generalized Anxiety Disorder. The results are promising, but further studies are required in order to refine and enhance the efficacy of this form of psychotherapy.

Figure 1: Patient enrolment, randomization, treatment and follow-up

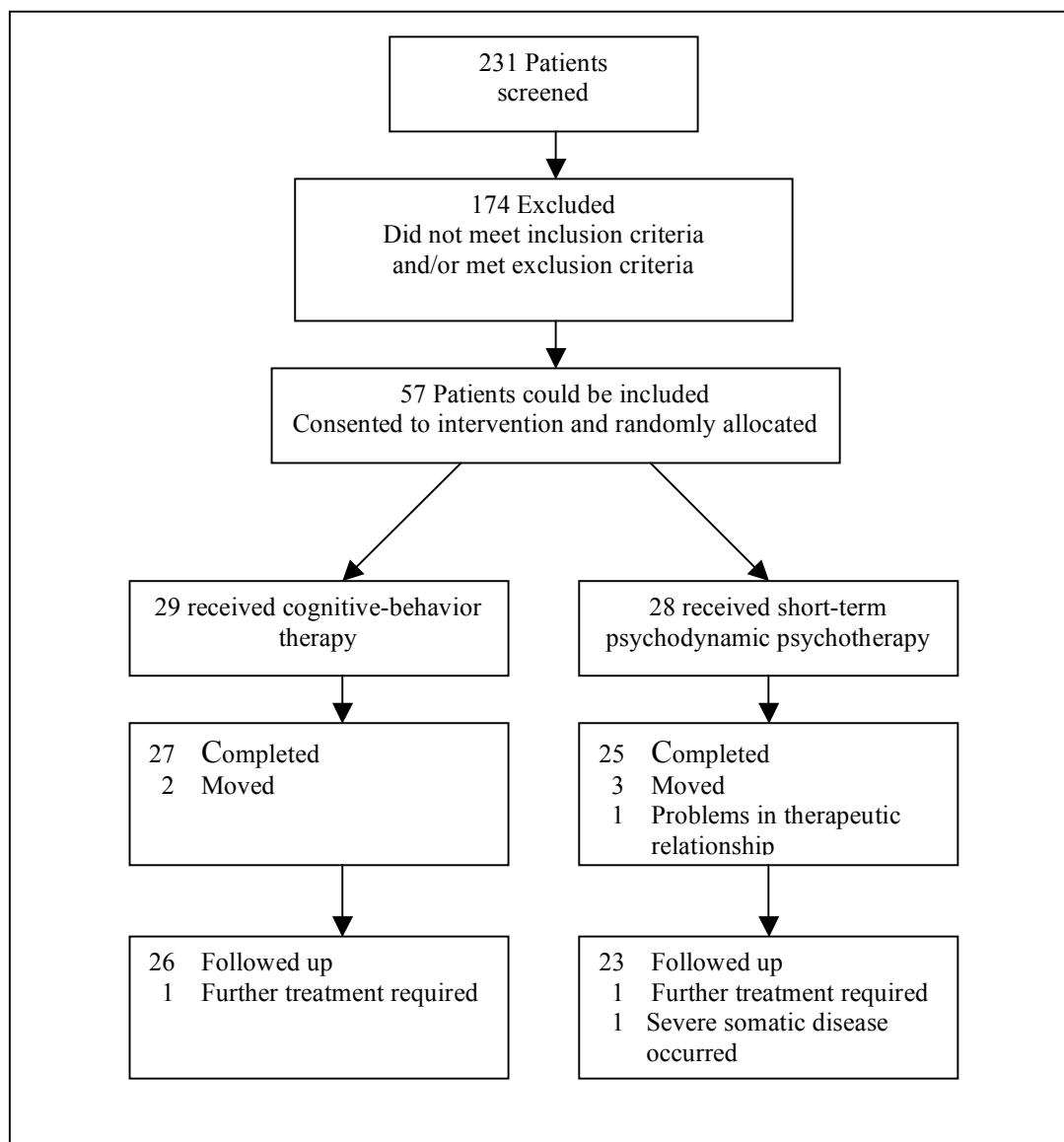




Table 1. Demographic and clinical characteristics

	<i>CBT</i> ( <i>N</i> =29)	<i>STPP</i> ( <i>N</i> =28)
Age at entry (years)	42.69 (SD=12.07)	42.29 (SD=12.81)
Gender (Females)	79.3%	82.1%
One or more comorbid axis I disorder(s)	75.9%	67.9%
Comorbid depressive disorder	27.59%	32.14%

*Note.* CBT: Cognitive-Behavioral Therapy

STPP: Short-Term Psychodynamic Psychotherapy