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Comparative Effectiveness of Cognitive and Dynamic Therapies for Major Depressive Disorder in a Community Mental Health Setting: A Randomized Non-Inferiority Trial

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Abstract

Importance—Dynamic psychotherapy is widely practiced in the community, but few trials have established its effectiveness for specific mental health disorders relative to control conditions or other evidence-based psychotherapies.

Objective—To determine whether dynamic psychotherapy is not inferior to cognitive therapy in the treatment of major depressive disorder in a community mental health setting.

Design—From 2010 to 2014, community outpatients with major depressive disorder were randomized to treatment delivered by trained therapists.

Setting—Community mental health center in Pennsylvania.

Participants—Twenty therapists employed at a community mental health center were trained by experts in either cognitive therapy or dynamic psychotherapy. A total of 237 adult outpatients with

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major depressive disorder seeking services at this site were randomized to 16 sessions of either dynamic psychotherapy or cognitive therapy delivered across 5 months.

Interventions—Short-term dynamic psychotherapy or cognitive therapy.

Main Outcome Measure—Expert blind evaluations with the 17-item Hamilton Rating Scale for Depression.

Results—There was a mean difference between treatments in change on the Hamilton Rating Scale for Depression of 0.86 scale points (95% CI [−.70–2.42]; SD = 7.73; Cohen $d = .11$), indicating that dynamic psychotherapy was statistically not inferior to cognitive therapy. There was a statistically significant main effect for time ($F_{1,198} = 75.92$, $P = .001$). There were no statistically significant differences between treatments on patient ratings of treatment credibility. Dynamic therapy and cognitive therapy were discriminated from each other on competence in supportive techniques ($t_{120} = 2.48$, $P = .02$), competence in expressive techniques ($t_{120} = 4.78$, $P = .001$), adherence to cognitive therapy techniques ($t_{115} = -7.07$, $P = .001$), and competence in cognitive therapy ($t_{115} = -7.07$, $P = .001$).

Conclusions and Relevance—This study suggests that dynamic psychotherapy is not inferior to cognitive therapy on change in depression for the treatment of major depressive disorder in a community mental health setting. The CI suggests that the effects of dynamic psychotherapy are equivalent to cognitive therapy.

Trial Registration—ClinicalTrials.gov (A Comparison of Cognitive and Dynamic Therapy for Depression in Community Settings; NCT01207271).

The effectiveness of cognitive therapy (CT)[1] for major depressive disorder (MDD) has been established in controlled efficacy trials[2–5] and real world effectiveness trials.[6,7] However, there has been substantial debate as to whether short-term dynamic psychotherapy (DT), which targets an individual's impairing relationship conflicts, has the research base to support its dissemination as an intervention for MDD. Although DT has been and is currently practiced worldwide,[8,9] the research literature across mental disorders is flooded with reviews debating whether DT has adequate evidence of effectiveness.[10–20] Despite the myriad of reviews debating this issue, few trials of DT specifically for MDD have met the strict design criteria detailed by Chambless and Hollon[21] and few attempts have been made to directly compare DT to CT.

Two trials involving the treatment of MDD have demonstrated that DT plus medication is superior to medication alone,[22,23] and one pilot study demonstrated that DT was superior to treatment-as-usual (TAU) for treating MDD in a community mental health setting.[24] The largest study to date[25] demonstrated that DT was statistically significantly not inferior to CT for treating MDD in an outpatient setting in the Netherlands.

We present here the results of a randomized non-inferiority trial directly comparing CT to DT for treating MDD in a community mental health setting. Our study builds on the previous non-inferiority trial[25] by including a broad assessment of functioning and quality of life, blind independent ratings of treatment fidelity, and a community mental health sample. Details of the protocol are published.[26] We developed and implemented our trial with a

focus on internal validity, including: (1) expert, individual and group supervision; (2) blind fidelity ratings; and (3) blind expert assessments of the primary symptom outcome.

The primary hypothesis for this trial was that DT would not be inferior to CT for treating MDD in a community mental health setting as measured by blind expert ratings of depressive symptoms. Our secondary hypothesis was that DT would not be inferior to CT across broader assessments of symptoms, functioning, and quality of life.

Methods

Study procedures were conducted in compliance with the University of Pennsylvania Institutional Review Board. Participants provided written consent. Patients received gift cards worth between $25 and $50 for each assessments and clinicians earned $300 for workshop attendance, $25 for supervision sessions, and $150 honorariums for every 2 patients treated.[26]

Setting

This trial was conducted in collaboration with NHS Human Services (NHS), a private, nonprofit organization that provides mental health services across seven Mid-Atlantic states, primarily to publicly funded consumers. The current study took place at one outpatient community mental health center (CMHC) providing services to approximately 4,900 individuals per year.

Participants

Patients—Patient participants were recruited from those seeking services for depression at the CMHC. The Quick Inventory for Depressive Symptomatology (QIDS)[27] was completed by all adult patients attending an intake assessment. Patients aged 18 to 65 who scored at least 11 on the QIDS were then screened by phone, and potentially eligible participants were scheduled for a baseline assessment. A research clinical evaluator conducted the Structured Clinical Interview for the *DSM-IV* Axis I disorders interview (SCID-I).[28] Patients who met criteria for MDD were included in the study if they did not have: (1) a diagnosis of bipolar disorder; (2) current or past diagnosis of schizophrenia, psychosis, MDD with psychotic features, or seizure disorder; (3) depression due to organic pathology; (4) substance/alcohol abuse requiring immediate referral to substance abuse treatment; (5) referral to partial hospital; or (6) suicidal thoughts judged by the clinic to require more intensive psychotherapy.

Clinicians—Clinicians employed by NHS were recruited through advertisement. All clinicians had a master's degree or above. Clinicians were matched to treatment based on previous training and education, theoretical orientation, and desire to be trained in a given treatment.

Interventions

Supportive-expressive dynamic psychotherapy—The DT consisted of supportive-expressive DT.[29,30] The treatment includes both techniques to build a positive working

alliance and expressive techniques to help patients gain self-understanding of their repetitive maladaptive relationship patterns. The treatment actively explores current relationship conflicts, and includes socialization to treatment and focus on interpersonal goals.

Cognitive therapy—Standard CT[1,31] consisting of structured sessions focusing on both behavioral activation and the exploration of depressogenic beliefs was implemented. Interventions included activity scheduling, evaluating automatic thoughts, and behavioral experiments.

Training and supervision—The training and supervision was provided by expert supervisors with substantial experience delivering and supervising the respective treatments. The DT supervisor had 20 years of clinical experience and the CT had 14 years at the time of study initiation. A training workshop was followed by intensive individual supervision across the first 3 training cases. Ongoing bimonthly group supervision was provided to clinicians across training and randomization phases. Supervisors listened to digital recordings of sessions to prepare for both the individual and group supervision sessions.

Nine CT clinicians and 11 DT clinicians completed the workshop and training and treated at least 1 randomized patient. Further details on training of therapists are provided by Connolly Gibbons et al.[26]

Assessments

All assessments were administered at baseline, months 1, 2, 4, and 5 at the CMHC. The Hamilton Rating Scale for Depression (HAM-D)[32,33] was used to evaluate the severity of depression. Trained clinical evaluators administered the SCID-I and HAM-D. These evaluators were not affiliated with the clinical site and were blind to treatment condition and study hypotheses. A diagnostic supervisor provided written feedback based on a random review of 10% of audiotaped interviews and conducted a monthly group conference call to maintain reliability.

Secondary outcomes included the BASIS-24,[34] the Quality of Life Inventory (QOLI),[35] and the Medical Outcomes Study 36-item Short Form (SF-36)[36] (mental and physical component scores).[37,38]

The Opinions About Treatment (OAT)[39] was administered following session 2 to assess patients' perceptions of treatment credibility. Patients were informed at randomization of their treatment assignment, but were not informed of the study hypotheses. Demographics, including race and ethnicity (assessed for descriptive purposes), were self-reported by patients at baseline into categories defined prior to the study by investigators.

Procedures

Eligible patients were randomized in a parallel design with a 1:1 allocation to either 16 sessions of DT or CT delivered across 5 months using a computer generated urn randomization algorithm[40–42] based on 7 pretreatment factors, including: gender,[43,44] long term relationship status,[43,45,46] minority status,[44,47,48] expectations of improvement,[49,50] depression severity,[43,45,46,49,51] use of psychotropic medications,[52,53] and recurrence of

depression.[49,54] The study statistician, who had no contact with study participants, generated the random assignment, and conveyed the assignment to the study research assistant at baseline. The research assistant then scheduled the patient for the first study therapy appointment. All patients were invited to complete assessments regardless of the number of treatment sessions attended. All appointments took place at the CMHC.

Assessment of Fidelity of Treatment Delivery

Measures of fidelity to DT were rated on one early session (usually session 3) of each DT case and a random sample of 19 CT cases. Measures of fidelity to CT were rated on one early session of each CT case and a sample of 20 DT cases. In order to benchmark our results, we rated the CT fidelity measures on one early session from 15 randomly selected cases that participated in an efficacy trial of CT.[2]

For DT, we used a community adaptation of the Penn Adherence/Competence Scale for Supportive Expressive Dynamic Psychotherapy.[24,55] CT adherence was assessed using the CT subscale of the Collaborative Study Psychotherapy Rating Scale[56]; the Cognitive Therapy Scale[57] was used to assess competence. A separate pool of 4 advanced graduate student judges was used to rate fidelity to each treatment in a balanced incomplete block design. All judges were blind to the research design, settings, and the interventions utilized in each sample.

Data Analytic Strategy

We conducted hierarchical linear models (HLM) comparing slopes across treatment groups including all observed data across the monthly assessments. Time was defined as the log of the number of weeks from the baseline assessment. All patients randomized to treatment were included in the analyses regardless of the number of treatment or assessment sessions attended. The HLM model included random intercept and random slope terms, with an autoregressive structure used to model the residual errors. In the HLM analysis, those with only a baseline value contribute to the estimate of the intercept as well as the variance component attributable to the random intercept. Our primary outcome was the model based change from baseline to endpoint on the 17-item HAM-D total score. We selected an a priori non-inferiority margin of a difference of 2.5 points on change in the HAM-D as the smallest clinically relevant change recommended by Montgomery[58] and previously implemented by Szegedi and colleagues.[59] We followed Hirotsu's unifying approach[60] to include both a test of non-inferiority followed by a subsequent test for treatment superiority only in the case that non-inferiority is not obtained. For this multiple decision process, the α level was set a priori at .025 to account for the two decisions. The non-inferiority of the secondary measures was evaluated using an a priori defined margin of Cohen *d* effect size of .29, which represents a small to moderate effect.

Power calculations used the formula per Julious[61] to guarantee a power of 80% for assessing non-inferiority and superiority, while accommodating the repeated measures design.[62,63] Included in the formula were the non-inferiority bound of 2.5 HAM-D points defined a priori, a pooled standard deviation set at 8.5, α set at .025, an attrition rate of 10%, repeated

assessments, and an estimated within-subject correlation of .40. Sample size was determined to be 230 subjects.

Results

Participant Flow

Recruitment occurred from October, 2010 through July, 2014. The QIDS was completed by 3,951 outpatients at treatment intake (Figure 1). The clinic intake worker excluded 851 patients based on diagnosis of psychotic disorder or immediate referral to a more intensive treatment program. Of 1,110 consumers screened by phone, 529 (48%) were excluded for lack of interest, failure of phone screen criteria, inability to contact, or repeated no show for assessment. Five hundred eighty-one baseline assessments were conducted, and 237 (41%) were randomized to treatment. Of the 118 patients randomized to DT, 103 (87%) attended at least 1 treatment session and 104 (88%) received at least 1 postbaseline assessment. Of the 119 patients randomized to CT, 99 (83%) attended at least 1 treatment session and 105 (88%) received at least 1 postbaseline assessment.

Baseline Characteristics

Baseline demographic characteristics are presented in Table 1. The majority of patients were female, single, not employed full-time, with a high school diploma or less. Forty-nine percent of patients were members of a minority group. There were no statistically significant differences between treatment groups on any of the baseline demographic variables (all *P's* > .08). Twenty-five percent of patients attended 1 or less sessions of psychotherapy, 50% attended 5 or fewer sessions, and 75% attended 11 or fewer sessions. There was no statistically significant difference between treatments in the number of sessions attended (t_{235} = 1.47, P = .14). Representative of the CMHC setting, 89% of patients had a concurrent Axis I diagnosis, 70% had a concurrent anxiety diagnosis, and 56% had a concurrent alcohol or substance use diagnosis. Baseline demographics for clinicians are presented in Table 2. Clinicians were predominantly female and Caucasian with an average age of 40 years old.

Treatment Credibility

Patients rated both treatments with high credibility. Two-tailed tests for paired samples indicated no differences between treatments on ratings of treatment sensibility (t_{162} = .19, P = .85), confidence in treatment (t_{162} = −1.14, P = .26), or confidence recommending the treatment (t_{162} = −.86, P = .39).

Comparative Effectiveness

Primary Outcome—For the primary outcome measure, there was a mean difference in change on the HAM-D of 0.86 scale points (SD = 7.73; d = .11) between CT and DT. With α set at .025, the upper bound of the confidence interval (CI) for this value is 2.42 HAM-D points. The CI upper bound of 2.42 is less than our a priori non-inferiority margin of 2.5 points, indicating that change in depressive symptoms for the DT group is statistically not inferior to the amount of change in depressive symptoms observed in the CT condition (Table 3). Evaluation of the CI suggests that DT is equivalent to CT on change in depression. There was a statistically significant main effect for time ($F_{1,198}$ = 75.92, P = .001, d = .55

within DT, d = .65 within CT, on change from baseline to endpoint). There was no statistically significant interaction between use of psychotropic medication and treatment group on rate of change in HAM-D ($F_{1,209}$ = 0.12, P = .73).

Secondary Outcomes—Despite small observed effect size differences between the treatments, it cannot be concluded that the DT was statistically non-inferior to CT on change on the BASIS-24 (d = .14, CI upper bound = .35), the QOLI total score (d = .22, CI upper bound = .43), or the SF-36 mental component score (MCS) (d = .15, CI upper bound = .36) (Table 3). There was a statistically significant main effect for time on the BASIS-24 ($F_{1,192}$ = 133.32, P = .001), the QOLI ($F_{1,188}$ = 44.55, P = .001), and the SF-36 MCS ($F_{1,205}$ = 60.52, P = .001). Superiority of CT over DT was not demonstrated for change on the BASIS-24 ($F_{1,192}$ = 1.07, P = .30), the QOLI ($F_{1,188}$ = 4.18, P = .04), or the SF-36 MCS ($F_{1,205}$ = .049, P =.48). DT was significantly non-inferior to CT on the SF-36 physical component score (PCS) (d = −.07, CI upper bound = .14, P < .025); however, both treatments demonstrated significant (but slight) deterioration across time ($F_{1,207}$ = 5.19, P = .02). Sixteen percent of patients in DT and 22% of patients in the CT condition demonstrated response to treatment as measured by a 50% reduction on the HAM-D score across treatment ($\chi^2_1=1.27$, P = .32).

Treatment Fidelity

Adherence to supportive techniques was not rated significantly higher in DT compared to CT (t_{120} = −.38, P = .70) (Table 4). However, competence in the use of psychodynamic supportive techniques (t_{120} = 2.48, P = .02), as well as adherence (t_{120} = 3.89, P = .001) and competence to expressive techniques (t_{120} = 4.78, P = .001), were rated significantly higher in DT compared to CT. Adherence to CT techniques (t_{115} = −7.07, P = .001) and CT concrete techniques[64](t_{115} = −7.04, P = .001) were rated significantly higher in CT compared to DT, but neither adherence to CT techniques (t_{110} = −.55, P = .58) nor adherence to CT concrete techniques (t_{110} = −1.42, P = .16) were rated significantly different from the CT efficacy sample. Competence in CT techniques was rated as significantly higher in CT compared to DT (t_{115} = −7.07, P = .001), but was not statistically significantly different from the CT efficacy sample (t_{110} = −1.21, P = .23).

Adverse Events

Five of the 118 patients randomized to DT and 10 of the 119 patients randomized to CT experienced at least one serious adverse event ($\chi^2_1=1.73$, P = .19). The majority of serious adverse events included non-psychiatric hospitalizations. None were judged to be related to study procedures or intervention.

Discussion

The trial results indicate that short-term DT is not inferior to CT in decreasing depressive symptomatology among patients receiving services for MDD in the community mental health setting. This investigation adds to the emerging literature of randomized trials[22–25] indicating that short-term DT is another efficacious intervention, in addition to CT, for treating MDD. DT and CT were discriminated from each other on adherence and

competence ratings with large effect sizes. CT adherence and competence ratings for our CMHC CT group were not significantly different from that observed with expert therapists in efficacy trials.

Our secondary analyses examining non-inferiority of DT compared to CT on measures of self-reported depression, functioning, and quality of life were largely inconclusive. Across these four secondary measures, the average effect size for differences between treatment conditions on change across treatment was $d = .11$, indicating that there was not a clinically meaningful advantage for CT. When this protocol was designed, we had no data to base the setting of the non-inferiority margin for these secondary measures and statistical power was only set for testing non-inferiority on the primary outcome measure. Our obtained data demonstrated large variation on these measures in this setting, resulting in the confidence intervals for extremely small observed effects extending beyond the .29 margin. Limitations of this study include the lack of a control condition, missing monthly outcome data for some patients, and a lack of a follow-up assessment. Further, these results may generalize only to the community mental health setting. Our results do, however, replicate a large randomized non-inferiority trial conducted in a general outpatient setting[25] suggesting that DT is not inferior to CT among patients receiving services in a broad range of community settings. It is noted that these treatments were not delivered with the same intensity as in efficacy trials, however these results represent the comparative effectiveness of these treatments in a real world setting. We could not consider therapist as an additional level in our HLM structure due to a limited number of repeated assessments. The model including therapist as a random effect yielded a variance estimate of 0 where statistical significance could not be evaluated due to non-convergence. Finally, the TAU and efficacy samples used to benchmark the fidelity ratings were not randomized samples.

Conclusion

Our investigation indicates that when intensive expert supervision is utilized in community mental health settings, DT is not inferior to CT on change in depression for the treatment of MDD. Both treatments were delivered in this community mental health setting with high fidelity and could be discriminated from one another.

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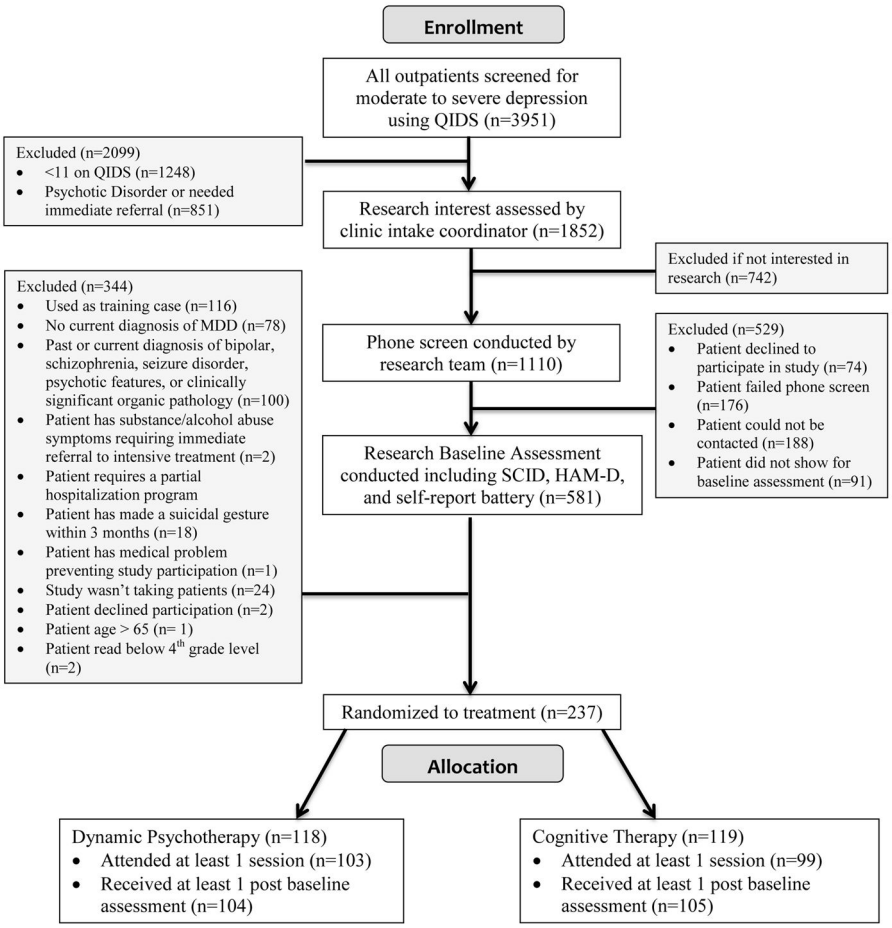

Figure 1.

Recruitment Flow Diagram for Cognitive and Dynamic Psychotherapy Conditions. Abbreviations: QIDS, Quick Inventory for Depressive Symptomatology; MDD, Major Depressive Disorder; SCID, Structured Clinical Interview for DSM-IV Axis I Disorders; HAM-D, Hamilton Rating Scale for Depression.

Table 1

Demographic Characteristics of Patients

Characteristics	Dynamic Therapy (n = 118)	Cognitive Therapy (n = 119)	*P* Value[a]
Female, No. (%)	90 (76.3)	88 (73.9)	.76
Marital Status, No. (%)[b]			
Single	69 (58.5)	65 (54.6)	
Married/Cohabitating	18 (15.3)	28 (23.5)	.13
Separated/Divorced	25 (21.2)	26 (21.8)	
Widowed	6 (5.1)	0 (0)	
Hispanic, No. (%)	4 (3.4)	6 (5.0)	.75
Race, No. (%)			
African-American	50 (42.4)	46 (38.7)	
Caucasian	63 (53.4)	58 (48.7)	.29
Other	5 (4.2)	15 (12.6)	
Employment, No. (%)[b]			
Full-Time	8 (6.8)	6 (5.0)	
Part-Time	6 (5.1)	14 (11.8)	
Stay at Home Parent	9 (7.6)	8 (6.7)	.23
Unemployed	62 (52.5)	61 (51.3)	
Student	7 (5.9)	12 (10.1)	
Disabled	26 (22.0)	18 (15.1)	
Highest level of education, No. (%)[b]			
< High School Diploma	36 (30.5)	20 (16.8)	
High School Diploma/GED	42 (35.6)	42 (35.3)	
Some College	32 (27.1)	50 (42.0)	.08
College Graduate	5 (4.2)	3 (2.5)	
Postgraduate or Professional degree	3 (2.5)	4 (3.4)	
Age, mean (SD), y	36.07 (11.84)	36.29 (12.31)	.89

[a] *P* values represent comparisons between treatment groups including t-test for continuous variables and Pearson Chi-Square test for categorical variables.

[b] Percentages add up to 100.1% or 99.9% due to rounding issues.

Table 2

Demographic Characteristics of Clinicians

Characteristics	Dynamic Therapy (n = 11)	Cognitive Therapy (n = 9)
Female, No. (%)	10 (90.9)	9 (100)
Hispanic, No. (%)	0(0)	0(0)
Race, No. (%)		
Caucasian	6 (54.5)	6 (66.7)
African American	2 (18.2)	3 (33.3)
Asian	3 (27.3)	0 (0)
Highest Degree, No. (%)		
Master's	10 (90.9)	9 (100)
Doctoral	1 (9.1)	0 (0)
Experience, mean (SD), y	5.95 (8.34)[a]	6.50 (6.81)
25th Percentile, y	1.75[a]	2.00
50th Percentile, y	3.50[a]	3.50
75th Percentile, y	5.88[a]	10.50
Age, mean (SD), y	44.80 (17.02)[a]	35.89 (11.59)
25th Percentile, y	31.50[a]	26.00
50th Percentile, y	40.00[a]	33.00
75th Percentile, y	63.25[a]	46.50

[a] n = 10

Table 3

Means and Standard Deviations of Outcome Measures Across Baseline and Endpoint

Outcome	Treatment	Baseline mean (SD)	Estimated Endpoint mean (SD)	Slope mean (SD)	Non-Inferiority Margin	Non-Inferiority Criteria
HAM-D	DT (n = 118)	21.05 (5.93)	16.89 (4.35)	−1.31 (0.86)	2.50[a]	0.86[c] (95% CI [−.70–2.42[d]]; SD = 7.73)
	CT (n = 119)	21.08 (5.69)	16.06 (4.23)	−1.56 (1.23)		
BASIS-24	DT (n = 118)	2.29 (0.49)	1.83 (0.48)	−0.14 (0.10)	.29[b]	*d* = .14; 95% CI (−.07−.35[d])
	CT (n = 119)	2.29 (0.50)	1.73 (0.51)	−0.17 (0.08)		
QOLI	DT (n = 118)	−1.40 (1.90)	−0.78 (1.54)	0.20 (0.25)	.29[b]	*d* = .22; 95% CI (.00−.43[d])
	CT (n = 119)	−1.49 (1.95)	−0.33 (1.39)	0.37 (0.38)		
SF-36 PCS	DT (n = 118)	44.98 (12.38)	44.40 (9.43)	−0.25 (1.73)	.29[b]	*d* = −.07; 95% CI (−.28−.14[d])
	CT (n = 119)	45.38 (12.66)	43.61 (10.22)	−0.55 (0.68)		
SF-36 MCS	DT (n = 118)	22.37 (9.05)	28.50 (7.47)	1.94 (2.63)	.29[b]	*d* = .15; 95% CI (.05−.36[d])
	CT (n = 119)	23.04 (9.52)	30.33 (8.04)	2.33 (2.58)		

Abbreviations: DT, Dynamic Psychotherapy; CT, Cognitive Therapy; HAM-D, Hamilton Rating Scale for Depression; BASIS-24, 24-item Behavior and Symptom Identification Scale; QOLI, Quality of Life Inventory; SF-36 PCS, Medical Outcomes Study 36-item Short Form Physical Component Score; SF-36 MCS, Medical Outcomes Study 36-item Short Form Mental Component Score.

[a]Mean difference in change on the HAM-D;

[b]Cohen *d* between group effect size;

[c]Mean differences derived from HLM model;

[d]Upper bound of CI calculated for *P* = .025.

Table 4

Descriptive Statistics for Fidelity Scales

Fidelity to Dynamic Psychotherapy					
Scale	**DT Community (n = 103)**	**CT Community (n = 19)**			
	mean (SD)	**mean (SD)**	***d(P)*[a]**		
Adherence Supportive	3.40(.50)	3.45(.60)	−.10(.70)		
Competence Supportive	4.38(.61)	4.00(.72)	.62(.02)		
Adherence Expressive	2.42(.70)	1.77(.55)	.98(.001)		
Competence Expressive	3.35(.79)	2.43(.64)	1.20(.001)		
Fidelity to Cognitive Therapy					
Scale	**CT Community (n = 97)**	**DT Community (n = 20)**		**CT Efficacy (n = 15)**	
	mean (SD)	**mean (SD)**	***d(P)*[b]**	**mean (SD)**	***d(P)*[b]**
Adherence CT	1.59(.53)	.72(.24)	1.78(.001)	1.66(.40)	.15(.58)
Adherence CT concrete	1.74(.76)	.53(.20)	1.82(.001)	2.03(.63)	.40(.16)
Competence CT	34.41(7.70)	21.57(5.63)	1.75(.001)	36.91(5.63)	.34(.23)

Abbreviations: DT, Dynamic Psychotherapy; CT, Cognitive Therapy; *d*, Cohen *d* effect size.

[a] *P* value in comparison to DT Community sample.

[b] *P* value in comparison to CT Community sample.