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EVALUATION OF THE EFFECTIVENESS OF SHORT-TERM INTEGRATIVE PSYCHOTHERAPY IN ANXIETY DISORDERS

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Abstract
A randomized trial compared short-term integrative psychotherapy (12 sessions combining cognitive-behavioral, rational, and relaxation techniques) with traditional rational psychotherapy (10–12 sessions) in 121 inpatients with ICD-10 F40–F41 anxiety disorders. Integrative therapy reduced mean Hamilton Anxiety scores from 33.1 to 8.7, achieving remission-level anxiety (HARS < 10) in 84 % of patients, whereas rational therapy lowered scores from 32.9 to 18.8 with 28 % in remission. Both treatments normalized mild depressive symptoms, but global severity (CGI-S) was “healthy” in 72 % versus 30 % of cases, respectively. Integrative therapy shortened hospital stay by ~13 days and cut direct costs more than ten-fold, with lower six-month relapse (4.5 % vs 14.8 %). These results endorse short-term integrative psychotherapy as a clinically and economically superior option for routine management of anxiety disorders.

Keywords: Anxiety disorders, integrative psychotherapy, treatment effectiveness, short-term psychotherapy.

Introduction

Anxiety disorders are among the most common mental health conditions globally, characterized by excessive fear, worry, and associated somatic symptoms. According to the World Health Organization, approximately 301 million people worldwide were living with an anxiety disorder in 2019, making it the most prevalent class of mental disorders. Such disorders not only cause significant psychological distress but also lead to serious socio-economic consequences. Chronic anxiety can impair occupational functioning and productivity, contributing to increased healthcare utilization and economic losses due to medical costs and work absenteeism. Globally, depression and anxiety disorders together are estimated to cost over one trillion US dollars annually in lost productivity. Despite the high prevalence and impact of anxiety disorders, a substantial treatment gap persists. Only about one in four individuals affected by anxiety receives any treatment for their condition. Limited awareness of effective treatments, stigma, and scarce resources for mental

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health care all contribute to this gap. Additionally, we aimed to assess whether the integrative method offers advantages in economic outcomes, such as shorter hospital stays and lower treatment costs, which are critical considerations in resource-limited mental health settings.

Study Objectives

The study's primary objective was to compare the clinical efficacy of short-term integrative psychotherapy versus standard rational psychotherapy in patients with anxiety neurotic disorders.

Materials and Methods

Study Design and Setting: A comparative clinical experiment was conducted at the Tashkent City Clinical Psychiatric Hospital. The design was a randomized, parallel-group trial comparing two psychotherapeutic interventions. The study was carried out between 2019 and 2022 and was approved by the relevant institutional ethics committee. All participants provided written informed consent prior to enrollment. Sample and Inclusion Criteria: The study included 121 adult inpatients (87 women, 34 men) aged 25 to 47 years (mean 34.5 ± 6.3) with a diagnosis of anxiety neurotic disorder according to ICD-10 criteria (primarily falling under F40–F41: including generalized anxiety disorder, panic disorder, phobic anxiety disorders, and mixed anxiety-depressive disorder). Participants were recruited upon admission for treatment of anxiety symptoms. Inclusion criteria were: (a) a confirmed primary diagnosis of an anxiety neurotic disorder by clinical assessment and standardized questionnaires; (b) at least moderate anxiety symptom severity at entry, defined by a Hamilton Anxiety Rating Scale (HARS) score > 25; (c) absence of severe comorbid psychopathology such as psychotic disorders or substance dependence; (d) no gross cognitive impairment or organic central nervous system pathology; (e) no evidence of high suicide risk or severe uncontrolled medical illness that would contraindicate active psychotherapy; and (f) patient willingness to engage in a psychotherapeutic program. Patients who met inclusion criteria were randomly assigned to one of two treatment groups (integrative therapy or rational therapy) using a simple randomization procedure. Therapeutic Interventions: Both interventions were delivered over a short-term inpatient treatment period of approximately 6 weeks. Therapy sessions in both groups were conducted individually (one-on-one with a therapist). Antianxiety or antidepressant medications were prescribed as needed in both groups as an adjunct to psychotherapy, in accordance with standard clinical protocols; medication use was evenly balanced between groups to avoid confounding (for instance, the proportion of patients receiving an SSRI did not differ significantly between groups, $p>0.99$).

Integrative Psychotherapy (Intervention Group, n = 67): The integrative psychotherapy program was a structured short-term approach developed by the study authors, consisting of 12 therapy sessions conducted three times per week (session duration ~60–90 minutes). The course length was about 1 to 1.5 months during the inpatient stay. This modality is termed "integrative" because it combines techniques from cognitive-behavioral therapy, rational emotive therapy, and hypnorelaxation. Each session or phase of therapy targeted different dimensions of anxiety:

Rational Psychotherapy (Control Group, n = 54): The control group received a course of traditional rational psychotherapy, which is a standard psychotherapeutic approach in which the therapist uses reasoned discussion and persuasion to alleviate the patient's symptoms. Treatment in this group

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consisted of approximately 10–12 individual sessions delivered 2–3 times per week (comparable overall duration of ~1–1.5 months). The rational therapy followed a conventional format as described in psychiatric practice literature: the therapist provided the patient with a detailed, didactic explanation of the nature and mechanisms of their anxiety disorder, helping the patient understand that their symptoms (e.g. palpitations, dizziness, worry) are the result of nervous system activation and not indicative of a catastrophic medical event.

Outcome Measures: Participants were evaluated at two time points: at baseline (upon admission, before the start of psychotherapy) and at the end of the treatment course (after ~6 weeks, at discharge). A battery of standardized clinical scales and assessments was used to quantify outcomes (HARS, HDRS-17, CGI-S):

Results

A total of 121 patients (71.9% female, 28.1% male) were included in the analysis. The mean age of participants was 34.5 ± 6.3 years. The two treatment groups did not differ significantly in age or sex distribution ($p > 0.5$ for both), indicating successful randomization. Approximately 68% of the sample had higher (university-level) or incomplete higher education, with no significant educational level differences between groups. The average duration of anxiety disorder prior to the study was about 2.8 years (SD ~2.1 years), and around 30% of patients had previously received some pharmacological treatment for anxiety on an episodic basis. However, none had undergone systematic psychotherapy before this study. At hospital admission (pre-treatment), all patients exhibited clinically significant anxiety symptoms. The most common clinical presentations included generalized anxiety (persistent free-floating anxiety) in 44% of patients, panic attacks in 27%, social anxiety in 19%, and mixed anxiety with depressive symptoms in 10%. Baseline psychometric assessments confirmed that the integrative and rational therapy groups were comparable in symptom severity. The mean HARS score at baseline was ~33 in both groups (Integrative: 33.1 ± 5.3; Rational: 32.9 ± 6.2), reflecting a severe level of anxiety on this scale. This small difference in baseline HARS (33.09 vs 32.94) was not statistically significant ($F(1,119) = 0.02$, $p = 0.89$). Mean HDRS-17 scores at baseline were ~14 in each group (Integrative: 14.1 ± 4.8; Rational: 13.9 ± 5.1), consistent with mild depressive symptoms on average; this did not differ between groups ($p = 0.82$). The average CGI-S score was about 3 in both groups (Integrative: 3.06; Rational: 2.91), which corresponds to a “mildly ill” overall clinical impression. This difference was also non-significant ($p = 0.53$). Thus, prior to treatment, the two groups were statistically homogeneous in terms of anxiety severity, depressive symptoms, and global illness severity. This homogeneity is important for ensuring that any post-treatment differences can be attributed to the therapy type rather than baseline disparities.

Integrative Therapy Group: Patients who received short-term integrative psychotherapy showed a marked reduction in anxiety symptoms over the course of treatment. Individual progress trajectories indicated that many patients experienced notable anxiety relief as early as the 4th or 5th session, with continued improvement through the end of therapy. By discharge, the mean HARS score in the integrative group had decreased from 33.1 at baseline to 8.7 ± 4.2. This corresponds to a drop of roughly 24 points, moving from the severe anxiety range into the single-digit range, which indicates only minimal residual anxiety. The within-group improvement on

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HARS was highly significant (paired $t = 27.72$, $p < 0.001$). The magnitude of anxiety reduction was large not just in statistical terms but also clinically meaningful. A 95% confidence interval for the mean HARS change (approximately –22 to –26 points) did not include zero, underscoring the robustness of the improvement. By the end of therapy, 83.6% of patients in the integrative group achieved a HARS score < 10, which can be considered essentially remission of clinical anxiety. In practical terms, these patients were nearly symptom-free or had only mild, occasional anxiety that did not meet criteria for an anxiety disorder. No patients in the integrative group experienced a worsening of anxiety during treatment; all showed some degree of improvement, and none failed to respond. Depressive symptoms also improved in the integrative therapy group. The mean HDRS-17 score dropped from 14.1 to 3.8 ± 2.7 post-treatment, indicating that, on average, patients went from mild depression to virtually no depressive symptoms. This reduction was statistically significant ($p < 0.001$). In fact, by the end of therapy, the average HDRS score fell below 4, a level at which depression is not considered clinically significant. Thus, any co-occurring depressive mood symptoms present at baseline were largely resolved alongside the reduction in anxiety. The improvements in depression can be attributed in part to the alleviation of anxiety (since anxiety relief often lifts mood) and also to specific therapeutic elements: the integrative approach included positive reframing and activation of patient resources, which likely had an antidepressant effect on these relatively mild baseline depressive symptoms. Global clinical state, as measured by CGI-S, improved dramatically in the integrative group. The mean CGI-S score declined from 3.06 (indicating "mildly ill") at baseline to 1.42 after treatment. A score around 1–2 corresponds to "normal, not ill" or only borderline symptomatic. This means that by discharge, the majority of integrative therapy patients were considered virtually healthy in terms of overall psychiatric evaluation. Prior to therapy, 55% of these patients were rated CGI-S 3 ("mildly ill") and 30% were CGI-S 4 ("moderately ill"). After therapy, 94% had a CGI-S of 1 ("normal, symptom-free") or 2 ("minimally symptomatic"), and only 6% remained at 3 (no patient was above 3). In other words, nearly the entire group achieved a full remission or only trivial symptoms. These CGI improvements parallel the HARS findings and indicate that the integrative therapy had a comprehensive positive impact on patients' condition. Importantly, no early adverse effects or symptom exacerbations were observed with integrative therapy. Patient engagement was high; all 67 patients completed the full course of 12 sessions (there were zero drop-outs or withdrawals in this group). Therapists noted that patients responded enthusiastically to the variety of techniques, which helped sustain motivation and compliance through the treatment course. Rational Therapy Group: Patients undergoing traditional rational psychotherapy also showed improvement, though to a lesser extent. The mean HARS score in the rational therapy group decreased from 32.9 at baseline to 18.8 ± 7.9 after treatment. This reduction of about 14 points indicates a moderate lowering of anxiety severity. The change was statistically significant (paired $t = 19.04$, $p < 0.001$). By the end of the rational therapy course, the average patient's anxiety level was in the moderate range (HARS in the high teens). The clinical response in this group was more variable: about 28% of patients achieved remission-level anxiety (HARS < 10) following treatment – these individuals experienced a very good outcome. Another 45% had post-treatment HARS scores in the 18–25 range, which corresponds to persistent moderate anxiety symptoms. Approximately 27% continued to have significant anxiety (HARS > 25) even after therapy, indicating that in about a

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quarter of cases, rational talk therapy alone was insufficient to bring anxiety down to mild levels by discharge. Some of these patients still suffered notable panic attacks or phobic avoidance and would likely require further intervention. On the HDRS-17 depression scale, the rational therapy group showed a mean reduction from 13.9 to 4.1 ± 3.0, which, similar to the integrative group, indicates virtually complete resolution of the mild baseline depressive symptoms. Post-treatment HDRS scores in this group were also in the low single digits on average, signifying no clinically relevant depression after therapy. There was no statistically significant difference between the two groups in terms of change in HDRS — both therapies were effective in eliminating the modest depressive symptoms that accompanied anxiety in these patients. This suggests that rational therapy, while primarily cognitive in focus, still provided enough support and reassurance to lift mood, and that depression in this sample was largely reactive to anxiety (and thus improved once anxiety lessened). The CGI-S global severity rating in the rational therapy group improved from a mean of 2.91 to 2.09. This indicates an overall change from the low end of "mildly ill" towards the "borderline normal" range on average. After rational psychotherapy, 52% of patients were rated as either CGI-S 1 or 2 (essentially in remission or minimal symptoms). However, the remaining ~48% were still rated 3 ("mildly symptomatic"). No patients in the rational group had a CGI of 4 or higher post-treatment (so everyone improved at least to mild range or better), but clearly nearly half had not achieved full remission of symptoms by the end of the inpatient course. In summary, rational psychotherapy did benefit patients — anxiety and depression scores improved significantly — but the extent of improvement was less uniform and less complete compared to the integrative approach. A subset of patients in the rational group retained moderate levels of anxiety requiring ongoing care.

Direct comparison of outcomes between the integrative and rational therapy groups revealed notable advantages for the integrative approach, especially regarding anxiety reduction and global recovery. A repeated-measures ANOVA of HARS scores (group × time) demonstrated a significant interaction effect ($F(1,119) = 74.92$, $p < 0.001$), indicating that the decline in anxiety from pre- to post-treatment depended on which therapy was administered. The effect size for this interaction was large (partial $\eta^2 = 0.39$), meaning roughly 39% of the variance in anxiety improvement could be attributed to the type of psychotherapy – a very substantial impact for a therapeutic modality. In practical terms, integrative therapy produced on average a ~24-point drop in HARS, whereas rational therapy produced ~14-point drop. The difference (~10 points greater reduction with integrative) is clinically meaningful, moving patients from moderate residual anxiety to minimal anxiety, whereas rational therapy often left moderate symptoms. Figure 1 (not shown here) illustrates the divergence: the anxiety severity curve for the integrative group drops much more sharply and to a much lower absolute level than that of the rational group by week 6. Not a single patient in the integrative group had an insignificant response (everyone reduced HARS by >5 points), whereas approximately 15% of patients in the rational group showed minimal improvement (HARS reduction < 5), essentially non-response. Additionally, no patients in integrative treatment experienced any worsening, whereas a few in the rational group reported transient spikes in anxiety early on (though none dropped out). Comparisons on the CGI-S metric further underscored the superior outcomes with integrative therapy. By the end of treatment, the distribution of CGI-S scores in the two groups was significantly different (Mann–Whitney U test,

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$p < 0.01$). In the integrative group, 72% of patients achieved a CGI-S of 1 ("normal, healthy") indicating full remission, compared to only 30% in the rational therapy group. Correspondingly, about half of the rational therapy patients were still rated as mildly symptomatic (CGI 3) at discharge, whereas in the integrative group this was the case for only ~6%. Thus, patients receiving integrative therapy were much more likely to be essentially symptom-free by the end of the hospital course. As noted above, both treatments were equally effective in addressing the mild depressive symptoms that some patients had. There was no significant group difference in HDRS improvement – both groups' HDRS scores dropped to near floor levels (~3.8 vs ~4.1 post-treatment, $p > 0.5$ for difference). This suggests that for secondary depressive symptoms, rational and integrative therapy offered comparable benefit. The lack of between-group difference in depression outcomes can be explained by the low baseline level of depression (a "ceiling effect" where there was limited room for differentiation) and the fact that both treatments provide emotional support and hope, which can ameliorate mild depression. In both groups, depression tended to remit earlier in the course of treatment (often by the midpoint of therapy) whereas residual anxiety took longer to fully resolve — a pattern also reported in literature on time-limited therapy for mixed anxiety-depression.

Conclusions

In summary, this study provides evidence that a short-term integrative psychotherapy is highly effective for treating anxiety neurotic disorders, surpassing the results of traditional rational psychotherapy in multiple domains. Key conclusions include: Superior Anxiety Symptom Reduction: A 1–1.5 month course of integrative therapy led to remission of anxiety symptoms (HARS < 10) in approximately 83–85% of patients, with mean anxiety levels dropping from severe at baseline to minimal post-treatment. In contrast, rational psychotherapy, while beneficial, achieved remission-level anxiety in only about one-quarter of patients and yielded a smaller reduction in HARS scores (around 40% improvement versus ~75% improvement with integrative therapy). Thus, the integrative approach provided a deeper reduction in anxiety. The difference in effectiveness between the methods was statistically significant ($p < 0.001$), with a large effect size (e.g., group×time interaction $F(1,119)=74.92$, $\eta^2=0.39$ on HARS), indicating a robust advantage of integrative therapy in alleviating anxiety symptoms. Global Clinical Improvement: Integrative psychotherapy produced more comprehensive recovery in overall mental health status. By the end of treatment, the majority of patients in the integrative group were rated as asymptomatic or nearly asymptomatic (CGI-S 1–2), whereas a significant portion (≈45–50%) of those in the rational therapy group still had mild but notable anxiety symptoms (CGI-S 3). About 72% of integrative therapy patients achieved full remission (CGI-S=1, "healthy"), compared to 30% in the rational therapy group. This underscores that integrative therapy not only reduces symptom scores but also translates to meaningful clinical recovery in most patients.

In conclusion, short-term integrative psychotherapy – combining cognitive, behavioral, and relaxation strategies – has proven to be a highly effective and efficient treatment for anxiety disorders in this study. It achieves faster and more complete anxiety relief than traditional rational talk therapy, while simultaneously reducing treatment duration and costs. Given the prevalence of anxiety disorders and the constraints on mental health resources globally, the implementation of

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such integrative therapeutic programs could significantly improve clinical outcomes and optimize resource utilization. We recommend that mental health services consider incorporating integrative psychotherapy into standard care for anxiety neuroses. Future research should continue to explore this approach, perhaps in diverse clinical contexts and with longer follow-up, to solidify the evidence base and fine-tune the intervention components. Nonetheless, our findings provide strong support for the feasibility and benefit of introducing an integrative method into routine psychiatric practice for anxiety disorders, ultimately improving patient recovery and contributing to more sustainable mental health care delivery.

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