1. A transdiagnostic approach to Psychiatric and Psychological Brief Psychotherapy PKP

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ABSTRACT

Based on an integrative behavioural and psychodynamic understanding of the case, PKP Brief Psychotherapy applies evidence-based, disorder-specific behavioural therapy interventions for anxiety, depression, alcohol dependence and chronic pain. In addition, a transdiagnostic intervention and baseline inventory is now available so that patients with less common diagnoses can also be treated across disorders. These will be discussed in this paper. Firstly, the development of the PKP project and its theoretical and conceptual background are described. The current state of research is briefly outlined.

Keywords

PKP brief psychotherapy, strategic brief therapy, survival rule, reaction chain to symptom, exposure therapy, PKP manual

1. Introduction

Psychological psychotherapists work with legally insured patients within the framework of the guidelines for psychotherapy. However, psychiatrists require a different format for the psychotherapeutic care of their patients during their consultation hours or in medical consultations during an inpatient stay than that offered by the guideline psychotherapy with 50-minute sessions.

Opinions differ on the question of whether a 20 to 25-minute setting is sufficient and whether the patient needs 50 minutes of attention. Those coming from a psychotherapy background cannot imagine that 25 minutes can be put to good use and may be sufficient. Those who come from acute care in psychiatric clinics and practices simply cannot afford the luxury of 50-minute sessions for reasons of care and make the unfeasible feasible for psychotherapists.

We have analysed this aspect thoroughly and have repeatedly found that 25 minutes is sufficient to carry out a relevant intervention well and effectively. However, a lot of time usually passes before therapist and patient have found a topic for the current session, as the therapist usually does not have a well-operationalised concept for the sequence of therapy content from session to session. In acute care, however, the content of the therapy is obvious and is agreed with the

patient immediately at the beginning of the session or even planned at the end of the previous session. It is therefore about the central theme of the therapy. Once this has been established and agreed, 25 minutes is very sufficient.

For seriously ill patients, 50 minutes is too much anyway, so this time frame is even counter-therapeutic. Problem-orientated conversations are very stressful for them. In addition, their concentration is not sufficient for such a long conversation. Not only is the problem topic close to the patient, but there may also be too much closeness to the therapist, against which the patient cannot protect themselves for so long.

The only thing that remains is that the psychiatrist/therapist must have all the information available from the beginning of the session - about the case, the therapy concept, the last sessions and the current plan. They must therefore be well prepared. In general, the shorter the therapy, the better the preparation for the session must be. Just as short-term therapy is generally more demanding. Time is precious, not only financially but also conceptually. The therapist must be constantly alert, attentive and empathetic, confront in a well-dosed manner and provide resource-orientated impulses for change. But this also makes short-term therapy more satisfying.

It is a great relief when the therapist literally has the therapy concept and the current procedure in hand - in the form of our PKP manual for each individual mental disorder. Based on the original basic idea of the consultation cards in A5 format, each page of the PKP handbook has the front of the card at the top and the back at the bottom (what needs to be noted), with one page of the handbook forming the therapy concept for each 20 to 25-minute consultation. The front page tells you what to do and the back page tells you what is important and what to pay attention to. Some pages can be printed out as worksheets if the patient needs to fill something in or if the therapeutic explanations need to be illustrated with a picture. It is a joint task to work on the given topic and find a solution. The patient and therapist focus on this, both have the same goal and both stay on the topic until a solution is in sight. The patient does not sit back to be treated. Instead, they are part of the problem-solving team and therefore take on more responsibility and commitment. At least subjectively, it comes closer to working together as equals.

We have consistently found that patients react very positively to the worksheets in the PKP manual and find it pleasant to work with them. Therapists have the same experience once they have overcome their initial inhibitions about using paper.

It is often already clear where we will continue working next time. The topic is determined by the next pages of the manual, which build on those worked on today. Patient and therapist can prepare for this in advance.

However, the therapy programme is modular and does not have to be worked through in a linear fashion and at a set pace. Some pages can be skipped, others take twice or three times as much time. And of course you can also take a break to discuss current issues. However, this should soon be assigned to the therapy topics of the programme so that the current topic does not lead away, but leads back again (Kaufmayer & Sulz 2018).

1.1a Depression as avoidance behaviour

There is a genuinely behavioural approach to understanding depression that is usually neglected: the view of depression as instrumental behaviour that serves a purpose and is intended to achieve a goal. This goes well beyond the conventional loss-of-reinforcement and "thoughts make you depressed" paradigm. This makes us no less behavioural than these two simple disorder models, which too often do not do justice to the case. Instead, the frequent and powerful principle of negative reinforcement takes centre stage. This is because the "lack of reinforcement makes depressive" principle is purely causal and neglects the fact that the depressive syndrome is a bundle of behaviours, each of which is maintained by negative reinforcement. Today's functional-analytical approach to behaviour adds the teleological component to the causal component, i.e. the instrumental component of avoidance behaviour and symptom formation. What appears evident in other symptom formations is only hesitantly conceded to depression. However, it is not just a result, a final state. It is an unconscious strategy of the human psyche that is maintained by its intended effectiveness. Harmful or threatening things are kept away from conscious experience, even at the cost of distorting reality or even denying the facts.

1.1b Depression as a compromising solution to conflict

We assume that the symptom is a means of resolving a conflict that cannot be resolved using normal psychological mechanisms. If there are two possible solutions to a conflict, the one that would generate too much fear, shame or guilt is avoided. It is often the defensive defence of one's own interests that would trigger these feelings. However, as the second alternative - continuing to put up with everything - has become unbearable, it cannot be chosen without further ado. This is where the symptom helps as a compromise.

The term compromise is meant in such a way that although the decision against self-care and self-assertion is made, one does not yet remain completely in the adapted, compliant habitus. This is because the symptom makes it impossible to continue adapting or even submitting. Someone who is depressed cannot maintain their previous conformist social behaviour, but withdraws and can no longer do as much for others as before. However, the others can tolerate this, as

they are not shouted at "I don't want to do it any more", but rather a pained "I can't do it any more" is breathed in a weak voice. The caregivers only become angry after a very long delay - when they realise how much shared experience they have to do without.

1.2 The survival rule as a conflict resolution strategy

It is exhausting and unreliable to rely on your current feelings in every conflict situation. Our psyche works very economically and efficiently. In this case, it provides a rule of action that determines how to act in conflict situations. Long before we can think about it, the emotional decision has already been made. And if we do start to resist, fear, shame or guilt immediately arise so that we stay on the right path. Our behaviour is therefore not simply conditioned or biologically predetermined, but is largely guided by rules that arise from our experiences in the first years of life. In this sense, Hayes, Gregg & Wulfert (1998) speak of "rule governed behaviour" (cf. Sulz 2017a,b).

The rules begin early in life. Bowlby (1975, 1976) describes the infant's "inner working model" as the quintessence of the mother's attachment behaviour. From then on, the child behaves in such a way that the probability of receiving sufficient attachment is as high as possible with precisely this mother. This is a rule that enables the child to survive emotionally. This corresponds to the "basic assumptions" of Aaron T. Beck (1979, 2004), the upper plans of Grawe (1998), the survival conclusions of Fanita English (1986) and the "survival patterns" of Samual Slipp (1973). Annemarie Dührssen (1995) popularised this heuristic independently of attachment theory in depth psychology.

If, as is usual in the language of behavioural therapy, we distinguish only between body - emotion - cognition and action, then the survival rule is physical as well as emotive and cognitive. From the cognitive perspective, Aaron T. Beck (1979) categorised the child's implicit basic assumptions about how the world works as cognitive. These are the child's conclusions from his experiences, especially with his parents, which are made up of his world view and his self-image. These are causal statements that predict how parents will react to which child's behaviour. As these basic assumptions are also present in adults, often hardly changed, their predictions will be less and less accurate. So what was extremely helpful in childhood becomes a misleading behavioural rule for adults. For example: If you defend yourself, you will be rejected and excluded. The opposite is true if you are appropriately defensive. There is more consideration and greater appreciation.

By dealing with this, we express this rule linguistically. But infants and toddlers are not yet able to speak. It is therefore a preverbal system rule that guides the mental processes without any explicit thinking or language.

We have created a "survival rule" from the formulae of the authors mentioned (Sulz 1994), which, in addition to the commandments and prohibitions, also specifies the system target values, i.e. the basal and central needs of the child and the existential threats and fears (central anxieties). This makes it not only a prediction with instructions for action in an otherwise unknown system, but also a rudimentary description of this system. The human mental system follows the principle of homeostasis and endeavours to keep the target values necessary for survival largely constant. Numerous studies make it clear that the survival rule and the other constructs of PKP are empirically verifiable (Sulz & Müller 2000, Sulz & Tins 2000, Sulz & Maßun 2008, Sulz, Beste et al. 2009, Sulz, Arco et al. 2011, Sulz, Bischoff et al. 2011, Sulz, Gahr et al. 2011, Sulz, Heiss et al. 2011, Sulz 2014, 2017a-e).

2. Introduction to the practice: basics and practice guidelines

The therapist can start right away with the disorder-specific therapy for depression (Sulz & Deckert 2012a,b, anxiety Sulz, Sichort-Hebing & Jänsch 2015a,b, alcoholism (Sulz, Antoni et al. 2012a,b) or chronic pain (Schober 2018). However, the therapy is more likely to run smoothly if the steps described in the transdiagnostic PKP manual "Psychotherapie-Grundkurs und Praxisleitfaden: Therapy Implementation in Clinic and Practice" (Sulz 2012) (problem, behaviour and goal analysis, modular therapy planning and the basic strategy of skills training and emotion exposure) are mastered beforehand. Then the individualising principle of modular psychotherapy can also be followed without further ado. So anyone who realises after using the disorder-specific PKP manuals for the first time, for example, that the general application of psychotherapy, especially behavioural therapy, has remained unclear, can gain more confidence with the help of these basics. Or acquire the complete behavioural therapy foundation (Sulz 2017a-d).

Implementation of PKP brief psychotherapy

PKP pursues a systematic therapy strategy using a series of interventions from the PKP manual pages as a continuation of short psychiatric and psychotherapeutic interventions. The conceptual basis is the 3-pillar model of Strategic Brief Therapy: symptom therapy (psychiatric), skills training (behavioural), personality development (psychodynamic). The manual pages contain short (10-25 minute) interventions that fulfil the current billing standards (EBM, GOÄ, OPS). International classifications, guidelines and recognised evidence-based methods are taken into account. The application is very flexible:

- 20-minute consultation: one manual page

- 50-minute therapy session: two manual pages
- 100-minute group session: two manual pages

The handbook pages can be edited by a single therapist or by a team (PKP logo: handover). They serve as a guide for patient contacts over several appointments, as well as documentation obligations, supervision and training through theoretical explanations on the back pages. They can be expanded as required with your own focal points by adding self-created worksheets. The manual pages enable the transparent integration of several therapists from the team treating the patient by working on different intervention series with self-contained units (modules or sub-modules, e.g. psycho-education by medical staff and activity development by nursing staff) without losing the overall concept.

2.1 PKP practice - preparation and application

PKP is structured in such a way that the therapist is guided through all the important steps of diagnosis and treatment from the first encounter with the patient to the conclusion of the therapy. Even the initial contact can be structured by "newcomers to psychiatry and PT". After the initial consultation with anamnesis and psychopathological findings, the patient is reminded of the need to carry out psychological tests, draw up an emergency plan and provide information.

2.1.1 PKP problem analysis and situation and behaviour analysis

Even if it initially seems difficult to develop a systematic understanding of the development and maintenance of symptoms, it quickly becomes clear how valuable it is for the patient and therapist to be able to repeatedly refer back to this understanding (individual plausible disorder model) in order to maintain orientation in the modular therapy process and to follow an effective path to the therapy goal.

2.2 PKP therapy implementation Pillar 1: Dealing with the symptom

The first pillar of therapy implementation focusses on the patient's main concern, i.e. getting their symptoms under control. This begins with understanding the symptoms and ends with relapse prevention:

- **My disorder model:** why my symptom arose and why it won't go away
- **Reaction chain to the symptom**: How I developed symptoms -
- Deciding at which link in the chain the therapy is most effective for the individual patient

- **Relapse prevention** as a component of symptom therapy (recognising situations that trigger relapse - recognising early relapse reactions - relapse prevention through lifestyle - relapse prevention through new relationship design)

2.3 PKP - therapy implementation Pillar 2: Skills training

The second pillar supports the development of skills on a cognitive, emotional and behavioural level. This module contains a selection of evidence-based interventions that can be used effectively for many mental disorders:

Day planning, activity building - Relaxation training - Exercise and sport - Social skills - Communication skills in important relationships - Problem solving - practical approach - Cognitive training - Analysis of previous behaviour problem - Self-instruction training - practical approach - Imaginations - practical application - Pleasure training - My feelings and dealing with my feelings - Independence training - Pampering and being pampered couples exercise - Empathy exercise.

There are thus 14 sub-modules available for building skills. In terms of modular psychotherapy, the therapist decides which sub-modules should be used for the individual patient.

The aim is to make available to the patient precisely those abilities and skills that he or she has previously lacked and to enable him or her to master psychosocially difficult situations without developing symptoms.

2.4 PKP therapy implementation Pillar 3: Personality development/clarification of motives

The manual pages of the third pillar resolve the patient's motives that stand in the way of therapy and strengthen his motives for change. This involves working with the behaviour-controlling, central feelings (fear, anger, rage, sadness), central needs and dysfunctional personality traits. The personality trait's own survival rule (the master plan (Grawe 1998) of its life internalised since childhood) is developed on the basis of the learning history. The 3rd pillar ends with the patient's new experience of "living instead of surviving": the symptom loses its function through successful living.

2.5 PKP practical guide How to use the PKP manual

PKP attempts to reformat the therapy process of goal-orientated psychotherapy (in guideline psychotherapy with 50-minute units) into shorter units of 20 to 25 minutes. These correspond to the usual EBM, GOÄ and OPS cycles. This has resulted in a series of consultations or ward rounds that allow you to stay on the ball and keep the thread in your hand. Every contact with the patient is a step forward on the way to achieving the goal. At the patient's next visit, work

continues (exactly) where it left off last time. This changes the relationship and the treatment for both the patient and the psychiatrist/psychotherapist. A goal emerges much more clearly than before, one that is worked on together: one that both work on, not just the therapist.

Most of the handbook pages serve as a template for the patient to copy. Depending on the topic, the patient fills in the card copied for him or her as required during the session or makes notes at home.

The reverse side of the therapy/consultation card contains explanations on how to work with this card in practice or notes on the theoretical background. It therefore supports training and supervision.

The **therapy manual in A4 format** contains the front of the therapy card at the top and the back at the bottom. This is very clear and the whole page can be photocopied and given to the patient - for understanding, consolidation and processing.

2.6 PKP practice guide Suggestion for the consultation/visit procedure

The PKP manual is placed on the therapist's desk**.**

The planned **therapy session duration** for PKP is 20 to 25 minutes. Every minute is precious - while the patient needs and wants a lot of time. Try to keep (strictly) to the time available to you and not to overrun by specifying the time frame available for the session at the beginning. The patient will quickly learn to adapt to this time. Anything that has been left out will be discussed the next time.

Suggest the therapeutic procedure with PKP to the patient during the initial consultation:

"I suggest that we see each other more closely for the time being. We can each have a 10 to 20-minute conversation, which is psychotherapy. We now know that psychotherapy is an essential treatment for almost all mental illnesses. Time is very short and we have to make good use of it. That's why we can't just stay with your acute complaints and problems, but must place them in the wider context of your illness. In each session, we will work on a therapeutic topic that is very important for overcoming the symptoms. It is useful to fill out project cards on the respective topic. This will give you mental clarity about your illness and the psychotherapy you need.

Even before our conversation here in the practice/visit begins, fill out a short report or copied CARD, e.g. a project card, on the current topic by recording everything worth mentioning from the past week/s or the current project. This will get you

in the mood for our conversation and give us a reliable overview so that we don't overlook anything important. At the end of our conversation, I will ask you to do something every day between our meetings that will help to replace the symptoms with effective behaviour. If you do nothing, nothing will happen. It may be tedious, but we need to tackle the things that will help to get your symptoms under control. Do you agree with this approach?"

If the patient agrees, a photocopy of card 2 "What symptoms do I have? (Simply list all the symptoms. Please name only one symptom per line ...) to take home.

So the patient has done his homework at the next appointments after the last lesson: he has filled out a **short report** on the events and activities of the last week at home/in the waiting room.

Normally, limit the time for the short report/HA to a few minutes. Some topics can be postponed until the next time.

The doctor/therapist **opens the session: "Today's topic is** ....." He explains the topic (module/submodule) and discusses the content of the manual page for this topic with the patient. The therapist focusses on positive, non-symptomatic statements made by the patient. In this way, a shared imagination can emerge that includes a helpful understanding of the topic and a plan for how the topic can be implemented in the patient's life. At the end of the consultation, **homework** is planned **again** so that the situation, people involved, day and time are determined as far as possible and the patient is asked to express their decision that they will tackle the project discussed, that it is their firm intention.

The patient deals with the topic until the next session, even if it is only to think about the topic for five minutes a day and recall the shared thoughts. If the topic on the therapy/ consultation card has not yet been completed, the patient continues to work on it in the next consultation, i.e. does not rush from card to card.

In this way, the patient is actively involved in the meantime - in thought and action, according to his or her limited possibilities due to the illness. He is required to make his contribution. They are mobilised emotionally, cognitively and actively and resistance is dealt with in the therapeutic relationship and used for relationship work.

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3. PKP research

In addition to the continuous evaluation of process and outcome, in 2003 we began studies on the differential effectiveness of the concept of PKP brief psychotherapy. As the individual interventions come from the repertoire of cognitive behavioural therapy, which has been empirically investigated many times in controlled studies, the study was only concerned with examining the special characteristics of the PKP approach. However, it was not even necessary to investigate the short-term setting, as the duration of therapy in almost all studies in the Anglo-American language area was between twelve and twenty sessions. There, our total number of sessions (24 hours of weekly acute therapy plus six hours of monthly maintenance therapy) would possibly no longer be referred to as short-term therapy.

3.1 The Braunschweig PKP study (PKP groups in the clinic)

Christian Algermissen and his therapy team reformatted the original consultation cards into A4 group therapy cards and tested the effectiveness of the treatments using a sophisticated study design (Algermissen, del Pozo, Rösser 2017. Algermissen & Rösser 2019). They came to the following conclusion: "The contents of the PKP can be implemented as a combined group and individual therapeutic treatment concept in general psychiatric and psychotherapeutically orientated wards of a care clinic. The results of a scientific evaluation (n = 1196) of this innovative therapy concept in the Clinic for Psychiatry, Psychotherapy and Psychosomatics at the Braunschweig Clinical Centre allow a positive assessment. The therapy concept is effective, conserves resources and is highly accepted by patients. Cross-sector treatment paths can be implemented in cooperation with a psychiatric institute outpatient clinic or registered specialists." (op. cit. p. 113)

3.2 The Munich PKP study phase 1 (short-term outpatient therapy)

The study period ran from 2010 to 2014 and the therapy sessions lasted 50 minutes. The course of a therapy session was such that the patient reported for ten minutes and the homework was discussed. The core of the therapy consisted of twenty-five minutes of discussing and working on the planned therapy topic with the help of the next PKP manual pages. At the end, the upcoming homework was discussed for ten minutes and feedback was obtained for the therapy session. With 24 weekly sessions, the acute phase of the therapy lasted about six months. This was followed by approximately six months of maintenance therapy (one session every four weeks). After a further six months, the catamnesis session took place. It was agreed from the outset that the therapy would end after these thirty sessions.

Symptomatology (VDS14, VDS90, BDI II) did not reduce in the waiting list, but was highly significant in the therapy group with a very high effect size (Hedges g = 2.0). The global functional level only increased highly significantly in the treatment group, also

with a large effect size (g = 1.7).

In this study, the influence of the dysfunctional survival rule decreased drastically over the course of therapy. For many patients, it could be replaced by a new permissive rule of life.

It is noteworthy that the depression values of the BDI II were still in the mildly depressive range at the end of the weekly acute therapy (14.1), fell into the non-clinical range after the monthly maintenance therapy (8.2) and fell further to 5.0 without any therapy after the catamnesis period. This means that the therapy does not have to be carried out until the depression has completely disappeared, but that the improvements continue afterwards until the patient is completely healthy.

3.3 The Munich PKP Study Phase 2 (short- and long-term outpatient therapy)

The second phase of the Munich PKP study consisted of the addition of long-term therapy for comparison. Peters and Sulz (2018) reported on this study. This was also conducted using the PKP concept, but the therapy topics were more in-depth and there was more opportunity to practise.

The evaluation of the BDI II showed a superiority of short-term therapy after 24 sessions (significant at the 1-promill level). After 30 sessions (at the end of maintenance therapy), the short-term group was just as good as the long-term group. And at the catamnesis point, both groups also remained equally well, i.e. the depression score had significantly decreased to a non-clinical level in both groups (see Fig. 4.2).

The evaluation of the VDS90 total score (symptoms across all disorder areas, i.e. the patient's overall mental disorder analogue to SCL-R, cf. Sulz & Grethe 2005, Sulz, Beste, Kerber et al. 2009) showed the same results. The same effect was also shown in the VDS14 standardised interview to assess the psychological findings (Sulz, Hörmann, Zaudig, Hiller 2002 and Sulz, Hummel, Jänsch, Holzer 2011): highly significant improvements in depressive symptoms after therapy and no significant differences between CCT and CBT. Dysfunctional personality traits, which were recorded with the VDS30 personality questionnaire, decreased significantly in the same way in both short-term and long-term therapy (total score across all scales).

The Global Assessment of Functioning (GAF checklist in DSM IV, Saß, Wittchen, Zaudig & Houben, 2003), like all other measurement instruments, showed highly significant improvements with high effect sizes.

However, we can state that in a direct comparison of short-term and long-term therapy, the former did not show worse results at any time. Long-term therapy was not superior in our study. However, the question arises as to whether there are patients who require long-term therapy. This appears to be the case for patients with high dysfunctional personality traits or personality disorders and for patients who had a poor global functioning level GAF at the start of therapy, i.e. people whose illness meant that they had difficulty coping with the general demands of everyday life.

Literature

Algermissen C., del Pozo M. A. & Rösser N. (2017). Psychiatric Short-Term Group Psychotherapy. Vortrag auf dem WPA Weltkongress für Psychiatrie in Berlin (19.10.2017).

Algermissen C. und Rösser N. (2019). Psychiatrische Kurz-Psychotherapie von depressiven Störungen in kombinierter Gruppen- und Einzeltherapie – ein Behandlungskonzept für Versorgungskliniken. Psychotherapie 24-1, S. 113-13

Beck, A. T. (1979). Wahrnehmung der Wirklichkeit und Neurose. München: Pfeiffer.

Beck, A. T. (2004). Kognitive Therapie der Depression (3. Aufl.). Weinheim: Beltz.

Becker, E.; Margraf, J. (2007). Generalisierte Angststörung. Ein Therapieprogramm. Weinheim: Beltz

Becker, E., Nündel, B. (2003). Die Generalisierte Angststörung – State of the Art. Psychotherapie 8-1, 146-155.

Blanck, G.& Blanck, R. (1981). Angewandte Ich-Psychologie. Stuttgart: Klett-Cotta.

Blanck, G. & Blanck, R. (1991). Angewandte Ich-Psychologie. Teil 1. Stuttgart: Klett-Cotta.

Blanck, G.& Blanck, R. (1994). Ich-Psychologie II. Stuttgart: Klett-Cotta.

Bowlby, J. (1975). Bindung. München: Kindler.

Bowlby, J. (1976). Trennung. München: Kindler

Deutsche Gesellschaft für Psychiatrie Psychotherapie und Nervenheilkunde DGPPN, BÄK, KBV, AWMF (Hrsg., 2010): Nationale Versorgungs-Leitlinie. Unipolare Depression (S3 Praxisleitlinien in Psychiatrie und Psychotherapie), Springer, Berlin

de Jong-Meyer R., Hautzinger M., Kühner C., Schramm E., (Fachgruppe DGPs, Deutsche Gesellschaft für Psychologie, Hrsg. 2007): Evidenzbasierte Leitlinie zur Psychotherapie Affektiver Störungen. Hogrefe, Göttingen

Diclemente und Prochaska (1995): Changing for Good: A Revolutionary Six-Stage Program for Overcoming Bad Habits and Moving Your Life Positively Forward. New York: William Morrow

Dilling H., Mombour, W. & Schmidt, M.H. (2016). Internationale Klassifikation psychischer Störungen. ICD-10 Kapitel V (F). Klinisch-diagnostische Leitlinien. (10. überarbeitete Auflage). Göttingen: Hogrefe Verlag.

Dührssen, A. (1995). Dynamische Psychotherapie. Ein Leitfaden für den tiefenpsychologisch orientierten Umgang mit Patienten (2. Aufl.). Göttingen: Vandenhoeck & Ruprecht.

Dunn, J. D., & Tierney, J.G. (2006). A step therapy algorithm for the treatment and management of chronic depression. American Journal of Management Care, 12, 335 – 343.

Fonagy, P. (1997). Attachment and theory of mind: Overlapping constructs? Association for Child Psychology and Psychiatry, Occasional Papers, 14, 31-40.

Fonagy, P. & Bateman, A. (2008). Attachment, Mentalization and Borderline Personality. European Psychotherapy, 8, 35-48.

Fonagy, P., Gergely, G., Jurist, E. L. & Target, M. (2008). Affektregulierung, Mentalisierung und die Entwicklung des Selbst (3. Aufl.). Suttgart: Klett-Cotta.

Fydrich T., Renneberg B. (2003). Soziale Phobie. In Leibing et al. (Hrsg.): Lehrbuch der Psychotherapie. Bd 3. S. 249-258.

Gerbershagen, H.U., Korb J., Nagel B. & Nilges P. DRK-Schmerz-Zentrum-Mainz: Das Mainzer Stadiensystem der Schmerzchronifizierung. Mainz Pain Staging System (MPSS). DRK Schmerz-Zentrum Mainz: Http: // www.drk-schmerz-zentrum.de, abgerufen im Mai 2018

Graßl, S. & Artner, J. (2018). Medizinische Aspekte und Psychiatrisch Psychosomatisch Psychologische Kurz-Psychotherapie (PKP)bei chronischem Schmerz. Psychotherapie, 23 (1), 183-201. München: CIP-Medien.

Gräff, U. (1998). Lebensgeschichte und Persönlichkeit. Eine empirische Untersuchung des Anamnesefragebogens und der Persönlichkeitsskalen des Verhaltensdiagnostiksystems VDS. Med. Dissertation LMU München.

Gräff-Rudolph, U. & Sulz, S. K. D. (2017). Entwicklung reifer Empathie

durch Entwicklung auf die zwischenmenschliche Stufe - bei Patienten.

Psychotherapie, 22(2), 59-74.

Hautzinger M. (2013): Kognitive Verhaltenstherapie bei Depressionen: Behandlungsanleitungen und Materialien. Beltz-PUV, Weinheim, 7. Auflage

Hayes S, Gregg J, Wulfert E: Akzeptanz- und Commitment-Therapie: Ein radikal behavioraler Ansatz. In: Sulz (Hrsg.): Kurz-Psychotherapien: Wege in die Zukunft der Psychotherapie. München: CIP- Medien, 1998, 143-162

Herpertz S., Caspar F., Mundt C. (Hrsg., 2008): Störungsorientierte Psychotherapie. Elsevier, München

Kanfer, F. H. & Karoly, P. (1972). Self-Control: A behavioristic excursion into the lions' den. Behavior Therapy, 3, 398-416.

Hautzinger M. (2013): Kognitive Verhaltenstherapie bei Depressionen: Behandlungsanleitungen und Materialien. Beltz-PUV, Weinheim, 7. Auflage

Hayes S, Gregg J, Wulfert E: Akzeptanz- und Commitment-Therapie: Ein radikal behavioraler Ansatz. In: Sulz (Hrsg.): Kurz-Psychotherapien: Wege in die Zukunft der Psychotherapie. München: CIP- Medien, 1998, 143-162

Kaufmayer T., Sulz S.K.D. (2018). Allgemeine und differentielle Wirksamkeit der Psych. Kurz- Psychotherapie (PKP) zur Behandlung depressiver Erkrankungen – eine empirische Studie im ambulanten Setting. Psychotherapie 23(1), S. 113-133

Korff von, M., Ormel, J., Keefe, F.J., ***et al***. (***1992***) Grading the severity of chronic pain. Pain, 50, 133-149. doi10.1016/0304-3959(92)90154-4.

Laux G, Dietmaier O. Praktische Psychopharmakotherapie. 7. Aufl. Elsevier Deutschland 2020

Lindenmeyer J. (2016). Lieber schlau als blau.9. Auflage. Weinheim: Beltz PVU

Mann K., Loeber S., Croissant B., Kiefer F. (2006): Qualifizierte Entzugsbehandlung von Alkoholabhängigen. Köln: Deutscher Ärzteverlag

Marlatt G, Gordon J. Determinants of relapse. Implications for the maintenance of behavior change. In: Davidson P, SM D, ed. Behavioral medicine. Changing health lifestyles. New York: Brunner Mazel, 1980:

Mathew, A.; Gelder, M.; Johnston, D. (1988).Agoraphobie. Berlin: Springer

McCullough J. (2007). Therapie von Chronischer Depression mit dem Cognitive Behavioral Analysis System of Psychotherapy (CBASP) – Trainingsmanual. München: CIP-Medien.

Mischel, W. (1972). Toward a cognitive social learning reconceptualization of personality. Psychological Review, 79, 433-453.

Miller und Rollnick (2009): Motivierende Gesprächsführung. Freiburg: Lambertus

Mischel, W. (2004). Toward an integrative science of the person (Prefatory Chapter). Annual Review of Psychology, 55, 1-22.

Mischel, W. & Shoda, Y. (1995). A cognitive affective system theory of personality: reconceptualizing situations, dispositions, dynamics, and invariance in personality structure. Psychol. Rev., 102, 246–68.

Möller HJ, Laux G, Kapfhammer HP (Hrsg) Psychiatrie, Psychosomatik, Psychotherapie. 4 Bände, web-basiert. 5. Auflage, Springer Berlin Heidelberg 2017

Munsch S., Schneider S., Margraf J. (2003). Panikstörung und Agoraphobie. In Leibing E., Hiller W., Sulz S. (Hrsg.): Lehrbuch der Psychotherapie Band 3: Verhaltenstherapie. München: CIP-Medien S. 231-240

Peters, M. & Sulz, S. K. D. (2018). Wirksamkeit der Psychiatrischen Kurz-Psychotherapie (PKP) - Ist Kurzzeittherapie der Depression einer Langzeittherapie ebenbürtig? Eine vergleichende Studie. Psychotherapie, 23(1), 151-164.

Piaget, J. (1978). Das Weltbild des Kindes. München: dtv.

Piaget, J. (1995). Intelligenz und Affektivität in der Entwicklung des Kindes. Frankfurt: Suhrkamp.

Saß, H., Wittchen, H.-U., Zaudig, M. & Houben, I. (2003). Diagnostische Kriterien des Diagnostischen und Statistischen Manuals Psychischer Störungen. DSM- IV-TR. Göttingen: Hogrefe, 47-49.

Schober S. (2018). Psychotherapiekarten für die Praxis: Chronischer Schmerz. PKP-Handbuch. München: CIP-Medien

Slipp, S. (1973). The symbiotic survival pattern: A relational theory of schizophrenia. Family Process, 12, 377-398.

Sulz, S. K. D. (1993). Depression Ratgeber. Alles, was Sie für das Verständnis und den Umgang mit Krankheit und Kranken wissen sollten - für Betroffene, für Angehörige, für alle beruflichen Helfer. 1. Auflage. München: CIP-Medien.

Sulz, S. K. D. (1994). Strategische Kurzzeittherapie. Wege zur effizienten Psychotherapie. München: CIP-Medien.

Sulz S. (2007): Supervision, Intervision und Intravision. München: CIP-Medien

Sulz S. (2008a): Als Sisyphus seinen Stein losließ. München, CIP-Medien

Sulz, S. (2008b). VDS Verhaltensdiagnostik-Materialmappe. Das komplette Verhaltensdiagnostiksystem VDS als Kopiervorlage – Fragebögen und Interviewleitfäden mit Auswertungsanleitungen. München: CIP-Medien.

Sulz S. (2009): Praxismanual zur Veränderung des Erlebens und Verhaltens. München, CIP-Medien

Sulz, S. (2010). Mentalization and metacognition as paradigms for development and therapy in Strategic Behavioral Therapy. European Psychotherapy, 9, 191-208.

Sulz S. (2012): Psychotherapie-Grundkurs und Praxisleitfaden: Therapie-Durchführung in Klinik und Praxis. München: CIP-Medien

Sulz, S. K. D. (2014). Wissenschaftliche Untersuchungen der Konstrukte, Konzepte und Interventionen des Strategischen Therapieansatzes (SKT, SBT, PKP und SJT). Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie, 19(2), 339-363.

Sulz S. K. D. (2017a). Gute Kurzzeittherapie in 12 plus 12 Stunden. Für PsychotherapeutInnen, die sich in Kurzzeittherapie einarbeiten wollen. München: CIP-Medien

Sulz S. K. D. (2017b). Gute Verhaltenstherapie lernen und beherrschen - Band 1: Verhaltenstherapie-Wissen: So gelangen Sie zu einem tiefen Verständnis des Menschen und seiner Symptome. München: CIP-Medien

Sulz S. K. D. (2017c). Gute Verhaltenstherapie lernen und beherrschen - Band 2: Verhaltenstherapie-Praxis: Alles was Sie für eine gute Therapie brauchen. München: CIP-Medien

Sulz S. K. D. (2017d). Verhaltensdiagnostik und Fallkonzeption. Bericht an den Gutachter. München: CIP-Medien

Sulz, S. K. D. (2017e). Depression Ratgeber & Manual, für Betroffene, für Angehörige, für alle beruflichen Helfer. 4. Auflage. München: CIP-Medien. 2013 auch als e-book erschienen.

Sulz, S.K.D.. (2019a). Fallkonzeption des Individuums und der Familie. In Leibing, E., Hiller, W., Sulz, S.K.D. (Hrsg., 2019). Lehrbuch der Psychotherapie. Band 3: Verhaltenstherapie. Gießen: Psychosozial-Verlag, S. 25-48

Sulz, S.K.D.. (2019b). Prozessuale und inhaltliche Therapiestrategien. In Leibing, E., Hiller, W., Sulz, S.K.D. (Hrsg., 2019). Lehrbuch der Psychotherapie. Band 3: Verhaltenstherapie. Gießen: Psychosozial-Verlag, S. 105-124

Sulz S. K. D. (2021a). Mit Gefühlen umgehen - Praxis der Emotionsregulation in der Psychotherapie. Gießen: CIP-Medien im Psychosozial-Verlag

Sulz, S.K.D. (2021b). Mentalisierungsfördernde Verhaltenstherapie. Gießen: Psychosozialverlag.

Sulz S. (2021c). Kurz-Psychotherapie mit Sprechstundenkarten. Wirksame Interventionen bei Depression, Angst- und Zwangskrankheiten, Alkoholabhängigkeit und chronischem Schmerz. Gießen: Psychosozial-Verlag

Sulz, S.K.D. (2022a). Heilung und Wachstum der verletzten Seele. Praxisleitfaden Mentalisierungsfördernde Verhaltenstherapie. Gießen: Psychosozial-Verlag

Sulz, S.K:D. (2022b): Praxismanual Mentalisierungsfördernde Verhaltenstherapie – Anleitung zur Therapiedurchführung. Gießen: Psychosozial-Verlag

Sulz, S.K.D. (2023). Die Emotion-Tracking-Studie zur Wirksamkeit von PBSP®-Interventionen (Studie 1). In Bachg, M., Sulz, S.K.D. (Hg.2023). Bühnen des Bewusstseins – Die Pesso-Therapie. Gießen: Psychosozial-Verlag S. 419ff

Sulz, S. K. D., Antoni, J., Hagleitner, r. & Spaan, L. (2012a). Psychotherapiekarten für die Praxis. Alkoholabhängigkeit. PKP- Handbuch. München: CIP-Medien.

Sulz, S. K. D., Antoni, J., Hagleitner, r. & Spaan, L. (2012b). Psychotherapiekarten für die Praxis. Alkoholabhängigkeit. Therapiekarten. München: CIP-Medien.

Sulz, S. K. D., Arco, K., Hummel, C., Jänsch, P., Richter-Benedikt, A., Hebing, M. & Hauke, G. (2011). Werte und Ressourcen in der Psychotherapiediagnostik und Therapiekonzeption VDS26-Ressourcenanalyse und VDS33-Werteanalyse. Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie, 16(1), 113-127.

Sulz S., Beste E., Kerber A.C., Rupp E., Scheuerer R., Schmidt A. (2009). Neue Beiträge zur Standarddiagnostik in Psychotherapie und Psychiatrie – Validität und Reliabilität der VDS90-Symptomliste und VDS30-Persönlichkeitsskalen. Psychotherapie in Psychiatrie, psychotherapeutischer Medizin und klinischer Psychologie. Bd. 14-2. - S. 215-234.

Sulz, S. K. D., Bischoff, C., Hebing, M. & Richter-Benedikt, A. (2011a). VDS23-Situationsanalyse - schwierige Situationen, die zur Symptombildung führen und Fokus therapeutischer Veränderung sind. Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie, 16(1), 104-111.

Sulz, S. K. D. & Deckert, B. (2012a). Psychotherapiekarten für die Praxis. Depression. PKP-Handbuch. München: CIP-Medien.

Sulz, S. K. D. & Deckert, B. (2012b). Psychotherapiekarten für die Praxis. Depression. PKP-Therapiekarten. München: CIP-Medien.

Sulz, S. K. D., Gahr, S., Manhart, C., Hebing, M. & Richter-Benedikt, A. (2011b). VDS36-Interaktionsanalyse zur Beziehungsdiagnostik in kognitiv-behavioralen Therapien. Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie, 16(1), 129-141.

Sulz, S.K.D. & Grethe, C. (2005). VDS90-SL - VDS90-Symptomliste (VDS90; Verhaltensdiagnostiksystem 90 - Symptomliste). PSYNDEX Tests Info. Psychotherapie, 10(1), 38-48.

Sulz, S. K. D., Hagspiel, S., Gerner, S., Hebing, M. & Hauke, G. (2011c). Lebens- und Krankheitsgeschichte: Der VDS1 Fragebogen in der klinischen und wissenschaftlichen Anwendung am Beispiel der Kindheit von Patienten mit Depression und Angstkrankheiten. Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie, 16(1), 93-102.

Sulz, S. K. D., Heiss, D., Linke, S., Nützel, A., Hebing, M. & Hauke, G. (2011d). Schemaanalyse und Funktionsanalyse in der Verhaltensdiagnostik: Eine empirische Studie zu Überlebensregel und Reaktionskette zum Symptom. Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie, 16(1), 143-157.

Sulz, S. K. D., Hörmann, I., Hiller, W.& Zaudig, M. (2002). Strukturierte Befunderhebung und Syndromdi- agnose in der psychotherapeutischen Praxis. Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie, 7(1), 6-16.

Sulz, S., Hummel, C., Jänsch, P., & Holzer, S. (2011). Standardisierte Erhebung des psychischen Befundes und Bestimmung der ICD-10-Diagnose: Vergleich von SKID I und VDS14-Befund-Interview. Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie, 16(2), 215–236.

Sulz, S. & Müller, S. (2000). Bedürfnisse, Angst und Wut als Komponenten der Persönlichkeit. Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie, 5(1), 22-37.

Sulz, S.K.D. & Schreiner, M. (2024). Emotion Tracking - Healing and Growth of the Wounded Soul. European Psychotherapy EP 2024 page 94-113

Sulz, S. K. D., Sichort-Hebing, M. & Jänsch, P. (2015). Psychotherapiekarten für die Praxis Angst & zwang. PKP-Handbuch. München: CIP-Medien.

Sulz, S. K. D., Sichort-Hebing, M. & Jänsch, P. (2015). Psychotherapiekarten für die Praxis Angst & zwang. Therapiekarten. München: CIP-Medien.

Sulz, S. & Maßun, M. (2008). Angst als steuerndes Prinzip in Beziehungen. Ergebnis einer qualitativen Analyse von Interviews. Psychotherapie in Psychiatrie, Psychotherapeutischer Medizin und Klinischer Psychologie, 13(1), 37-44.

Sulz, S. & Tins, A. (2000). Qualitative Analysis of Satisfaction and Frustration of Basic Needs in Childhood – an Empirical Study. European Psychotherapy, 1, 81-98.

Sulz, S. K. D. & Sichort-Hebing, M. (2018). Persönlichkeitsstil, dysfunktionaler Persönlichkeitszug und Persönlichkeitsstörung als limitierender Faktor bei Kurzzeittherapien. Psychotherapie, 23(1), 202-231.

Wagner P., P. Bräunig (2006): Psychoedukation bei bipolaren Störungen. Ein Therapiemanual für Gruppen. 2. Auflage. Schattauer, Stuttgart

Wittchen H.-U.,. Möller H.-J, Vossen A., Hautzinger M., Kasper S., Heuser I. (1995): Hexal-Ratgeber Depression, Wege aus der Krankheit. Karger, Basel

Zaudig, M., Hauke W., Hegerl U. (2002) Die Zwangsstörung, Diagnostik und Therapie. Stuttgart: Schattauer.

Zielke, M. Kopf-Mehnert C. (1978). Veränderungsfragebogen des Erlebens und Verhaltens VEV. Weinheim. Beltz-Test

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