3. Brief psychiatric and psychological psychotherapy PKP for anxiety and obsessive-compulsive disorders

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Abstract

Psychiatric and psychological brief psychotherapy PKP for anxiety and obsessive-compulsive disorders guides you safely through the specific therapeutic measures of evidence-based behavioural therapy. The therapy cards make it possible to go through the individual therapy steps directly with the patient, so that exactly what works takes place. There is a set of cards for all major anxiety disorders - on the front, what to do and on the back, what to bear in mind. Patients really enjoy working with the cards and therapists feel confident in using them. Even if the ring binder is used instead of the cards (with what to do at the top and what is important at the bottom), working with PKP works very well. It starts with a plausible disorder model for the patient, continues with self-observation, preparation of the intervention, its implementation and effectiveness testing

Keyword

behavioural therapy - anxiety therapy - obsessive-compulsive disorder - obsessive-compulsive treatment - brief psychiatric therapy PKP - agoraphobia - panic disorder - generalised anxiety disorder - social phobia - compulsive actions - obsessive thoughts - survival rule - reaction chain - AACES

Introduction

PKP Anxiety & Compulsion is a powerful, complex anxiety therapy tool (Sulz, Sichort-Hebing & Jänsch 2015a,b). At the same time, it makes anxiety and coercion therapy manageable and easy to use. The concept and practice are well

structured so that the overview is never lost. Transdiagnostic, i.e. cross-disorder (Sulz 2017a,b) and disorder-specific considerations and strategies (Herpertz, Caspar & Mundt 2008) complement each other in such a way that the therapy process is fluid. Joint reflection ensures that the patient is always involved and that no therapy decisions are made that they have not fully understood and agreed with. They are well prepared for the challenging passages of the expositions. The result is a modular, individualised psychotherapy for anxiety or obsessive-compulsive disorder.

As with the other PKP therapy sets (Sulz & Deckert 2012a,b, Sulz, Antoni et al. 2012a,b), only evidence-based interventions are used here, the effectiveness of which has been proven in many studies and which are, for example described in the third volume (Leibing, Hiller & Sulz 2014) of the textbook on psychotherapy (Munsch, Schneider & Margraf 2014, Aufdermauer & Reinecker 2014, Fydrich & Renneberg 2014, Zubrägel, Bär & Linden 2014, Lakatos 2014, Sulz 2014) and by Sulz (2017a,b).

After a careful diagnosis (Hoyer & Margraf 2003, Sulz 2017d, Zaudig, Hauke & Hegerl 2002) with the VDS90 symptom list (Sulz & Grethe 2005), the VDS14 diagnostic interview (Sulz, Hörmann, Hiller & Zaudig 2002) and the subsequent ICD classification (Sulz, Hummel, Jänsch & Holzer 2011), the treatment recommendations of the PKP manual are discussed.

Pillar 1: Dealing with the symptom

PKP Anxiety & Compulsion assumes that anxiety disorders are not treated with pharmacotherapy and primarily includes psychotherapeutic strategies. Psychopharmaceutical treatment is not discussed in PKP. We begin with the joint psychoeducational development of basic knowledge about anxiety and compulsion. This ensures that the patient does not simply have anxiety or obsessive-compulsive symptoms, but that they consider and reflect on their symptoms (mentalise them in Fonagy's sense). He goes to a meta-level and metacognition takes place (thoughts about thoughts) and even this brief distancing is the beginning of self-control ability.

Let's take a look at the PKP manual for the treatment of anxiety and compulsion, which consists of 116 instructions for action. The treatment is based on three pillars: symptom therapy, skills training and motivational clarification -

personality development. The first (and most important) pillar is symptom therapy. The therapy cards address the following topics:

Analysing the development of my anxiety or obsessive-compulsive disorder
When did the illness begin? Pathogenic life and relationship behaviour. And now I analyse how exactly it happened that I developed my anxiety-compulsion symptom. Triggering life conditions (S = situation) . Triggering life event. How the survival rule influences the reaction chain to the symptom.

Symptom therapy
First we learn how to deal with the symptom (the anxiety or the compulsion).
Learning to deal with my symptom: EXPOSURE
My own reaction chain to the symptom
Symptom therapy step by step
Acknowledge the primary emotion - Control the primary impulse - Achieve a realistic expectation of effectiveness - Delete the secondary emotion - Establish masterful behaviour

What maintains the symptom? Consequences of alternatives to symptom formation

Relapse prevention: Recognising relapse-triggering situations - Recognising early relapse reactions - Relapse prevention through lifestyle - how, when, where? - Relapse prevention by organising relationships - how, when, where? - If a relapse has occurred - emergency card

Utilising the time between conversations My project/task card

Pillar 2: Skills training and Emotion Exposure

The second pillar is skills training. It supports the development of skills on a cognitive, emotional and behavioural level. This module contains a selection of proven interventions for anxiety and compulsion: new behaviour (assertiveness, independence training, trying out new habits). New feelings and new regulation of feelings (Getting to know my feelings - learning to deal with my feelings - Model of emotion regulation in anxiety & compulsion - An emotion theory of anxiety & compulsion - Feelings help people ... - 43 feelings - My feelings of sadness - My feelings of joy - My feelings of fear - My feelings of anger - How I have dealt with my feelings so far - Disorders of emotion regulation - Moods and their function - Expressing feelings - Emotion communication - When a feeling determines my actions too much: Emotion exposure - When an emotion is not/barely perceptible: emotion discovery - Functional handling of emotions). New relationships **(**Balance between self and relationship **- Re-evaluation** of difficult situations - Imagination exercise interaction problem **-** Self-acceptance according to my life story **-** Resource mobilisation - Decision to change - Letting go, saying goodbye, mourning the old - My future).

Pillar 3: Clarification of motives: from dysfunctional survival rule to functional pemission giving life Rule

The instructions for action in 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 central feelings (fear, anger, rage...), central needs and dysfunctional personality traits that control behaviour. 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:

My (old) survival rule and my NEW permission-giving life rule:
Start by working out the survival rule: Central needs of a patient - The patient's central fear - Personality traits based on ICD-10 - Learning history - Formulating the survival rule - Contract: Acting against the survival rule - Living instead of surviving - My new life rule

A model for thinking about the development of anxiety and obsessive-compulsive disorders

There are very difficult life situations in which a conflict seems impossible to resolve. Some people react with psychological, psychosomatic or physical symptoms. Some simply experience stress without specific symptoms. And some are traumatised. Others, however, have sufficient inner and outer resources to help them cope with the situation unscathed.

Those who are unable to cope with the situation may have too few skills that would be necessary in this very special situation. Or they would have to resort to behaviour that their psyche forbids. In this case, they are caught up in an inner conflict in which they have no free choice. He cannot weigh up the advantages and disadvantages of one alternative or the other. Rather, he is fixed from the outset on a usually very unsatisfactory way of resolving the conflict. Since childhood, he has carried within him prohibitions and commandments that helped him as a child to deal with a difficult family situation. At that time, the child's emotional survival was at stake and an implicit survival rule had to be strictly adhered to. This rule often states that no anger should be shown and that it is best not to be recognised at all. Defensive assertion of one's own concerns is forbidden. Instead, they must adapt to the powerful others.

Or the survival rule wants to ensure that the bond with the parents is sufficiently secure. So the child must be careful not to lose sight of its mother and ideally be so well-behaved and lovable that she will never leave and will never send it away. Own wishes that do not correspond to those of the parents are best not felt at all. Defiance and self-will are not allowed. Later on, these are people who are not allowed to be independent so that they do not move too far away from their carer. Separation is the greatest threat to them.

In adulthood, these childhood imprints result in pathogenic relationships that contain a predetermined breaking point, so that exactly what should be prevented happens.

One day, a kind woman can no longer stand being in her golden cage, breaks out, realises that she now has no one to protect her and promptly develops agoraphobia or panic disorder.

A man who has always swallowed his anger is no longer able to do so one day, begins to fight back violently and promptly develops a social phobia.

Anyone who sees the world as potentially dangerous and now wants to start exploring or even conquering it anyway is alerted to dangers by phobic stimuli in such a way that from then on they have nothing else to do but fearfully avoid them (specific phobia).

When basic safety signals in life are increasingly lost, a state of being at the mercy of others develops, which can only be controlled by constant worry. New dangers are constantly looming, the future is so uncertain that it has to be virtually ploughed up by thoughts of worry. Again and again and always only briefly providing reassurance.

Security through organising, washing, checking and brooding also only lasts for a short time and has to be re-established again and again. Hundreds of times, without interruption, so that there is no room for normal life in between.

A look at PKP practice for anxiety and compulsion: practical work with the modules

As with PKP depression, we start by recording and analysing the symptoms.

Symptoms of anxiety/phobia & compulsion are often (Hoyer & Margraf 2003):
Anxiety, anxiety, rapid pulse, chest discomfort, dry mouth, dizziness, hyperventilation, sweating, shortness of breath, urge to urinate/stool , nausea, cold hands, trembling, tremor, muscle tension, compulsive hand washing, compulsive ordering, compulsive repetition, compulsive rituals, compulsive thoughts, compulsive rumination, compulsive lack of resolution.

The aim of this list of symptoms is for the patient to switch from the mode of the sufferer to the mode of the observer and reporter by talking "about" their complaints. If we only write down the symptoms that belong to anxiety & phobia,

then the patient practises distinguishing between what belongs and what does not belong. Obsessive-compulsive symptoms repeat themselves agonisingly often and cannot be stopped.

After collecting them, the next step is to mentally organise them:

Categorising the symptoms - examples of anxiety

Feelings of anxiety: fear, anxiety, insecurity; thoughts of anxiety: "Something bad is going to happen now"; perceptions of anxiety: e.g. a questioning look is perceived as criticism; memories of anxiety: I didn't make it last time either; fear actions: Fleeing, avoiding
Fear body processes: Shortness of breath, racing pulse, etc.

The aim of these questions is for the patient to step out of their anxious experience and reflect on their symptoms from a metacognitive perspective (mentalised), e.g. "I'm going to die!" Is this a feeling or a thought or is it reality?

Finally, the patient is **assigned to an illness category according to ICD-10.**

F 40.0 agoraphobia (.00 without panic disorder, .01 with panic disorder), F 40.1 social phobia, F 40.2 specific phobia (animal phobia, exam anxiety, injection phobia, dentist phobia), F 41.0 panic disorder without agoraphobia: F 41.1 generalised anxiety disorder, F 42.0 predominantly obsessive thoughts or ruminations, F 42.1 predominantly obsessive actions (obsessive rituals), F 42.2 mixed obsessive thoughts and actions.

Clinical profiles of anxiety and obsessive-compulsive disorders
We orientate ourselves on "profiles" of the individual anxiety disorders.

Clinical profile of agoraphobia (Munsch, Schneider & Margraf 2003)
Fear of places and situations from which escape could be difficult or embarrassing. Fear of situations in which no help would be available in the event of a sudden panic attack. The fears may relate to going out unaccompanied, being away

from familiar places, crowds of people of any kind, public places, etc. The feared situations are avoided or only endured with great fear or with company. The avoidance often extends to several situations until normal activities are largely hindered or even impossible.

Clinical profile of panic disorder (Munsch, Schneider & Margraf 2003)
Spontaneous occurrence of panic without real danger for a limited period of time (30 minutes). Usually triggered by stimuli internal to the body, more rarely by cognitive stimuli. Most common somatic symptoms: Palpitations, palpitations, shortness of breath, dizziness, sweating, chest pain, tightness in the chest, trembling, nausea. Most common cognitive symptoms: Interpretation of physical symptoms e.g. "fear of dying", "losing control". Most common behavioural symptom: help-seeking behaviour, escape behaviour.

Clinical profile of social phobia (Fydrich & Renneberg 2003)
Persistent, exaggerated fear of one or more social or performance situations in which one fears failing, being judged negatively or displaying embarrassing, humiliating behaviour. The confrontation/anticipation of the situation usually triggers physiological symptoms (e.g. blushing, trembling, nausea, urge to urinate or defecate), negative thoughts (about oneself and expected derogatory reactions from others) and/or avoidance behaviour. The anxiety has a significant impact on everyday professional and/or private life.

Clinical profile Specific (isolated) phobia (Aufdermauer & Reinecker 2003)
Clear fear or avoidance of a specific object or situation. Symptoms of a panic attack have occurred at least once since onset. Significant emotional distress due to symptoms or avoidance behaviour. Realisation that these are exaggerated and unreasonable.

Clinical profile of generalised anxiety disorder (Becker & Nündel 2003. Die Generalisierte Angststörung - State of the Art. Psychotherapy 8-1, p. 146)

Excessive, generalised and multiple worries, fears and anxieties on most days. For at least several weeks. Not limited to specific situations. Experienced as difficult to control. Frequent symptoms in addition to worry: motor tension (physical restlessness, tension headache, trembling, inability to relax), -vegetative overexcitability (light-headedness, sweating, palpitations, dizziness, upper abdominal discomfort, dry mouth**).**

Clinical profile of compulsive behaviours - compulsive rituals (Zaudig, Hauke & Hegerl 2002)
are repeatedly occurring behaviours (e.g. washing hands) or mental actions (e.g. counting) that the affected person feels compelled to perform, even though they may seem pointless or at least excessive. Frequently as washing and cleaning compulsions as well as control compulsions.
Others are compulsions to organise, count, collect or repeat. They often serve to protect themselves and/or loved ones from danger. Resistance to compulsive behaviour is often unsuccessful and leads to severe feelings of guilt and shame.

Clinical profile of obsessive thoughts (Zaudig, Hauke & Hegerl 2002)
are repeatedly occurring and persistent thoughts, impulses or imaginings that are perceived as pointless and disturbing and are associated with a great deal of suffering. People try in vain to defend themselves against these stereotypical thoughts. They are perceived as useless or even repulsive, they are perceived as their own thoughts. They are not experienced as coming from outside, as is the case with schizophrenia.

In the **behavioural diagnostic interview** (Sulz 2017d), we ask the following questions:
Please describe your fears/compulsions, how does this occur? In which situations or moments does the anxiety/compulsion occur, what triggers it? How often and for how long do you deal with your anxiety/compulsion each day? What are you no longer able or willing to do because of your fears/compulsions? How are your family life, relationships, work and leisure time affected? How do you react to your fears/compulsions, how do you try to deal with them? When did your anxiety/compulsion symptom first occur? What was your life like then? Were there any stressful events or circumstances? How do you explain your anxiety/compulsions?

AACES: The immediate action in dealing with anxiety or compulsion (Sulz 2017d,Theßen, Theßen et al. 2024)

1. mindfulness: I pay attention to early anxiety signals/tension. 2. acceptance: I accept my anxiety/tension. 3. commitment - willingness: I decide to confront the situation, e.g. to think my worry thoughts through to the end. 4th exposure: I confront my anxiety without doing what it wants me to do (flee and avoid, neutralise, reassure). 5. self-affirmation: I then affirm myself for my correct handling of the fear/compulsion. This is followed by initial mindfulness exercises that should be maintained on a daily basis.

Reaction chain and maintaining consequences (Sulz 2017c)

The reaction chain from the symptom trigger in the situation to the development of the anxiety symptom is the hub for understanding and treating anxiety and compulsions.

A typical observable situation (e.g. one that is extremely frustrating) is selected. Then the six links of the reaction chain are identified: 1. the primary emotion in response to this situation (e.g. anger). 2. the primary impulse to act that results from this emotion (e.g. attack) 3. the thought: considering the consequences of my actions (e.g. then I will be rejected). 4. a counteracting secondary feeling (e.g. feeling of fear, guilt, powerlessness). 5. my observable behaviour (e.g. doing what my counterpart wants). 6. symptom formation (e.g. social anxiety).

If the patient can say that most other people in this situation would have been very angry and would have defended themselves, we can say: "Then let's write in the most natural feeling in such a frustration/injury as the primary emotion."

"Let's assume that you would actually also react with great anger/rage if you had had good experiences with showing anger from childhood, and imagine the anger was there. What would the anger want to do?" The answer could be: "Full of anger, saying that I don't want that." "What would happen if you said that?" Answer e.g. "There would be a big argument, irreconcilable enmity." "Then let's put that in here as your expectation of negative consequences. How do you feel when you visualise that?" The answer can be: "Powerless, helpless, inferior, weak, insecure and fearful" This answer is noted in the line "counteracting secondary feeling" or added as a supplement. Finally, the reaction chain leading up to the anxiety symptom is analysed together and it is established that the symptom can develop in this way (plausible model).

The patient is asked about the **consequences of maintaining the symptom** (functional analysis): What would someone who feels able to cope with the triggering situation have done instead of developing a symptom? These are often coping behaviours that put a slight strain on the relationship, but do not endanger it or even stabilise it. What would have been the consequences of such behaviour if you had acted in this way (taking into account central fear and central needs)? Here, too, fantasies of catastrophe and the end of the world regularly crop up. As the aim is to establish the actual state, the irrationality of these fantasies does not (yet) need to be dramatically demonstrated to the patient at this stage . Rather, the validation of his previous way of experiencing things is indicated, signalling confirmation, acceptance and understanding. So to what extent was the symptom help, protection, problem-solving and suffering the price you had to pay for it? This question aims to give the patient an understanding of their symptom and its functionality and a cognitive disorder model, a theory of illness that validates them and their psyche, removes the accusation of failure or guilt and also brings understanding for the symptom.

Explanations of the disorder-specific therapy system

After the diagnosis, we turn to the therapy.

Every anxiety or obsessive-compulsive disorder has special features that must be taken into account in therapy. Firstly, the specific disorder model, which allows us to understand how the disorder developed. Then self-observation with recording of the symptoms. The difficulty hierarchy categorises the symptom-triggering situations. The habitualisation model shows how the symptom diminishes through habituation. Then comes the preparation for therapy: Exposure I, II & sometimes also III. And finally the implementation of therapy: Exposure IV

Exposure for agoraphobia (Munsch, Schneider & Margraf 2014, Mathew & Gelder 1988, Schneider & Margraf 1998)

Patient and therapist go into the symptom-triggering situation (e.g. underground train).

Ask the patient how they are feeling in view of the exercises.

Reinforce him and encourage him.

No surprises, always emphasise the patient's freedom of choice.

During the exercise, continuously ask about the level of tension (scale 0-10).

Explore physical symptoms, feelings and thoughts.
Keep focussing your attention on the here and now of the situation.
Only end the exercise when the tension has decreased (below 4).
The patient soon carries out the exposures alone.
The therapy appointments should be soon after the self-exposure or a short report on the telephone.
Feedback for behaviour during exposure and response prevention.
Clear reinforcement by therapist and self-reinforcement (praise and reward) for the really strong performance.
Review: Remembering, reflecting on and recognising this difficult action, agreeing further self-management.
Plan your own projects after the exposure therapy.

Exposure panic disorder (Munsch, Schneider & Margraf 2014)
Important: Correction of misinterpretations of physical symptoms with the help of cognitive restructuring and interoceptive exposures/behavioural experiments*:

- for palpitations, physical stress exercises such as stress posture, running, climbing stairs, squats, confrontation with own ECG, caffeine consumption
- Hyperventilation in case of breathlessness, request to stop breathing voluntarily
- turn on the spot if dizzy.

9 rules for dealing with panic (modified from Mathew, Gelder & Johnston 1988):

1. Remember: panic is just an exaggerated normal body reaction.
2. Feelings of panic are not harmful or dangerous - just very unpleasant
3. Pay attention only to what is happening here and now, not to what you fear might happen.
4. Concentrate on what you can hear, see, smell and touch.
5. Don't exacerbate the fear with anxiety-producing thoughts.
6. Wait and give the fear time to pass on its own.
7. Don't fight it, don't run away from it.

8. Remember: every fear is an opportunity to practise and make progress.
9. Breathe calmly and slowly, but not too deeply.
10. When you are ready to move on, start slowly and calmly. There is no need to hurry.

Exposure for specific phobia (Aufdermauer & Reinecker 2014)

Clarification of physical illness: There are always physical illnesses that can trigger anxiety-like symptoms (e.g. thyroid disorders) or make therapy more difficult. The patient has usually become accustomed to a large number of subtle safety reactions in order to minimise the symptom. These must be identified and omitted during exposure. If not already done during the preparation of the anxiety protocol, an "anxiety thermometer" (1-10) is now introduced, defined as zero = no anxiety, 5 = moderate anxiety, 10 = maximum anxiety. By obtaining information about the phobic object, the patient becomes an expert and can learn to discriminate harmless situations from dangerous situations (It's very easy: wagging tail: Dog is happy, growling: dog feels threatened, ears pinned back: biting). Inform important caregivers which behaviour promotes avoidance on their part and which behaviour helps to confront fear. Make clear agreements (e.g. little is spoken during the exposure or the therapist will try to prevent the patient's avoidance/escape tendencies).

Therapeutic attitude: Complementary to the central need (safety), but without slipping into dysfunctional behaviour.
Exposure initially accompanied by the therapist with therapist behaviour as a model.
Decision in favour of graduated or massaged approach:
Graduated: "Fight your fear one step at a time" - usually starting with medium difficulty.
Massaged: "Expose yourself to the most difficult situation until your fear has greatly diminished or disappeared" - this often takes 45 minutes.

Therapy for social phobia (exposure plus behavioural experiments) (Fydrich & Renneberg 2003, Ginzburg & Stangier 2012)

Exposure could also be used to treat social phobia, as with other anxiety disorders. However, it has been shown that the therapy outcome is better if a cognitive experience is added to the emotional experience of exposure:
Hypothesis: I previously expected a negative outcome to the situation. Without my safety behaviour, this would have happened.
Behavioural experiment: I compare the outcome of the situation when I encounter it once with and once without my safety behaviour.
Cognitive evaluation of the behavioural experiment: Even without safety behaviour, the feared outcome did not occur. I can therefore do without my safety behaviour in future.
This is how behavioural experiments are carried out:

The patient performs an exercise from the fear hierarchy. 1. with the safety behaviour (put on a jacket, press your arms against your body, draw attention to your own sweating). 2. without safety behaviour (do not put on a jacket, let your arms hang loosely, focus your attention on the content of the presentation and concentrate on the audience). The consequences are then reviewed.

Worry exposure for generalised anxiety disorder (Becker & Nündel 2003, Becker & Margraf 2007, Korn, Sipos & Schweiger 2012)
The various worries (e.g. the children could fall ill, mistakes happen at work, there is not enough money, etc.) are collected with the patient.
And categorised according to their difficulty on a scale from 0 % (no difficulty) to 100 % (currently insurmountable difficulty).
Five levels are usually sufficient, e.g. 20 %, 40 %, 60 %, 80 % and 100 %.

The worries should be described in concrete terms so that all significant anxiety dimensions are defined in terms of their degree of difficulty
Execution of worry exposure in sensu: patient is asked to close their eyes; therapist presents the scene that was previously worked out together; therapist builds in longer pauses at the points where anxiety should occur; patient should give a signal (possibly raise their finger) if they are unable to keep the scene in front of their eyes; therapist then repeats the last sequence; exposure in sensu should last approx. 10-20 minutes; therapist ends the exercise by slowly counting backwards from 3 and the patient opens their eyes.

Exposure with reaction prevention for compulsive behaviour (Lakatos & Reinecker 2002)
Therapeutic approach: Complementary to the central need (safety), but without slipping into dysfunctional behaviour. Exposure initially accompanied by the therapist. Decision in favour of graduated or massaged approach (graduated: "Fight your fear one step at a time" - massaged: "Expose yourself to the situation until your fear has greatly diminished or disappeared" - this often takes 45 minutes).

Example of an exercise for control compulsions in the home environment
The exercise is discussed again in advance. It is important to reinforce the patient's personal responsibility ("What exactly would you like to practise with me today? What have we agreed, what are you going to do now?")
The patient switches on the electrical appliances one after the other (cooker, coffee machine, iron, toaster, etc., turns on the tap, opens a window, etc.)
The therapist uses the anxiety thermometer to assess the patient's level of anxiety and asks about physiological symptoms and cognitions.
The patient then switches off all electrical appliances, turns off the tap, closes the windows and refrains from checking anything. The therapist waits outside the door. They then leave the flat together. The therapist and patient discuss the tension on a park bench or in a café. The exercise is only ended when the tension has dropped to approx. 3 (scale 1-10). It must be ensured that the patient does not return home immediately.

Example of an exercise for **purely obsessive thoughts**

1. look for action correlates of the obsessive thoughts (e.g. if a woman is afraid of stabbing her child with a knife, she should handle the knife in the presence of the child. 2. write down the thought and say it out loud several times a day for 10 minutes ("I could stab my child, I could stab my child.....). 3. confrontation with the obsessive thought in sensu: a script is created: "Imagine you have done it, you have stabbed your child, what happens then?"

Using the script, the patient is put into a state of mild relaxation and the therapist reads the script aloud: "Imagine you have stabbed your child, the police arrest you, everyone turns away from you, you will be alone in prison....."

The therapist confronts the patient with the consequences of their supposed impulses so that exposure to the underlying emotions becomes possible.

Conclusion

PKP Anxiety & Compulsion was developed for the psychotherapy of anxiety and obsessive-compulsive disorders in psychiatric practices and clinics. This made it possible to systematically and effectively treat patients with these disorders beyond the scope of standardised therapy. The approach has long since been discovered by psychological psychotherapists working in private practice or in a psychotherapeutic clinic and has been used to great benefit for therapists and patients. The question of application is not about WHAT (evidence-based interventions), but about HOW (disorder-specific treatment customised for the individual patient combined with transdiagnostic (cross-disorder) strategies). Both the consultation/therapy cards and the spiral handbook help to apply complex strategies in a way that is simple and acceptable to the patient. They are a guide that leads safely through the therapy.

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

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