5. Psychiatric & psychological brief psychotherapy PKP for depression - an empirical outcome study

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Abstract

This paper reports on a field study comparing depression treatment with Psychiatric and Psychological Brief Psychotherapy (PKP) with a waiting list control group. The theoretical and research background of PKP is the assumption that psychological symptoms in general and depression in particular can be interpreted behaviourally as avoidance behaviour: In a very difficult interpersonal situation, people refrain from defensively asserting their own interests. In order for this avoidance to succeed, feelings such as anger, rage or sadness must be consistently suppressed. This is only possible with the help of symptom formation. The aim of therapy is therefore to make these feelings accessible again by carrying out emotion exposures. PKP is a modular psychotherapy in which the goal and approach are individually tailored to the personal problems of each patient. Work was carried out in 24 weekly sessions with consultation and therapy cards. The therapy culminated in 6 four-weekly maintenance therapy sessions. There were highly significant improvements with good to very good effect sizes. Only a few patients required conversion to long-term therapy. The catamnesis after a further 6 months showed stable therapeutic success.

Key words

Psychiatric-Psychological Brief Psychotherapy PKP - Strategic Brief Therapy SKT - Strategic-Behavioural Therapy SBT - dysfunctional survival rule - behavioural therapy - consultation cards - therapy cards - depression treatment

Introduction

Depressive patients receive effective treatment far too rarely and far too late. One reason for this is that psychological psychotherapists have waiting times of up to a year. On the other hand, it is also due to the fact that psychiatrists have so far not seen any possibility of carrying out systematic psychotherapy in a short-term setting of 20 to 25 minutes in their

consultation hours, although guideline therapies are not limited to almost 50 minutes. We have therefore composed a cognitive behavioural therapy from evidence-based interventions that provides a clearly structured therapy session in a time frame that can also take place in inpatient treatment. The first focus is on cognitive and metacognitive therapy strategies that involve the reattribution of depressogenic and depressive thoughts.

Secondly, we focussed on emotions (Sulz & Lenz, 2000): Affective-Cognitive Behaviour Therapy ACBT (Woolfolk & Allen, 2013) and Strategic Brief Therapy (Sulz, 2012) assume that emotions lead to dysfunctional cognitions and that direct modification of feelings and coping with feelings is beneficial. This gave rise to the Psychiatric-Psychological Brief Psychotherapy PKP for depression (Sulz & Deckert, 2012a, b), which used consultation cards for psychiatric practices and clinics and therapy cards as psychological brief psychotherapy for psychotherapists - for psychiatric practices or hospital wards as a brief intervention in a 20 to 25-minute conversation format, for psychotherapeutic practices or clinics as 50-minute individual conversations or as group sessions (Algermissen et al. 2017).

The premise is that depression is an avoidance behaviour that serves to prevent unmanageable or forbidden feelings (joy, fear, anger, sadness).

These prohibitions were already adopted as a survival rule in childhood, in line with Beck's (1979) basic assumptions and Bowlby's inner working model (1975, 1976).

The survival rule, which becomes dysfunctional in adulthood, leads to a chain of reactions in the situation that triggers the depression, culminating in the symptom: instead of defending oneself competently, one gives in and accepts the depression.

The treatment consists of three pillars (modules): The first pillar or module is symptom therapy. If this is not sufficient because skills are lacking, the second pillar follows with the second module, skills training. If the existing skills are not used because the inner prohibitions and commandments of the dysfunctional survival rule do not allow this, the third pillar, the third module, is used - replacing the survival rule with a new rule of life that gives permission (see also Sulz 2021a,b).

The skills training consists of a fourfold emotion exposure (joy, fear, anger and sadness exposure).

This intervention system keeps the psychotherapy short.

Methodology

1. study design

After screening for inclusion in the study and diagnosis, the patients were divided into a therapy group for the 6-month brief psychotherapy and a waiting list control group with a waiting period of 6 months.

The survey lasted four years, from the beginning of the first initial interview with the first patient to the end of the last catamnesis session with the last patient.

The therapy design was determined:

- The therapies take place in the outpatient clinic of the CIP Academy Munich.
- The therapy sessions there lasted 50 minutes in accordance with the therapy guidelines
- Structure of a therapy session: 10 minutes patient report and homework discussion, 25 minutes working on a new therapy topic using the PKP therapy cards, followed by 10 minutes preparing the homework and feedback for the session.
- Approximately 6 months duration, exactly 24 weekly sessions
- Followed by 6 months of maintenance therapy with one session per month
- Catamnesis session after a further 6 months.

It was agreed with the patients that this would be a short-term therapy with no possibility of extension.

The sixteen PKP-trained study therapists (13 female and 3 male) received weekly to fortnightly group supervision as well as occasional individual supervision.

The patients in the therapy group therefore did not have to put up with the usual 6-month waiting period, while the control group patients were placed on the waiting list with the assurance that they would be able to start their therapy in 6 months. They never met as a group during the waiting period. During this time, a contact person was available for them in the outpatient clinic. After the waiting period, they received regular psychotherapeutic treatment in the outpatient clinic. However, the further course of their treatment was then no longer recorded.

This means that one patient remained in the outpatient clinic for one and a half years (Figure 2).

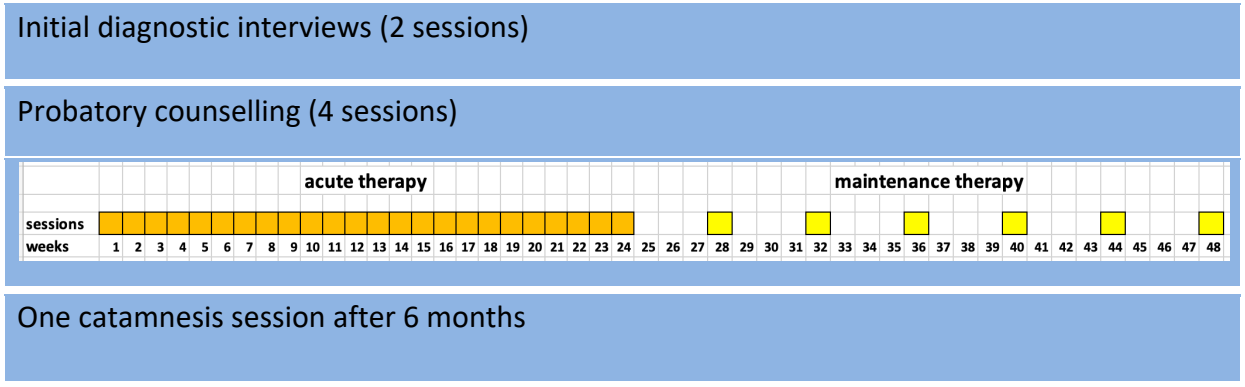

Figure 2: Overview of the treatment duration in the experimental group

We adopted the concept of maintenance treatment from Dunn and Tierney (2006), who showed that relapses are to be expected primarily in the first six months after the end of treatment.

The measurement points were:

- t_0- initial survey, identical in the waiting group and experimental group
- t_1- first follow-up measurement after the 8th therapy session, only in the therapy group
- t_2- second follow-up measurement after the 16th therapy session, only in the therapy group
- t_3- end of acute therapy at the 24th session, identical in the waiting group and experimental group
- t_4- end of maintenance therapy at the 30th session, six months after the end of acute therapy (therapy group only)
- t_5- catamnesis measurement, 31st session, six months after the end of maintenance therapy (therapy group only)

The inclusion criteria were

- mild to moderate depressive episode (F32.1), dysthymia (F34), adjustment disorder with depressive symptoms (F43.20 and F43.21). The diagnosis was made using the standardised VDS14 interview (Sulz, Hörmann, Hiller, Zaudig, 2002) and the VDS90 self-observation scale (Sulz et al., 2009).

- Patients should be between 18 and 75 years of age and have a relatively good knowledge of German. Patients who had been pre-medicated with a constant antidepressant medication for at least three months were also included - with the requirement that this be maintained throughout the study. Comorbid disorders were recorded and not defined as an exclusion criterion.

The exclusion criteria were:

- Exclusion criteria: psychotic symptomatology, significant suicidal risk, a lifetime diagnosis of bipolar disorder, cyclothymia, psychoorganic brain syndrome, mental retardation, borderline personality disorder and eating disorders of any kind, unless they had been demonstrably remitted for one year. First diagnosis of panic disorder, generalised anxiety disorder, social phobia and post-traumatic stress disorder (i.e. if the depression was a secondary diagnosis). Additional exclusion criteria were self-harming behaviour, substance dependence or harmful abuse (except nicotine dependence). Non-response to electroconvulsive therapy or to three adequate attempts of different drug therapies with at least two different classes of antidepressants within three years prior to the start

of the study were also defined as exclusion criteria (i.e. no treatment-resistant depression). The same applied to non-response to two different psychological psychotherapies in empirically based procedures in the last three years. Patients with a serious somatic illness with unstable medication or an uncertain course of illness also had to be excluded from the study.

2. sample

77 patients were allocated to the therapy group (TG) and 54 patients to the waiting list control group (WG). There were no significant differences with regard to socio-demographic data:
Gender: 57.1 per cent were female in the TG; 59.3 per cent in the WG.
Age: 38.8 years old in the TG and 41.7 years old in the WG.
Educational level, professional and family situation were very similar in both groups.

20 per cent had a mild depressive episode (F32.0), around 30 per cent had a moderate depressive episode (F32.1) and around one third had a moderate recurrent depressive episode (F33.1).

Dropout rates

Dropouts in the therapy group: A total of five patients discontinued therapy, one of them during the acute therapy phase, one during maintenance therapy and three patients during the catamnesis phase. The reasons for dropping out were a change of residence (n = 2)**,** utilisation of inpatient rehabilitation (n = 1), a new, unspecified crisis (n = 1) and taking a trip around the world (n = 1). Overall, the dropout rate in the intervention group is therefore 6.1 per cent.

Dropouts in the waiting list group: 33 patients (37.9 %) of the original 87 patients in the waiting list control group had to leave the group for various reasons. The reasons given were Change of residence (n=1), acute suicidal crisis (n=1), no time for therapy (n=1), approved psychosomatic stay (n=1), remission of symptoms (n=4), start of therapy outside the study (n=7), and no stated reasons (n=18).

3 Measuring instruments

Table 1 shows which measurement instruments were used before, after and during the course of the study.

Table 1: Diagnostic procedures and survey times

Time point	**Session number**	**Patient self-assessment**	**External assessment therapist**	**External assessment by diagnostician,**
t_0: Initial assessment (by initial counsellor)	Diagnostics, 2 appointments	BDI-II, QMP02, SEE, SF12,		VDS14, GAF
1st-7th week	1-7	STEPP, FB-ÜR, reaction chain	STEPT, therapy contract	
t_1: 8th week	8	STEPP, BDI-II, SEE	STEPT	
9th-11th week	9-11	STEPP	STEPT	
Week 12	12	STEPP	STEPT, QMP/T05	
13th-15th week	13-15	STEPP	STEPT	
t_2: 16 Week	16	STEPP, BDI-II, SEE	STEPT	
Week 17-23	17-23	STEPP	STEPT	

24th week **t_3End of acute therapy** (after approx. 6 months)	24	STEPP, BDI-II, QMP02, SF12, VEV, SEE, VDS90, FB-ÜR	STEPT, QMP/T05, GAF, VDS14
25-47th week	25-29	STEPP	STEPT
48th week **t_4End of maintenance therapy** (after approx. 1 year)	30	STEPP, BDI-II, QMP02, SF12, VEV, SEE, FB-ÜR	STEPT, QMP/T05, GAF, VDS14
t_5Catamnesis measurement (6 months after the end of maintenance therapy)	31	STEPP, BDI-II, QMP02, SF12, VEV, SEE, VDS90, FB-FOR	STEPT, QMP/T05, GAF, VDS14

Legend:
BDI II = Beck Depression Inventory II (Hautzinger, Keller, & Kühner, 2006)
STEPP/STEPT = Time sheet for general and differential individual psychotherapy for patient and therapist
VDS35c = Questionnaire on the survival rule (Hebing, 2012, Sulz, 2017d)
GAF scale for global assessment of the level of functioning (Saß et al., 2003)
QMP02Ability to work and medical care needs (Sulz, 2005)
QMP/T05 Target Approach Scale (Sulz, 2005)
Reaction chain from the situation to the symptom (Sulz 2017, a,b,c)

RMET = Reading the Mind in the Eyes Test (Baren-Cohen, Weelwright, Hill, Raste, & Plumb, 2001)
SEE Scale for Experiencing Emotions (Behr & Becker, 2004)
SF12 = Short Form 12 Health Questionnaire (Morfeld, Kirchberger, & Bullinger, 2011)
VDS14 (Sulz, Hörmann, Hiller, & Zaudig, 2002, and Sulz, Hummel, Jänsch, & Holzer, 2011)
VDS90 (Sulz & Grethe, 2005, Sulz et al., 2009)
VEV change questionnaire on experience and behaviour (Ziehlke & Kopf-Mahnert, 1978)

4. statistical calculations

Preliminary remarks: A significance level of 5 % with two-sided testing was assumed. Correction of the cumulative alpha error was made so as not to falsely reject the null hypothesis.

The t-test was used as the significance test. In the t-test, the Hedges index is used as a measure of effect size. It is assumed that if there is a two-sided five per cent significance level and an effect size (Hedges g = 0.20), there is a sufficiently significant difference between the groups investigated (Table 2). The significance level was set at 5 % (two-sided with alpha correction).

Table 2: the effect sizes used measurement

Test	*Effect size measure*	*Classification of the effect size*		
		small	medium	large
t-test	Hedges (g)	0,20	0,50	0,80

The Reliable Change Index (RCI) was used to test the differential effect of the reliable change in therapy.

According to Sulz and Grethe (2005), the individual severity of the illness or stress was categorised in gradations from 0 to 0.49 (no syndrome), 0.5 to 1.49 (mild syndrome), 1.5 to 2.49 (moderate syndrome) and 2.5 to 3 (severe syndrome).

With the RCI, patients could be categorised into groups according to the development of their symptoms:

Clinically significantly improved patients

This category includes those patients whose overall condition has improved significantly according to VDS90. For these patients, there were no longer any noticeable burdens in the measurements at the end of acute therapy ($t_{3)}$, at the end of maintenance therapy (t_4) or in the catamnesis (t_5). Their values were in the range below 0.5 ("no syndrome"), so that they corresponded to those of the "healthy" population.

Improved patients

There was a significant change in these participants between the initial examination and the time points t_3, $t_4$and t_5. Nevertheless, the values at these three measurement points are still in the clinically relevant range.

Deteriorated patients

Patients whose values deteriorated significantly during the course of treatment and between the measurements were categorised here.

Unchanged patients

Patients in this group showed no changes in their values between the initial measurement and the three final measurements.

Some patients could not be categorised in this classification and must be assigned to a separate group. This is the "normal" category. These people had no abnormal values at the start of the study and there were no significant changes.

There was also a group of ***dropouts***.

Results

5.1 Psychological findings (VDS14)

Table 3: VDS14, mean values and standard deviation in the therapy group

	$t_{(0)}$ (before therapy) (n = 65)	$t_{(3)}$ (after acute therapy) (n = 63)	$t_{(4)}$ (end of maintenance therapy) (n = 48)	$t_{(5)}$ (catamnesis measurement) (n = 37)
Depressive syndrome	M = 1,54 (SD = 0.64)	M = 0,40 (SD = 0.73)	M = 0,27 (SD = 0.49)	M = 0,24 (SD = 0.44)
Anxiety syndrome	M = 0,65 (SD = 1.36)	M = 0,13 (SD = 0.34)	M = 0,13 (SD = 0.39)	M = 0,08 (SD = 0.28)
Symptomatology total	M = 0,24 (SD = 0.22)	M = 0,09 (SD = 0.15)	M = 0,06 (SD = 0.12)	M = 0,07 (SD = 0.16)

Legend: M: mean value; SD: standard deviation

The t-test t0-t3 is significant for depressive syndrome at the 1-promill level, Hedges is 1.67 (very high effect), for overall symptoms Hedges is 0.78 (good effect), also significant at the 1-promill level (Tab. 3). However, there are no significant t0-t3 differences in the waiting group.

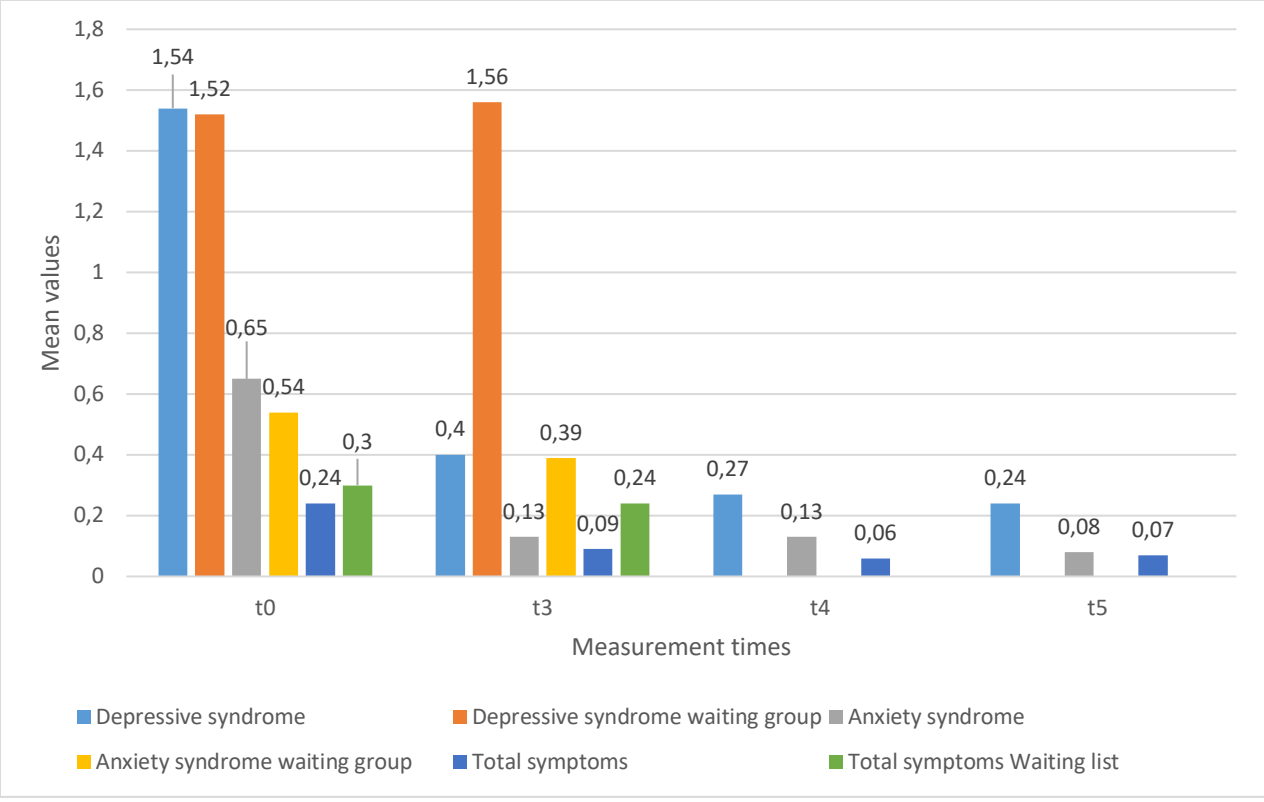

Figure 3a: Development of the mean values, VDS14 (external judgement)

The mean value comparison of the treatment and waiting list control group using the t-test results in a highly significant group difference (1-promill level) and a hedge of 2.07 (very high effect).

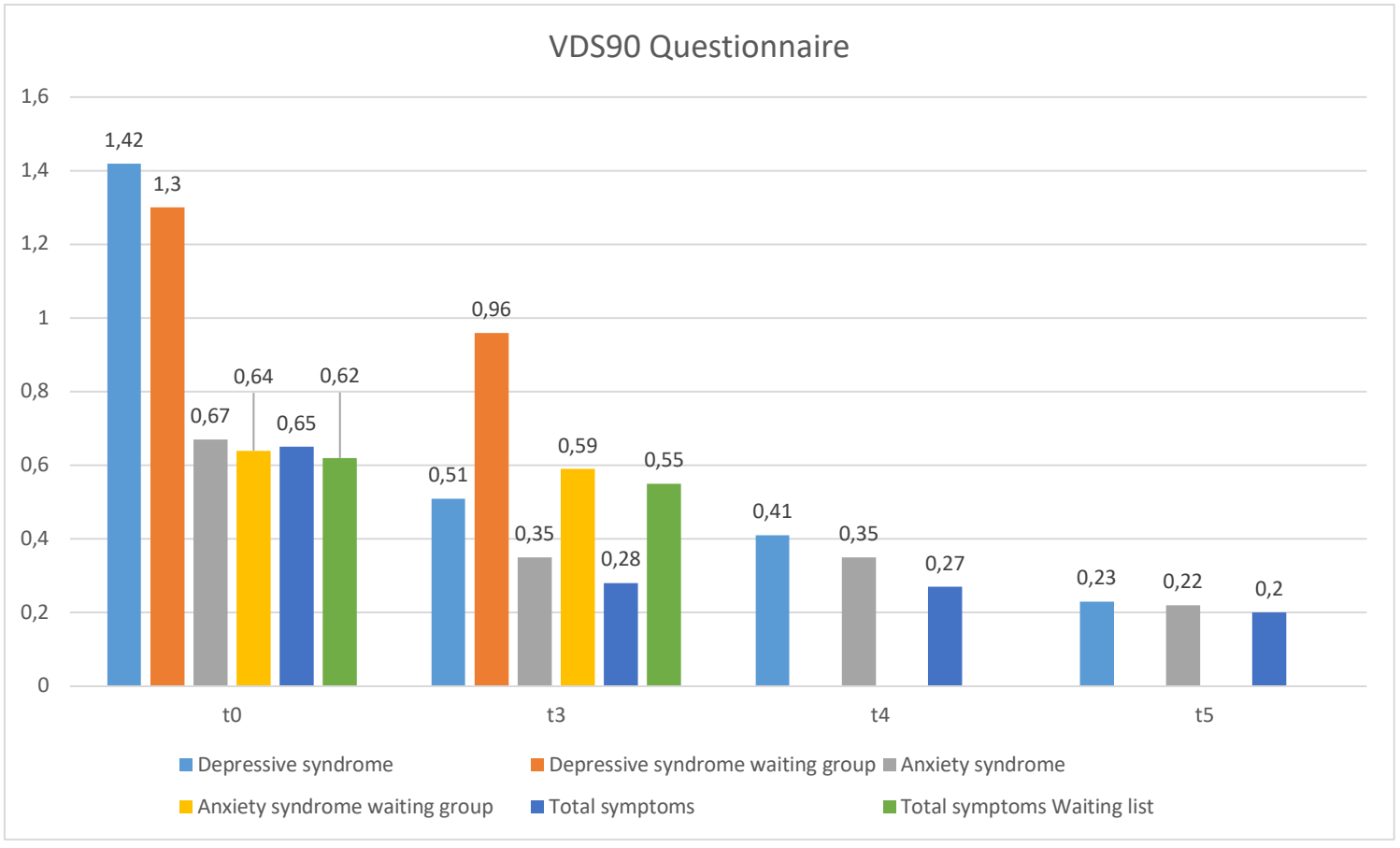

Figure 3b: Course of the mean values, VDS90 (self-evaluation questionnaire)

The calculations of the patient's self-assessment with the VDS90 yielded almost identical results. They are therefore not reproduced here.

5.2 Functional ability and performance (GAF)

The GAF produces corresponding results (Figure 4)

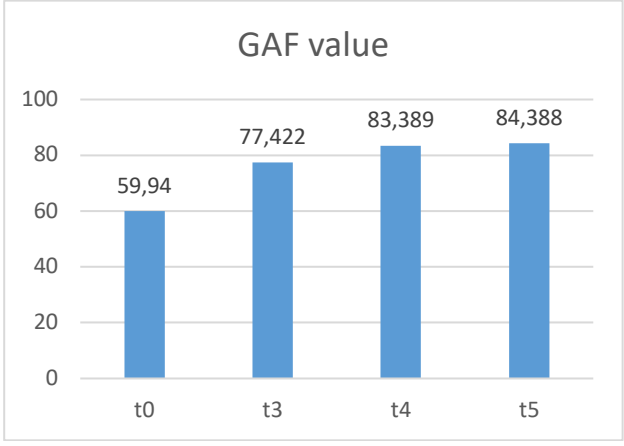

Figure 4: Development of the GAF value over time in the therapy group

Legend:

100-91	Optimal function in all areas
90-81	Good performance in all areas
80-71	At most slight impairments
70-61	Slight impairment
60-51	Moderately pronounced impairment

The change from t0 to t3 is highly significant with a very high effect size (Hedges 1.67). The mean value comparison of the two groups is highly significant with a very high effect size (Hedges 1.71).

5.3 Differential effectiveness

What about the differential effectiveness? Figure 5 shows the resulting groupings:

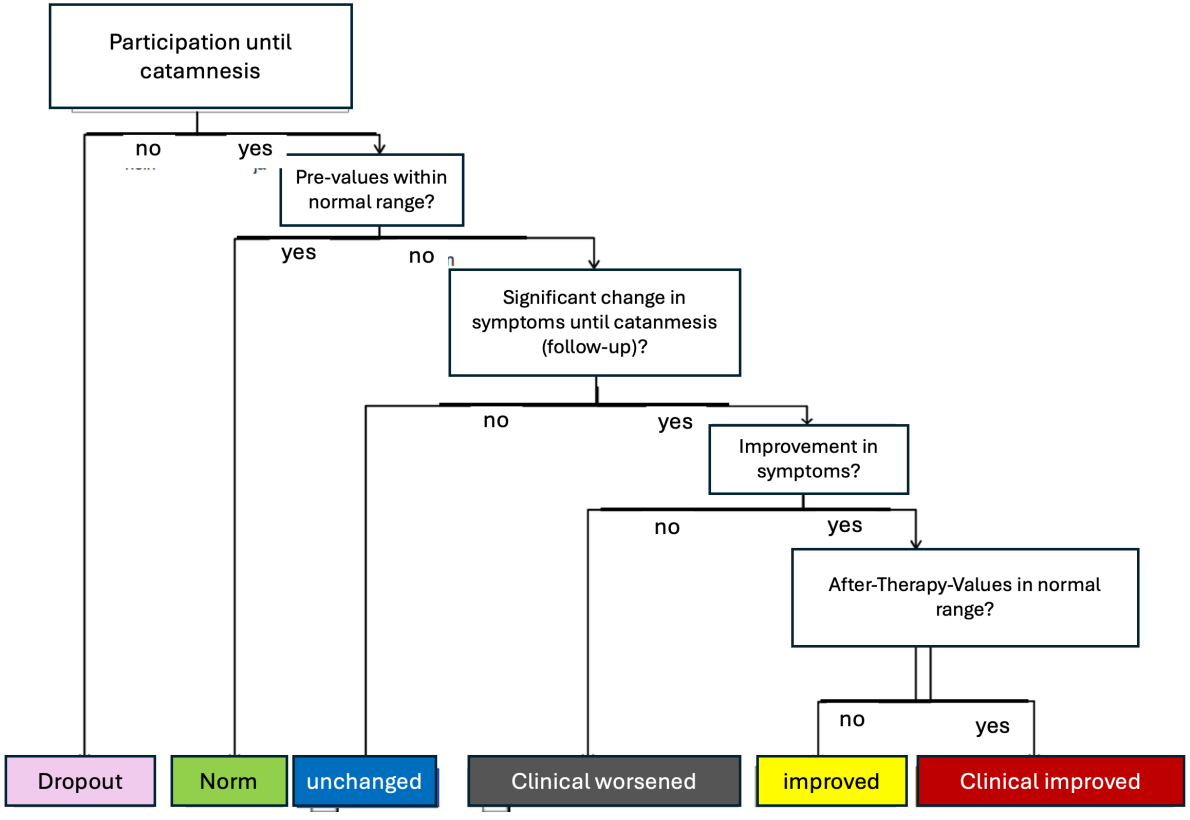

Figure 5: Categories of differential effectiveness (according to Hebing, 2012)

There are many significant improvements in depressive syndrome. If all comorbidities and non-specific symptoms are included, the treatment success is relativised, but still shows very good results.

Around one third (33.3 %) of patients showed a clinically significant improvement in symptoms by the end of acute therapy (n = 69) compared to the beginning of the study, and a further 40.6 % showed an improvement (Fig. 6). In 15.9% there was no change and in 10.1% of patients there were no abnormal values according to VDS90 (labelled "normal"). This results in a mathematical total of 105 % due to the inclusion of dropouts (5 %). The ratios would be incorrect if the constant number of dropouts were compared with the decreasing number of patients.

A clinically significant improvement was recorded in 34.5% of patients at the end of maintenance therapy (n= 58) and a fundamental improvement in 44.8%. In 13.8% there was no change and in 6.9% of participants there were no abnormal values at the beginning according to VDS90. In 37.2% of patients, there was a clinically significant improvement by the time of the catamnesis (n = 43) and in 39.5% there was a fundamental improvement. In 11.6 % there was no change and a further 11.6 % had no findings. Overall, there were no patients who could be assigned to the group of deteriorated patients.

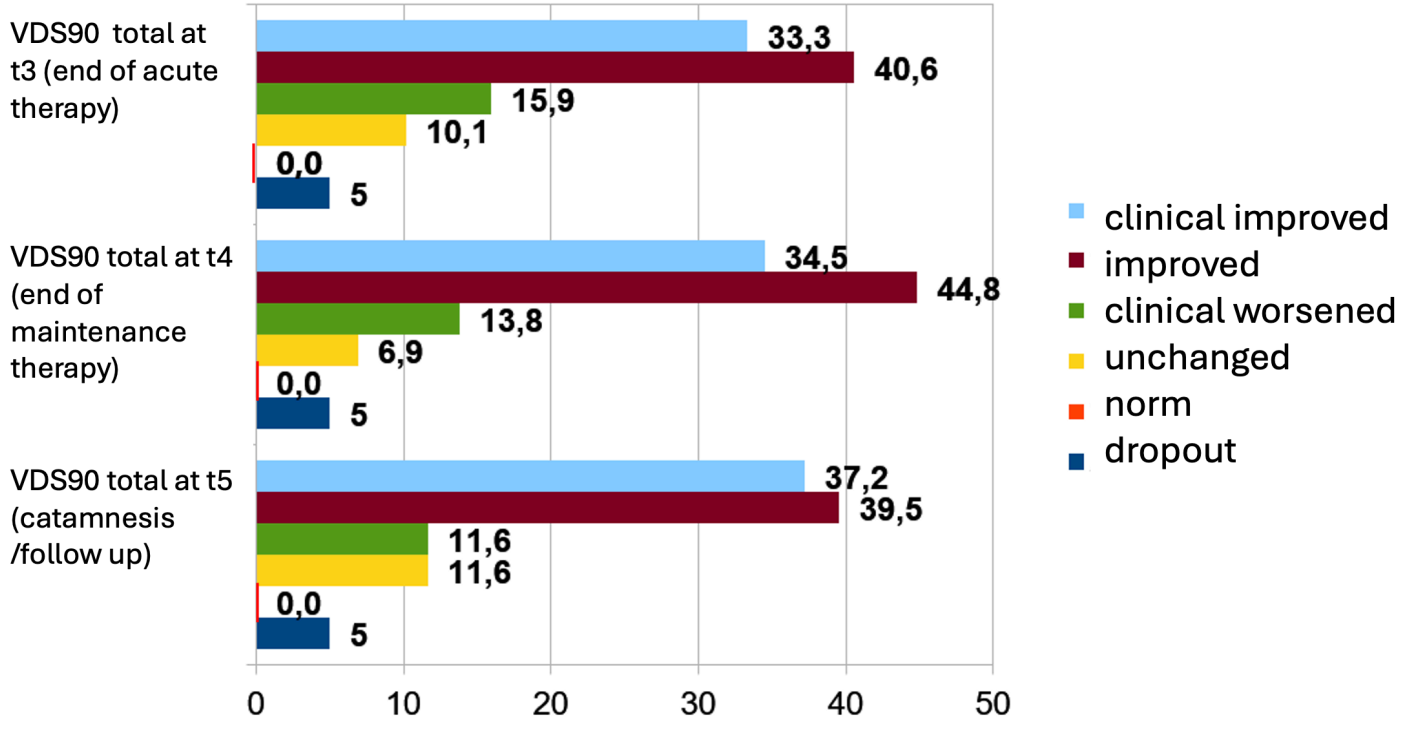

Figure 6: Statistical and clinical relevance of changes in the overall symptoms of the therapy group, percentage change , figures in per cent

In the attempt to find predictors for differential treatment success, only the current employment situation remained in the multiple regression equation with an explained variance share of 27%.

5.4 Replacing the dysfunctional survival rule with a new permissive life rule

We can use the VDS35c to assess very well how great the impact of the survival rule is on the patient's experience and behaviour. We ask the following questions (Fig. 7):

- How true was/is your previous rule of survival for you? How much did/do you believe in its correctness?
- How much did/does your survival rule determine your experience and behaviour?
- How much did/do you fear negative consequences if you broke your survival rule?
- How often did/do you act against your survival rule?
- How strong were/are the negative feelings when you broke your survival rule?
- How well did/do you manage to act against your survival rule?

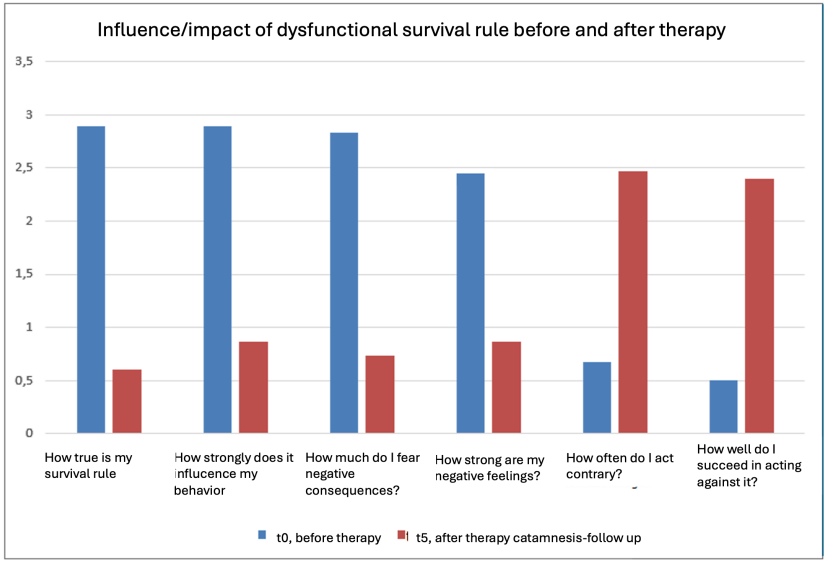

Figure 7: Influence of the survival rule before and after therapy

Across the different time points (t0 to t5), we can see in Table 4 that highly significant changes occurred. The effect sizes t0 to t3 (end of acute therapy) were the highest, but there were also further improvements after the end of acute therapy.

Table 4: Change in the flexibility of the survival rule

				95% confidence interval of the difference					
	M	SD	Standard error Mean	Lower	Upper	t	df	p	Hedges g
Truth of the survival rule									
Pair 4 ($t_{(0)}$ -$t_{(3)}$)	0,50	0,90	0,15	0,19	0,81	3,25	33	0,003	-0,82
Pair 5 ($t_{(3)}$ -$t_{(4)}$)	0,26	0,82	0,13	0,00	0,51	2,05	42	0,047	0,37
Pair 6 ($t_{(4)}$ -$t_{(5)}$)	-2,00	0,59	0,11	-2,22	-1,78	-18,66	29	< 0,001	-0,48
Influence of the survival rule									
Pair 4 ($t_{(0)}$ -$t_{(3)}$)	0,59	0,96	0,16	0,25	0,92	3,58	33	0,001	-1,11
Pair 5 ($t_{(3)}$ -$t_{(4)}$)	0,12	0,79	0,12	-0,13	0,36	0,96	42	0,342	0,16
Pair 6 ($t_{(4)}$ -$t_{(5)}$)	0,39	0,62	0,11	0,16	0,61	3,50	30	0,001	-0,52
Fear of negative consequences									
Pair 4 ($t_{(0)}$ -$t_{(3)}$)	0,68	0,91	0,16	0,36	1,00	4,33	33	< 0,001	-1,14
Pair 5 ($t_{(3)}$ -$t_{(4)}$)	0,19	0,99	0,15	-0,12	0,50	1,24	41	0,221	0,25
Pair 6 ($t_{(4)}$ -$t_{(5)}$)	0,16	0,78	0,14	-0,12	0,45	1,15	30	0,258	-0,36
Acting against the survival rule									
Pair 4 ($t_{(0)}$ -$t_{(3)}$)	-0,44	1,05	0,18	-0,81	-0,08	-2,45	33	0,020	0,64
Pair 5 ($t_{(3)}$ -$t_{(4)}$)	0,07	0,92	0,14	-0,22	0,36	0,50	41	0,618	0,10
Pair 6 ($t_{(4)}$ -$t_{(5)}$)	-0,32	0,70	0,13	-0,58	-0,07	-2,56	30	0,016	0,68

Neg. Feelings in case of violation against the survival rule									
Pair 4 ($t_{(0)}$ -$t_{(3)}$)	0,65	0,69	0,12	0,41	0,89	5,46	33	< 0,001	-1,08
Pair 5 ($t_{(3)}$ -$t_{(4)}$)	-0,05	0,85	0,13	-0,31	0,22	-0,36	41	0,720	-0,07
Pair 6 ($t_{(4)}$ -$t_{(5)}$)	0,39	0,76	0,14	0,11	0,67	2,83	30	0,008	-0,45
Success in acting against the survival rule									
Pair 4 ($t_{(0)}$ -$t_{(3)}$)	-0,50	1,02	0,18	-0,86	-0,14	-2,85	33	0,007	0,82
Pair 5 ($t_{(3)}$ -$t_{(4)}$)	-0,23	0,87	0,13	-0,50	0,04	-1,76	42	0,086	-0,31
Pair 6 ($t_{(4)}$ -$t_{(5)}$)	-0,26	0,63	0,11	-0,49	-0,03	-2,28	30	0,030	0,20

Legend: M: mean; SD: standard deviation; df: Degrees of freedom; t: t-value; Hedges g: Effect size

5.5 VEV: Subjective experience of the change in one's own experience and behaviour

The VEV is a direct measurement instrument that patients use to assess their own change. For this reason, no survey was carried out with this instrument at time t_0.

The following values were determined for the therapy group at the measurement times t_3, $t_4$and t_5(Fig. 8): At the end of acute therapy (t_3) the VEV mean value was M = 211.19 (SD = 37.42), at the end of maintenance therapy (t_4) M = 214.00 (SD = 38.99) and at catamnesis (t_5) M = 228.68 (SD = 41.66). These values are shown below in the form of a bar chart.

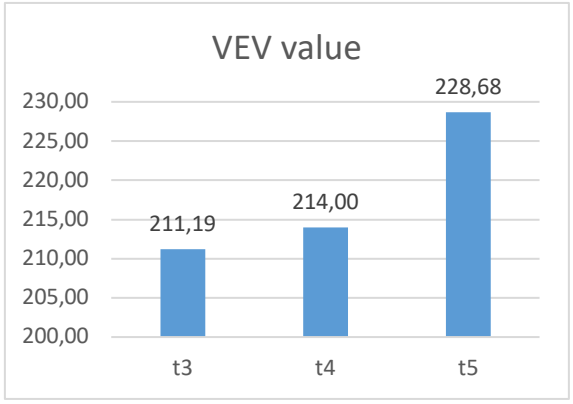

Figure 8: Development of VEV values in the therapy group

According to Zielke and Kopf-Mehnert (1978), the significance limits of the instrument depend on the score achieved. They lie at the 0.1% level from 200 points . This means that the average change at all measurement points is significant in the therapy group.

5.6 SEE scale for experiencing emotions (Behr & Becker 2004)

TheSEE depicts the experience of emotions through two dimensions: Acceptance (which should increase over the course of therapy) and flooding (which should decrease). Expectations in this regard were confirmed (Figure 10).

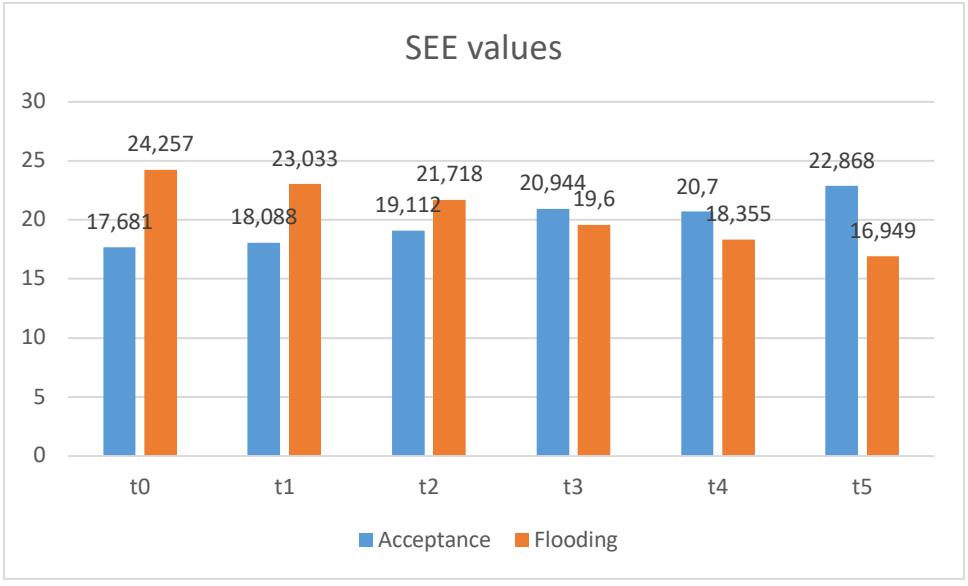

Figure 10: Development of SEE values in the therapy group : Acceptance of feelings increases and flooding decreases

All changes are significant: the effect sizes are in the medium range. The group differences are significant: there are statistically significant differences between the groups at time $t_3$both for the acceptance of own emotions (t = 2.76; df = 116; p = .007) and for the subjective emotional flooding (t = -2.56; df = 116; p = .012).

5.7 RMET: The ability to recognise feelings in the eyes of others

The RMET = Reading the Mind in the Eyes test (Baren-Cohen, Weelwright, Hill, Raste, & Plumb, 2001) was administered at four measurement points (only in the therapy group).

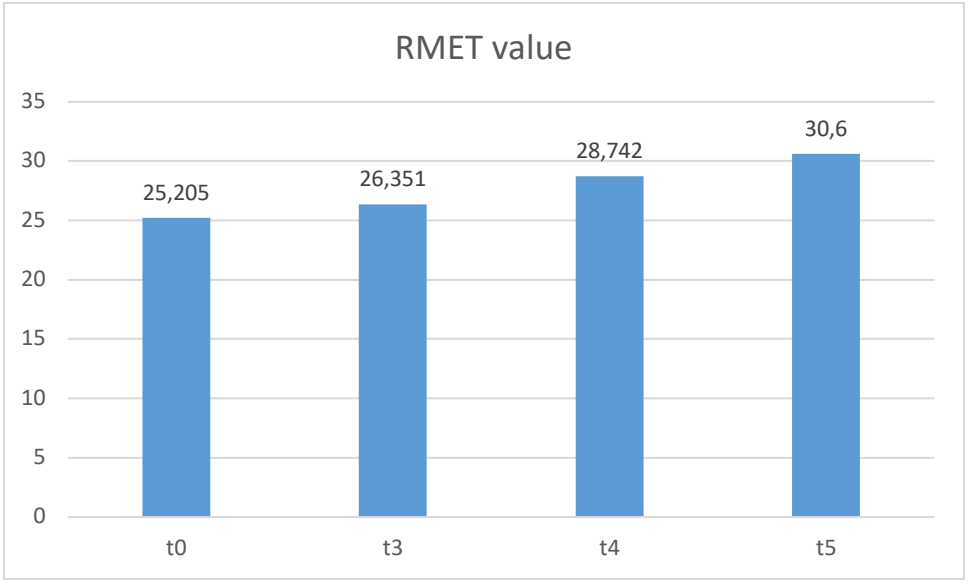

Figure 11: Development of RMET values in the therapy group

The overall values show (Fig. 11) that there is an improvement in emotional reading ability in the therapy group. Between the measurement times $t_0$and $t_3$with p = .057 and between $t_4$and $t_5$with p = .085, this is pronounced as a trend, while between $t_3$and $t_4$with p = .009 a statistically significant improvement in emotional reading ability was measurable. There were medium effect sizes.

Discussion and summary

The Psychiatric & Psychological Brief Psychotherapy PKP resulted in significant improvements in all relevant measurements. These were significantly higher than in the waiting list control group. It can therefore be assumed that the short-term setting is effective. Almost all patients did not require continuation and conversion to long-term therapy. Symptoms were quickly reduced in external (VDS14) and self-assessment (VDS90, BDI II). The global level of functioning (GAF) as a general indicator of the recovery process also showed significant improvements. Emotion regulation (dealing

with emotions SEE) also improved significantly (more acceptance and less flooding). The ability to recognise feelings in other people's faces improved significantly (RMET). Finally, the patients in the therapy group reported a clear positive change in experience and behaviour in VEV.

A more profound aspect is the rigidity and impact of the dysfunctional survival rule on the patient's current experience and behaviour. All previous studies that have applied SST or SBT (Hebing, 2012, Graßl, 2013, Hoy, 2014, Algermissen, del Pozo, & Rösser, 2017) have shown that clinical improvement also led to a flexibilisation of the survival rule, that it could often be replaced by a permission-giving life rule, so that its influence on behaviour became much less. This study also confirmed this. After therapy, patients believed less that the survival rule was correct and appropriate, were less afraid of violating it and also acted against it more often.

Limitations:

Random assignment was not possible within the given framework. Rather, assignment was based on the order of registration at the outpatient clinic. The therapy group was filled first, then the other patients were placed on the waiting list. It can be argued that this resulted in significantly greater external validity than random allocation. However, the high dropout of the waiting list control group is consistent with experience in other studies. Some patients came with a previous medication, which they were to keep unchanged during the study.

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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