6. Psychiatric & psychological brief psychotherapy (PKP) proves to be on a par with long-term therapy - results of a comparative study

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Abstract
This is the second study to evaluate Psychiatric and Psychological Brief Psychotherapy (PKP) for depression. Following the very good therapy results of the first study, the short-term therapy (24 weekly sessions, 6 four-weekly sessions as maintenance therapy) was compared with a long-term variant of PKP (44 weekly sessions without maintenance therapy). This corresponds to the current psychotherapy guidelines for patients with statutory health insurance, which provide for two times twelve sessions for short-term therapy and up to 36 additional sessions for long-term therapy.
PKP is a modular psychotherapy with the three modules of symptom therapy, emotion exposure and skills training as well as working with the dysfunctional survival rule as a maladaptive schema that prohibits, for example, anger and defensive assertion.
The short-term variant is on a par with the long-term variant: highly significant improvements with good to very good effect sizes. The decisive changes take place in the first 24 sessions. After that, there are only slight improvements. If these results can be replicated, the recommendation is to prioritise short-term therapies.

Keywords
Psychiatric and psychological short-term psychotherapy for depression, modular psychotherapy, symptom therapy, response chain to symptom, emotion exposure, skills training, dysfunctional survival rule, permission-giving life rule, maladaptive schema

Introduction

This paper reports on the second outpatient PKP study. While the first study was an outcome study comparing patients after six months of PKP treatment with a waiting list control group, this second study compares short-term and long-term therapy. At first glance, almost everyone would say that long-term therapy with almost twice as many therapy sessions is

much more effective than short-term therapy. But what if the goals have already been achieved after short-term therapy? What needs to be improved? In any case, we have to differentiate between trial therapies, which usually have no more than 20 sessions (in the USA usually only 12), and therapies in the care of patients with statutory health insurance, in which short-term and long-term therapies are carried out roughly equally often. This also raises the question of the therapy goal. Should the therapy be continued until clinical depression is no longer present? Or only until the depression no longer interferes with the patient's lifestyle? Or until predisposing factors have been eliminated in such a way that depression is no longer to be expected? There is also the problem that the rule of thumb is that only one third of patients are symptom-free, one third are improved and one third are not improved.
At present, we can assume that a large number of patients do not need long-term therapy. We can assume that there are more than just those who only receive short-term therapy.

What makes a therapy efficient or effective? When it achieves a set goal in a reasonable amount of time. In our modular psychotherapy approach, these are very personal goals for each patient that are appropriate to their individual problem situation.
If a patient's depression is aimed at avoiding grief, then the goal of therapy is to initiate grief work (through grief exposure). In short-term therapy, it will not progress as far as in long-term therapy. The aim is not to complete it, but to set it in motion and keep it going. If the depression serves to avoid anger, the aim is to be able to defend oneself in the future in difficult situations such as the one that triggered the depression by asserting oneself angrily. If you don't feel anger, you won't be able to defend yourself strongly enough. Exposure to anger and rage is indicated here as an intervention. Those who have previously dealt with relationships in a dependent manner, in which the other person determined what was to be done when and how, and did nothing on their own, will formulate independence as a therapy goal together with the therapist. Intervention is independence training.

In pursuing the goal, we can draw on numerous evidence-based cognitive-behavioural approaches (e.g. Lewinsohn, 1974; Beck, 1996; Grawe, 1998; Sulz, 1998a,b; Hayes, Strosahl & Wilson, 1999; McCullough, 2007; Gräff-Rudolph & Sulz, 2009; Wells, 2009; Sulz, 2011; Hebing, 2012). In the last twenty years, great importance has been attributed to emotions in symptom formation (e.g. Sulz & Hauke, 2010). This has been followed by intensive research into emotional processes in psychopathogenesis and psychotherapy (e.g. Elliott, Watson, Goldman & Greenberg, 2008; Greenberg, 2000; Sulz, 2000a, 2010; Sulz & Lenz, 2000; Sulz & Sulz, 2005). However, the treatment of people with depressive syndromes is still frequently

inadequate or inappropriate (Kanter, Busch, Weeks & Landes, 2008; Deckert, 2014). One of the reasons for this is that therapists do not rely on the effectiveness of the available short-term therapies and opt for long-term therapies. In addition, therapists make too little use of confrontational methods that evoke intense feelings. This also contributes to perpetuating the lack of available short-term therapy places (Schwartz & Flowers, 2015).
The Psychiatric and Psychological Brief Psychotherapy for Depression (PKP; Sulz & Deckert, 2012a,b) attempts to increase the incentive for effective short-term therapies.
A topic or intervention can be carried out in fifteen minutes within a 20- to 25-minute visit or consultation setting with the help of an action instruction (or therapy card or consultation card). Two topics can therefore be dealt with in a 50-minute setting.
Based on the patient's individual problem situation, the interventions systematically build on each other - with a consistent therapy concept. Despite the name PKP manual, it is not what is conventionally referred to as a therapy manual - in this sense it is not a manualised therapy, but a personal modular psychotherapy. Because the therapy is more or less customised for the patient, it can remain short (it leaves out what does not apply to the patient). And it can be more effective because there is more time for the patient's personal problems.

As an extension to the disorder-specific PKP manuals, the transdiagnostic PKP manual (Sulz, 2012) is a guide that offers the range of goals and interventions and at the same time helps to progress towards a personalised approach.

It is based on Strategic Short-Term Therapy SKT (Sulz, 1994) and Strategic Behavioural Therapy SBT (Sulz, 2001; Sulz & Hauke, 2009 Hauke, 2012).
The treatment, which consists of three pillars (modules), begins with the first pillar, symptom therapy, with the question of the unconscious symptom strategy: What is the patient trying to achieve with the symptom? What is the function of the symptom? In the case of depressive syndromes, PKP assumes that the depressive mood is superimposed on intense, overwhelming emotions. The feeling of numbness results in helplessness in the organisation of relationships and life and social withdrawal. This withdrawal in turn results in negative reinforcement due to the elimination of potentially negative events such as conflicts, threats or loss. Ultimately, the depressive patient no longer has to deal with the impulses of their feelings and their stressful consequences, as the depression successfully suppresses the emotions. The strategy of depression treatment therefore consists of the reverse functionality: making the vital emotions available again.

As the study was conducted in a naturalistic outpatient setting (field study), the results have a high external validity, but are also susceptible to sources of error that are difficult to control (e.g. holidays, sick leave, therapeutic compliance, additional treatments). Many of these sources of error are inherent and unavoidable in all outpatient naturalistic therapy studies. Nevertheless, this must be taken into account in the assessment. We have chosen to prioritise external validity so that the results can have the greatest possible clinical-practical significance.

Methodology

Research question

The decisive question deals with the efficiency of PKP, i.e. the question of when the maximum therapeutic effect is achieved (dose-effect relationship). This means that this question can only be answered by comparing short-term and long-term therapy. The hypothesis here is that the maximum therapeutic effect is achieved after short-term therapy and is not further increased in long-term therapy.

Design

The patients in this group received twenty-four 50-minute weekly therapy sessions (acute therapy) followed by six monthly therapy sessions (maintenance therapy). A final catamnesis session took place six months after the last maintenance therapy session.
The long-term therapy (LTT) group received forty-four 50-minute weekly therapy sessions and no subsequent maintenance therapy. Six months after the last therapy session, a final catamnesis session was also held here.

Sample

There were 77 patients in the CCT group (ICD-10 F32: 51%, F33: 35%, F34.1: 4%, F43.2: 9%) and 79 patients in the LZT group (F32: 37%, F33: 50%, F34.1: 1%, F43.2: 13%). In both groups, the proportion of patients who received antidepressant medication (and who were to remain on it unchanged) was 34%. The patients were treated by a total of 34 therapists in the outpatient clinic of the CIP Academy in Munich. The distribution of socio-economic status was statistically the same in both groups (female: 57%, age (MW): 39 (18-73), professional employment: 69% in the CCT, 72% in the CCT).

Measuring instruments

The following instruments were used to measure the effectiveness of PCP: the Beck Depression Inventory (BDI-II; Hautzinger, Keller, & Kühner, 2009), the Behavioural Diagnostic System (VDS; Sulz, 1992, 2000b, 2008), the Global Assessment of Functioning (GAF; Saß, Wittchen, Zaudig & Houben, 2003) and the Change Questionnaire of Experience and Behaviour (VEV; Zielke & Kopf-Mehnert, 1978). The BDI-II, VDS90, VDS30 and VEV were self-assessment scales and the VDS14 and GAF were external assessment scales, which were completed by the treating therapists.

Statistical calculations

Single-factor ANOVAs with repeated measures were carried out for all measurement instruments. The between-group factor was the affiliation to the respective treatment group (CCT vs. LTC) and the measure used to assess the effectiveness of the PCP. The repeated measurement factor was the time of therapy (initial interview, end of short-term therapy, end of maintenance therapy or long-term therapy, catamnesis) and was used as a measure for assessing effectiveness. Eta squared (η^2) was used to assess the effect size. Values less than .06 represent a small effect, values between .06 and .14 represent a medium effect and values greater than .14 represent a strong effect.

Results

Beck Depression Inventory (BDI-II)

Before the therapy, there were no significant differences between the two therapy groups with regard to depression, so that the prerequisite for comparability with regard to this parameter was met. The statistical calculation of the effectiveness of PKP resulted in a value of $F(3) = 101.12$ ($p<.001$), $\eta^2 = .65$. This indicates a very large effectiveness of PKP, i.e. a strong effect. The calculation of the efficiency showed no significant difference between the CCT group and the CCT group, $F(1) = .36$ ($p>.05$), $\eta^2 = .01$. This indicates that the treatment was just as efficient in the CCT as in the CCT. Table 1 and Figure 1 show the reported values in the BDI-II at the different measurement times.

Table elle 1
Results in the BDI-II

	Initial interview	**24**	**30/44**	**Catamnesis**
CCT	*M* = 24,94 (*SD* = 3.39)	*M* = 6,73 (*SD* = 2.62)	*M* = 7,24 (*SD* = 2.14)	*M* = 5,91 (*SD* = 2.41)
LZT	*M* = 22,54 (*SD* = 3.99)	*M* = 12,04 (*SD* = 3.07)	*M* = 6,79 (*SD* = 2.51)	*M* = 7,08 (*SD* = 2.83)

Notes. M: mean value; SD: standard deviation

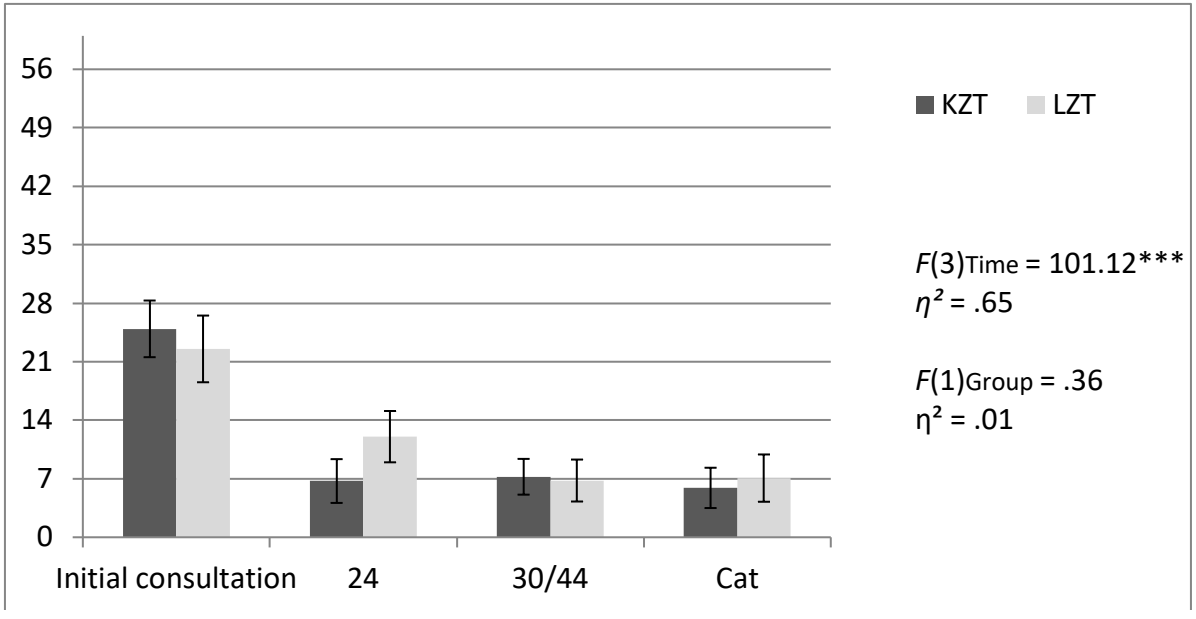

Figure 1: Point averages in the BDI-II; ****p<0*.001 (KZT = Shortterm Therapy, LZT= Longterm Therapy)

Even this first clear result is not expected by many and shows that short-term therapy is just as effective in treating depression as long-term therapy.

VDS90 - Depression

Before therapy, there were no significant differences in terms of depression. The statistical calculation of the effectiveness of PKP resulted in a value of $F(3) = 87.69$ ($p<.001$), $\eta^2 = .62$. This indicates a highly significant effectiveness of PKP with a strong effect. The calculation of efficiency showed no significant difference between the CCT group and the CCT group, $F(1) = .3$ ($p>.05$), $\eta^2 = .01$. This indicates that the treatment was as efficient in the CCT as in the CCT. Table 2 and Figure 2 show the reported values in the VDS90 - Depression at the different measurement times.

Table 2
Results of the VDS90 - Depression

	Initial interview	24	30/44	Catamnesis
CCT	*M* = 1,51 (*SD* = 0.22)	*M* = 0,42 (*SD* = 0.17)	*M* = 0,4 (*SD* = 0.13)	*M* = 0,25 (*SD* = 0.16)
LZT	*M* = 1,26 (*SD* = 0.25)	*M* = 0,69 (*SD* = 0.19)	*M* = 0,38 (*SD* = 0.15)	*M* = 0,45 (*SD* = 0.19)

Notes. M: mean; SD: standard deviation

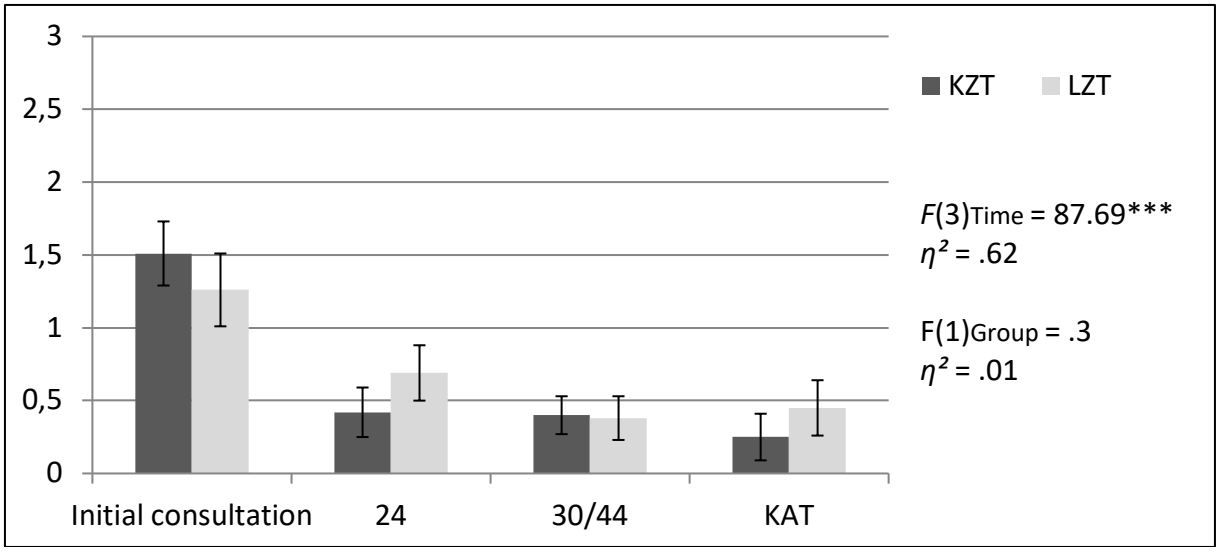

Figure 2: Point averages in the VDS90 - depression; ****p<0*.001 (KZT = Shortterm Therapy, LZT= Longterm Therapy)

The second result also suggests that short-term therapy is just as effective as long-term therapy. It is an equally effective depression treatment.

VDS90 - total score

Before therapy, there were no significant differences in overall symptoms between the two therapy groups. The statistical calculation of the effectiveness of PKP resulted in a value of $F(3) = 70.62$ ($p<.001$), $\eta^2 = .57$. This indicates a highly significant effectiveness of PKP with a strong effect. The calculation of efficiency showed no significant difference between the CCT group and the CCT group, $F(1) = .54$ ($p>.05$), $\eta^2 = .01$. This indicates that the treatment was just as efficient in the CCT as in the CCT. Table 3 and Figure 3 show the reported values in the VDS90 total score at the different measurement times.

Table 3
Results in the VDS90 - total score

	Initial interview	24	30/44	Catamnesis
CCT	*M* = 0,66 (*SD* = 0.1)	*M* = 0,25 (*SD* = 0.08)	*M* = 0,26 (*SD* = 0.08)	*M* = 0,23 (*SD* = 0.08)
LZT	*M* = 0,62 (*SD* = 0.12)	*M* = 0,41 (*SD* = 0.1)	*M* = 0,26 (*SD* = 0.09)	*M* = 0,27 (*SD* = 0.1)

Notes. M: mean value; SD: standard deviation

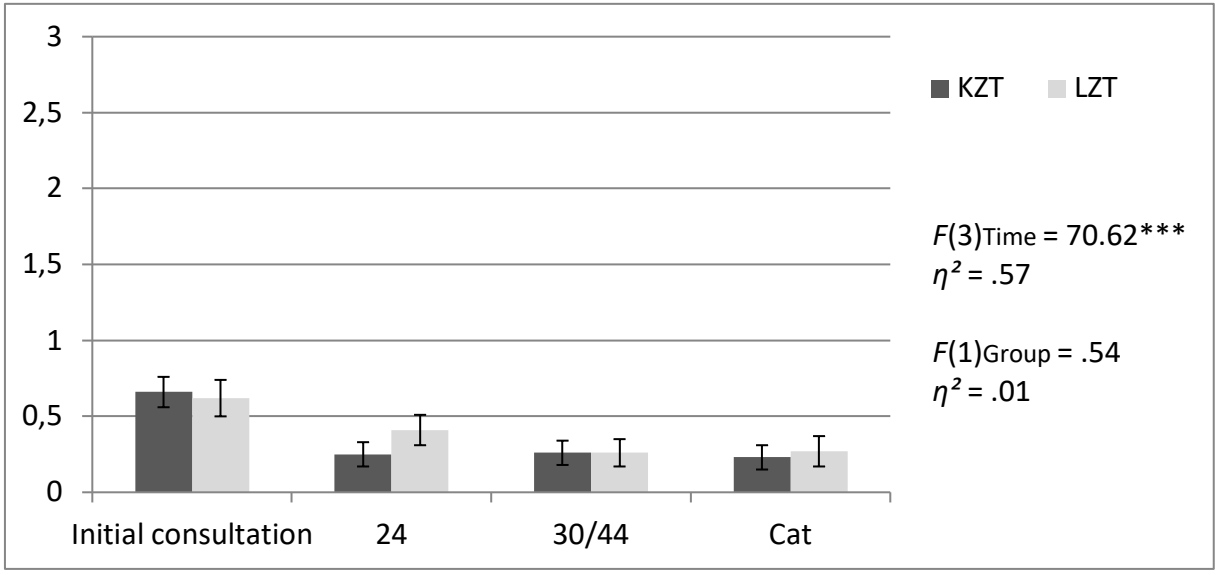

Figure 3: Point averages in the VDS90 - total score; ****p<0*.001 (KZT = Shortterm Therapy, LZT= Longterm Therapy)

VDS30 - Dysfunctional personality total score

Before therapy, there were no significant differences in terms of dysfunctional personality traits. The statistical calculation of the effectiveness of the PKP resulted in a value of $F(3) = 43.11$ ($p<.001$), $\eta^2 = .47$. This indicates a highly significant effectiveness of the PKP with a strong effect. The calculation of efficiency showed no significant difference between the CCT group and the LTC group, $F(1) = .1$ ($p>.05$), $\eta^2 = 0$, indicating that the treatment was as efficient in CCT as in LTC. Table 4 and Figure 4 show the reported values in the VDS30 personality at the different measurement times.

Table 4
Results of the VDS30 - Personality

	Initial interview	24	30/44	Catamnesis
CCT	*M* = 0,81 (*SD* = 0.13)	*M* = 0,57 (*SD* = 0.13)	*M* = 0,49 (*SD* = 0.1)	*M* = 0,43 (*SD* = 0.12)
LZT	*M* = 0,81 (*SD* = 0.16)	*M* = 0,71 (*SD* = 0.15)	*M* = 0,37 (*SD* = 0.12)	*M* = 0,39 (*SD* = 0.14)

Notes. M: mean value; SD: standard deviation

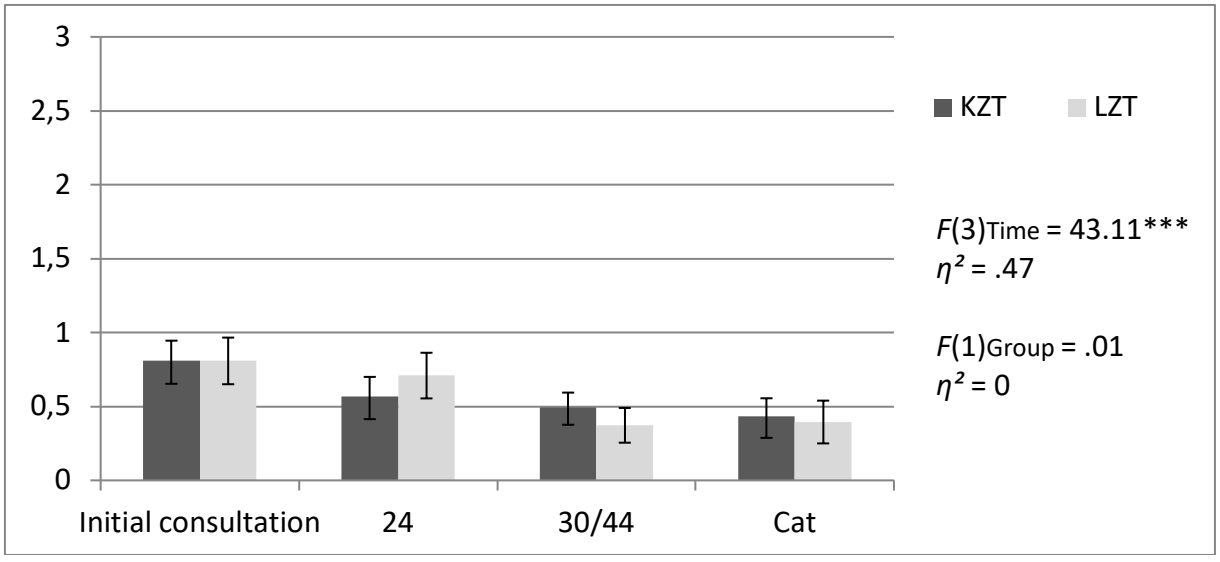

Figure 4: Point averages in the VDS30 - Personality; ****p<0*.001 (KZT = Shortterm Therapy, LZT= Longterm Therapy)

This result is even less expected than the equally good improvements in depression. It is widely believed that personality change requires long-term therapy. However, we have consistently found that these changes are also possible in a short-term setting - and in this study are just as great as in long-term therapy.

Change in experience and behaviour questionnaire (VEV)

The VEV was not collected in the initial interview, as it only records the change after therapy has taken place. The statistical calculation of the effectiveness of PKP resulted in a value of $F(3) = 3.77$ ($p<.05$), $\eta^2 = .07$. This indicates a highly significant effectiveness of PKP with a medium effect. These results must be interpreted taking into account that the baseline is the measurement after the 24th hour. It is therefore advisable to interpret them on the basis of the absolute values. According to the authors (Zielke & Kopf-Mehnert, 1978), values above 200 are significant at the 0.1% level in the sense of a subjectively perceived change. The calculation of the efficiency showed no significant difference between the CCT group

and the LTC group, $F(1) = .64$ ($p>.05$), $\eta^2 = .01$. This indicates that the treatment was just as efficient in the CCT as in the LTC. Table 5 and Figure 5 show the reported values in the VEV at the different measurement times.

Table 5
Results in the VEV

	24	30/44	Catamnesis
CCT	*M* = 215,27 (*SD* = 11.94)	*M* = 210,7 (*SD* = 13.05)	*M* = 226,85 (*SD* = 13.07)
LZT	*M* = 198,0 (*SD* = 14.3)	*M* = 221,61 (*SD* = 15.63)	*M* = 214,43 (*SD* = 15.66)

Notes. M: mean value; SD: standard deviation

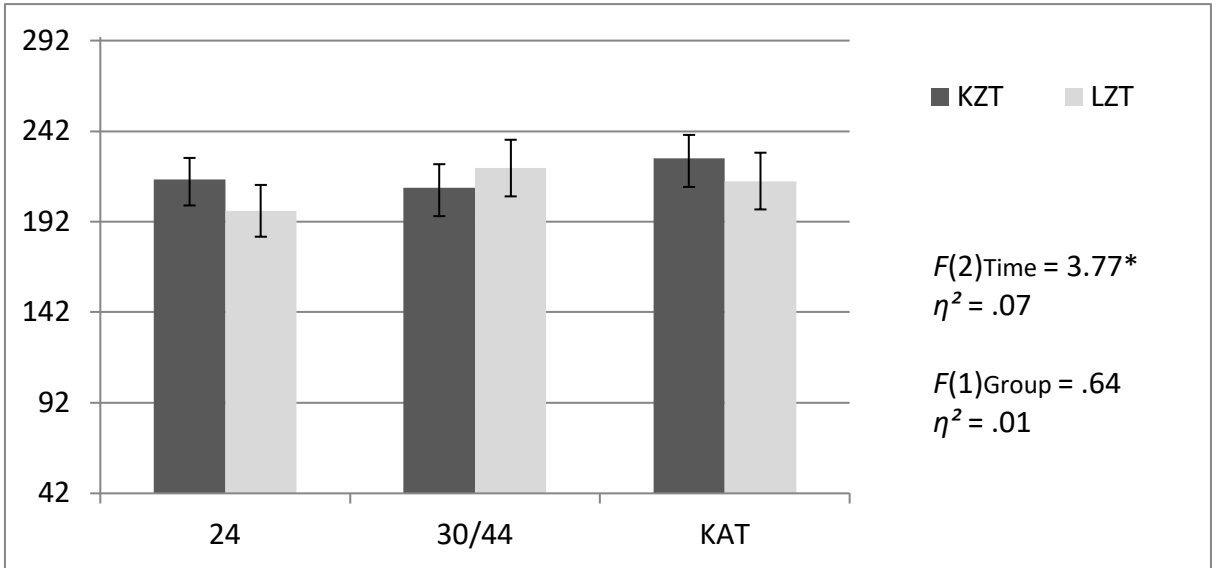

Figure 5: Point averages in the VEV; *$p<0.05$ (KZT = Shortterm Therapy, LZT= Longterm Therapy)

Patients' experience and behaviour in their everyday lives improved in the same way with short-term therapy as with long-term therapy.

VDS14 - Depression

Before therapy, there were no significant differences in terms of depression between the two therapy groups. The statistical calculation of the effectiveness of PKP resulted in a value of $F(3) = 143.36$ ($p<.001$), $\eta^2 = .73$. This indicates a highly significant effectiveness of PKP with a strong effect. The calculation of the efficiency showed a significant difference between the CCT group and the CCT group, $F(1) = 7.18$ ($p<.05$), $\eta^2 = .12$, indicating that the treatment was slightly more efficient in the CCT than in the CCT. Table 6 and Figure 6 show the reported values in the VDS14 - Depression at the different measurement times.

Table 6
Results of the VDS14 - Depression

	Initial interview	24	30/44	Catamnesis
CCT	*M* = 1,63 (*SD* = 0.21)	*M* = 0,33 (*SD* = 0.25)	*M* = 0,22 (*SD* = 0.14)	*M* = 0,26 (*SD* = 0.19)
LZT	*M* = 2,01 (*SD* = 0.21)	*M* = 0,97 (*SD* = 0.25)	*M* = 0,16 (*SD* = 0.14)	*M* = 0,27 (*SD* = 0.19)

Notes. M: mean value; SD: standard deviation

Once again, we can conclude that short-term therapy reduces depressive symptoms (at least) as well as long-term therapy.

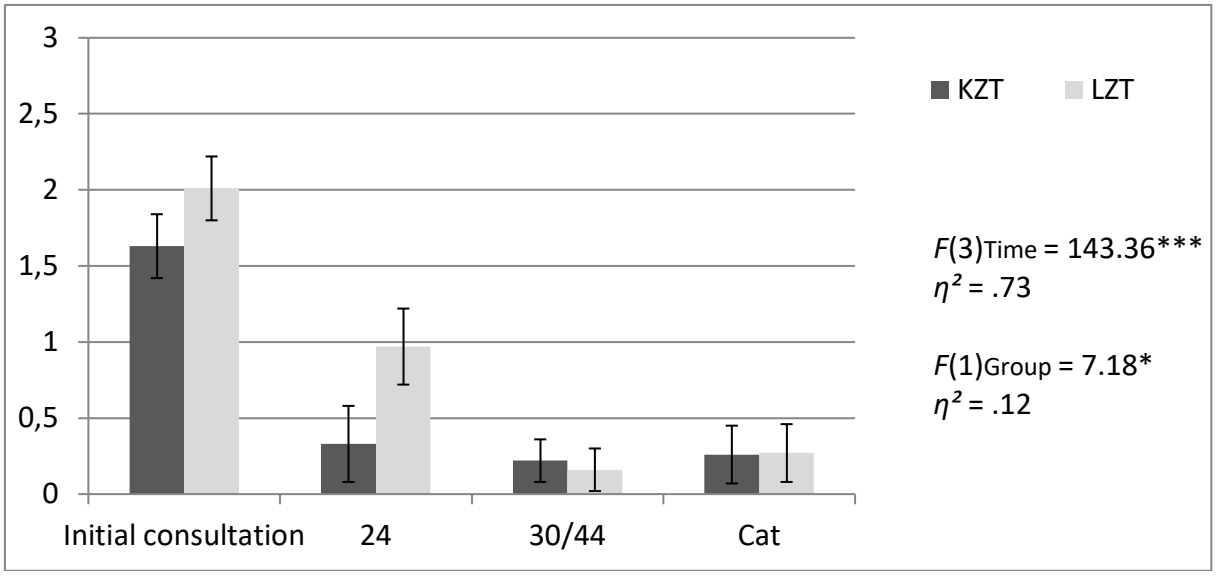

Figure 6: Point means in the VDS14 - depression; **p<0*.05, ****p<0*.001 (KZT = Shortterm Therapy, LZT= Longterm Therapy)

Global assessment of the level of functioning (GAF)

Before therapy, there were no significant differences in the level of functioning between the two therapy groups. The statistical calculation of the effectiveness of PKP resulted in a value of $F(3) = 174.61$ ($p<.001$), $\eta^2 = .77$. This indicates a highly significant effectiveness of PKP with a strong effect. The calculation of the efficiency showed a significant difference between the CCT group and the CCT group, $F(1) = 8.34$ ($p<.01$), $\eta^2 = .14$, indicating that the treatment was more efficient in the CCT than in the CCT. Table 7 and Figure 7 show the reported values in the GAF at the different measurement times.

Table 7
Results in the GAF

	Initial interview	24	30/44	Catamnesis
CCT	*M* = 59,94 (*SD* = 2.76)	*M* = 77,42 (*SD* = 3.72)	*M* = 83,39 (SD = 3.53)	*M* = 84,39 (SD = 3.62)
LZT	*M* = 54,17 (*SD* = 3.14)	*M* = 68,46 (*SD* = 4.23)	*M* = 77,88 (*SD* = 4.01)	*M* = 80,38 (*SD* = 4.12)

Notes. M: mean value; SD: standard deviation

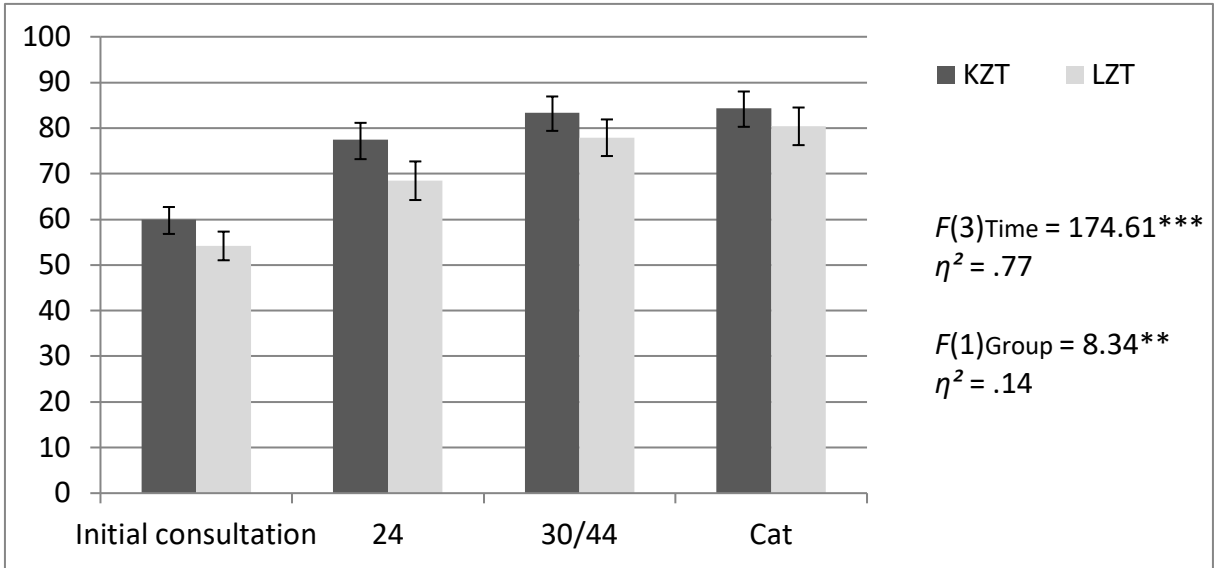

Figure 7: Point mean values in the GAF; ***p<0*.01, ****p<0*.001 (KZT = Shortterm Therapy, LZT= Longterm Therapy)

The extent to which the patient is still impaired in everyday life by their depression is a very important and indispensable indicator. Someone can be very depressed and still maintain their level of functioning. And someone can have a milder depression and no longer have their everyday functions available.

Discussion

Psychiatric and psychological brief psychotherapy PKP showed a strong effect in all areas recorded. This confirms the previous findings of Kaufmayer and Sulz (2018) and Algermissen, del Pozo & Rösser (2017). PKP appears to be suitable for successfully treating people with depressive syndromes. Both the patients themselves and the therapists agree with this.
In the present study, it was of particular interest whether short-term therapy is on a par with long-term therapy. The assumption that CCT is sufficient if the functionality of depression (emotion avoidance) is consistently reversed through emotion exposure was confirmed. It is striking that the therapists rated the depression as more pronounced and the global level of functioning as lower in the LTC group after the 24th hour than in the CCT group. The discrepancy between the self-assessment and the external assessment is significant, but small. There could be an anchor bias: The therapists knew how many total therapy hours were available. This could have led the therapists in the LZT group to believe that their patients had not improved too much after the 24th therapy session, as the therapy goal would only be achieved after 20 further sessions.

This field study should be followed by further research, including randomisation of patients.

Summary

Brief psychiatric and psychological psychotherapy for depression appears to be an effective and efficient therapy method that can be used both in the outpatient therapy setting and in the inpatient therapy setting (Algermissen, del Pozo & Rösser, 2017). In the present study, it was shown that the short-term therapy variant of PKP is on a par with the long-term therapy variant. Consequently, a brief and emotion-exposing approach is recommended for the treatment of depressive syndromes. If these results can be replicated, it would be more than justified to carry out much more short-term therapy and much less long-term therapy. It is also important to note that there are quite a few patients who continue to make significant progress even after treatment has ended.

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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