7. Psychiatric Brief psychotherapy PKP of depression in combined group and single-therapy for psychiatric departments - Looking back on 14 years PKP-Practice in hospital

Christian Algermissen, Nina Rösser & Serge K. D. Sulz

Abstract

As the length of stay of depressive patients in acute psychiatric inpatient treatment is usually only six weeks and individual treatments are not feasible for staffing reasons, it is necessary to use structured short-term treatments in a group setting on the hospital ward. Psychiatric Brief Psychotherapy PKP is a variant of Strategic Brief Therapy adapted for psychiatric clinics and practices (Sulz, 2007, 2017a, Sulz et al., 2011). Established evidence-based cognitive and emotive treatment techniques are integrated (Sulz & Hauke, 2009). In particular, PKP uses brief interventions to develop a treatment strategy, which makes PKP particularly suitable for creating a completed therapy step during a consultation or clinic visit. PKP can be implemented as a combined group and individual therapeutic treatment concept in general psychiatric and psychotherapeutically orientated wards of a care clinic (Algermissen & Rösser, 2019, 2021). Our large therapy study shows the results of a scientific evaluation (n= 1196) of this innovative therapy concept (in the Clinic for Psychiatry, Psychotherapy and Psychosomatics at Braunschweig Hospital. PKP is effective and conserves resources - with high patient acceptance. In co-operation with a psychiatric outpatient clinic or psychotherapists in private practice, cross-sector treatment paths can be planned. A catamnestic examination shows a high level of consistency in the therapy results. This shows that far more systematic psychotherapies can be applied in psychiatric clinics without having more staff available. This could significantly increase the effectiveness of inpatient psychiatric treatment.

Keywords

Inpatient group therapy - PKP - brief psychiatric psychotherapy - modular psychotherapy - behavioural therapy - outcome study - three pillars of therapy - therapy modules - symptom therapy - skills training - emotion exposure - dysfunctional survival rule - permission-giving rule of life - affective-cognitive developmental theory of behaviour - psychiatric care clinic

Introduction

Anyone who has to be treated as an inpatient in a psychiatric clinic for depression will primarily receive medication. In the first week, there is no question of offering the patient 50 minutes of individual psychotherapy. However, more time than necessary passes before disorder-specific systematic psychotherapy begins (Sulz & Deckert 2012).

Around 40% of the patients treated rated "individual therapy sessions as the most important element, far ahead of all other therapy options" (Härter et al. 2004). However, a significant proportion of inpatients do not receive any disorder-specific therapy.

This dilemma of, on the one hand, available and effective psychotherapy approaches and, on the other hand, insufficient framework conditions for the implementation of special psychotherapy concepts in inpatient psychiatric care is something that the therapy method of Psychiatric Brief Psychotherapy (PKP) attempts to take into account and resolve as far as possible. The PKP treatment concept for depression is based on modular group and personalised individual therapy, which can be organised across professional groups in the inpatient therapy situation.

Brief psychiatric psychotherapy (PKP)

As a *short form* of strategic behavioural therapy (SBT) (Sulz & Hauke 2009, Sulz et al. 2011, Sulz 2017b,c), brief psychiatric psychotherapy (PKP) has a comprehensive background in disorder and therapy theory. PKP represents an optimisation of cognitive behavioural therapy. The overarching treatment strategy is derived from the affective-cognitive developmental theory of behaviour (Sulz 2017a,b), which is supported in particular by the theoretical concepts of self-regulation (Kanfer, Reinecker & Schmelzer 2006) and self-organisation (Haken & Schiepek 2005, Bischof 1993) as well as findings from cognitive developmental psychology (Piaget & Inhelder 1981, Kegan 1986) and integrates the constructivism of the Palo Alto group (Watzlawik 1981) and the "body-feeling theory" (Damasio 2003) as a modern neurobiological theory of emotion.

Fundamental to Strategic Behavioural Therapy (SBT) and therefore also determining for the therapeutic approach in Brief Psychiatric Therapy (PKP) is the assumption that the human psyche always strives for a stable state (homeostasis) and that a person's observable behaviour, thinking, inner experience and perceptions serve to restore this stable state through processes of self-regulation and self-organisation in the event of disturbances from the environment. If relevant

deficits in the available behavioural repertoire have arisen as a result of the individual's developmental history or if inadequate behavioural stereotypes and rigid behavioural patterns persist in adulthood, this has considerable medium to long-term disadvantages for successful control and the achievement of a stable mental state (homeostasis). "If the dysfunctional part of these behavioural stereotypes dominates, this leads to pathogenic life and relationship patterns", which overwhelm the homeostatic system of the psyche and "lead to the development of symptoms in a specific trigger situation" (Sulz & Hauke 2009).

Dysfunctional behavioural stereotypies, which correlate more with the person than with the situation, can on the one hand be linked to false cognitive "basic assumptions" (Beck et al. 1986 4) about the functioning of the self and the world. Equally relevant, however, behavioural stereotypes are determined on an emotional level by a person's biographically derived pattern of interpersonal needs and fears. These components of a behavioural pattern come together to form a survival rule for each person - just as a child tries to ensure emotional survival with its parents and family. The behaviour-determining survival rule served to create a psychologically stable state (homeostasis) in the developmentally vulnerable childhood phase (predominantly the first to fifth year of life) in terms of the child's adaptive performance (e.g. emotional "survival" through diligence and obedience). However, this often very rigid emotional-cognitive schema leads to disadvantageous behaviour in adulthood if, in a specific life situation with the changed real requirements of adulthood (e.g. adult self-assertion instead of childish adaptation through diligence and obedience), the difficult-to-change, mostly unconscious survival rule becomes dysfunctional and contributes to the manifestation of depressive or anxious symptoms, for example.

The equal consideration of cognitions and emotions as therapeutic starting points, the application of the principles of mindfulness and acceptance and the concept of schema make Strategic Behavioural Therapy (SBT) and its short form, Brief Psychiatric Psychotherapy (PKP), clearly a treatment approach of the so-called 3rd wave of behavioural therapy. The unique feature of SBT/PKP is a (heuristic) psychological explanatory model for mental disorders that supplements the assumed multifactorial aetiology of a mental disorder with a developmental psychological perspective on the functionality of a symptom in the context of the homeostatic self-regulation of the psyche. This enables a distinctly personalised therapy strategy (see below).

Brief psychiatric psychotherapy for depressive disorders

Disorder-specific psychotherapy requires a hypothesis on the development of depression in order to justify specific therapeutic interventions. In many cases, cognitions represent a very favourable starting point for changing the depressive reaction chain (Beck 1979, Beck et al. 1986, Hautzinger 2013). In other cases, however, it is the direct modification of emotions or a change in behaviour in dealing with central needs and relationship issues that become the content of strategic depression treatment (Gräff-Rudolph, U. & Sulz 2009, Deckert 2014).

In Brief Psychiatric Therapy, the strategic-behavioural explanatory model with a focus on the functionality of depressive mood (not depression) is used in addition to the most important disorder models for depression (cf. Lewinsohn 1974, Seligman 1979, Beck et al. 1986). *"Depressive mood can be considered in terms of its consequences for the human psyche. ... The consequences can be viewed probabilistically as a function of depression"* (Gräff-Rudolph, U. & Sulz 2009). In contrast to emotions such as joy, anger, sadness or fear, which relate to an event, a person or as a reaction to their behaviour and can begin quickly, change rapidly, last for a short time, but in particular can become intense and threatening, moods such as depression have no direct reference to an event, a person or their behaviour. Moods do not arise and change quickly, but usually last longer and, above all, do not become as intense or threatening. If these differences are assessed as functional, the heuristic statement can be formulated: The function of a depressive mood is to avoid detrimental or threatening consequences of intense emotions or painful affects, e.g. anger and sadness and associated affective actions. The depressive mood is maintained by negative reinforcement, the avoidance of an aversive event (Gräff-Rudolph, U. & Sulz 2009, Sulz 1998). In this respect, this theory of depression is a simple model of behavioural theory that unfolds the functional analysis as a vertical behavioural analysis in the sense of Klaus Grawe (1998) on a macro level.

Strategic-behavioural intervention strategies can be derived from this functional explanatory model of depressive mood. *"If the strategy of depression is to replace feelings with depression, the therapy strategy is to replace depression with feelings. This is done according to the principle of exposure"* (Gräff-Rudolph, U. & Sulz 2009).

Exposure to emotions plays a central role in strategic behavioural depression treatment. In the first phase of treatment, the focus is on exposure to positive experiences ("joy exposure") through, for example, activity building or pleasure training, followed later in the course of therapy by exposure to fear, anger and sadness. *"In a second step, the patient learns to deal with these feelings, usually through cognitive self-control and competent interaction and relationship management"* (Gräff-Rudolph, U. & Sulz 2009). Strategic-behavioural depression treatment, or its abbreviated form PKP,

therefore has three focal points, very similar to Emotion and Mentalisation Enhancing Behaviour Therapy EMVT (Sulz 2021a,b).

- Emotion exposure
- Development of metacognitive self-control of feelings
- Building competent empathic interaction and relationship skills

Initially, a modular brief psychotherapy was developed on the basis of brief psychotherapeutic interventions for individual therapeutic work in the psychiatric consultation setting and orientated towards the guideline recommendations. The practical relevance was increased in particular by the introduction of around 60 disorder-specific therapy cards (called consultation cards in psychiatric practice) in card index box format (Sulz & Deckert, 2012a,b). Each therapy card provides the patient with the working material on the front and supports the therapist on the back by explaining the practical procedure or providing information on the theoretical background of the brief intervention. Each brief intervention is designed in "consultation hour format" for a period of 20 to 25 minutes. The therapy cards are divided into three groups according to the pillar architecture of strategic behavioural therapy, i.e. therapy cards for disorder-specific psychoeducation (1st pillar/module: symptom therapy), therapy cards for the sub-modules of various coping strategies (2nd pillar/module: skills training & emotion exposure), including for activity building and "joy exposure" as well as anxiety, anger and grief exposure and therapy cards for building social skills. 12 therapy cards guide the work on the personality level (3rd pillar/module), i.e. the development of personality-related motives and the resulting survival rules.

Inpatient PKP treatment concept at Braunschweig Hospital

All of these brief interventions for the treatment of depression form the basis for the inpatient treatment concept of Psychiatric Brief Psychotherapy PKP presented here. The treatment concept was developed, implemented and evaluated on an openly managed general psychiatric and psychotherapy ward with a total of 34 treatment places at the Clinic for Psychiatry, Psychotherapy and Psychosomatics at Braunschweig Hospital. There were no treatment specialisations for the two wards. Geriatric psychiatry and addiction

therapy patients were preferentially treated on other, appropriately specialised wards of the clinic.

The main aim of the inpatient therapy concept is to take into account the specific situation at care clinics with limited personnel and financial resources. A realistic length of stay of four to six weeks is assumed for patients with depression. Within these limitations, we believe that only a combined group and individual therapy treatment concept is effective. A modular structure of group therapy enables individual therapy topics to be dealt with in closed group situations on the one hand, and the weekly inclusion of new patients in the four-week group concept on the other. In addition, the therapy process is accompanied by individual therapy with a thematic reference to the PKP depression group. In particular, the cross-professional organisation of the inpatient treatment concept offered the opportunity to implement the contents of brief psychiatric psychotherapy in a resource-saving, synergistic and natural way in the inpatient therapy process.

Organisational form of the "PKP Depression Group"

The PKP depression group, which is central to the treatment concept, consists of modules 1-4, whereby modules 1 + 2 are organised in parallel as group A (psychoeducation/activity development) and module 3+ 4 as group B (emotion exposure/central behavioural scheme). Groups A and B are each led by a (psychological) group leader.

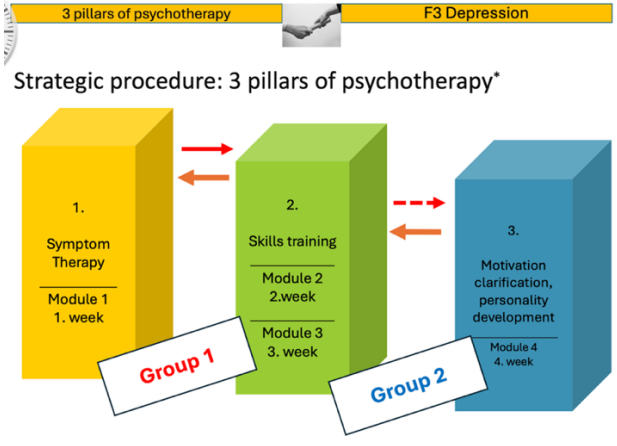


Figure 1 Group therapy and pillar architecture

Each module consists of three therapy sessions of 75 minutes each, which take place within a week (e.g. Monday/Wednesday/Friday) and relate to each other. Each module deals with a therapy topic in the group to such an extent that further personalised treatment of the therapy topic can follow in individual psychotherapy. Accordingly, it takes a total of four weeks to complete all four modules, which involves attending 12 sessions.

All therapy materials (revised therapy cards) are digitised as worksheets in A4 format and stored centrally so that they can be printed out at any time from any PC in the clinic and a r e immediately available to the various professional groups and in different therapy situations.

For more than half of the patients admitted to the group concept, it is recommended that they switch from group A (10-12 participants) to group B (6-8 participants) after the first two weeks and after completing the first two modules (psychoeducation/activity development). Some patients end group therapy with participation in group A, as further emotion-focused work in modules 3 and 4 of group B (emotion exposure/central behavioural schema) is not indicated either at the time of therapy or, for example, due to predominantly biological factors accompanying the depressive disorder.

The different sequence of modules 1 and 2 or modules 3 and 4, which results from the different starting times of the participants, is of equal value, as all modules are self-contained.

For more information see Algermissen & Rösser (2019).

Therapy content of the "PKP depression group

Module 1 - Psychoeducation

An initial key objective in Module 1 is to correctly describe depressive symptoms within the group and to recognise them in oneself and other participants. Metacognitively recognising and naming one's own depressive symptoms and becoming aware that similar depressive symptoms are also experienced by others is often associated with a better understanding of the disorder "depression" and an initial psychological

relief. At the same time, the patient's theory of mind/mental theory is trained and elaborated in this way (Sulz 2021b). Using worksheets, the participants are asked to understand the diagnosis of depression for themselves and to "check" it with guidance in order to achieve an acceptance of the illness that is beneficial for the treatment. In addition, the group participants receive psychoeducational information about the "illness" of depression and learn about the various explanatory models for the development and maintenance of depression. Based on the vulnerability-stress model, the indication for (usually) combined psychopharmacological and psychotherapeutic treatment is explained. At the same time, the question about the functionality of depression ("What happened immediately before you became depressed?") opens up the perspective that the depressive mood may "protect" against intense and threatening emotions (emotion avoidance, see above). The relevance of the basic feelings of fear, anger and sadness for the development and maintenance of depression is clarified in the group discussion and the rationale for emotion exposure (in Module 3) and the conscious "handling of difficult feelings" is also presented. Depression therapy can aim to gradually replace the depressive mood with vital feelings, the intensity of which can be regulated again by the individual.This involves the corrective experience of self-efficacy (in coping with anxiety), self-assertion (in dealing with anger and resentment) and becoming open to new things (in overcoming grief).

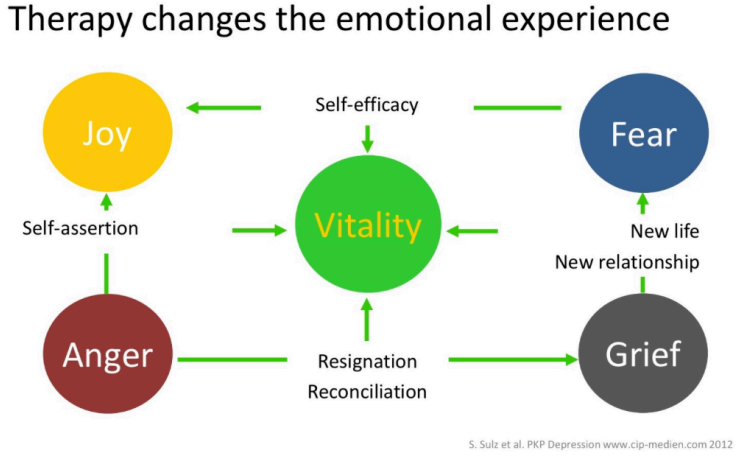


Figure 2 Exposure to emotions: from depression back to vital feelings

Module 2 - Building positive activities

Behavioural activation and the use of reinforcers to build up positive activities is an effective component of all cognitive-behavioural therapy approaches for treating depression (Hautzinger, 2013). Pleasantly experienced activities can also be understood and "practised" as a planned "exposure" to positive emotions such as "joy" and "satisfaction". However, drive disorders, negative expectations and the experience of persistent and almost insurmountable joylessness make it difficult for depressed patients to take the initiative. Feelings of duty and responsibility often dominate behaviour and impair positive experiences. The aim of this module is therefore the joint search for activities that are likely to be enjoyable or meaningful in a group context and the concretisation of these individually suitable activities in the form of daily plans and implementation protocols. It is helpful to guide self-observation of mood changes, as gradual improvements in mood are often not noticed by depressed patients or are negatively distorted in their assessment. The importance of exercise and sport, relaxation training, pleasure exercises and sensory experiences as sources of positive experiences are developed and integrated into the planning of positive activities.

In this area in particular, the cross-professional organisation of therapy content is a significant advantage. Behavioural activation, e.g. through concrete planning of positive activities and guidance on self-observation, can be considerably intensified and efficiently supported by specialist psychiatric nursing. Exercise, sports and creative therapists can provide additional programmes to build up positive activities or open up sources of positive (sensory) experience.

Module 3 - Dealing with difficult feelings (exposure to emotions)

According to the strategic-behavioural disorder model (see above), depressive mood can have the function in a certain life situation of protecting against uncontrollably intense emotions such as existential fear, insurmountable grief or aggressive anger. In the reversal of the disorder model, the aim is to reduce the associated avoidance of emotions through interventions to expose emotions. By simultaneously learning to effectively regulate the threateningly intense emotion, it is possible to gradually process the emotion in therapy. The depressive mood is then no longer maintained by emotion avoidance. The healthy vitality of

emotions can be experienced anew as the depressive mood recedes.

Emotion-focussed therapy work in a group of 6-8 participants is challenging, but is possible in suitable inpatient settings and accompanied by in-depth individual psychotherapy. In many cases, the group context is also advantageous, e.g. through the multi-perspectivity and greater experiential knowledge of the group. The basic emotions of fear, sadness and anger/rage are each dealt with in a 75-minute therapy session. The respective emotion schema is activated with a "brainstorming session" about personal experiences with one of these basic emotions and the various physical perceptions in connection with an emotion. The basic function of the basic emotion being worked on (fear - recognising danger, sadness - letting go, anger/rage - self-assertion) and typical trigger situations are worked out and the strategies already available to the group participants for dealing with the emotions of fear, sadness and anger are explored and, if necessary, evaluated in lists of pros and cons. This already reveals a helpful repertoire of behaviour in the group.

Based on the group results, the specific antidepressant PKP interventions for the respective emotion exposure are described. In order to take into account the importance of interpersonal issues in the development of depression, the PKP therapy concept for anxiety exposure includes in particular brief interventions for self-assertion, communication and independence training, as well as a frequently important "pleasure instead of duty" exercise for depressed patients with high self-demands, a pronounced sense of responsibility, strong self-discipline and dysfunctional conscientiousness.

For anger/rage exposure, there are short interventions on recognising, allowing and expressing anger and rage, on adequacy and on "constructive negotiation" on the background of anger/rage. In particular, an exercise on discriminating between feelings and actions or fantasy and reality in connection with intense anger and rage is suitable for joint implementation in the group.

Carrying out a grief exposure in the context of a small group requires special attention for individual participants during and after the therapy session and, if necessary, a flexible organisation of the group situation. This is about remembering the precious/loved one that was lost and feeling how much it is missed and what the moment of loss felt like, what pain, despair and grief there was. It is about the willingness to allow the painful feelings of grief and loss instead of avoiding them. In the group context, an imagination exercise ("boat exercise") is used to approach a topic of grief. The brief interventions mentioned usually take place in a more intensive individual setting. The overriding aim of this module is to clarify for the patient

whether the avoidance of certain emotions is relevant to the development and maintenance of the depressive mood and the quality of the avoided emotion. The group participant should be motivated to continue emotion-focussed work in an individual therapy setting. The inpatient treatment setting generally offers a supportive and well-suited therapy situation for emotion exposure.

Module 4 - Survival rule as a central behavioural pattern

Certain life situations can trigger a depressive episode if essential behavioural options for coping with a stressful life situation (e.g. autonomy and independence in a relationship conflict) are lacking and cannot be learned directly by the person affected. In terms of developmental psychology, the diversity and variability of behavioural options in adulthood are related to the breadth of experience in the course of the individual's development and learning history in childhood (Piaget & Inhelder, 1981; Kegan, 1986; Sulz 2007b). Both emotionally threatening or frustrating experiences and often limited opportunities to satisfy central needs in early biographical relationships lead to the development of corresponding cognitive-emotional schemata and behavioural or relationship patterns (see above). The respective schema was promising in childhood to guarantee emotional "survival" and often represented a positive adaptive achievement. However, if these learned cognitive-emotional schemata persist in the changed adult situation, they also remain decisive for interpersonal behaviour and the adult's relationship design and often become dysfunctional in their rigidity and unconsciousness (see above).

The occurrence of strong (primary) emotions such as fear, anger or sadness activate these schemata and tend to always lead to the same (secondary) emotional reaction (e.g. feelings of helplessness and inferiority). Recognising and describing the central emotional-cognitive schema, the so-called survival rule, is the aim of Module 4. The construct of the survival rule can be used to explain maladaptive behaviour in interpersonal relationships that perpetuates depression and can therefore be changed therapeutically. Based on the primary personality trait (e.g. "I am reserved and adapted") and the central needs and fears of a person, a personalised survival rule is developed, i.e. a conditional sentence is formulated:

"Only if I always ... (act according to my personality trait) and if I never ... (act contrary to my personality trait) do I preserve ... (the central need) and prevent ... (the central fear). In the case of a self-insecure-

dependent personality, the survival rule could be:

Survival rule - dependent personality trait

Only if I always think, feel and act according to the wishes of my carer,
and if I never allow my own needs to be incompatible with theirs,
I keep the protection, the warmth and the security
and prevent being abandoned.

The development of survival rules in a group context is possible in a simplified initial form and should primarily encourage continued work on clarifying one's own behavioural motives relevant to the development of depression and further personality development. As a basis for therapeutic work, however, further differentiation and review of the survival rule is necessary. This concern is in turn delegated to individual PKP therapy. In the same way , a first "development rule" ("By no longer ... and instead ..., I become free ... for myself and for real relationships") is created in the group context and delegated to individual therapy for concrete elaboration. The "development rule" serves as a starting point for individual change projects and for the development of opposing or alternative behavioural options to the survival rule. This gives it a special significance in further individual therapy. The development of a less change-orientated self-acceptance, which includes self-compassion in the sense of Gilbert (2009), can also become the goal of brief psychiatric psychotherapy.

PKP individual therapy

PKP individual therapy is carried out in parallel to group therapy by the respective inpatient reference therapists. Initially, simple therapeutic support and supplementary explanations are required in addition to the group sessions, as the patients are still affected by depressive symptoms and reduced attention span. In the course of the therapy, however, the relevant therapy topics from the group therapy are taken up, continued in a personalised manner and deepened. The group therapy process provides multiple therapeutic starting points, the treatment of which can be weighted differently by the reference therapist and with different objectives and therapy strategies. Accordingly, the reference therapist must be familiar with the group concept and the therapeutic content of Brief Psychiatric Therapy and with the basic principles of

Strategic Behavioural Therapy, in particular with the techniques of emotion exposure and working with the survival rule. Completion of Modules 3 and 4 of the PKP therapy concept also marks the start of intensive individual therapy work on changing the dysfunctional survival rule and on personal development.

PKP therapist conference

A therapist conference is held every two weeks to intensify communication between group leaders and reference therapists and to discuss both individual cases and organisational issues in addition to the day-to-day exchange of case-related information.

Cross-sectoral organisation of brief psychiatric psychotherapy The PKP group concept, which is primarily designed for inpatients, can also be opened up to outpatients if individual PKP therapy is also available in an outpatient context, e.g. in the psychiatric institute outpatient clinic or by a qualified outpatient medical or psychological psychotherapist. The offer of further outpatient participation in the PKP depression group is also useful for patients who are discharged from inpatient treatment for various reasons during the PKP group therapy period and can also complete their depression treatment in this way on an outpatient basis.

PIA group to work on the survival rule

Project work to replace the dysfunctional commanding and forbidding survival rule with a new permission-giving rule of life (not a survival rule), to improve one's own emotion regulation and personal development can also be continued as part of a special group programme in the psychiatric outpatient clinic.

Evaluation of the inpatient PKP treatment concept

The data from a multi-year evaluation of the PKP depression group between August 2011 and December 2016 provided clear evidence that this special therapy programme at Braunschweig Hospital is suitable for generating an effective treatment process for inpatients with depression on a general psychiatric and

psychotherapy ward.

Methods: Following a phase of concept implementation (8/2011-6/2012), the evaluation of the PKP treatment concept began in July 2012 and was carried out until December 2016 as a continuous quality assurance measure. Within the clinical routine, several measurement instruments (BDI-II; Hautzinger, Keller & Kühner, 2006; SCL-18; Franke, 2017; CGI-Scale; Guy, 2000) were used in parallel with the group intervention. The aim of this "clinical evaluation" was to determine the course of therapy during the group intervention. In addition, the participants' subjective assessments of the relevance of the developed survival rule were surveyed.

Results

In the period from the start of the PKP depression group in August 2011 to December 2016, a total of 1196 patients took part in the PKP depression group or the combined inpatient PKP treatment concept, predominantly patients from the general psychiatric and psychotherapy wards. More than half (58.2 %), i.e. 696 participants, completed the PKP depression group in full (modules 1-4). 206 participants (17.2%) in the group therapy ended the PKP depression group as planned after modules 1 and 2, e.g. because the indication for participation in group B (emotion exposure/survival rule) was not given (see above). For a further 118 group participants (9.86%), group participation ended during participation in group B (modules 3-4) and after completion of modules 1 and 2, e.g. due to early discharge. For 157 participants (13.1%), group therapy ended either after participation in only one module (114 patients) or after the first group sessions (43 patients). 14 patients (1.2 %) took part exclusively in Group B (emotion exposure/survival rule) after therapeutic consideration. Five participants in the depression group showed unsystematic participation (module 1/3, 1/4 or 2/3).

Of the 1196 participants, a total of 7 treatment cancellations (0.6%) were documented for specific reasons (updating trauma experience, acute mania, psychotic symptoms, etc.). 32 patients (2.6%) took part in the outpatient depression group via the psychiatric outpatient clinic.

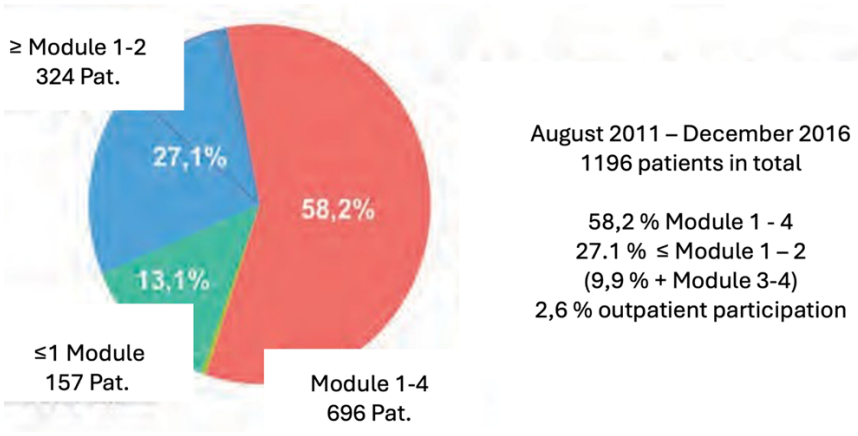
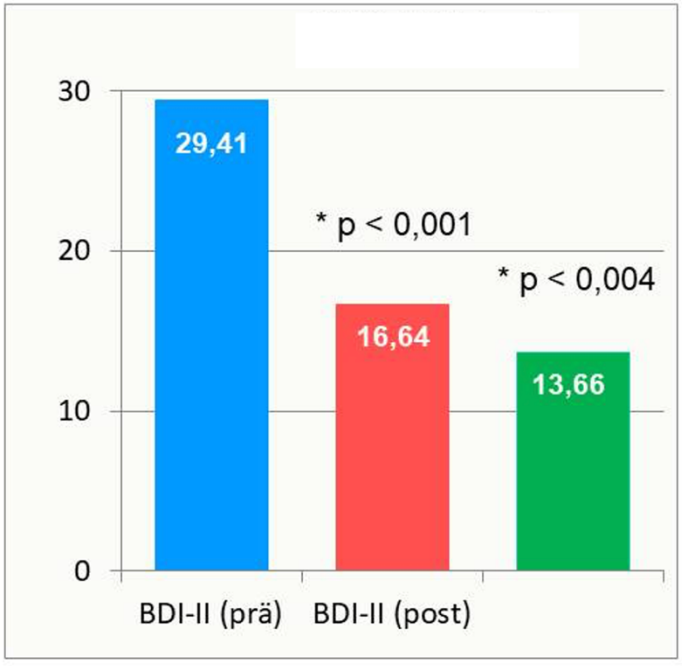


Figure 3 How many patients completed how many modules?

During the four-week PKP depression group, the scores on the Beck Depression Inventory (BDI-II; Hautzinger et al., 2006) decreased significantly ($p < 0.001$) and with a strong effect ($d = 1.144$) in the participants with full participation in the PKP therapy concept ($n = 696$). The values for the suicide item in the BDI-II ($p < 0.001$, $d = 0.626$) also decreased.

At the same time, the participants received other therapies such as psychopharmacotherapy and complementary therapies to the standard treatment.



August 2011 – December 2016
696 patients (Modules 1 – 4)

284 evaluations
(Response rate: 40,8 %)

BDI II (pre—ost): p < 0,001
Effect size: d = 1,144

BDI (Catamnesis): p < 0,004
Effect size: d = 0,268

Figure 4 Beck Depression Inventory (II): Pre/post comparison

Starting in August 2012, the clinical evaluation was expanded to include the SCL-18 (Symptom Checklist, syn. Mini-SCL) and a scale for 'overall clinical impression'. The SCL-18 is a short form of the symptom checklist (SCL-90-S) that is well validated for psychotherapy patients, reduced to the 3 scales for somatisation, depressiveness and anxiety with 6 items each (Derogatis, 1977; Franke et al. 2011; Franke, 2014, 2017). The 'Clinical Global Impression' corresponds to the most commonly used international external assessment instrument, the Clinical Global Impression-Scale (CGI-Severity), in German translation (Guy, 2000; CIPS, 2005).

There were significant (p< 0.001) symptom reductions on all SCL-18 scales. The effect manifested itself most strongly on the depression scale (d= 1.067), followed by effects on the anxiety scale (d= 0.714) and the

somatisation scale (d= 0.641). The "Global Severity Index" (GSI) of the symptom checklist, which correlates well with clinical improvement, also showed a good effect size (d = 1.022), limited only by a low response rate of 39%. The external assessment using the Clinical Global Impression Scale (CGI-S) confirmed a significant psychological improvement (p < 0.001) in the statistical comparison of the pre/post raw scores (d = 1.166).

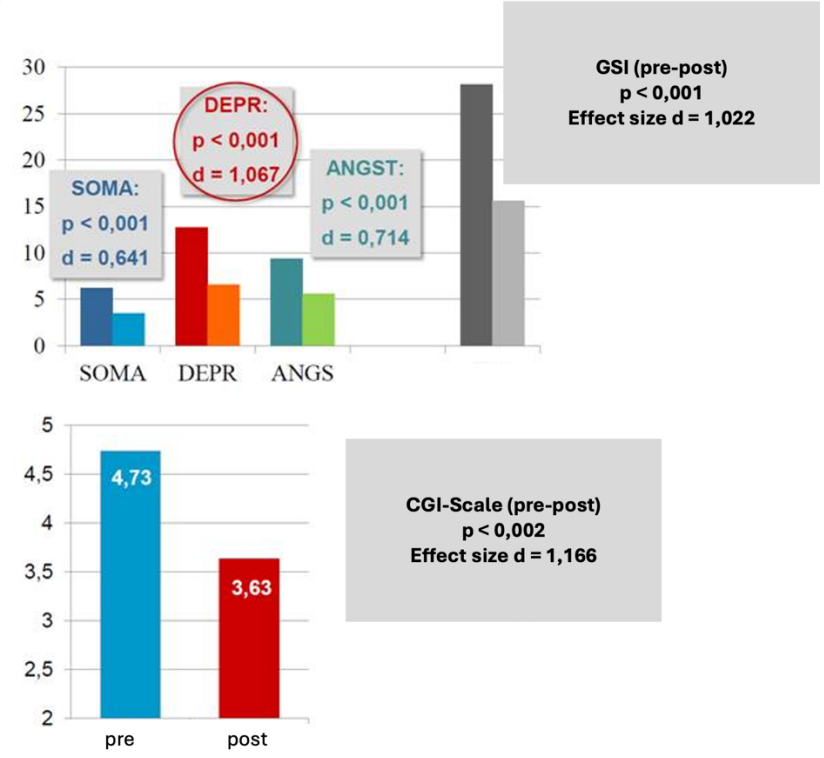


Figure 5 SCL-18 (Mini-SCL) and CGI-S in pre/post comparison

With the development of the survival rule in module 4, 79.5% of the group participants were motivated to continue working with the survival rule in therapy. 89.9% of participants rated the therapy topic of the survival rule as moderately to very relevant for them (response rate 41.9%).

The catamnestic survey clearly showed, in line with expectations, that the patients' experiences and behaviour in the post-inpatient course were less determined by the survival rule overall ($p < 0.001$, $d = -0.635$). Negative consequences were less feared in the event of a "violation of the survival rule" ($p < 0.001$, $d = -0.6$).

Although more negative feelings occurred in connection with "violations of the survival rule", these did not reach a significance level ($p = 0.075$). According to their own judgement, the patients surveyed in the catamnestic interviews were more successful overall in "acting against the survival rule" ($p = 0.005$, $d = -0.336$).

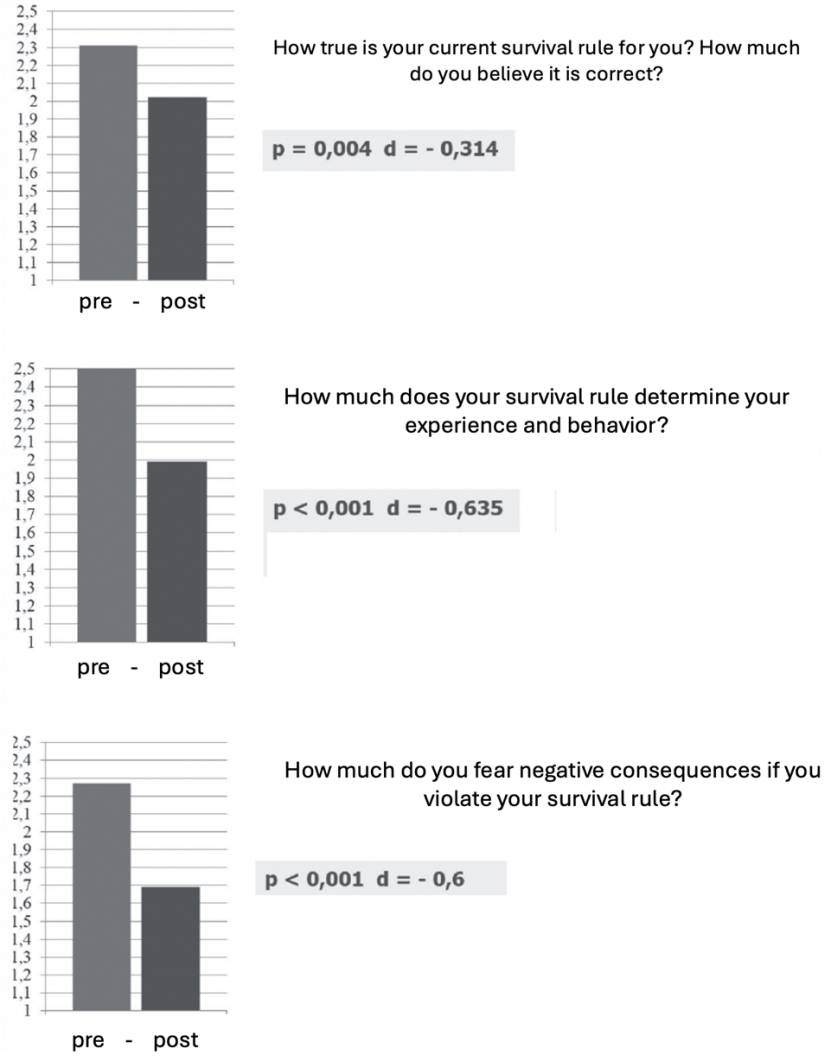


Figure 6 Impact of the dysfunctional survival rule before and after therapy

Discussion

As with field studies in general, this naturalistic study can be expected to have high external validity. This greater predictability for everyday psychiatric care compared to strictly controlled RCT studies conducted under laboratory conditions compensates somewhat for the lack of a control group. Research funding and research staff were not available. This makes the importance of consistently continuing treatment practice and evaluation for more than ten years all the greater. RCT studies usually have comparatively small samples (hardly more than 100 test subjects), whereas this study can report on the course and outcome of treatment in almost 1,200 patients. The reported significances and effect sizes show that effective therapies took place and clinically relevant improvements were achieved.

Brief interventions and the therapy technique of Psychiatric Brief Psychotherapy (PKP) formed the basis for a combined group and individual therapy with the primary aim of realising and testing a special psychotherapy for depression in an acute care clinic with typical limitations in terms of length of stay and personnel resources.

The new form of organisation with parallel groups in weekly changing composition has proven its worth. In practice, sufficiently homogeneous group atmospheres were also created for work with and the survival rule. The embedding of the treatment concept in two organisationally linked wards favoured the development of supportive group situations. The complexity of the treatment approach was sufficiently taken into account by the accompanying individual therapy. The development of therapeutic topics in the group context and the delegation of these topics for further processing in individual therapy represented an efficient organisational form of the strategic therapy process. In addition, positive group effects (e.g. reciprocal modelling, stimulation and feedback functions, conveying hope) could be used (Theßen, Algermissen & Sulz 2025, Fiedler 2005).

The organisational form of the PKP treatment concept also proved to be a good prerequisite for cross-sectoral treatment paths, provided that supplementary individual therapy was possible through further outpatient treatment in a psychiatric institute outpatient clinic or with a registered "PKP therapist" parallel to participation in the PKP depression group.

The results of the clinical evaluation document that within the first four-week period of the PKP treatment concept and with participation in the depression group, significant positive therapy effects and regression of depressive syndromes

can be seen or expected. The respective significance of the various therapeutic elements of inpatient depression treatment for clinical improvement, such as participation in brief psychiatric psychotherapy compared to the effectiveness of antidepressant psychopharmacotherapy or the complementary effects of other complementary therapies and inpatient environmental factors, cannot be determined on the basis of our evaluation. There was a lack of suitable control conditions for such statements. In addition, the unsatisfactory response rate in recording the impact of the survival rule, primarily due to the lack of scientific personnel, limited the validity of the clinical evaluation.

Overall, however, and above all due to the high number of cases (n = 1196), we believe that the clinical evaluation provided evidence that effective and effective inpatient depression treatment could be realised using the inpatient PKP treatment concept. The treatment concept has shown stability from 2011 to 2025, independent of the therapist.

The high relevance that participants attributed to the central construct of the PKP treatment concept, the survival rule, also indicates a high level of acceptance for the underlying functional disorder model of PKP. This was also our everyday experience.

In summary, the PKP treatment concept could be implemented well in the inpatient treatment programme of a medium-sized psychiatric care clinic. The reproduction of our results is essential for the positive verification of the inpatient PKP treatment concept. This article therefore also aims to facilitate the testing of the inpatient PCP treatment concept for depression elsewhere in a comparable form. Our therapy materials and measuring instruments for PKP evaluation can be made available free of charge.

In summary, this was a naturalistic outcome study to evaluate the new PKP treatment concept for the inpatient psychiatric-psychotherapeutic treatment of almost 1200 depressive patients. The highly structured setting made it possible for patients to be admitted at any time and receive psychotherapeutic treatment for the expected duration of their stay. The use of the staggered group setting, accompanied by individual therapies working according to the same approach, which could be continued in the same way as the groups after discharge from inpatient treatment, was central. While retaining and continuing the personalised modular psychotherapy concept, one patient could be handed over to the outpatient PKP therapist. The results of the evaluation are encouraging and show that new effective psychotherapy approaches can be implemented in psychiatric inpatient care. This could also be implemented for other mental disorders. Disorder-specific PKP is available for anxiety and obsessive-compulsive disorders, for chronic alcoholism and for pain disorders. In addition, PKP is available as a transdiagnostic modular psychotherapy approach (Sulz 2012), which can be used for a large number of other mental disorders. PKP can also be seen as a more

psychoeducational and disorder-specific arm of Strategic Behavioural Therapy SBT. This has been divided into the two therapy strands PKP and EMVT (Sulz 2021a,b, 2022a,b). Emotion and Mentalisation Enhancing Behaviour Therapy EMVT is the new transdiagnostic therapy approach for the treatment of Axis I disorders and Cluster C personality disorders first published in 2021. This is a modular psychotherapy that focuses entirely on the specifics of the individual patient. It consists of seven modules: attachment security, survival rule, mindfulness, emotion tracking, mentalisation/metacognition, development from the body and affect level to the thinking level and development from the thinking level to the empathy level. It is an ideal complement to PKP. Its use begins when the symptoms no longer determine thinking, feeling and behaviour, but when the patient wants to understand their illness and leave it behind them in the long term. In contrast to approaches such as MBT and schema therapy, which were developed for the treatment of clusters A and B (too much emotionality), EMVT can help the patient to find their feelings and use them to build a secure bond and a satisfying relationship.

Literature

Algermissen, C. & Rösser, N. (2019). Psychiatrische Kurz-Psychotherapie von depressiven Störungen in kombinierter Gruppen- und Einzeltherapie – ein Behandlungskonzept für Versorgungskliniken. Psychotherapie, 24(1), 113–135.

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

Beck, A.T., Rush, A.J., Shaw, B.F. & Emery, G. (1986). Kognitive Therapie der Depression. Weinheim: Beltz.

Bischof, N. (1993). Untersuchungen zur Systemanalyse der sozialen Motivation: Die Regulation der sozialen Distanz – von der Feldtheorie zur Systemtheorie. Zeitschrift für Psychologie, 201, 5-43.

CIPS Collegium Internationale Psychiatriae Scalarum (2005). Internationale Skalen für Psychiatrie. Göttingen: Hogrefe.

Damasio, A. (2003). Der Spinoza-Effekt: Wie Gefühle unser Leben bestimmen. München: List. Deckert, B. (2014). Psychiatrische Kurz-Psychotherapie (PKP) der Depression. Psychotherapie, 19, 287-304.

Deckert, B. (2014). Psychiatrische Kurz-Psychotherapie (PKP) der Depression. Psychotherapie, 19(2), 287–304.

Derogatis, L.R. (1977). SCL-90-R, administration, scoring & procedures manual-I for the R(evised) version. John Hopkins University School of Medicin: Eigendruck.

DGPPN, BÄK, KBV, AWMF (2017). Nationale Versorgungsleitlinie Unipolare Depression. Heidelberg: Springer.

Fiedler, P. (2005). Verhaltenstherapie in Gruppen: Psychologische Psychotherapie in der Praxis. Weinheim: Beltz.

Franke, G.H., Ankerhold, A., Haase, M., Jäger, S., Tögel, CH., Ulrich, C. & Frommer, J. (2011). Der Einsatz des Brief Symptom Inventory 18 (BSI-18) bei Psychotherapiepatienten. PPMP Psychotherapie Pychosomatik Medizinische Psychologie,61, 82-86.

Franke, G.H. (2014). SCL-90-S. Symptom-Checklist-90-Standard. Göttingen: Hogrefe (Testzentrale). Franke, G.H. (2017). Mini-SCL. Mini-Symptom-Checklist. Göttingen: Hogrefe (Testzentrale).

Gilbert, P. *(2009). Introducing compassion-focused therapy. BJPsych Advances in Psychiatric Treatment, 15, 199–208.*
Gräff-Rudolph, U. & Sulz, S.K.D. (2009). Strategische Depressionstherapie: Die Energie der Gefühle für befriedigende Beziehungen nutzen lernen. In: S.K.D. Sulz & G. Hauke (Hrsg.), Strategisch- Behaviorale Therapie (SBT): Theorie und Praxis eines innovativen Psychotherapieansatzes. München: CIP Medien.
Grawe, K. (1998) Psychologische Therapie. Göttingen: Hogrefe.
Guy, W. (2000) Clinical Global Impressions (CGI) Scale, Modified. In: J.A. Rush (Hrsg.), Handbook of Psychiatric Measures. Washington DC: American Psychiatric Association.
Haken, H. & Schiepek, G. (2005). Synergetik in der Psychologie: Selbstorganisation verstehen und gestalten. Göttingen: Hogrefe.
Härter, M., Sitta, P., Keller, F., Metzger, R., Wiegand, W., Schell, G., Stieglitz, R.-D., Wofersdorf, M., Felsenstein, M. & Berger, M. (2004). Stationäre psychiatrisch-psychotherapeutische Depressionsbehandlung. Nervenarzt , 75, 1083-1091.
Hautzinger, M., Keller, F. & Kühner, C. (2006). Beck Depressions-Inventar Revision. Göttingen: Hogrefe. Hautzinger, M. (2013). Kognitive Verhaltenstherapie bei Depressionen. Weinheim: Beltz.
Hinsch, R. & Pfingsten, U. (2015). Gruppentraining sozialer Kompetenzen GSK. Weinheim: Beltz.
Kanfer, F.H., Reinecker, H. & Schmelzer, D. (2006). Selbstmanagement-Therapie. Heidelberg: Springer Medizin.
Kegan, R. (1986). Die Entwicklungsstufen des Selbst: Fortschritte und Krisen im menschlichen Leben. München: Kindt.
Klermann, G.L., Weissman, M.M., Rounsaville, B.J. & Chevron, E.S.M.S. (1984). Interpersonal Psychotherapy of Depression. New York: Basic Books.
Lewinsohn, P.M. (1974). A Behavioral Approach to Depression. In: R.J. Friedman & M.M. Katz (Hrsg.), The Psychology of Depression (S.194-209). New York: Wiley.
McCullough, J.P. (2006). Psychotherapie der chronischen Depression: Cognitive Behavioral Analysis System of Psychotherapy - CBASP. München: Urban & Fischer.
Piaget, J. & Inhelder, B. (1981). Die Psychologie des Kindes. Frankfurt: Fischer.
Roediger, E. (2016). Schematherapie: Grundlagen, Modell und Praxis. Stuttgart: Schattauer.
Röttgers, H.-O. & Konrad, C. (2017). Praxis des Cognitive Behavioral Analysis System of Psychotherapy (CBASP). In: C. Konrad (Hrsg.), Therapie der Depression: Praxisbuch der Behandlungsmethoden (S.117-140). Berlin: Springer.
Schramm, E. (2010). Interpersonelle Psychotherapie. Stuttgart: Schattauer.
Seligman, M.E.P. (1992). Erlernte Hilflosigkeit. Weinheim: Beltz.
Statistisches Bundesamt (2017). Diagnosedaten der Krankenhäuser (Eckdaten der vollstationären Patienten und Patientinnen). http://www.gbe-bund.de/oowa921-install/servlet/oowa/aw92/dboowasys921.xwdevkit/xwd_init?gbe.isgbetol/xs_start_neu/&p_aid=i&p_aid=43944074&nummer=815&p_ sprache=D&p_indsp=-&p_aid=28380234
Sulz, S.K.D. (1998). Therapeutische Strategien bei Depression. In: S.K.D. Sulz (Hrsg.), Das Therapiebuch. München: CIP-Medien.
Sulz, S.K.D. (2007a). Die Schematherapie Jeffrey Youngs: ein integrativer Therapieansatz zur Behandlung von Persönlichkeitsstörungen. Psychotherapie, 12, 183-195.

Sulz, S.K.D. (2007b). Entwicklung als Therapie: von Piaget Entwicklungstheorie zu McCulloughs CBASP und zur strategischen Kurzzeittherapie. Psychotherapie, 12, 60-76.
Sulz, S. (2012). Grundkurs und Praxisleitfaden: Therapiedurchführung in Klinik und Praxis. PKP-Handbuch. München: CIP-Medien.
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. & Deckert, B. (2012a). Psychiatrische Kurzzeittherapie PKP: Handbuch Depression. München: CIP Medien.
Sulz, S.K.D. & Deckert, B. (2012b). Psychiatrische Kurz-Psychotherapie: PKP – Depression-Therapiekarten. München: CIP-Medien.
Sulz, S.K.D., Deckert, B. & Gräff-Rudolph, U. (2011). Strategische Depressionstherapie als Psychiatrische Kurz-Psychotherapie (PKP): Arbeit mit Sprechstundenkarten. Psychotherapie,16, 324-330.
Sulz, S.K.D. & Hauke, G. (2009). Strategisch-Behaviorale Therapie (SBT): Theorie und Praxis eines innovativen Psychotherapieansatzes. München: CIP-Medien.
Theßen, L., Algermissen, C., Sulz, S.K.D. (2025). Emotion and mentalization-supporting behavioural therapy in the group (EMVT-G). European Psychotherapy EP 2025, Volume 16, 141-184
Theßen, L., Antoni, J., Hagleitner, R., Sulz, S.K.D. (2025). Psychiatric and psychological brief psychotherapy for chronic alcoholism. European Psychotherapy EP 2025, Volume 16, 74-94

Theßen, L., Backmund-Abedinpour,S., Sulz, S.K.D. (2025). A transdiagnostic approach to Psychiatric and Psychological Brief Psychotherapy PKP. European Psychotherapy EP 2025, Volume 16, 10-28
Theßen, L., Deckert, B., Sulz, S.K.D. (2025).Psychiatric and psychological brief psychotherapy for depression PKP. European Psychotherapy EP 2025, Volume 16, 29-54
Theßen, L., Kaufmayer, T., Sulz, S.K.D. (2025). Psychiatric & psychological brief psychotherapy PKP for depression - an empirical outcome study . European Psychotherapy EP 2025, Volume 16, 95-121
Theßen, L., Peters, M., Sulz, S.K.D. (2025). Psychiatric & psychological brief psychotherapy (PKP) proves to be on a par with long-term therapy - results of a comparative study. European Psychotherapy EP 2025, Volume 16, 122-140
Theßen, L., Sichort-Hebing, M., Jänsch, P., Sulz, S.K.D. (2025). Brief psychiatric and psychological psychotherapy PKP for anxiety and obsessive-compulsive disorders. European Psychotherapy EP 2025, Volume 16, 55-73
Watzlawik, P. (1981). Die erfundene Wirklichkeit. München: Piper.
Wiegand, H.F., Saam, J., Marschall, U., Chmitorz, A., Kriston, L., Berger, M., Lieb, K: & Hölzel, L.P. (2020). Probleme beim Übergang von der stationären zur ambulanten Depressionsbehandlung. Analyse administrativer Versorgungsdaten einer großen deutschen Krankenkasse. Deutsches Ärzteblatt, 117(27–28), 472–478 u. I–IX.
Young, J.E., Klosko, J.S. & Weishaar, M.E. (2005). Schematherapie: Ein praxisorientiertes Handbuch. Paderborn: Junfermann.

Correspondencee Address

Dr. med. Christian Algermissen
Klinik für Psychiatrie, Psychotherapie und Psychosomatik
Harzklinikum Dorothea Christiane Erxleben GmbH
Thiestraße 7–10
38889 Blankenburg
Christian.Algermissen@harzklinikum.com