



QUALITY ASSURANCE AND EFFECTIVENESS STUDY OF POSITIVE PSYCHOTHERAPY*

During the past years, physicians as well as the medical community in general, have increasingly asked for proof of effectiveness in the sense of quality assurance for diagnosis and therapy within the framework of cost reduction in health service. Such examinations are to a great extent carried out in somatic and biological medicine therefore; psychotherapy faces a great challenge in this respect.

On the basis of the extensive data pool of the effectiveness studies of Positive Psychotherapy, a user-friendly software program has been developed for clinics and private practices, which makes possible the analysis of all tests used. The program also offers the option to integrate further specific tests when they are needed. The results are presented in a chart form with an integrated standard area. They include interpretation aids, which are oriented - with regard to the content - to the instructions of the tests. The Circle for Further Education for Psychotherapy and Family Therapy of Wiesbaden conducted by Dr. Peseschkian has prepared an effectiveness study in the sense of quality assurance since 1974. The results of this study were presented and discussed.

The presentation included the following items*:

- Positive Psychotherapy Theory
- Effectiveness Study
- Quality Assurance Theory
- A user friendly software program to put all of this into practice

Dr. Peseschkian, the founder of Positive Psychotherapy and president of the ICCP, with his aim at acquiring "Quality Assurance", was awarded the 'Richard Merten Prize' for 1997 (Germany's most respected Prize awarded for Quality Assurance in the field of Medicine).

The prize is given out on an annual basis. A committee (Kuratorium) consisting of experts and medical professionals chooses the winner.

*The complete material is available as a separate presentation which forms a part of our archives.

POSITIVE PSYCHOTHERAPY: EFFECTIVENESS OF AN INTERDISCIPLINARY APPROACH

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Positive Psychotherapy: Effectiveness of an Interdisciplinary Approach*

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Abstract

Positive Psychotherapy (PPT) is a form of short-term psychotherapy based on transcultural psychology and is currently applied in 15 countries. First results of a German PPT effectiveness study are discussed here. In a longitudinal study, patients treated with PPT showed a distinct reduction of symptoms as well as an improved way of feeling and behaving when compared to a control group where no significant changes were observed. An additional cross-sectional comparison between the post-measures of the longitudinally assessed PPT patients and different groups of other follow-up assessed patients (up to 5 years after finishing therapy) revealed no significant differences. This finding is viewed as an indication of the lasting stability of the therapeutic effects of PPT.

Introduction

Positive Psychotherapy (PPT) is a form of short-term psychotherapy, based on transcultural psychology (e.g. Peseschkian 1982, 1986, 1987). While the application of most psychotherapeutic methods is limited to specific populations (e.g. individuals with specific diagnosis and/or sufficient language abilities, distinct social classes, or special (sub-)cultures), PPT claims to be transferable to a variety of symptoms and cultural settings. Looking for solutions to problems occurring in transcultural encounters and wanting to improve psychotherapeutic methods, Nossrat Peseschkian, the founder of PPT, focused on answering the following two questions: What do all people have in common? In what ways are they different? This cross-cultural analysis resulted in Peseschkian's formulation of the so-called 'Actual Capabilities', which are covered in an inventory of 19 different bipolar conflict contents listings (e.g. Peseschkian & Deidenbach 1988). With this method, the concepts, norms, values, behavioural patterns, motives and viewpoints that are valid in a given culture and are therefore influential for an individual's socialization, can be addressed. Needless to say that individual deviations

from these norms (as well as their implications for the individual) can also be negotiated in this context. This inventory promotes the systematic examination of the contents of an individual's upbringing and education as well as the identification of the individual's inner conflicts and his/her conflicts with other people. Content areas related to conflicts can be dealt with and be relativized through the use of cross-cultural comparisons and other techniques. This typically effects a change of perspective on the part of the client, which is the basis for further therapeutic work.

In 1995, the founder of PPT Nossrat Peseschkian and other Positive Psychotherapists started developing a test battery for a new approach, aiming at integrating quality assurance in their daily therapeutic routines. In addition, the data collected through this quality assurance was to be used for evaluations of the effectiveness (e.g. Seligman 1995) of PPT. Various German scientists from different universities participated in this project¹. This paper presents the study design and the first evaluation of the effectiveness of PPT, i.e. results of the first phase of this on-going project. While neglecting most issues pertaining to quality assurance (which usually centres around single case studies), aspects related to the effectiveness study (which is based on group evaluations) are stressed here. At the present time, a group of positive therapists working with this approach to quality assurance are collecting further data. This procedure should result in a considerable data pool, allowing for large-scale statistical evaluation of different aspects of PPT.

Study design

Two methods have been established to assess the effects of psychotherapeutic interventions: efficacy studies and effectiveness studies (Seligman 1995, Howard, Moras, Martinovich & Lutz 1996, Roth & Fonagy 1966). Efficacy studies follow a classical experimental design, typically involving "single-blind" raters, patients meeting the criteria for a single diagnosed disorder (exclusion of patients with multiple disorders), random assignment of patients to the different groups, fixed number of therapeutic sessions, manualization of the therapeutic procedure, control of so-called non-specific effects, etc. Effectiveness studies, on the other hand, scrutinize the effects of psychotherapeutic treatment under the actual conditions of the field. Since everyday therapeutic practice is the object of study in such an approach, the less often a researcher has to intervene (e.g. control different variables as in an efficacy study), the better. While many researchers have come to the conclusion that efficacy studies are the "golden standard" for measuring the effects of psychotherapy, some reviewers have recently pointed to various critical points (e.g. Seligman 1995, Howard, Moras, Brill, Marinovich & Lutz 1996, Roth & Fonagy 1996), especially with regard to the limited generalizability of their results to the actual conditions of everyday clinical practice. While we believe that each type of design has its merits and shortcomings, being interested in the effects of PPT in the field we decided to apply a design, which follows the effectiveness approach.

Sample description

Therapists

Studying the effectiveness of the PPT method requires ensuring that the participating therapists show a high degree of identification with the method (e.g. Grawe, Donati & Bernauer 1994). It was assumed that members of the German Association of Positive Psychotherapy would sufficiently identify themselves with the method. Therefore, the members were asked to voluntarily take part in this study.

¹ Author's note: We would like to thank the other scientists involved in this project: Prof. Dr. med. K. Jork, Frankfurt; S. Peseschkian, Wiesbaden; Prof. Dr. med. G. Sachse, Wiesbaden; Prof. Dr. med. Kick, Heidelberg; Dr. med. H. Peseschkian, Moscow; Prof. Dr. med. U. Cegla, Bad Ems; Dr. med. H. Röhke, Huenfeld; Dr. med. A. Remmers, Ortenberg.

Of the 32 colleagues partaking in this first study phase, 23 Therapists educated in PPT (15 Physicians, 3 Psychologists and 4 Special Education Specialists and 1 other), who work in Germany in private practices or in clinics or hospital settings, were willing and able to document and evaluate their psychotherapeutic practice. The average age of these therapists was 45.1 yrs. (sd = 7,7); n= 15 (65.2 %) of the therapists were male and n= 8 (34.8 %) were female. Their average amount of therapeutic experience was 7.68 years (sd = 7.42).

Patients

The sample of this first study phase (N = 402) consists of people with different psychiatric, psychosomatic and “somatic“ disorders, diagnosed according to ICD-10. For descriptive purposes, subjects were ascribed to different categories of ICD-10 diagnoses, according to the first diagnosis they received.

N = 117 patients (23.6 %) suffered from depressive disorders, n = 80 patients (19.8 %) from anxiety disorders, n = 85 (21.2 %) from somatoform disorders, n = 83 (20.5 %) from adjustment disorders, n = 23 (8.2 %) from personality disorders, n = 7 (3.4 %) from substance-related disorders, and n = 7 (3.4 %) from different somatic diagnoses. The average duration of therapy for the n = 331 patients who had been treated with PPT was 30.5 sessions (sd = 19.3).

While one group of patients was assessed prospectively, only follow-up assessments were made retrospectively for another group (mixed longitudinal and cross-sectional design):

I: Prospective evaluation

The following exclusion criteria were applied in this part of the study: a) insufficient comprehension of the German language, b) patients suffering from mental illness caused through organic brain syndromes, c) missing IDC-10 diagnosis, and d) subjects in acute psychotic phases.

In the prospective part of the study, different groups of subjects (patients and control groups) received a battery of questionnaires (described below) twice.

A. Patients treated with PPT received the questionnaire battery at the beginning and at the end of their therapy (pre- and post-assessment to register therapeutically induced changes).

As already stated, this study focuses on the question of whether PPT is effective under natural therapeutic conditions. Therefore, instead of randomly assigning patients to experimental or control groups, the participating therapist included all new patients, who started therapy with them between the time when the therapist agreed on participating in the study (starting in January 1996) until March 1997. When a sufficient amount of data (n = 110 patients) had been collected an evaluation of the first project phase was started.

B. A control group consisted of all patients of the participating therapists with psychiatric diagnoses, who could not be treated immediately (lack of time and/or therapists) and were therefore on the waiting list for psychotherapeutic treatment. Analogous to the pre- and post measurement of PPT patients, these patients were asked to fill out the test battery a second time, three to four months after making the first assessment. No psychotherapeutic treatment took place between the two measurements. This group consisted of N = 54 patients.

An additional control group (N = 17) was made up of patients with “purely somatic“ diagnoses, who also had had no psychotherapeutic treatment, but in the opinion of the therapists required therapeutic help.

By involving these two control groups, a) Eysencks argument pertaining to the possibility of spontaneous recovery of psychiatric patients (independent of therapy) and b) other non-specific effects caused through receiving special attention were to be controlled in forthcoming phases of this project. Since no significant differences (χ^2 - tests) with regard to age, sex and diagnosis could be found between the intervention group and each of the two control groups (except for a relative surplus of men in the somatic control group compared to both other groups and more somatic diagnoses in the second control group), the two control groups were put together and compared with the patients who were treated with PPT.

II. Retrospective evaluation

In addition to the exclusion criteria used for the prospective evaluation, patients were only included in the retrospective part of the study when a WIPPF questionnaire (see below) was filled out when the subjects were in therapy, as well as extensive case documentation were available.

A single assessment of PPT patients was made for this retrospective part at different time periods after their treatment had been completed, in order to cross-sectionally compare these assessments with the post-assessments of the prospectively rated PPT patients. Since it has been shown that the measured efficacy of some therapeutic schools vary differently over the course of time and that effects measured are also dependent on the time span of the follow-up (Grawe, Caspar & Ambuhl 1990a), data was collected over the following retrospective time spans:

- 1. retrospective group (N = 84): 3 - 10 months after finishing psychotherapy.
- 2. retrospective group (N = 91): 10 months - 4 years after finishing therapy.
- 3. retrospective group (N = 46): 4 - 5 years after finishing therapy.

The retrospective test battery consisted of the same measurement instruments as the immediate post-assessment of the prospectively investigated group.

Criteria for test selection

Test instruments used in this study should meet the requirements of both quality assurance and effectiveness studies. The following criteria were established for the selection of tests:

1) The notion of "health/illness" has been related to a variety of different facets (e.g. Biefang 1980, Schulte 1993). Aiming at covering different dimensions of this concept, the selection of instruments was based on the bio-psychosocial model of mental illness (Engel 1980), which implies making assessments on the biological level (e.g. symptoms), the psychological level (e.g. personality traits), and the social level (e.g. interpersonal skills) (Lutz 1993).

2) Instruments used for quality assurance require a high degree of acceptance on the part of both the patient as well as the therapist. The instruments should therefore be economical, quick and easy to fill out/administer/evaluate, and still yield a lot of information relevant for status and process diagnosis, which in turn can be used in the therapeutic process (c.f. Øvretverit 1992).

3) Since patients with various syndromes are treated with PPT (e.g. Peseschkian 1993), the applied instruments should also cover a variety of symptoms, rather than being designed for the specific assessment of single syndromes, e.g. anxiety or depression.

4) The use of commonly accepted psychometric instruments, suited for the assessment of change,

promotes comparison of the results of the effectiveness study to the findings of other effectiveness and/or efficacy studies (c.f. Schulte 1993). Therefore Grawe's recommendations for a standardized psychotherapy documentation (Grawe & Braun 1994) were generally followed, especially with regard to the instruments relevant for the effectiveness study.

Test Battery

In accordance with these four criteria, the following tests were selected:

1) Initial status and changes of various symptoms (nine scales: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, anger-hostility, phobic anxiety, paranoid ideation, and psychoticism), global symptom severity, the positive symptom distress, and total amount of symptoms (per patient) were measured with the "Symptom-Check-List (SCL-90- R)" from Derogatis (German translation by Franke 1995).

2) The Changes in Feeling and Behaving Questionnaire ("Veränderungsfragebogen des Erlebens und Verhaltens (VEV)" by Zielke & Kopf-Mehnert (1976) is a standard tool in German-speaking countries, developed by client-centred therapists especially for the evaluation of therapy induced changes. At the end of therapy, the patient is asked to retrospectively assess changes occurring between the beginning and end of therapy with regard to his/her feeling and behaviour. Results are based on the bipolar scale "relaxation, security and, optimism vs. tension, insecurity, and pessimism".

3) The "Giessen-Test (GT)" by Beckmann, Brähler & Richter (1990) is a personality inventory, commonly used in German speaking countries where it is also applied for assessing therapeutic effects. It consists of six bipolar scales: social resonance, dominance, control, basic mood, permeability, and social abilities.

4) The Wiesbaden Inventory for Positive Psychotherapy and Family Therapy ("Wiesbadener Inventar zur Positiven Psychotherapie und Familientherapie (WIPPF)" by Peseschkian & Deidenbach (1988) is a personality questionnaire based on the theory of PPT. The so-called "Primary and Secondary Capabilities", which represent potential areas of conflict (19 scales), are assessed with this instrument as well as typical patterns of conflict reactions (4 scales) and the type and influence of parental role-modelling (4 scales). This primary diagnostic tool of PPT is typically administered at the beginning of therapy in order to identify the individual's problem topics.

5) The JPC-Questionnaire of locus of control ("IPC-Fragebogen zu Kontrollüberzeugungen (IPC)" by Krampen (1981) is founded on the classical "locus of control" concepts and consists of three scales: a) internal control, i.e. the general conviction of having self-control over one's fate, b) external control, i.e. the general conviction of being controlled by others in social situations, and c) fatalism, i.e. the general conviction that one cannot influence one's fate (this scale is restricted to non-social situations). This inventory has been found to differentiate between the effects of some therapeutic schools (Grawe, Caspar & Ambühl 1990b).

6) The German version of the Inventory of Interpersonal Problems (IIP-D) by Horowitz, Strauss & Kordy (1994) was used (together with some scales of the above described questionnaires) for the assessment of the individual's social level of functioning. Interpersonal behaviour with which the individual has difficulties or which s/he shows excessively is detected with this instrument which consists of 9 specific and 1 global scale.

7) At the beginning of a PPT, patient and therapist agree upon three to four goals, which should be pursued in the course of therapy. For repeatable process diagnostics, a specific Goal-Attainment-Scaling (GAS) questionnaire was constructed, which covers these goals. The patient is asked to assess how much closer s/he has got to (respectively farther away from) each of his/her individual goals on a

Likert scale. Utilizing this type of process diagnostics, the patient and the therapist are continuously reminded of the therapeutic goals.

8) The Bielefeld Clients Experience Sheet (“Bielefelder Klienten-Erfahrungs-Bogen“ (BIKEB)) by Höger (1993), a self-report questionnaire for patients, is also used as a process diagnostic tool, giving the therapist feedback of the way the patient experiences the quality of the therapeutic sessions and the quality of the therapeutic relationship (six scales: getting on with the therapist, getting on with oneself, experience of change, degree of experienced security and trust, degree of experienced calmness, experience of bodily relaxation vs. exhaustion). This test was also used in a modified form, covering the same items as the Original BIKEB, but instead of rating the last session, the patient was asked to rate the complete range of his/her therapy. The table shows when each questionnaire was administered.

Target variables for demonstrating effectiveness

With the above described test battery a large data collection was established, founded on up to 69 different scales. It therefore seemed necessary to determine specific variables as target variables, i.e. the demonstration of effectiveness would require “improvement“ of these specific variables. In view of the symptomatic heterogeneity of our sample, it seemed appropriate to focus on a significant “reduction of symptoms“ as well as a significant improvement of ‘therapy-related changes in the way subjects‘ experience and behave“. Accordingly, the “Global Severity Index“ of the SCL-90-R, which measures the overall amount of mental distress, and the global score of the VEV were determined as target variables.

Table I: Administration time of each test

Test	before therapy	every 4 sessions	after therapy	4-10 mths. after therapy	10 mths.-4 yrs. after therapy	4-5 yrs. after therapy
SCL-90R	x		x	x	x	x
VEV			x	x	x	x
GT	x		x	x	x	x
WIPPF	x		x	x	x	x
IPC	x		x	x	x	x
IIP-D	x		x	x	x	x
GAS		x ³	x ³	x ³	x ³	x ³
BIKEB		x ³	x ^{3,4}	x ^{3,4}	x ^{3,4}	x ^{3,4}

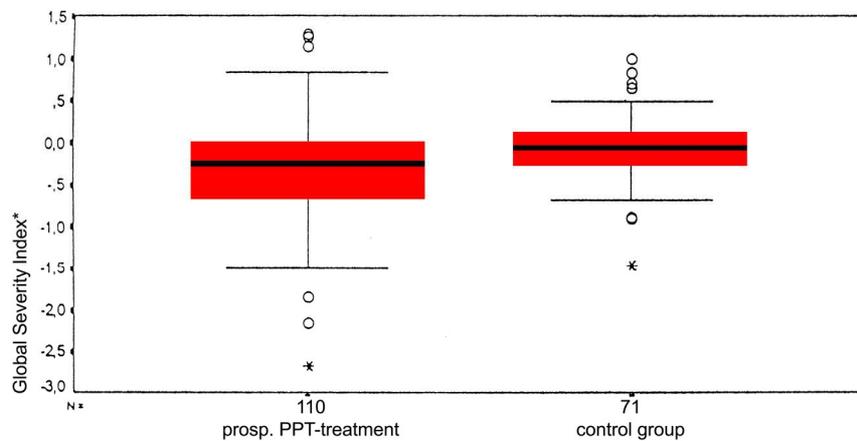
1 re-assessment; 2 post-assessment; 3 not administered to control group; 4 modified form; * in this first study phase, a different sample was used for each group of follow-up assessments (cross-sectional design).

Results

For statistical analysis of the target variables, different comparisons (t - tests) between the prospectively assessed PPT-patients and the control group were made before computing effect sizes (Hedges 1982).

With the SCL-90, a highly significant improvement of the symptoms (p .000) between pre- and post-measurement was demonstrated for PPT patients as assessed through the Global Severity Index. In

comparison, as expected, no significant differences ($p > .05$) could be found here for the control group (figure 1).

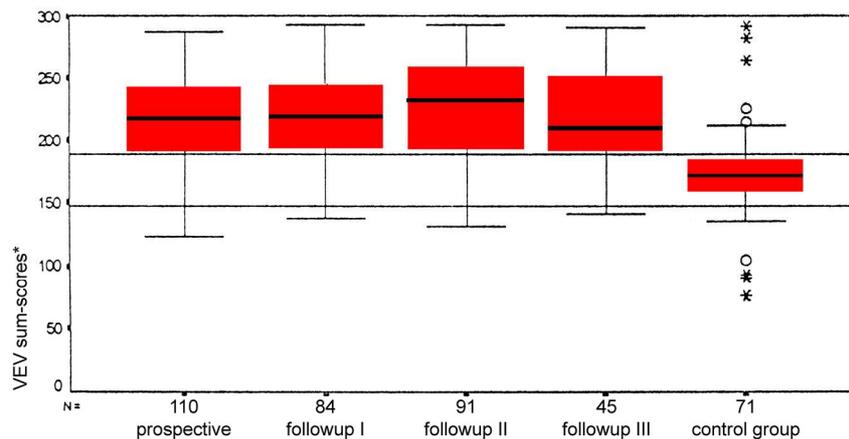


* Sum-scores: approx. 0.0 = no change between 1. and 2. assessment; scores < 0 = improvement

Figure 1: SCL 90-R. Differences between Pres- and Postassessment

In addition, comparing the pre-/post-differences of the prospectively assessed PPT patients and the control group also showed highly significant differences ($p = .002$) in favour of the PPT patients. The effect size amounted to $e = 0.476$.

The VEV is used to determine therapy induced changes in the way subjects experience and behave. This highly sensitive questionnaire was used in the post-measurement of the prospectively assessed PPT patients and the control group as well as in all retrospective data gathering. A comparison between the VEV scores of PPT patients and the control group also reveal highly significant differences ($p < .0005$), which even reached an effect size of $e = 1.24$. As expected, the results of the PPT patients showed marked improvements (figure 2).



* Sum score: < 148 = negative changes; scores from 148-188 = no change; scores > 189 = improvement

Figure 2: VEV Comparison of changes

Estimating whether the improvements found immediately after therapy stay stable for a longer period of time, the post-assessments of the prospectively investigated PPT patients and the results of the 3 different retrospectively assessed PPT patients were compared cross-sectionally. No significant differences ($p > .05$) between the immediate post and retrospective assessments could be detected - nei-

ther for the VEV ($F = 1.179$) nor for the SCL-90 ($F = 2.473$). This can be viewed as an indicator for the stability of the effects of therapy (table II).

Table II: Table of results

Group	N=	VEV Mean	VEV Stand. Dev.	SCL-90-R Mean before / after therapy +	SCL-90-R Stand. Dev. before /after therapy +
Prospective treatment group	110	215,39	34,55	1.16/0.83 (-.33)++	0,69/ 0.66 (0.64)++
Retrospect. Treatment group: 3-10 months	84	215.87	33,15	/0.68	/0.56
Retrospect. Treatment group: 10 mths. – 4 yrs.	91	224.24	40,03	0.63	/0.51
Retrospect. Treatment group: 4-5 yrs.	45	217.14	39.02	/ 0.66	/ 0.55
Prospective control group	71	172.90	34,15	0.88 / 0.81 (-.06)++	053 / 0.58 (0.40)++

+ respectively 1st / 2nd assessment of the control group.

++ (mean intra-individual differences between 1st und 2nd measurement).

Discussion and conclusions

The major objective of this study was to assess the effectiveness of PPT under conditions of everyday practice (e.g. Seligman 1995, Howard et al. 1996), as encountered by PPT clinicians working in Germany. Accordingly a design was chosen, which emphasizes external validity and attempts to ensure generalizability of findings to other clinicians, clinical settings, and patient groups situated in the same cultural context. This procedure can be contrasted with randomised clinical trials (efficacy studies), which optimise internal validity of a study, but limit its generalizability. Since the method of PPT is applied for treatment of a variety of disorders, patients with various diagnoses were included in this study, calling for the use of questionnaires covering a variety of symptoms, instead of more specific tests tailored to specific syndromes.

While acknowledging critical issues pertaining to the use of effect sizes and planning further analysis of the clinical significance of our results (e.g. Jacobson & Truax 1991), we would still like to compare descriptively the effect sizes achieved here with those reported in other studies.

In their comprehensive comparison of therapeutic schools, Grawe, Donati & Bernauer (1994) summarize the results of meta-analyses of different therapeutic outcome studies. The mean effect sizes reported in this summary for dynamic/humanistic therapies range from $e = .29$ (Nicholson Berman 1983 as cited in Grawe, Donati & Bernauer 1994) to $e = .64$ (Smith et al. 1980); for behavioural/cognitive therapies, the mean effect sizes range from $e .75$ (Nicholson & Berman 1983) to $e = 1.08$ (Shapiro & Shapiro 1983). In our effectiveness study, we found an effect size of $e = 1.24$ on the VEV (pertaining to therapeutically-induced changes in the way subjects feel and behave) and $e = .476$ on the Symptom-Checklist SCL-90R for patients treated with PPT.

While viewing the results of behavioural/cognitive therapies, one should keep in mind that these studies usually focus on relatively homogeneous samples (e.g. specific diagnostic disorders), which allows for the application of more specific questionnaires. The use of questionnaires constructed for the assessment of specific syndromes and homogeneous samples (i.e.. reduction of range) in turn tend to increase the observed effect sizes. Employing more general questionnaires (and indexes), which are necessary for the assessment of such a heterogeneous sample as in our study, entails having a variety of different items which are often inappropriate for a more or less larger part of the sample and variables with higher ranges (Jacobson & Truax 1991).

One final aspect in favour of PPT should be stressed; namely its being a form of short term therapy. The average duration of treatment for patients involved in this study was 30,5 hours.

To summarize, we conclude that respectable therapeutic gains have been demonstrated in this first study phase for patients suffering from various symptoms treated with the PPT method under normal conditions in Germany.

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