

Euthymic Therapy to Reduce Residual Symptoms of Depression and Strengthen Self-Care A Randomised Controlled Trial

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Abstract

Background: Besides morbid factors, salutary factors have been reported to strongly influence one's general state of health. The present study evaluates a psychotherapeutic intervention aimed at reducing residual symptoms of depression by strengthening self care through reinforcing individual resources and salutary factors.

Methods: 46 outpatients with (partially) remitted major depression were randomly allocated to the intervention ('Euthymic Therapy') or to the validated active control group (Psychoeducation). Treatment consisted of seven weekly sessions administered in a group format. Depression severity and self care were measured at baseline, after the intervention ($n=44$) and at three months follow-up ($n=37$).

Results: Both groups showed a significant decrease in depression severity by self rating (BDI II) and by expert rating (HAM-D-21) after the intervention and stayed stable at the three-month follow-up. Additionally, a trend of increased self-care (MR FSF) could be observed after the intervention. The groups did not differ in measures of depression or self care.

Conclusions: Results indicate that 'Euthymic Therapy' is comparably effective to psychoeducation in the treatment of residual symptoms in (partially) remitted patients with depression. As we have good evidence for the effectiveness of psychoeducation, the finding that 'Euthymic Therapy' reduces depressive residual symptoms and therefore the risk of relapse as well as this active reference treatment widens the therapeutic frame of effective group interventions in tertiary prevention (German J Psychiatry 2012; 15 (1): 15-22).

Keywords: Euthymic Therapy, psychoeducation, depression, self care, health

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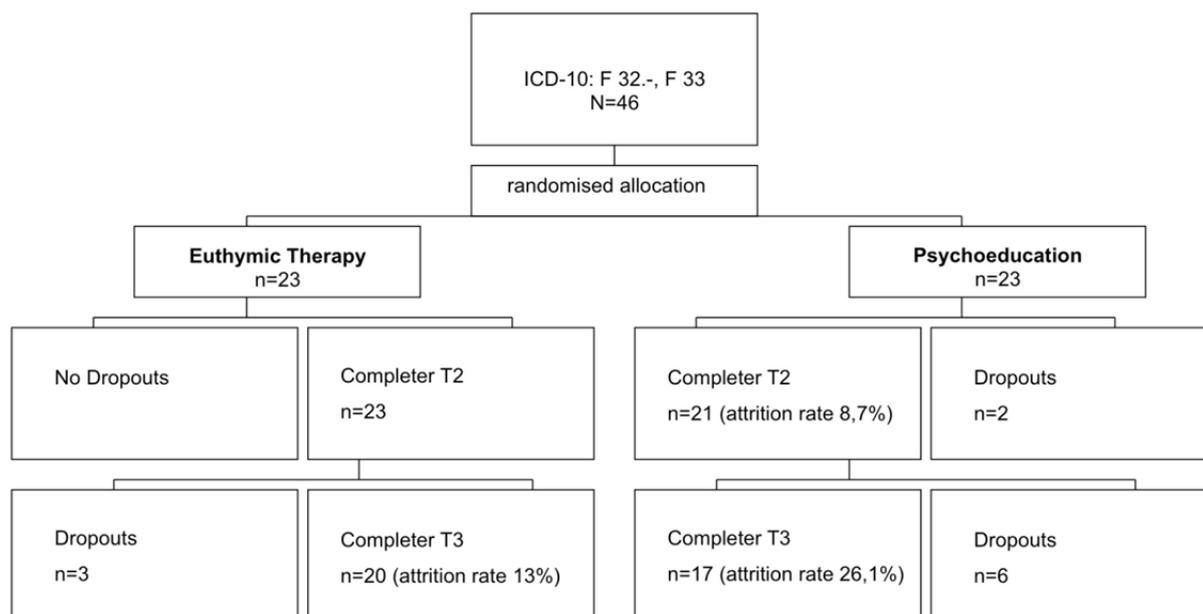
Introduction

With a lifetime prevalence of 17.1 percent (Jacobi et al., 2004), and as the primary cause of disability (Murray & Lopez, 1997), depression is a severe problem in societies worldwide. As depression is an episodic disease with an increased risk of recurrence after each new episode (Laux 2008) and often of a chronic nature (Judd et al., 1998), tertiary prevention is a crucial aspect of therapeutic intervention (Kilian & Becker, 2006). The risk of relapse is even higher when a depressive patient suffers from residual symptoms (Hardeveld et al., 2010; Rush et al., 2006a),

(Judd et al., 1999). Conversely a reduction in the residual symptoms decreases the risk of relapse significantly (Holländare et al., 2011). This supports the hypothesis, put forward by Judd et al. (1999), that the ability of cognitive behavioural therapy to prevent relapse is directly related to its capacity to remove residual symptoms. Rush et al. (2006b) claim that the goal of treatment in depression treatment should always be full remission, and thus, a key component in preventing relapse is the treatment of residual symptoms

Compared to conventional treatment approaches that focus directly on the reduction of symptoms, Hollon et al. (2002) highlight the importance of exploring new proactive strategies to prevent subsequent relapse and recurrence. In recur-

Figure 1: Study Flowchart



rence prophylaxis of psychiatric disorders, psychoeducation (PE) was developed in the context of cognitive behavioural therapy and is recommended for a diverse range of psychiatric disorders [(Behrendt & Schaub, 2005), (Mühlig & Jacobi, 2006), (Pinquart et al., 2007)]. This has been established for years and their effectiveness in the treatment of depression is well documented [(Hansson et al., 2008), (Learman et al., 2003), (Schaub et al., 2007)]. The manual we used (Pitschel-Walz et al., 2003) is a further advancement of the PE by Lewinsohn et al. (1984), which has been shown to be successful in treating and preventing new cases of major depressive disorders in two metaanalyses (Cuijpers et al. 2009, Donker et al. 2009). Participants of the PE intervention had 38% less chance of developing a major depressive disorder than those who did not participate ($p < 0.05$) (Cuijpers et al. 2009). In the six studies in which PE was compared to other psychotherapies (cognitive behavioural therapy, problem-solving therapy, interpersonal psychotherapy and counselling) the interventions achieved comparable results in the treatment of depression (Cuijpers et al. 2009). Allart van Dam et al. (2003) showed that participants undergoing PE exhibited fewer depressive symptoms one month after completion of the course when compared to a no-intervention control group. Subsequently Allart van Dam et al. (2007) concluded that PE is an appropriate intervention for participants with low initial levels of depressive symptomatology, in order to prevent depressive symptoms. Therefore in the presented study PE was considered to be an effective therapy for a control group in the treatment of (partially) remitted patients.

Euthymic Therapy (ET) is a cognitive behavioural, resource-strengthening group intervention program, which aims to increase hedonic experiences such as joy and happiness. These programs are based on theoretical models of health prevention (Antonovsky 1979). Antonovsky, a pioneer in health promotion, has notably emphasized that the health

status of a person lies on a continuum, and ranges somewhere between health and disease. Furthermore, Antonovsky suggested that salutary factors have a protective effect on an individual's health. The importance of health prevention for psychiatric diseases and resource reinforcement is now well recognized in psychology and clinical treatment (Seligman 2002). The effects of psychotherapy in the treatment of major depression have been found to be robust [(Grawe et al., 1994), (Jacobi 2006)], but often cannot be attributed to single treatment effects. As a consequence even placebo effects have been proposed [(Goldstein et al., 2000), (Grawe & Grawe-Gerber, 1999), (Grissom 1996)]. Some relevant but unspecific effects of psychotherapy have also been classified by Seligman (2005), such as providing hope, attention and trust, as well as activating personal resources and fostering strength to buffer against crises (Frank 2007). Connecting theoretical models and research findings, it can be suggested that psychotherapy not only helps via reducing symptoms, but also by strengthening the individual salutary resources of a patient. Heinz (1994) and Lutz (1995) suggested that illness and health resources should be considered orthogonal factors and Lutz (1995) proposed that psychotherapy mainly works directly on the reduction of symptoms (referred to as "factor illness"), while ET on the other hand strengthens the experience of health ("factor healthiness"). In the context of positive psychology, the so-called "broaden-and-build-theory" (Fredrickson & Joiner, 2002) has been introduced. It postulates that short-term induction of positive emotions leads to a change of habitual cognition and behaviour in the long run (Isen 1987), (Ashby et al., 1999), which can result in the increase of permanent growth resources. Resources are then committed to stimulate positive emotions and to activate an upwards spiral of self-sustained resource activation (Dick 2003; Dick-Niederhäuser, in press), (Fredrickson 2005)]. ET uses these attention-focusing effects to change short-term positive emotions into long-term personal well-being (Dick 2007). By

concentrating one's attention on positive experiences like strength and pleasure, enjoyable emotions are activated (Lutz 2000). However, to date ET has not been evaluated in the treatment of affective disorders, although surveys with nurses or psychotherapists have previously suggested the effectiveness of ET in clinical practice [(Scheibner 2003), (Stahlmann 2005)]. Some unpublished studies with small sample sizes suggest that ET is effective for patients with various psychiatric diagnoses [(Bausch 1984), (Brotzler 1983), (Koppenhöfer 1990), (Menzel 1987), (Schendel 1994), (Schneider 1983), (Volkwein 1987), (Zornek 1994)]. However, a randomized controlled study assessing the clinical effects of ET has not yet been performed. Our project thus aimed to assess the effects of ET on depressive symptoms and resources in a randomized, controlled, parallel-group design. We expected ET to reduce depressive residual symptoms and improve self care (Hoffman et al., 2008) as effectively as the validated reference treatment (PE).

Methods

Study overview

This study was designed as a randomised, controlled clinical trial. Assessments were made at least one week before (baseline=T1) and one week after (T2) the psychotherapeutic group intervention period as well as on a follow-up visit three months after the last therapy intervention (T3). ET was performed based on the manual by Koppenhöfer (2004). For the active control group, a PE manual frequently used in Germany was applied (Pitschel-Walz et al., 2003). Both treatments were conducted over seven weeks of weekly 60-minute sessions, and were offered in small groups of a maximum of eight patients. In both intervention groups, treatment was provided by the same trained cognitive behavioural therapist, who had over six years of experience with both treatments. Standards of good clinical practice were strictly adhered to.

Interventions

The active comparator condition consisted of participation in the PE group therapy which was designed by Pitschel-Walz et al. (2003) for people with unipolar depression. The course is a cognitive behavioural intervention that teaches the participants information about depressive disorder and its symptoms, causes and treatment options, and techniques to influence their mood and to enhance their coping skills, enabling them to deal with the problems related to their depressive symptoms. Sessions aimed to build up participants' autonomy and teach them recognize and cope with signs of an upcoming episode. As ET works through the implementation of positive internal and external perception by activating and training the physical sensations of a patient, the first step is to build up an adequate positive sensation to feel more joy and happiness in everyday life. In experimental

phases the therapist uses potentially pleasant materials, such as fresh herbs or mottled oranges, in order to activate for example the sense of smell. Each lesson is dedicated to one of the five senses (smell, taste, sight, touch or hearing) and the patient selects sensual input that he judges as helpful in a certain situation. Participants are encouraged to explore and to talk about joyful sensory perceptions and memories aroused through the stimulation of their senses. Positive imagery helps to integrate the new sensory experiences. In the long term, participants experience strengthened emotional and cognitive well being. In particular, the program aims to strengthen participants' self-care (Lutz 2007). Improved ability to reflect introspectively is proposed to empower participants to sense their needs more precisely. Training in sensing and judging personal needs for health is key to increasing self-care, and therefore represents the central focus of ET. The transfer of these newly learned skills into participants' everyday lives is of great importance, and is achieved by practicing these tasks between the weekly sessions at home. The program is described in a manual by Koppenhöfer (2004).

Participants

The study population was estimated a priori at 44 patients, in order to achieve a medium effect size ($f = 0.25$) and ensure a power of 95 percent.

In the present study we included either patients who showed a response (50% reduction in baseline severity) assessed by the Hamilton-21 (HAMD-21) rating scale, or patients in remission (HAMD-21 ≤ 9) but still reporting residual symptoms. Of 54 people assessed, 46 outpatients met the above criteria of (partially) remitted major depression (ICD-10: F32, F33) and were included. Drug treatment-as-usual was continued, and it was ensured that no change in medication occurred within two weeks prior to the start of the group intervention. Participants were excluded if they had a history of bipolar disorder, cyclothymia, schizophrenia, schizoaffective disorder, organic brain damage or substance abuse/dependence. Participation in a pharmaceutical study and ongoing individual psychotherapy were further exclusion criteria as well as borderline (ICD-10: F60.3) or antisocial personality disorders (ICD-10: F60.2).

The local ethical review board approved the survey. All patients gave fully informed written consent to participate in the study. The 46 participants were randomly allocated to the ET group ($n=23$) and to the PE group ($n=23$) by a study unrelated person. In the intervention condition (ET), all 23 completed the intervention and post-intervention assessments and 20 completed the follow-up assessments three month later. In the control group 21 completed the PE and post-intervention assessments and 17 completed the follow-up assessments.

Clinical Measurements

For all treatment groups, blinded and trained clinical psychologists conducted the assessments. The diagnosis of

depression was confirmed with the Structured Clinical Interview for DSM-IV (SCID-I), a fully structured diagnostic interview for the assessment of mental disorders (Wittchen et al., 1997). Comorbid personality disorders were assessed using the SCID-II (Fydrich et al., 1997). At baseline, clinical and sociodemographic characteristics were assessed using a systematic basic assessment scale of clinical and sociodemographic variables in psychiatry (Cording et al., 1995).

Depression severity was measured by self rating with the BDI-II (Beck et al., 1996) as well as by expert rating with the HAMD-21 (Hamilton, 1960). Self care was self-rated using a questionnaire created to measure degree of self care and ability to experience pleasure [Marburg self-care questionnaire, MR FSF (Lutz 1999, unpublished)].

The MR FSF measures participants degree of self care and ability to experience pleasure. The self-rating was normed by a group of 900 patients with pain disorder. Internal consistency of the MR FSF is estimated to have a Cronbach's alpha score of .93. Factor analysis show that items can explain sixty percent of the variance.

Statistical Analysis

SPSS (Statistical Package for Social Science) Version 16.0 was used for conducting statistical analyses. Descriptive statistics included frequencies and percentages for categorical variables, mean and standard deviations. G*power 3 which performs high-precision statistical power analyses was used to analyze the quality of the design (Faul et al., 2007). As Cohen (1988) suggests effect size was interpreted as small ($r=.1$) medium ($r=.3$) and large ($r=.5$). Data were analysed by a 2 (intervention group, control group) x 3 (T1, T2, T3) repeated-measures ANOVA for all measures, treating timepoints as within-subject factors (Bortz 1999). To examine the data for our depression measures, we also analysed the data by pairwise comparisons, adjusting for multiple comparisons. In case of inequalities of covariances, corrections were used before interpreting the data. For our analysis we used a per-protocol approach.

The between-within power analysis by g*power 3 for a medium effect for a sample size of 37 indicate the power (1-beta) of the repeated measure analysis to be 91 percent. For depression measures (BDI-II and HAMD-21) we adjusted the alpha level to .025, taking into account the fact that they measure the same psychological construct.

Results

Sample descriptions

The study included 46 (partially) remitted outpatients with major depression (ICD-10: F32.-, F33). 44 patients were assessed at T2. Assessment of 37 participants was successfully performed at the three-month follow-up (T3). Prior to the intervention, patients in the control and intervention groups

did not differ significantly with respect to any of the following socio-demographic variables: gender, education, marital status, prior hospitalisation episode, prior psychotherapy, relapse within three years, suicidal activity, present contact to a psychiatrist, and present antidepressant drug treatment. 20% of the patients received no psychiatric medication. The remaining 80% had pharmacological treatment as follows: 38% antidepressant monotherapy, 27% combination of two antidepressants, 8% combination of antidepressant and mood stabilizer, 5% combination of antidepressant and atypical neuroleptic and 2% combination with others. Table 1 summarizes the clinical and socio-demographic characteristics of the sample. With respect to these variables included to reduce potentially confounding factors, the two study groups were comparable before the intervention period (see Table 2).

Table 1. Socio-demographic variables for study population and intervention groups, means with standard deviations in claims

Variables	Study Population M (SD)	Euthymic Therapy M (SD)	Psycho-education M (SD)
Female	0.70 (0.44)	0.65 (0.49)	0.77 (0.44)
High Education ^a	0.43 (0.50)	0.40 (0.50)	0.47 (0.52)
Single	0.81 (0.40)	0.80 (0.41)	0.82 (0.39)
Prior Hospitalisation Episode ^b	0.62 (0.49)	0.60 (0.50)	0.65 (0.49)
Prior Psychotherapy	0.78 (0.42)	0.85 (0.37)	0.47 (0.47)
Suicidal Actions	0.19 (0.40)	0.10 (0.31)	0.29 (0.47)
Present Contact to Psychiatrist	0.76 (0.44)	0.65 (0.49)	0.88 (0.33)
Antidepressant medication	0.81 (0.40)	0.70 (0.47)	0.88 (0.34)

Data were collected at pre-testing (T1). All variables have been dichotomized (min = 0; max = 1). No significant group differences could be found using the t-test for two independent samples.

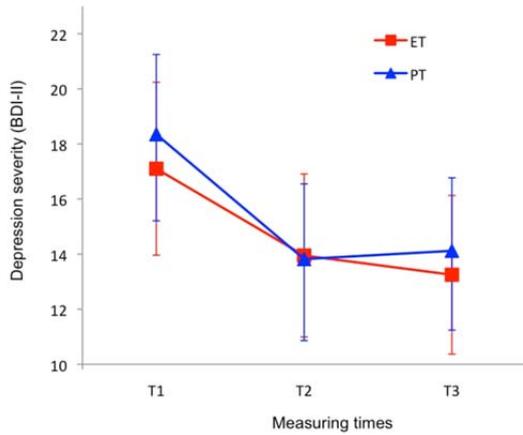
^aThe high education variable includes everyone with a high school degree (German 'Abitur') or more.

^bVariable 'Prior Hospitalisation Episode' only includes those concerning the treatment of MDE.

Response to treatment

The BDI-II was used to measure participants' depressive symptoms via self-report. A reduced alpha was chosen with .025. Box's test of Equality of Covariance Matrices showed that variances are not equal across groups (Box's $M = 20.281$, $p = .005$). After adjustment for these inequalities with Greenhouse-Geisser corrections, the within-subject effects showed a medium significant main effect for measure points ($F(1.674) = 5.668$, $p = .008$, $r = .37$). The group effect showed no significance ($F(1) = 0.031$, $p = .861$, $r = .03$). No

Figure 2: Changes of depression severity (BDI-II: Beck Depression Inventory-II, self-rating) over three measurement occasions (T1, T2, T3) in Euthymic therapy (ET) and Psychoeducation (PE).

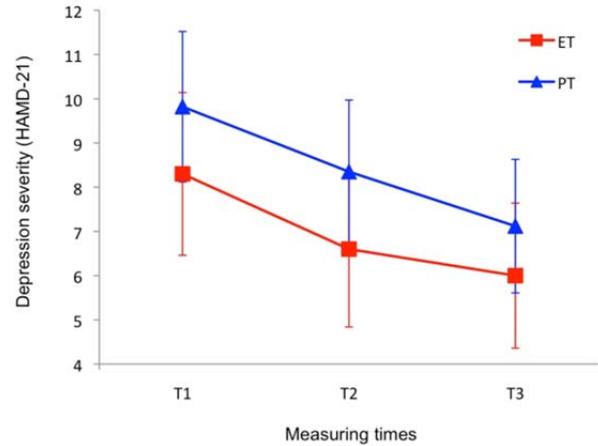


interacting effect with the group variable was found ($F(1.674) = 0.138, p = .835, r = .06$). Means and standard deviations are shown in Table 2.

Pairwise comparisons of the marginal means show a medium effect size ($r = .45$), a significant mean difference from T1 to T2 of 3.84 ($p = .017$) and a trend from T1 to T3 with a mean difference of 4.043 points ($p = .050$) controlling for multiple comparisons (Figure 2).

The HAMD-21 interview was used to measure depression severity by expert rating. For Analysis a reduced alpha of .025 was chosen. The Box's test of Equality of Covariance Matrices showed that variances were not equal across groups (Box's $M = 27.937, p = .000$). After adjustment of these

Figure 3: Changes of depression severity (HAMD-21: Hamilton Rating Scale for Depression, 21 items) across three measurement occasions (T1, T2, T3) in Euthymic therapy (ET) and Psychoeducation (PE).



inequalities with Hyndt-Feldt corrections, the within-subject effects showed a significant main effect of medium effect size comparing measure points ($F(1.857) = 4.282, p = .020, r = .33$). Group effects were not significant ($F(1) = 0.462, p = .501, r = .11$). Once again no interacting effect with the group variable was found ($F(1.857) = 0.069, p = .922, r = .045$) (Figure 3). Means and standard deviations are shown in Table 2. Analysing the development by pairwise comparisons showed a trend from T1 to T3 ($F(1) = 2.503, p = .059$).

Results regarding self care

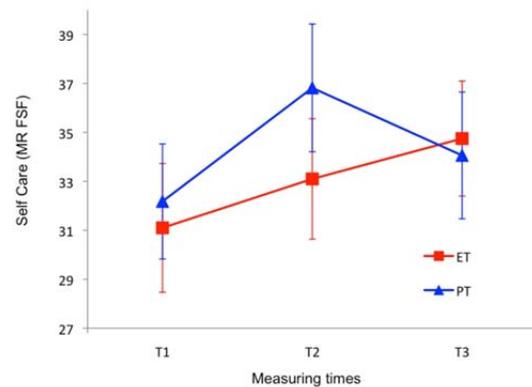
For self care, the Box's test of Equality of Covariance Matrices showed that variances were equal across groups (Box's $M = 11.732, p = .101$). Measure time points showed a trend towards improvement ($F(2) = 2.836, p = .065, r = .27$). No interaction effects with the group variable can be reported ($F(2) = 1.105, p = .337, r = .18$), although the graph visualizes a slightly different pattern of changes for both groups (Figure 4). The group effect shows no statistical significance for

Table 2. Clinical variables for study population and intervention groups, means with standard deviations in claims and confidence intervals

Variables	Euthymic Therapy		Psychoeducation	
	M (SD)	[95% CI]	M (SD)	[95% CI]
BDI-II, T1	17.10 (13.28)	0.11–0.22	18.35 (12.55)	0.12–0.25
HAMD-21, T1	8.30 (8.66)	0.05–0.12	9.82 (6.11)	0.05–0.12
MR FSF, T1	31.10 (15.98)	0.25–0.38	32,18 (11.88)	0.25–0.39
BDI-II, T2	13.95 (12.56)	0.08–0.19	13.82 (11.80)	0.08–0.20
HAMD-21, T2	6.60 (7.44)	0.03–0.10	8.35 (7.00)	0.05–0.12
MR FSF, T2	33.10 (16.31)	0.26–0.40	36,82 (15.20)	0.29–0.45
BDI-II, T3	13.25 (11.15)	0.08–0.19	14.12 (12.65)	0.08–0.20
HAMD-21, T3	6.00 (7.69)	0.03–0.09	7.12 (5.40)	0.04–0.10
MR FSF, T3	34.75 (16.30)	0.28–0.42	34,06 (14.85)	0.26–0.42

Abbreviations: BDI-II: Beck Depression Inventory-II, HAMD-21: Hamilton Rating Scale for Depression-21, MR FSF: Marburg self-care questionnaire.

Figure 4: Changes of Self Care (MR FSF) over three measurement occasions (T1, T2, T3) in Euthymic therapy (ET) and Psychoeducation (PE)



the MR FSF measure ($F(1) = 0.084, p = .774, r = .14$). Means and standard deviations are shown in Table 2.

Discussion

Both therapeutic interventions lead to a reduction in self-reported (BDI-II) and observed (HAMD-21) depressive residual symptoms. This effect was found after the intervention period, remaining relatively stable over a three-month period, during which no further treatment was given. This suggests that for reducing depressive residual symptoms both approaches achieve the same effect: increasing patients' resources without focusing on symptoms is equally effective as the conventional symptom oriented approach. The therapeutic range can be widened using ET and reach more patients in the phase between response and recovery. The importance of therapeutical range for the treatment of residual symptoms is obvious as this is a key component in preventing relapse in the treatment of depression (Rush et al., 2006b).

Regarding self-care, ET showed a superior effect, as compared to PE. While both therapies were effective in increasing self care, their respective courses of response differed. Interestingly, PE was associated with a faster increase in self-care, followed by a reduction at T3. This may be explained by psychoeducational procedures, which directly encourage positive activities in the last sessions. A direct effect of session six in the participants' self measure at T2 one week later could be demonstrated. The graph also shows a drop in self-care behaviour three months later for the same group. The reduction of self-care behaviour in the PE group may have been caused by participants who had not internalized self-care behaviour, and therefore failed to maintain the changes. We find a somewhat different pattern for ET participants: self care continued to increase steadily, even up to the three month follow-up visit (T3). This result supports the theory of the upwards spiral of positive emotions and resources [(Dick 2003), (Dick-Niederhäuser in press), (Fredrickson 2005)]. It might take longer for participants to internalize self-care behaviour, as the therapy starts with the basic intervention of changing sensations and creating positive emotions. Thus, a learning process might have initially started during the therapy, and eventually lead to autonomic, more generalized self-care behaviour in the natural environment. Further studies with longer follow-up may give proof to this hypothesis. There appear to be some motivational advantages of ET over PE: If the dropout rate of the study is taken into account, we find stronger participant compliance to ET. During the intervention period, two PE participants dropped out, while none of the ET participants left treatment. Although participants were not required to state the reason for their leaving, explanations were always given, such as "I do not always want to think and talk about my illness" or "after the group session my mood becomes worse than before". After T2, the dropout rates were similar for both groups (ET = 3 patients; PE = 4 patients). These data indicate a small advantage for ET during treatment.

Limitations: The sample size is relatively small. To ensure a power of 95 % the sample size was estimated a priori at 44 patients. Nevertheless, our measurements with only 37 participants still yielded a power of 91%. Our study examined patients who showed a significant response to previous treatment (50% reduction of symptoms) as well as patients in remission who still reported residual symptoms, which constitutes a somewhat heterogeneous population that is nevertheless quite representative for patient status following inpatient treatment. Hence, our population is quite representative for ambulant patient-centered care. The results can not be generalized to acutely ill patients or to other mental illnesses. The limited time of follow-up may provide hints concerning the further course of illness, but is too short to detect an effect on relapse prevention. We can only deduce through the literature that reduction of residual symptoms decreases the risk of relapse significantly (Holländare et al., 2011).

In conclusion, results show that ET reduces residual depressive symptoms as effectively as PE. The study suggests that ET can strengthen a patient's compliance to therapy. Furthermore, results indicate a self-care promoting effect, which tends to be longer lasting for ET. A long term follow-up appears to be necessary in order to determine the long-term effects of ET.

References

- Allart van Dam E, Hosman CMH, Hoogduin CAL, Schaap CPDR. Prevention of depression in subclinically depressed adults: Follow-up effects on the 'Coping with Depression' course. *J. Affect. Disord.* 2007;97:219-228
- Antonovsky A. Gesundheitsforschung versus Krankheitsforschung. In: Franke A & Broda M (eds.) *Psychosomatische Gesundheit. Versuch einer Abkehr vom Pathogenese-Konzept.* Tübingen: DGVT 1993:3-14
- Ashby FG, Isen AM, Turken AU. A neuropsychological theory of positive affect and its influence on cognition. *Psychol Rev.* 1999;106(3):529-550
- Bausch I. Das Selbstbild depressiver Patienten in Abhängigkeit von angewandter Therapie. Unpublished Diplomarbeit. Universität Heidelberg 1984
- Beck AT, Steer R, Brown GK. *Manual for Beck Depression Inventory-II.* San Antonio TX: Psychological Corporation 1996
- Behrendt B, Schaub A. *Psychoedukation und Selbstmanagement.* Tübingen: DGVT 2005
- Bortz J. Versuchspläne mit Messwiederholungen. In J. Bortz (ed), *Statistik für Sozialwissenschaftler*, 5. Aufl. Berlin: Springer 1999:321-346
- Brotzler D. Empirische Untersuchung eines Therapieprogramms zur Entwicklung von "Genußfähigkeit" bei Depressiven. Unpublished, Diplomarbeit. Universität Heidelberg 1983
- Cohen J. *Statistical Power Analysis for the Behavioral Sciences*, 2. Aufl., Hillsdale: Erlbaum 1988

- Cording C, Gaebel W, Spengler A. Die neue psychiatrische Basisdokumentation. Eine Empfehlung der DGPPN zur Qualitätssicherung im (teil-)stationären Bereich (The new psychiatric basic documentation. A recommendation by the DGPPN for quality assurance in inpatient treatment). *Spektrum Psychiatrie Nervenheilkunde* 1995;3-41
- Cuijpers P, Muñoz RF, Clarke GN, Lewinsohn PM. Psychoeducational treatment and prevention of depression: the "Coping with Depression" course thirty years later. *Clin Psychol Rev.* 2009;29:449-58
- Dick-Niederhäuser A. Therapeutic change and the experience of joy: Toward a theory of curative processes. *J Psychother Integ.* in press
- Dick A. Psychotherapie und Glück. Quellen und Prozesse seelischer Gesundheit. Bern: Hans Huber 2003
- Dick A. Durch Psychotherapie Freude, Vergnügen und Glück fördern. In: Frank R (ed) *Therapieziel Wohlbefinden. Ressourcen aktivieren in der Psychotherapie* Heidelberg: Springer; 2007:44-53
- Donker T, Griffiths KM, Cuijpers P, Christensen H. Psychoeducation for depression, anxiety and psychological distress: a meta-analysis. *BMC Med.* 2009;7:79
- Faul F, Erdfelder E, Lang AG, Buchner A. G*Power 3: a flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behav Res Methods* 2007;39:175-191
- Frank R. Therapieziel Wohlbefinden. Ressourcen aktivieren in der Psychotherapie. Heidelberg: Springer 2007
- Fredrickson BL. Positive Emotions. In: Snyder CR, Lopez SJ (eds), *Handbook of positive psychology.* Oxford, New York: Oxford University Press; 2005:120-134
- Fredrickson BL, Joiner T. Positive emotions trigger upward spirals toward emotional well-being. *Psychol Sci.* 2002;13:172-175
- Fydrich T, Renneberg B, Schmitz B, Wittchen HU. SKID-II. Strukturiertes Klinisches Interview für DSM-IV. Achse II: Persönlichkeitsstörungen. Interviewheft. Göttingen: Hogrefe 1997
- Goldstein AJ, de Beurs E, Chambless DL, Wilson KA. EMDR for panic disorder with agoraphobia: comparison with waiting list and credible attention-placebo control conditions. *J Consult Clin Psychol.* 2000; 68:947-956
- Grawe K, Grawe-Gerber M. Ressourcenaktivierung. Ein primäres Wirkprinzip der Psychotherapie. *Psychotherapeut.* 1999;44:63-73
- Grawe K, Donati KR, Bernauer F. Psychotherapie im Wandel – von der Konfession zur Profession. Göttingen: Hogrefe 1994
- Grissom RJ. The magical number .7 +/- .2: meta-meta-analysis of the probability of superior outcome in comparison involving therapy, placebo, and control. *J Consult Clin Psychol* 1996;64:973-982
- Hamilton M. A rating scale for depression. *J Neurol Neurosurg Psychiatry* 1960;23:56-62
- Hansson M, Bodlund O, Chotai J. Patient education and group counselling to improve the treatment of depression in primary care: A randomized controlled trial. *J. Affect. Disord.* 2008;105:235-240
- Hardeveld F, Spijker J, De Graf R, Nolen WA, Beekman A. Prevalence and predictors of recurrence of major depressive disorder in the adult population. *Acta Psychiatr Scand.* 2010;122:184-191
- Heinz A. Der Begriff seelischer Gesundheit. Arbeit zur Erlangung des Magister Artium in Philosophie und Soziologie, Freie Universität Berlin 1994
- Hoffmann N, Hofmann B. Selbstfürsorge in der Psychotherapie. In: Hoffmann N, Hofmann B (eds) *Selbstfürsorge für Therapeuten und Berater.* Weinheim, Basel: Beltz 2008:12-25
- Holländare F, Johnson S, Randestad M, Tillfors M, Carlbring P, Andersson G, Engström I. Randomized trial of Internet-based relapse prevention for partially remitted depression. *Acta Psychiatrica Scandinavica.* 2011; 124:285-294
- Hollon SD, Thase ME, Markowitz JC. Psychosocial Intervention Development for the Prevention and Treatment of Depression: Promoting Innovation and Increasing Access. *Biol Psychiatry* 2002;52:610-630
- Isen AM. Positive affect, cognitive processes and social behavior. In: Berkowitz L (ed) *Advances in Experimental Social Psychology.* New York: Academic. 1987:203-253
- Jacobi F, Klose M, Wittchen HU. Psychische Störungen in der deutschen Allgemeinbevölkerung: Inanspruchnahme von Gesundheitsleistungen und Ausfalltage. *Bundesgesundheitsblatt - Gesundheitsforschung - Gesundheitsschutz* 2004;47:736-744
- Jacobi F. Entwicklung und Beurteilung therapeutischer Interventionen. In: Wittchen HU, Hoyer J(eds), *Klinische Psychologie und Psychotherapie* Berlin: Springer; 2006:554-580
- Judd LL, Paulus MP, Zeller P. The role of residual sub-threshold depressive symptoms in early episode relapse in unipolar major depressive disorder. *Arch Gen Psychiatry.* 1999;56:764-765
- Judd LL, Akishal HS, Maser JD, Zeller PJ, Endicott J, Coryell W, Paulus MP, Kunovac JL, Leon AC, Mueller TI, Rice JA, Keller MB. A prospective 12-year study of subsyndromal and syndromal depressive symptoms in unipolar major depressive disorders. *Arch Gen Psychiatry.* 1998;55:694-700
- Kilian R, Becker T. Die Prävention psychischer Erkrankungen und die Förderung psychischer Gesundheit. In: Kirch W, Badura B (eds) *Prävention. Ausgewählte Beiträge des nationalen Präventionskongresses.* Heidelberg: Springer; 2006:443-472
- Koppenhöfer E. Therapie und Förderung genussvollen Erlebens und Handelns. In: Zielke M, Mark N (eds) *Fortschritte der angewandten Verhaltensmedizin.* Heidelberg: Springer; 1990:250-263
- Koppenhöfer E. *Kleine Schule des Genießens.* Berlin: Pabst 2004
- Laux G. Depressive Störungen. In: Möller HJ, Laux G, Kapfhammer HP (eds) *Psychiatrie und Psychotherapie* Heidelberg: Springer; 2008:399-470
- Learman LA, Gerrity MS, Field DR, van Blaricom A, Romm J, Choe J. Effects of a depression education program on residents knowledge, attitudes and clinical skills. *Obstetrics and gynecology* 2003;101:167-174
- Lewinsohn PM, Antonuccio DO, Breckenridge JS, Teri L. The 'Coping with Depression' course. Eugene: Castalia Publishing Company 1984

- Lutz R. Euthyme Therapie und Salutogenese. In: Frank R (ed) Therapieziel Wohlbefinden. Ressourcen aktivieren in der Psychotherapie. Heidelberg: Springer; 2007:55-68
- Lutz R. Euthyme Therapie. In: Margraf J (ed) Lehrbuch der Verhaltenstherapie, 1. Berlin: Springer; 2000:167-182
- Lutz R, Mark N. Wie gesund sind Kranke? Göttingen: Hogrefe 1995
- Menzel S. Therapieprogramm zum Aufbau positiven Erlebens und Verhaltens bei Depressiven – eine empirische Untersuchung. Unpublished Diplomarbeit. Institut für Psychologie der Westfälischen Wilhelms-Universität Münster 1987
- Metzler P, Krause B. Methodischer Standard bei Studien zur Therapieevaluation. *Methods of Psychological Research* 1997;2:55-67
- Murray CJL, Lopez AD. Global mortality, disability, and the contribution of risk factors: Global Burden of Disease Study. *Lancet* 1997;349:1436-1442
- Mühlig S, Jacobi F. Psychoedukation. In: Wittchen HU, Hoyer J (eds), *Klinische Psychologie & Psychotherapie*. Heidelberg: Springer; 2006:543-550
- Pinquart M, Duberstein PR, Lyness JM. Effects of Psychotherapy and other behavioral interventions on clinically depressed older adults: A meta-analysis. *Aging & Mental Health* 2007;11:645-657
- Pitschel-Walz G, Bäuml J, Kissling, W. *Psychoedukation Depressionen*. München, Jena: Urban & Fischer 2003
- Rush A, Trivedi MH, Wisniewski SR. Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR*D report. *Am J Psychiatry* 2006a;163:1905–1917
- Rush A, Kraemer HC, Sackeim HA. Report by the ACNP task force on response and remission in major depressive disorder. *Neuropsychopharmacology* 2006b;31:1841–1853
- Schaub A, Kopinke J, Neusser A, Charypar M. Kognitiv-psychoedukative Gruppenintervention bei stationären Patienten mit depressiven Erkrankungen – Ergebnisse einer prospektiven Pilotstudie. *Verhaltenstherapie* 2007;17:167-173
- Scheibner G. Genuss-„Therapie“ in der Psychiatrie. *Psych Pflege* 2003;9:150-152
- Schendel M. Genußtherapie bei chronifizierten Alkoholikern. Unpublished thesis. Technische Universität Braunschweig 1994
- Schneider A. Euthymes Verhalten und Erleben: Eine Pilotstudie – Zusammenhänge mit Merkmalen sozialer Integration. Unpublished thesis. Fachbereich Psychologie der Philipps-Universität Marburg 1983
- Seligman MEP. Foreword: The Past and Future of positive psychology. In: Keyes CLM, Haidt J (eds) *Flourishing. Positive psychology and the life well-lived* Washington: APA 2002:XI-XV
- Seligman MEP. Positive psychology, positive prevention and positive therapy. In: Snyder CR, Lopez SJ (eds) *Handbook of positive psychology*. Oxford: Oxford University Press; 2005:3-9
- Stahlmann S. Wie viel Raum bleibt dem Genuss? Euthyme Behandlungsmaßnahmen bei alkoholabhängigen Patienten. *Psych Pflege*, 2005;11:23-30
- Van Gent EM, Zwart FM. Psychoeducation of partners of bipolar-manic patients. *J. Affect. Disord.* 1991;21:15-18
- Volkwein H. Die Förderung positiven Erlebens bei Patienten einer orthopädischen Fachklinik: Führen positive Lebensereignis auch zu positiven Selbstbeschreibungen? Unpublished thesis. Fachbereich Psychologie der Phillips-Universität Marburg 1987
- Wittchen HU, Zaudig M, Fydrich T. SKID: Strukturiertes Klinisches Interview für DSM-IV, Achse II. Göttingen: Hogrefe 1997
- Wittchen HU, Wunderlich U, Gruschwitz MS, Zaudig M. SKID-I, Strukturiertes Klinisches Interview für DSM-IV. Göttingen: Hogrefe 1997
- Zornek G. Empirische Untersuchung zur Wirksamkeit von Gruppentherapie im stationären Setting unter besonderer Berücksichtigung der Genussgruppe. Unpublished thesis. Psychologisches Institut der Ruprecht-Karls-Universität Heidelberg 1994