29 Communication with Chronically Physically Ill Patients

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> Studies across various diseases indicate adherence levels are lower when patients have both depression and chronic illness.
>
> Haskard-Zolnierek, Williams 2014: 456

Abstract: Communication with chronically physically ill patients, such as coronary heart disease (CHD) or diabetes mellitus, places significantly different demands on the physician than with acute diseases. Whereas in acute cases the focus is on a goal-oriented, explorative and empathically supportive approach to the symptoms and therapy, communication with the chronically ill requires a much more comprehensive focus. In addition to the symptoms (which are usually less pronounced than in acute cases) and (long-term) drug therapy, aspects such as long-term emotional coping with the disease and lifelong demands on

health behavior must be addressed through communication, because their success is of central importance for quality of life and prognosis. In this context, the individual facets of health literacy, coping with illness, and life situation should be surveyed in particular. Maladaptive denial, certain psychosocial risk factors, and mental comorbidities represent significant barriers to successful disease management and adaptive health behaviors and should be addressed through appropriate communicative approaches. The chapter introduces useful communicative techniques with numerous concrete examples.

29.1 Introduction

Communication with patients suffering from a physical illness is part of the everyday professional life of physicians. Therefore, the topic is basically touched upon in all chapters of this book. However, to present a "specific" chapter here requires an introductory justification:

Even confronting an *acute* physical illness (e.g., an acute myocardial infarction) is a challenge for anyone. In addition to the need to cope with acute symptoms such as pain and shortness of breath (or their residuals under therapy), patients are burdened above all by uncertainty as to what their cause is. Depending on the type of symptomatology and the diagnosis (rather "benign" or "malignant") - which, moreover, is only established by more or less intrusive diagnostics - all those affected therefore experience an immediate mental reaction, which can range from relative equanimity to complete flooding with anxiety (so-called "acute stress reaction").

In acute illnesses (provided the patient is conscious), the communicative requirements for physicians consist of both purposeful-explorative and *empathic-supportive* conversation (§ 20, 21), both to enable a rapid diagnosis and to support the patient in coping with the acute symptoms.

Characteristic of acute diseases, however, is their time-limited course, so that - if death or post-acute disability does not occur quickly - complete healing or disappearance of the (acute) symptoms occurs with or possibly without therapy. Typically, this "benign" course is accompanied by a "spontaneous" decrease of mental stress.

The situation is different in the case of *chronic* diseases or diseases that, after initial acute manifestation, develop into a chronic or chronic-recurrent, lifelong course. Examples of this group are the "common dis-

eases" coronary heart disease (CHD) and diabetes mellitus type 2, as well as bronchial asthma, chronic obstructive pulmonary disease (COPD), arterial hypertension, rheumatoid arthritis and several other diseases from almost all medical fields. Here, in contrast to acute diseases, there is never a complete cure. Although patients are often (relatively) symptom-free, they remain ill for life and usually also require lifelong treatment, which places considerably different or greater demands on *emotional, cognitive* and *action-related coping with illness* than is the case with acute illnesses.

The example of CHD will be used to illustrate how the relationship between acute and chronic forms of progression can be: Acute manifestations (such as myocardial infarction) are possible, but more frequent are "subacute" symptoms such as (stable) angina pectoris ("chest tightness"). After treatment (e.g., Percutanous Coronary Intervention, PCI), angina pectoris often disappears, but "chronic CHD" persists in the form of atherosclerosis of the coronary arteries with the lifelong risk of (re)occurrence of subacute or acute symptoms. Since CHD is based on a complex set of causes consisting of *biological* (e.g., dyslipidemia), *behavioral* (e.g., smoking), and *psychosocial* (e.g., "chronic stress") factors, the longer-term prognosis is largely dependent on whether it is possible to influence all relevant factors as favorably as possible (Albus et al. 2019, Albus, Haass 2022, Albus et al. 2022, BÄK et al. 2024).

This results in extended requirements for doctor-patient communication: in addition to mastering any acute situations (see above), in chronic diseases such as CHD it is above all a matter of recording and taking into account the individual overall *biopsychosocial* constellation (§ 4).

This includes, in particular, promotion of health literacy (especially understanding of causes and treatment of the disease), *coping with illness* (e.g., "denial" vs. "active coping") and *health behavior* (e.g., not smoking, healthy diet, appropriate exercise, adherence to medication) against the background of the individual *psychosocial constellation* (e.g., level of education, income, extent of social support, psychosocial risk factors). In up to one third of patients with chronic physical diseases, symptoms of *psychological comorbidity* (e.g., depression, anxiety disorder) (§ 30, 31) are also present, which should be identified and treated as early as possible (Albus et al. 2019, Albus et al. 2022, Kulzer et al. 2023).

All diagnostic and therapeutic measures that go beyond the immediate doctor-patient discussion also require *participatory decision-making*.

Since this topic has already been dealt with intensively in other chapters of the handbook (§ 10, 22, 26), it will be taken up and specified here only under the aspect of motivation, which is significant for the patient's subsequent adherence.

29.2 Establishing a relationship

Patients with chronic illnesses benefit greatly from a sympathetic and active approach in order to build a strong therapeutic relationship. Many patients need concrete emotional, educational and practical support in order to cope with the lifelong demands of their illness. The physician, as the primary contact person for physical illnesses, is usually considered to have a special competence to be helpful in this regard.

With most patients, it is possible to establish a helpful therapeutic relationship without major problems after taking into account the general maxims of medical conversation (§ 17-23). However, patients with *maladaptive* health behaviors, e.g., persistent smoking or medication *nonadherence*, present special challenges to the physician. Talking with these patients can be difficult, as it is typically characterized by a strong negative affect toward the disease and its treatment. This can lead to great skepticism and, in some cases, latent or openly aversive behavior toward the physician.

In the initial interview and in the follow-up appointments, great importance should therefore be attached to building up the therapeutic relationship. To this end, the main recommendations for conducting the interview were given in advance (§ 3, 17-18), which will be deepened and extended below: It is of utmost importance, especially in the case of patients with *maladaptive* health behavior, that the physician does not appear as a "controller", but as an interlocutor who (at the same time) is able as a human being to turn without prejudice also to the "sins" in dealing with the physical illness, otherwise the chance is very small that a sustainable therapeutic relationship will be established. To this end, it is helpful not only to address the patient's current concerns (e.g., acute physical complaints) in the conversation, but also to explicitly acknowledge the burdens caused by the disease (e.g., the need for complex medication, frequent blood glucose monitoring in type 1 diabetes mellitus, etc.) and to ask about how to deal with them without making rash judgments. With an *empathic* approach, it is then also possible to explore the mental state and life situation. With these essential com-

plexes of topics, a lack of social support, a feeling of chronic occupational overload (a form of "stress") or symptoms of mental comorbidity (e.g. depression, anxiety disorder) can then be uncovered as the background of maladaptive health behavior.

Here, reference is made once again to the many examples of patients who, at the beginning of the conversation, had already submitted a specific relationship offer as a "service provider" to the physician with a purely "biomedical" patient concern, which was only gradually shaped by the physician in the direction of a cooperative relationship (§ 19.8, 22.4, 22.5). For example, consider the approximately 25-year-old patient whose diagnosis ("diabetes mellitus type 1") had been known for some time and whose treatment with insulin ("injections") had so far been successful according to objective criteria (i.e., HbA1c), but who felt that his quality of life was considerably limited. However, he opens the conversation with a distinctly biomedical "ticket".

E 29.1		"Desired switch to pump"
01	D	Mr. Müller! . what brings you to us? .
02	P	Diabetes type 1
03	D	yes .
04	P	basal bolus .
05	D	hm .
06	P	desired switch to pump
07	D	Yes, that is . uh . there are difficulties in the basal bolus concept with you? .
08	P	let's say so . I would like a simplification, more variability ...
09	D	yes .
10	P	and greater freedom ...
11	D	yes ...
12	P	because disappearing with the pen . and so . is so .. sometimes in my profession specifically also not so favorable .
13	D	yes . yes .
14	P	so .
15	D	so, the disappearance means that you then have to leave once in a while because you need to inject the insulin .
16	P	right, for example .

With the "entry ticket", the physician was given the role of a service provider right at the beginning of the conversation, who was to provide the

"preferred" service ("desired switch to pump") without further consultation. The attending physician's manner of intervention initiated the shift to a collaborative model by first gently inquiring about the "difficulties" with the previous treatment process. Then, in the subsequent exploration, not only occupational "difficulties" came up, but complex motivational stories that concerned the overall lifestyle as a "diabetic". In the further "biopsychosocial" anamnesis, which was described in detail above (§ 22.5), a series of psychosocial burdens (shame, fear, overcoming pain, tormenting oneself, etc.) came to light, which made the apparently "biotechnical" concern of a change of therapy ("injection" versus "pump") increasingly comprehensible, before both interlocutors could agree on a trial change of the therapy procedure.

29.3 Topics and functions of communication

In the following, the specific topics and functions of communication with chronically physically ill patients will be differentiated. The order of presentation chosen here is by no means intended to suggest a fixed sequence of conversations, which is to be developed flexibly and in dialogue with the patient, entirely in the spirit of the *art of medical conversation* (§ 17).

29.3.1 Strengthening emotional coping with illness

Problems in emotional coping with illness, such as fears or feelings of being overwhelmed or helpless, are usually readily reported even by primarily skeptical patients if an empathic approach is taken. It is essential, however, that patients can trust that any complaints will be answered without "cheap tips" from the physician (e.g., "You need to pull yourself together"). To establish this trust, the physician must "go the extra mile," i.e., he must actively and empathetically ask about feelings in the context of the disease and not make hasty judgments.

In the case example, a physician explores a patient with CHD who has presented several times for "feelings of weakness" without evidence of progression of the underlying disease.

E 29.2		"It was okay ..."
01	D	How were you feeling emotionally when you were diagnosed with CHD?
02	P	It was okay ...
03	D	I could imagine that you were quite shocked at first after the diagnosis.
04	P	That was also the case.
05	D	What did you feel? Can you be more specific?

The option to talk to a doctor about feelings of emotional stress in the context of a physical illness is a new experience for many patients. It is also an important prerequisite for being able to address adaptive and any maladaptive parts of coping with the disease and health behavior in the course of the disease.

29.3.2 Promotion of health literacy

In a more recent, comprehensive definition, health literacy is the knowledge and motivation to find, understand, evaluate and apply health-related information (Soerensen et al. 2012). Recent epidemiological studies show that about 54% of the German general population has limited health literacy (Schaeffler et al. 2017). Among people with CHD, about 30% showed low health literacy (Ghisi et al. 2018). Consistently across all samples, low health literacy was associated with older age, low education, low socioeconomic status, and migration background (Ghisi et al. 2018, Schaeffler et al. 2017). The consequences are severe; for example, among CHD patients, low health literacy is associated with smoking, poor diet, physical inactivity, and obesity (Aaby et al. 2017), contributing to more frequent hospitalizations and poorer quality of life (Ghisi et al. 2018).

In Part IV of this book ("Manual and Practice"), essential hints for the communicative recording of health literacy have already been given, such as those concerning questions about the subjective theory of illness (§ 21.5), about external vs. internal control beliefs (assumptions that an illness is more likely to be influenced by external or by one's own active factors; § 22.2), and about treatment expectations (§ 22.2). These indications are elaborated on below with the help of further suggested formulations.

The following questions are appropriate for encouraging patients to describe their health literacy:

Box 29.1 Health literacy questions

- Do you have any idea how your illness may have developed?
- Could you describe to me how your illness works?
- Do you know of any approaches to treating your illness? Which ones?
- What can you do yourself to ensure your illness progresses well?

Health literacy is also relevant for the "classical" facets of coping with illness, which have become known under the generic terms "*active coping*", "*ability to distract and self-construct*", and "*resignation and self-blame*" ("depressive coping") (Albus, Herrmann-Lingen 2025). The following table lists concrete examples of formulations:

Box 29.2 Questions about coping with the disease

Questions about "active coping":

- Do you think you can actively do something good for your health? What?
- Have you been looking for information about your condition lately? Which?

Questions about the ability to distract and self-build:

- When was the last time you did something nice? What was it?
- Do you know the thought of comforting yourself with the fact that others are worse off than you?

Questions of resignation and self-blame:

- Do you know the thought that everything doesn't make sense anymore after all?
- Have you ever thought you didn't deserve better?

These types of questions can always only create occasions for thinking and talking about topics, which are then to be deepened and linked conversationally. If the conversation develops favorably and the physician asks appropriate follow-up questions, these types of questions also initiate *patient narratives* (§ 9, 19, 20) in which biographically relevant events, experiences and attitudes to individual complexes of topics can

be brought up (guilt and atonement, meaningfulness and meaninglessness, resignation up to suicidality, but also self-confidence and confidence). These narrative self-representations of patients, in turn, allow conclusions to be drawn about the (deficits in) resources in coping with the illness of the patients as well as about their expected health behavior.

29.3.3 Motivational interviewing

Maladaptive health behavior (e.g., medication non-adherence, persistent tobacco use, malnutrition, etc.) can significantly worsen the prognosis of chronic physical diseases such as CHD or diabetes mellitus (Albus et al. 2019, Albus, Haas 2022, Kulzer et al. 2023). Often, patients are well aware of the harmfulness of their behavior, but do not change it or do not change it sustainably. This is either due to *maladaptive denial processes*, or the behavior cannot be changed due to insufficient *motivation*, lack of social *support,* or psychological *comorbidity* (e.g., depression). It is not uncommon for maladaptive disease behavior to meet the criteria of a psychological comorbidity (e.g., psychogenic eating disorders in diabetes mellitus, nicotine dependence in CHD), in the development and maintenance of which multiple *biopsychosocial* factors are involved.

As significant as these maladaptive behavior patterns are, it is often difficult to focus on them. Patients usually fear reproach and embarrassment. The communicative approach to the topic should be accordingly empathetic. A key point is not to answer a patient's opening with reproaches (e.g., "If you continue to smoke, there is nothing I can do for you"). In addition, it is advisable not to address this area too early, but only after a viable doctor-patient relationship has been established.

In recent literature, recommendations for dealing with maladaptive health behaviors with the goal of stimulating or supporting change are referred to as "motivational interviewing". Rollnick et al. (2010) provided a list of the "top 10 most useful questions for motivational interviewing," which are presented below:

Box 29.3	Questions in the context of motivational interviewing

- What did you notice about this?
- How important is it to you to change your behavior?

- How confident are you that you can change it?
- What advantages do you see in this?
- What disadvantages do you see in this?
- What makes the most sense to you?
- What would this change in the future?
- In what way?
- How are you doing with it now?

Rollnick et al. 2010

Since patients cannot always respond to questions of this kind with simple answers, the topics associated with these questions must be repeatedly introduced into the *motivational interview* in suitable variations, especially since the patients' living conditions and attitudes may also have changed in the meantime. Similarly, specific ongoing topics can develop in the discussion of psychosocial risk factors, because here, particularly in the case of chronic illnesses, patients can be expected to have more or less long-term difficulties in adjusting (short-term "setbacks" but also persistent "relapses" into "old" behavior patterns such as smoking, malnutrition, etc.).

29.3.4 Consideration of psychosocial risk factors

Certain psychosocial factors have a significant influence on the development and course of numerous chronic physical diseases. For example, it is well established for CHD that, in addition to sociodemographic characteristics such as a low level of education and little social support, it is above all problems of *affect and relationship regulation* such as depressiveness, anxiousness (even below a "disease-worthy" level) and hostility - typically subjectively represented as "stress" - as well as social withdrawal can accelerate the manifestation of symptoms and hinder the implementation of optimal therapeutic strategies (Albus et al. 2019, Albus et al. 2022).

The ability to change health behavior also depends on the extent of social support (Albus et al. 2022, Albus, Herrmann-Lingen 2025). To understand this, however, it is important to note that it is not a matter of the mere availability of social support (e.g. married yes/no), but of the subjectively perceived goodness of the support, whether it is actually supportive emotionally and/or in terms of practical life. Recent studies show, for example, with regard to a change in behavior (non-

smoking, losing weight, more exercise, etc.) that this is all the more successful if the partner makes the same change in parallel. If, for example, he or she was already a non-smoker or active in sports beforehand, the positive effect is much weaker (Jackson et al. 2015).

Because of this, numerous national and international guidelines on the diagnosis and treatment of CHD and diabetes mellitus now recommend not only looking for symptoms of psychological comorbidity, but also additionally looking for other psychosocial risk factors and providing appropriate psychosocial services if these are detected (Visseren et al. 2021, BÄK et al. 2024).

The German National Health Care Guideline for Chronic CHD (BÄK et al. 2024) recommends the following formulations for this purpose, which of course already presuppose suitable topic developments that can be followed up with targeted questions.

Box 29.4 Questions about psychosocial risk factors

Low socioeconomic status

- Are you a worker or a craftsman?
- Is your secondary school diploma or elementary school diploma (or less) your highest level of education?

Social isolation/lack of social support

- Do you live alone?
- Do you have/miss one or more people you trust and can count on for help?

Occupational stress

- Do you often feel very challenged in your work?
- Do you miss being able to influence the design of your work tasks?
- Do you receive significantly too little pay or recognition for your work efforts?
- Are you worried about your job or career advancement?

Family stress

- Do you have serious problems with your life partner or family?

Hostility and tendency to anger

- Do you often get annoyed by little things?
- Are you often annoyed by other people's habits?

Negative affectivity and social inhibition ("Type D pattern").

- Do you often feel anxious, irritable and depressed in general?

- Do you find it difficult to share your thoughts and feelings with strangers?

BÄK et al. 2024

For the communicative approach, it is important to avoid shaming the patient by a (strongly) confrontational approach. Instead, a tangential approach should be preferred (§ 3, 17, 32). At its core is (initially) an *empathic* dialogue aimed primarily at providing additional information about psychosocial factors. Only then is a possible reference to the disease itself cautiously established. In this way, an *approach* to problems of *self- and relationship regulation* is also achieved, which are averted, for example, by smoking, malnutrition, too much alcohol, etc. A favorable starting point for this can be the focusing of stressful life events, relationship problems or everyday annoyances.

In the following case example, the physician addresses the issue of social support in a patient with inadequate blood glucose levels in type 2 diabetes mellitus.

E 29.3		"I'm just supposed to keep it together"
01	D	Who all belongs to the household?
02	P	My wife and my two children
03	D	Can you talk to your wife about the diabetes?
04	P	my wife always says I should just pull myself together. Easy for her to say ... that doesn't help at all ...
05	D	I can empathize with that. What would you experience as helpful?

In the next case study, a patient with CHD needs the next stent after only one year. The patient suspects "stress" as the cause, but he is not aware of his part in the conflict situation.

E 29.4		"What can I do about it?"
01	P	If I didn't have stress, I would be fine ...
02	D	Yes, stress can indeed play an important role in heart disease. Can you tell me more precisely what you mean by stress?
03	P	I had total stress at work ... much trouble with my boss.

04	D	What were you angry about?
05	P	He picks on me all the time.
06	D	How did you deal with it then?
07	P	How? What can I do about it?
08	D	Well, I can already understand your anger, but I wonder if you can find a way to defuse the conflict with the boss. That would also be good for your health. Would you like to share an occasion?

Based on the most concrete possible description of stressful situations, it is usually possible, if the therapeutic relationship is sustainable, to develop the conviction with the patient that it makes sense for him to turn to his own experience and behavior in order to cope better with certain potentially stressful situations. This process can be deepened in the sense of *basic psychosomatic care* (§ 15, 42). In selected cases, it can also give rise to specialist psychotherapy.

29.3.5 Detection of mental comorbidity

Due to the considerable importance of *psychological comorbidity* (especially depression and anxiety disorders) for the quality of life and prognosis of various physical diseases (CHD, diabetes mellitus, oncological diseases), numerous national and international guidelines now recommend that the doctor-patient consultation should routinely look for indications of psychological comorbidity. If this is detected, psychotherapy and/or medication should be initiated (Albus et al. 2019, Albus et al. 2022, Visseren et al. 2021, BÄK et al. 2024).

For the field of chronic CHD, the National Health Care Guideline Chronic CHD (BÄK et al. 2024) recommends the following screening questions:

Box 29.5 Mental comorbidity screening questions.

Depression

- In the last 14 days, have you often felt down, sadly depressed, or hopeless?
- In the last 14 days, have you had significantly less desire and pleasure in doing things you usually enjoy?

Panic disorder

- Do you have sudden attacks that make you feel terrified and suffering from symptoms such as rapid heartbeat, shaking, sweating, shortness of breath, fear of death, and more?

Generalized anxiety disorder

- Do you feel nervous or tense?
- Do you often worry about things more than other people?
- Do you feel like you are constantly worried and can't control this?

BÄK et al. 2024

In an extension of the *Cologne Evaluation of Medical Communication* (C-EMC; see § 17 and Appendix 44.2), which records six essential domains or steps of a general initial medical consultation, we have developed a "C-EMC Diabetes and Depression" (C-EMC-DD), which extends the C-EMC to include diabetes- and depression-specific dimensions (see § 29.6). The evaluation form differentiates the extent to which typical symptoms of diabetes mellitus and depression are recorded. The "anchor examples" for suitable questions, which each domain contains, can at the same time serve as a manual for a suitable exploration in the case of a comorbidity of diabetes mellitus with depression.

29.3.6 Dealing with maladaptive denial

In contrast to any psychological stress, it must also be expected in the case of chronic diseases that coping with the disease may be determined by *maladaptive denial.* Although this stabilizes the mental state, it leads, as introduced above, to markedly maladaptive behavior patterns, such as non-adherence to medication, failure to change health behavior in the direction of not smoking, etc. In this situation, appropriate communicative handling of maladaptive denial is an essential prerequisite for nevertheless establishing access to the patient.

For this purpose, it is helpful that the physician makes clear that from a psychodynamic point of view "denial" basically serves to prevent flooding with fears. Physically healthy people as well as sick people need a "sufficient" (=adaptive) denial in order not to be flooded by fears of future suffering, infirmity and death. By the way, this is by no means always done consciously, but denial processes run predominantly unconsciously.

In the context of a disease, denial only becomes maladaptive if the specific requirements of therapy for health behavior are neglected. The background of such maladaptive denial can be seen in the fact that the individual does not have sufficient resources available to adequately "control" his or her fears in relation to an illness, to master them adaptively (Albus, Herrmann-Lingen 2025). In return, maladaptive denial weakens as soon as it is possible to foster a sense of *meaningfulness, comprehensibility, and manageability* of the patient's illness within a supportive doctor-patient relationship, in line with a *salutogenic* perspective. (Albus, Herrmann-Lingen 2025).

This insight has far-reaching consequences for physicians' communication behavior: An intrusive, reproachful approach ("If you don't stop smoking, you'll be dead in six months") is counterproductive. It is better to gently address possible feelings of fear or helplessness in the face of the disease. However, under no circumstances should one insist if the patient does not pick up on this. Instead, it makes more sense to acknowledge the psychological stabilization that has been achieved and, in a second step, to actively address the individual's coping with the disease. In this context, "blind spots" in health behavior can then also be gently addressed.

The following case example describes a sequence from a conversation with a CHD patient who had a heart attack a quarter of a year ago and started smoking again shortly after hospitalization.

E 29.5		"Just kept doing what we were doing"
01	D	How are you doing with your heart disease?
02	P	Good, no problems.
03	D	I would imagine that you were quite shocked shortly after the heart attack?
04	P	Yeah sure, but not anymore ...
05	D	How do you manage to feel good again today?
06	P	Just continued as before.
07	D	And it is also important that you make sure that you are mentally well. But today I would also like to check with you whether the disease itself is well under control. Is that okay?

This procedure gives maladaptive-denying patients in particular the opportunity to report on their "achievements" in coping with the disease, promotes an easing of initial skepticism or latent anger toward the phy-

sician, and creates trust. Subsequently, the characteristic facets of the individual coping with the disease can usually be worked out without problems, and these can be carefully deepened in the direction of any maladaptive points.

29.4 Complementary treatment offers

In certain constellations, such as evidence of low disease-specific health literacy, psychosocial risk factors, or mental comorbidity, complementary treatment services are indicated. For example, *patient education programs* are available for a number of internal medical conditions (primarily diabetes mellitus, arterial hypertension) that include a well-evaluated approach to promoting disease-related knowledge and management of relevant therapeutic approaches (Visseren et al. 2021, Kulzer et al. 2023, BÄK et al. 2024).

In patients with CHD, a primarily multimodal approach that includes knowledge transfer, sports and exercise therapy, and psychosocial support has proven effective and is offered as an outpatient or inpatient rehabilitation intervention (Visseren et al. 2021, Titscher et al. 2022).

When complementary treatment options are discussed, it is of utmost importance that the patient does not feel "shunted off" but that he or she can clearly understand why he or she is being advised to take the measure as a complement to (primary) medical care.

The following conversation with a CHD patient who visits the doctor very frequently due to massive interaction problems at work and who is advised by the doctor to undergo psychotherapy is intended to demonstrate this in conclusion:

E 29.6		"I'm not crazy"
01	D	I suggest that you consider undergoing further therapy, such as psychotherapy, to address and overcome the issues with your work situation.
02	P	I don't know ... how is that going to help?
03	D	Your life situation is totally stressful. This is not good for your soul and body. The therapy is intended to support you in finding new ways to resolve the conflicts.

04	P	But I'm not crazy ...
05	D	I see it that way, too. But I am convinced that it makes sense to put your treatment on two legs now: One leg is me; I care for you as before as a doctor. But you also use psychotherapy to cope with stress, that's the other leg. You will make better progress on two legs.

29.5 Further information

Numerous publications as well as further and advanced training opportunities are available to deepen the contents described above. The following references therefore by no means claim to be exhaustive, but highlight only two sources that the authors consider particularly suitable. For students, physicians, psychologists, and other health care professionals who would like to delve more deeply into the topic of biopsychosocial aspects and therapeutic approaches in cardiovascular diseases, for example, the practical guide "Psychocardiology" by Herrmann-Lingen at al. (2022) is recommended.

Herrmann-Lingen has also initiated a continuing education curriculum on the topic of "Basic Psychocardiological Care", which has now been offered for almost 10 years through the "Further and Continuing Education Academy of Cardiology" of the German Cardiac Society ().

29.6 Cologne Evaluation of Medical Communication - Diabetes and Depression (C-EMC-DD)

As already explained, we have developed a "C-EMC Diabetes and Depression" (C-EMC-DD, Fig. 29.1.) as an extension of the *Cologne Evaluation of Medical Communication* (C-EMC; see § 17 and Appendix § 44), which covers the recording of six essential domains or steps of a general initial medical consultation, which extends the C-EMC by diabetes- and depression-specific dimensions (see below). The "anchor examples" for suitable questions, which each domain contains, can at the same time serve as a manual for a suitable exploration in the case of a comorbidity of diabetes mellitus with depression.

Fig. 29.1: Cologne Evaluation of Medical Communication – Diabetes and Depression (C-EMC-DD) (see next page)

	Cologne Evaluation of Medical Communication - DD					C-EMC-DD
	OSCE checklist for physician discussion of co-morbidity: diabetes, depression					[1]2009
	© Department of Psychosomatics and Psychotherapy,University of Cologne					[2]2018
No.	Course	Interviewer	Date	Patient (SP)	Rater	Sum:
						☐☐ 73

1 General anamnesis	☐☐ 18	4 Additional symptoms depression	☐ 7
1 Establish a relationship • Greeting and introduction • Situating and orienting (time, goals)	❶	**1 Concentration** "How about your ability to concentrate (at work, reading the newspaper)?"	❶
2 Listen to concerns • Encourage storytelling • Actively listen and support	❶❷❸❹	**2 Self confidence** "How would you rate your self-esteem (self-confidence)?"	❶
3 Allow emotions • Respond empathically • Promote emotional openness	❶❷❸❹	**3 Guilt** "Do you often blame yourself?"	❶
4 Explore details • Exploring dimensions of complaints • Complete general medical history	❶❷❸❹	**4 Future prospects** "How do you see your future - more optimistic or more pessimistic?"	❶
5 Coordinate procedure • Clarifying information and expectations • Negotiate therapy plan (SDM)	❶❷❸❹	**5 Sleep** "How (good) is your sleep?"	❶
6 Draw a conclusion	❶	**6 Appetite** "How is your eating behavior and appetite?"	❶
		7 Suicidality "Do you sometimes think that you'd rather be dead?"	❶

2 History of diabetes	☐☐ 20	5 Anamnesis Depression (cont.)	☐☐ 12
1 Symptoms • Thirst, nausea, etc. • Hypoglycemia, nocturia, etc.	❶❷❸❹	**1 Onset and course** • Beginning "When did this start?" • Phases/episodes "What were the worst times?" "Were there times of improvement?"	❶❷❸❹
2 Start and course • Diagnosis made when, by whom? • Phases (condition, findings)	❶❷❸❹	**2 Subjective ideas** • Concepts "What do you imagine depression, etc. to be?" • Explanations "Do you see causes yourself?"	❶❷❸❹
3 Preliminary examinations • Referrals (specialist) • Briefings (current occasion)	❶❷❸❹		
4 Pretreatments • Therapy plans (nutrition, insulin, etc.) • Therapy success (adherence, coping)	❶❷❸❹	**3 Findings and pretreatments** • Diagnoses with comorbidity "What have you been in treatment for (depression, anxiety, etc.)?" • Therapies (medication, psychotherapy)	❶❷❸❹
5 Complete medical history • Risk factors (CHD, cholesterol) • Concurrent / secondary diseases (CHD, retinopathy, nephropathy, etc.)	❶❷❸❹		

3 Anamnesis depression	☐ 4	6 Coordinate procedure	☐☐ 12
1 Introduction open "How are you doing mentally?"	❶	**1 Clarify expectations** • Ideas, wishes, fears "What do you think might help?" • Control beliefs "What can you change about your lifestyle (diet, exercise, etc.)?"	❶❷❸❹
2 Suspected diagnosis: 2-question test • Main symptom 1 "Have you felt mostly down, sad, or depressed in the last 14 days?"	❶		
• Main symptom 2 "In the past 14 days, have you mostly lost interest in things that usually bring you joy?"	❶	**2 Communicate information** • Info Need "Do you have any questions?" • Diabetes sequelae/prevention • Comorbidity: "During depressive episodes, you seem to be extremely neglectful of your self-care."	❶❷❸❹
3 Follow-up question after affirmation • Main symptom 3 "Did you feel mostly tired and exhausted during this time?"	❶	**3 Negotiate therapy plan (SDM)** • Adherence or change of therapy • Psychotherapy or consult • Topics/targets for follow-up appointments (rounds)	❶❷❸❹

❶ [❶ = not met;❶ = met]❶❷❸❹ [❶ = not met ...❹ = fully met]

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Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

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