30 Communication with Depressed Patients

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> The melancholic shows an extraordinary degradation of his ego feeling, a great ego impoverishment. With grief, the world has become poor and empty; with melancholy, it is the ego itself.
>
> Freud 1917/1949: 431

Abstract: The aim of this article is to provide communicative treatment competence in dealing with depressed patients. Basic aspects of terminology, genesis, epidemiology as well as diagnostics (§ 30.1) and psychotherapeutic treatment of depressive disorders are introduced (§ 30.2). Based on this, specific strategies for medical consultation are

taught. Depending on the respective stage of the course of depression, the focus is on basic therapeutic attitudes and intervention principles (§ 30.3) and these are illustrated by examples.

30.1 Basics

30.1.1 Depression term

Depressive experience is a significant theme of human life, at any time and in any culture. However, the concept of depression has been subject to considerable changes throughout history (Böker 2011). As "melancholy" (black gall), a physically caused - and thus no more than a depressive state of mind sent to humans by the gods - was already described in ancient Greece in the Corpus Hippocraticum (Hippocrates, De morbis I, 30). The term "depression," however, did not find its way into medical terminology until the early 19th century. In this context, Kraepelin's paradigmatic description of "manic-depressive insanity" as a disorder of thought, mood, and will (Kraepelin 1899) led to the "triumphant advance" (Böker 2011) of the concept of depression, replacing melancholia after two and a half centuries. However, Kraepelin's concept that depression was only a partial manifestation of a manic-depressive illness entity was contradicted and finally the independence of unipolar and bipolar affective disorders was postulated (Wernicke 1900, Kleist 1953). Jaspers described a "deep sadness" and an "inhibition of all mental activity" as the core of depression (Jaspers 1913/1965). Until the introduction of the WHO classification system in the tenth edition (ICD-10, 1992), etiopathogenetic model concepts served as the basis for classifying depressive disorders, most recently into reactive, neurotic, and endogenous depression. Today, the strictly operationalized concept of depression is understood in a purely symptomatic-descriptive way.

Box 30.1	Depressive experience

Depressive states begin in such a way that things that mean a lot to one are withdrawn from feeling; one feels inwardly weak [and] unstable. One looks for some kind of support in people, things, activities. If the feeling

rises again at such an anchor, the future becomes easier, one perhaps forgets oneself again completely. But perhaps there always remains a fear somewhere that the feeling will slip away again, so one does not really trust one's feeling and thus also the future.

Binswanger 1960

30.1.2 Depression models

Specific depression models and psychotherapeutic treatment approaches can be found in psychodynamic, interpersonal, behavioral, humanistic, and systemic schools of theory (Böker 2008). Psychoanalytic theory on the etiology and treatment of depression ranges from its classical concepts by Abraham ("early childhood upset", 1912) to Freud ("grief and melancholia", 1917) to modern integrative-multimodal concepts by Benedetti ("depression subtypes," 1981) and Rudolf ("basic depressive conflict", 2003). The theoretical background of Interpersonal Psychotherapy (Klerman, Weissman 1984) is based on the ideas of the interpersonal school (Sullivan 1957) and attachment theory (Bowlby 1969). Cognitive behavioral therapy is based primarily on the work of Beck ("cognitive triad", 1974), Lewinsohn ("social reinforcement theory", 1974), and Seligmann ("Learned Helplessness", 1975). Conversational psychotherapy, which originated in the humanistic tradition and was modified with elements of Gestalt therapy by Greenberg ("emotion-centered therapy", 2005), is also considered scientifically evident.

Luyten and Blatt summarize the current understanding of the genesis of depression from a psychodynamic perspective. The central moment is the loss of an important person or an inner or outer goal or hold, when at the same time protective coping or defense mechanisms are exhausted or insufficiently invested. Depression can thus be understood as a ubiquitous human reaction to helplessness. However, findings from personality, attachment, and emotion theory also contribute to the psychodynamic understanding of depression development (Luyten, Blatt 2012).

30.1.3 Epidemiology, comorbidity and sequelae

Depressive disorders are characterized by a complex and multifactorial genesis and a large interindividual variance. Despite this heterogeneity,

depression is understood as a common final pathway of multiple biological and psychological mechanisms. Because of its high prevalence, its considerable socioeconomic importance, and not least the great personal suffering of those affected, it is accorded the status of a widespread disease (Schauenburg et al. 1999). The S3 guideline Unipolar Depression (BÄK et al. 2022) is the only treatment guideline that addresses a mental disorder with the predicate of a National Health Care Guideline. As summarized below, the S3 guideline provides information on the epidemiology, comorbidity, and sequelae of depressive disorders, among other topics.

Epidemiology

The lifetime prevalence, i.e. the risk of developing depression (all forms) over a lifetime, is 16-20% nationally and internationally. Women are affected about twice as often as men; they become ill earlier and have longer episodes of illness and a higher risk of relapse. Depression occurs at any age, occurs to a considerable extent already in childhood and adolescence and is the most frequent mental disorder at a later age. The lack of a trusting personal relationship and a low socioeconomic status are considered safe risk factors for the occurrence of depression.

Comorbidity

Depression has a high comorbidity with other mental disorders. The co-occurrence of another mental disorder is more frequent in depressed patients than (unipolar) depression in its pure form. Thus, in about 60% of depressed patients, at least one other significant mental disorder can be identified, especially anxiety disorders, substance-related and somatoform disorders. Depressed patients with comorbid mental disorders have a less favourable prognosis, associated with an increased risk of chronicity and suicide and frequent resistance to treatment. However, the interactions of depressive disorders with physical illnesses are also diverse and well documented. The prevalence for the development of a depressive disorder in (chronic) somatic diseases is about twice as high. It is evident that psychotherapeutic treatments significantly improve the psychological situation even in physically ill patients.

Consequences

Depression is one of the most important widespread diseases. Depressive symptoms lead to a severe impairment of physical and mental well-being and are associated with a high mortality rate, especially due to suicides. Depression has serious effects on the social network of patients, combined with high demands on their relatives, especially on the children of depressive parents. Depressive disorders reduce occupational performance, leading to higher rates of days lost from work and premature retirement.

30.1.4 Classification, clinical picture and diagnostics

Depression typically has a phasic course that can last for at least two weeks (time criterion), often several months, and in some patients, years. Episodes lasting more than two years are considered chronic by definition. Complete remission after the episode has resolved is considered more prognostically favorable than incomplete remission with lingering residual symptoms, in which the risk of relapse remains elevated. More than half of patients experience more than one depressive episode in their lifetime. If only depressive episodes occur, this is referred to as unipolar depression. If not only depressive but also manic episodes occur in the course of a patient's life, it is called a bipolar affective disorder. Chronic forms of depression include dysthymia, which is usually subsyndromal, depressive episodes that persist for more than two years, and the combination of dysthymia with a depressive episode ("double depression").

Box 30.2	Classification according to different characteristics

Severity
- mild
- moderate
- severe
- additional: psychotic symptoms or somatic syndrome

Course
- monophasic
- recurrent

- chronic
- bipolar

Comorbidity
- comorbid mental disorder
- comorbid physical illness

The clinical picture of depression is characterized by a prolonged state of clearly depressed mood, lack of interest and listlessness, which is often associated with a wide range of physical complaints. Depressed people are usually impaired in their entire way of life by a considerable loss of function. More than almost any other illness, depression is accompanied by a high level of suffering, since the illness has a central impact on the well-being and self-esteem of depressed people. As an expression of a potentially life-threatening course of the disease, suicidality is considered one of the most important symptoms that should be considered and clarified in every case of depression (BÄK et al. 2022).

Box 30.3 Depressive Episode (symptoms)

Essential features
- Depressed mood
- Anhedonia
- Reduced energy, fatigue[1]

Additional features
- Low self-worth[2]
- Guilt[2]
- Hopelessness[3]
- Suicidality
- Disrupted sleep
- Change in appetite/weight
- Reduced ability to concentrate
- Psychomotor agitation or retardation

[1] Main and secondary criteria according to ICD-10
[2] Secondary criterion in ICD-11
[3] Summarized criterion in ICD-11.
[4] New criterion in ICD-11

BÄK et al. 2022

30.2 Therapy

30.2.1 Psychotherapy in depression treatment

A large number of high-quality studies provide convincing evidence of the general effectiveness of psychotherapy in the treatment of depressive patients. Psychotherapy is just as effective as pharmacotherapy in the short term, but superior to it in the long term. Studies show that so-called carry-over effects, i.e., longer-term effects after the end of treatment, are significantly more pronounced with psychotherapies than with pharmacotherapies, so that significantly fewer relapses occurred. Therefore, psychotherapeutic treatment is recommended in the post-acute phase to stabilize the success of therapy and to reduce the risk of relapse (Niecke, Albus 2011).

Especially in severe depressive episodes and in chronic forms of depression, a combination treatment of psychotherapy and pharmacotherapy has statistically significant additive effects compared to monotherapy, which is why patients should be informed about the superiority of a combination treatment. With regard to a differential indication between the two forms of treatment, the patient's subjective concept of the illness and his or her treatment preference are of decisive importance (Niecke, Albus 2011).

With regard to the value of specific psychotherapy methods, their common features, such as the importance of the patient-therapist relationship, are emphasized. There is a particular need for research on the effectiveness of psychotherapy in somatic comorbidity. Studies show that sudden and significant symptom improvements ("sudden gains") often occur within the first five weeks of therapy under psychotherapy and that, in cases of severe depression, therapists with several years of experience are more effective than novices (Niecke, Albus 2011).

30.2.2 Psychotherapeutic effective factors

It is well known from psychotherapy research that so-called "non-specific", method-independent efficacy factors ("common factors") are of decisive importance in the treatment of depressive patients and that, in contrast, method-specific therapy techniques have only a subordinate effect on the treatment outcome (Wampold 2001). These common, pro-

cedure-independent factors include the quality of the therapeutic relationship (alliance), the therapist's interpersonal skills (competence), and the therapist's conviction in his or her treatment method (allegiance). The quality of the therapist-patient relationship has the strongest influence on the treatment outcome, across all schools of therapy. This includes, above all, a warm, appreciative and fear-free contact between the therapist and the patient (Orlinsky et al. 1994).

However, general and specific effective factors cannot be seen independently of each other and are inextricably linked in a common context (Wampold 2001). Thus, the great importance of general effective factors in psychotherapy must not be confused with therapeutic nihilism. Nevertheless, it can be deduced for treatment that it is crucial for the practitioner to give his patient the right signals on the relational level as well, beyond the disorder-specific intervention technique (Böker 2008). In a sense, a sustainable and trusting doctor-patient relationship forms the foundation in the treatment of depressed patients. A trusting relationship could be made an issue as follows:

E 30.1		"I don't know" (therapeutic relationship).
1	D	can you tell me what's bothering you?
2	P	hm ... I don't know.
3	D	maybe you don't know if you can trust me?
4	P	hm ....
5	D	okay, it is very important for the treatment that you tell me as frankly and openly as possible what is going on ... so that I can better understand your inner distress ... I promise you I will do my utmost to support you where I can.

30.3 Medical conversation

30.3.1 Relationship and intervention principles in the acute depressive phase

In the acute phase of depression, the depressive symptom burden is usually at the forefront of the patient's experience. Thus, reducing symptoms as much as possible becomes the primary goal of treatment.

It is important for the patient to experience and recognize that and how he can control his symptoms, but also how he can regain his psychosocial functioning and participation.

The communicative demands on the therapist in the acute phase are described by Kruse and Wöller (2018): They relate in a central way to his emotional-empathic presence and availability as a real person. For the patient, it is of utmost importance to be able to turn to a counterpart who is there for him, listens to him, and with whom he experiences relief, reassurance, and recognition. The purely verbal content of the conversation often takes a back seat to the offer of being available to the patient as a counterpart ("being there"). In order to "liven up" the conversation, a higher level of activity on the part of the physician is often necessary, because the ability of acutely depressed patients to resonate is considerably limited (devitalization).

It is advisable to adopt a supportive and supportive attitude. In this phase, working through inner-emotional or interpersonal conflicts generally still represents too much of an overload situation, which can under certain circumstances also destabilize the patient-doctor relationship, and is at best indicated when the symptom burden is low (Kruse, Wöller 2018). Their interventions should primarily aim at reassurance and relief and serve to enhance well-being and self-esteem. Addressing the patient's inner distress and acknowledging his or her suffering are also helpful interventions. It is important for the success of treatment that the practitioner can be experienced as a "bearer of hope" who conveys confidence without trivializing the patient's suffering. The following example is taken from a visit during inpatient psychotherapy, after the patient had announced in the last visit that she intended to take a written exam as part of her studies.

E 30.2		"I can't do all this" (inspire confidence).
1	D	good morning Mrs. X [handshake while standing] ... [both sit down] and ... how did it develop?
2	P	[smiles] hm, well, not so good [looks down at the floor in shame].
3	D	what is the problem, what happened?
4	P	i didn't go ... i just couldn't concentrate properly ... i can't do *all* that.
5	D	that's right, you don't go there if you can't concentrate. that would be hara-kiri ... then to take notes. you may now think you

		could never do that ... but maybe you just can't *yet.*
6	P	[smiles; with eye contact] hmm, maybe.

In addition to medical education of the patient with regard to diagnosis and information on help in coping with the disease (psychoeducation), it can be helpful to involve a caregiver who is important to the patient (BÄK et al. 2022) in order to inform him or her about the need to relieve the patient and not to overburden him or her. The joint coordination of an overall treatment plan - in the sense of participatory decision-making - focuses on different therapy options (psychotherapy, medication), different actors in care (primary care, psychotherapists, psychiatrists) and different treatment settings (outpatient, inpatient). Critically weighing the risk-benefit ratio of the planned approach, the patient's preferences and dislikes should be considered in any case. In patients with massive symptom burden, especially in the presence of suicidality (§ 30.3.2), delusional symptoms, or severe psychosocial stress factors, it is often necessary to initiate emergency admission.

Box 30.4 Communication in the acute phase

- Availability and empathic presence
- Active and supportive attitude
- Relief and reassurance
- Recognition of suffering
- Raise hope and confidence
- Psychoeducation (if necessary with reference person)
- Create treatment plan
- Address and clarify suicidality

30.3.2 Relationship and intervention principles in the post-acute depressive phase

As the acute symptom burden subsides, the focus of therapy shifts to sustainable stabilization and the development of an understanding of the symptoms. For this purpose, it is helpful to think about the patient's affects, conflicts and relationship ("No symptom without affect, no affect without conflict and no conflict without relationship"). Therapeutic attitudes and intervention principles have been described many

times in the psychodynamic literature (e.g., Rudolf 2003, Will et al. 2008, Böker 2011, Kruse, Wöller 2018).

Disorder of emotion regulation

Depressed patients have considerable difficulties in perceiving, differentiating and expressing their affects. The so-called feeling of numbness is therefore considered a symptom of particularly severe depressive states. Therapeutically, it is beneficial if, in a first step, the patient learns to perceive his permanent emotional tension and his lack of emotional relief. In further steps, the underlying emotions as well as the object-related neediness or disappointment should be sensed and identified (Rudolf 2003). If negative affects bound up in the depression, such as disappointment anger, despair, revenge impulses or feelings of guilt, can be expressed by the patient, this is usually experienced as relieving. Therefore, encourage your patient to tell you about his or her feelings and wishes. To do this, you can specifically ask your patient about his or her emotional state. It can also be helpful to think about what feelings the patient triggers in you (countertransference) or to empathize with the patient and try to formulate corresponding feelings instead of the patient. Communicating emotions and needs - rather than wordless expectations - is a key element in communicating with depressed patients (see Box 30.7 and § 20).

E 30.3		"..." (Addressing affects)
1	D	... hm, yes that hurts
2	P	yes [cries].

Conflict and coping

As in the case of other mental disorders, it is an important therapeutic task to identify the conditional situation triggering the symptomatology. In most cases, the onset of a depressive episode is related to a specific conflict situation in terms of both time and meaning. Typical biographical depression triggers are acutely stressful or chronically accumulating separation or loss experiences in which coping efforts have come to a standstill. Explore with your patient the trigger context, as well as his or her preferred coping strategies. Help him access his negative bio-

graphical experiences and understand functional and dysfunctional parts of his coping strategies. If the patient succeeds in admitting, bearing and mourning losses and limitations, this is a crucial prerequisite for ultimately reconciling with his own biography and traumatizations.

Conflict and structure

Different depressive conciseness types can be assigned to different conflict mechanisms, for example self-esteem and guilt or dependency conflicts (cf. Benedetti 1981). A difference between an aspired but often unrealistically inflated self-image and a perceived self-image can lead to strong, shameful self-doubt and self-deprecation ("I am worthless"). Therapeutic interventions for narcissistic self-esteem crises should focus on the lack of self-assertion and the high potential for offending on the one hand, and promote self-care and frustration tolerance on the other. A leading guilt theme with self-accusation ("I am to blame") and self-punishment tendencies (e.g. self-injury) can be understood as an expression of a maladaptive attempt at resolution in which an unresolved interpersonal conflict has been shifted into the intrapsychic. Therapeutic interventions should focus conflicts of conscience on self-acceptance and the relativization of self-blame (possibly also of other-blame) and relieve them of tormenting feelings of guilt. Another type of depressive conciseness is related to a dependency conflict, which can either be expressed by passive-dependent supply desires, often accompanied by addictive tendencies ("I couldn't get enough") or, conversely, characterized by a forced altruistic mode of renunciation ("I don't need anything or anyone"). In the case of dependency conflicts, therapeutic interventions should aim at a balance between the desire for attachment and the desire for independence. The conflict mechanisms described here only in cursory form are moderate to a low level of integration of the psychological structure, which may require additional specific interventions that will not be further elaborated here.

Attachment disorder

In shaping their relationships, depressive patients show characteristic maladaptive interaction patterns. Rudolf prototypically describes the depressive symptom formation in the relationship context as a "basic depressive conflict" (Rudolf 2003): The depressively structured patient has a great longing for positive relationships. In the hope of a kind, just,

and providing counterpart, he thereby puts his own needs on the back burner. Rather, he still tries to sense and fulfill the expectations of the counterpart and thus makes the offer of a harmonious and completely unaggressive relationship. On the one hand, a positive reaction of the idealized counterpart is hoped for, on the other hand, the central pathogenic conviction is mobilized at the same time, to be disappointed again in this relationship. This leads to a highly ambivalent reaction in which, in addition to an excessive desire for relationship, there is at the same time a suppressed anger that leads to the devaluation of the relationship offer ("What he wants, he doesn't get and what he gets, he doesn't want"). Thus, a sole, unconditionally friendly contact behavior is not sufficient if the subliminally present aggression cannot be reflected at the same time. Often this dysfunctional pattern of interaction is also perceptible in the patient-doctor relationship and can be directly examined and treated here. In doing so, it is important to work on the ambivalence, to correct the distorted object perceptions and to counteract the resulting withdrawal from the objects ("isolation reinforces depression"). However, do not question the idealizations or address the averted aggression too soon. Ultimately, it is critical that the patient experience reassurance that there are significant others to whom he or she can turn without fear of relationship breakdown due to aggressive impulses.

Box 30.5 Communication in the post-acute phase

- Active, approachable and interested attitude
- Perception and differentiation of feelings
- Communication and expression of feelings
- Explore triggering situations
- Identify and handle conflicts
- Identify and work on coping strategies
- Strengthen self-worth
- Promote self-care
- Relief from feelings of guilt and shame
- Edit negative beliefs
- Reflect on the design of the doctor-patient relationship

30.2.3 Management of suicidality

Suicidality (*neo-Latin*: sui = oneself, caedere = to break, to cut down, to kill) is a frequent symptom in the context of depressive disorders, and major depressive disorders are the most frequent cause of completed suicides. It is recommended that, as a matter of principle, the occurrence of suicidal crises should be expected in every depressed patient and that an assessment of current suicidality should be made routinely. In order to assess the current suicidal tendency, open discussion with direct, serious and sympathetic questions about suicidal fantasies, including urgent suicidal impulses, is essential. For an assessment of the current self-endangerment, it is important to clarify whether the patient can name reasons for restraint. Ask about binding external factors (e.g., family, children, partner, religion) and internal factors (e.g., hope and trust, previous experiences of crisis management, future perspective) that keep the patient in life and prevent suicide. The more binding factors can be named, the more reasons patients find to live, the less likely they are to act on their suicidal thoughts.

Box 30.6	Management of suicidality

- "Have you ever felt that life was not worth living?"
- "Frequently?"
- “Could you rate the intensity (scale from 0 to 10)?”
- "Do you have a plan of how you would do it?"
- "Have you made any specific preparations?"
- "Is there anything that's holding you back?"
- "Have you ever attempted suicide?"

In suicidal depressive patients, the primary focus should be on suicidality. The short-term goal in cases of acute suicidality is to establish intensive contact for active, immediate support and relief until the crisis subsides. A sustainable therapeutic relationship can have a suicide-preventive effect per se. Essential features of the conversation and relationship offered to suicidal patients are: Providing space and time (offer of affection), securing emotional access and an appropriate emotional response from the patient, and reassuring the patient that help is possible.

30.4 Further information and references

More detailed knowledge on the epidemiology, etiology, diagnosis, and psychotherapeutic treatment of depressed patients can be found in the textbooks of psychosomatic medicine (Köhle et al. 2017, Rudolf, Henningsen 2017), special monographs on the psychodynamics and psychotherapy of depression (Schauenburg, Hofmann 2007, Will et al. 2008, Böker 2011, Huber, Klug 2016) as well as corresponding treatment manuals (e.g., Taylor 2010, Steinert et al. 2016) and the S3-Guideline for unipolar depression (BÄK et al. 2022).

In addition to the specific communication techniques with depressed patients mentioned here, please refer to the articles on key medical skills (§ 6) and emotions (§ 20).

References

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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