2. Psychiatric and psychological brief psychotherapy for depression PKP

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Abstract
This work presents the Psychiatric and Psychological Brief Psychotherapy PKP for depression, which is based on the three pillars (modules) of symptom therapy (dealing with the symptom), skills training (exposure to joy, fear, anger and grief) and working with the dysfunctional survival rule (establishing a new life rule that gives permission). Originally working with consultation cards, a PKP manual for each disorder is now the guideline for the specific therapeutic procedure. The difference to conventional therapy manuals is the modular structure, which is aimed at personalised, individual therapy planning and implementation. This results in a flexible therapy concept that differs from patient to patient.

Key words
Behaviour therapy - short-term psychotherapy - symptom therapy - skills training - emotion exposure - anxiety exposure - joy exposure - anger exposure - grief exposure - modular psychotherapy - dysfunctional survival rule - permission-giving life rule

The three pillars of PKP depression therapy

Pillar 1: Dealing with the symptom (Module 1)

The PKP manual for depression treatment consists of 61 instructions for pillars 1 and 2 and a further twelve for pillar 3. The first pillar is symptom therapy. These are supplemented by 14 instructions by Gerhard Laux, who provides a concise yet complete overview of antidepressants.

We start with the module on **understanding and treating symptoms:**

a) *What symptoms do I have?*
b) *What is depression?*
c) *What is the difference between emotion and mood?*
d) *Depression avoids anger and sadness*
e) *The emotional star: vital pendulum swings*

f) Depression therapy = emotion instead of mood

Like all PKP manuals, this one also contains psychotherapeutic strategies and assumes that the psychiatrist has already initiated drug treatment. The subsequent instructions by Gerhard Laux are primarily used to check whether the pharmacotherapy that may be taking place in parallel is indicated and represents a harmonious combination of psychotherapy and psychopharmacotherapy for the patient in question. The first step is the joint psychoeducational development of basic knowledge about the patient's depressive illness. This ensures that the patient is not simply depressed, but that he looks at his depression and reflects on it (mentalises it in Fonagy's sense). He goes to a meta-level and metacognition takes place (thoughts about thoughts) and even this brief distancing makes the depressive suffering temporarily less intense.

Pillar 2: Skills training (Module 2)

The second pillar supports the development of skills on a cognitive, emotional and behavioural level with four skills modules: Joy Exposure, Anxiety Exposure, Anger Exposure and Grief Exposure. Each module contains a selection of evidence-based antidepressant interventions, e.g.

Joy exposure:.

a) Pleasure training
b) Building positive activities
c) Relaxation training
d) Pampering
e) Exercise and sport

Exposure to pleasure - the respective procedure is described in detail on the back of the consultation cards - allows the gain in direct experience of positive feelings to occur safely despite resistance typical of depression. The patient will reply that a positive activity is not fun, but only exhausting. Yes, it is exhausting because it is swimming against the depressive current. Only doing nothing would make the mood even more depressed. It's not really good, but it's not as depressive as doing nothing. The therapist must not let up. It's important to wring this effort out of the patient. Well-dosed, persistent.

This is followed by

Exposure to fear:

a) self-assertion training
b) Communication training
c) Independence training
d) pleasure instead of obligation training

Exposure to anxiety increases the patient's social radius. The patient regains the confidence to interact more with other people. If the patient has a dependent or insecure personality structure, you could stay with this topic for two years. However, as soon as he dares to do the activities discussed and carries them out and you manage to maintain a sufficient amount of practice, you should not fail to move on to **anger exposure**. Dealing with anger in a socially competent way is the centre of antidepressant therapy. This area of emotion regulation is a construction site that can rarely be completed during the entire therapy. **Exposure to grief** only occurs when a major loss has not been mourned.

Exposure to anger:

a) Perceiving anger and rage
b) Allowing intense anger/rage
c) Discriminating between feelings and actions and fantasy and reality
d) Expressing anger and rage
e) Checking the appropriateness of anger/rage
f) Constructive negotiation

Grief exposure:

a) Remembering the precious, loved one I lost
b) Feeling how much I need him/her
c) Visualising the moment of loss
d) Realising the pain, despair and grief
e) Leaving the feeling there until it has disappeared by itself

Looking back and looking ahead:

What I can do now, dare to do, let go and how I resist

Pillar 3: From the dysfunctional survival rule to the permission-giving rule of life (Module 3)

The instructions for action in Pillar 3 first explore the central needs for belonging and autonomy that arose in childhood, which were frustrated by the parents to such an extent that it was necessary to find out how the parents are nevertheless prepared to satisfy them. The resulting commandments ("Only if you always ...") and prohibitions ("And if you never ...") are a reflection of the emotional conditions of survival with these parents. They were retained into adulthood, even though they are no longer valid. This is why a new rule, which is no longer a survival rule but an affirmative rule of life, can replace them and remove powerful therapeutic resistance.

A mental model of depression - how depression can develop

The interaction between the parents with their parental behaviour and the child with its innate characteristics and temperament leads not only to satisfaction but also to frustration and threats, which permanently bring certain needs to the fore, e.g. the need for security or the need for attention. It also leads to a person permanently focussing on avoiding specific threats or fears and thus building up an individual profile of avoidance actions. Another important result of his childhood is the inhibition of his aggressive tendencies towards members of his social community. The content of the anger tendencies is characteristic of a person and is also the result of the interaction between parents and child or between the child and other important attachment figures (e.g. brother, sister, grandparents). The permanent blocking of the tendency to rage and attack is an important task of self-regulation. Many people go so far as to become insecure and anxious. Psychological homeostasis (a control loop that tries to keep everything in balance) can be understood as a set of rules and the most important rule is the one that ensures survival. The processes are preconscious, i.e. the arbitrary (conscious) psyche is unaware of these connections.

Relationships are mostly about emotional survival, i.e. preventing psychological damage. A survival rule that is optimally tailored to the social environment in childhood becomes unsuitable (dysfunctional) in adult life if it is not changed. Patients have dysfunctional survival rules that ensure that their experiences and behaviour do not lead to the desired results, i.e. are detrimental to the person concerned. They also prevent the relationships of their adult life from remaining supportive

and satisfying for both sides. In our observations, we are therefore initially concerned with the personality traits that prevent success. The survival rule and the sub-optimal experience and behavioural stereotypes defined by the personality restrict a person's active behavioural repertoire considerably in some cases. As a result, they are less able or unable to cope with difficult problems. The triggering life situation, for example, can only be responded to by the development of symptoms. Experiences and behaviours that would have led to mastering the problem are forbidden. They would violate the survival rule and jeopardise emotional survival. Which life situation leads to the formation of symptoms is therefore also determined by the personality of the person affected. Therapeutic modification of these personality traits and behaviours is therefore a high priority in psychotherapeutic goal definition and treatment planning.

How to use the instructions in the PKP manual

PKP offers the option of reformatting the therapy process of goal-orientated psychotherapy (in guideline psychotherapy with 50-minute units) into shorter units of 25 minutes. These correspond to the usual EBM, GOÄ, OPS clocking. This has resulted in a series of consultations or ward rounds that make it possible to stay on the ball and keep the red thread in hand. Every contact with the patient is a step forward on the way to achieving the goal. At the patient's next visit, work continues (exactly) where it left off last time. This changes the relationship and the treatment for both the patient and the psychiatrist. A goal emerges much more clearly than before, one that is worked on together: one that both work on, not just the doctor.
The PKP practice is modular and focussed on the individual patient. Exactly that and exactly as many interventions as are conducive to the individual therapy process.
At times, especially when understanding the illness, it may be possible to work on several instructions (one instruction corresponds to one page in the PKP manual) in one hour - if the patient can follow the statements quickly. Later it will be the other way round, that we would like to have several sessions for one topic. Some instructions are omitted because the therapist or the patient is not familiar with the topic or the way the topic is being worked through. Or simply because of time constraints. The categorisation with one page for each instruction facilitates a flexible approach. We can proceed in small steps with some patients and in larger steps with others and then need fewer instructions. Sometimes we realise that we have already covered the topic of an instruction sufficiently with the previous one. We therefore skip this one.
If we persistently follow the individualised path of the modules and sub-modules at the same time, we are still taking an antidepressant path that is effective in the short and medium term. This work with the instructions is by no means

superficial. They ensure that the patient becomes more and more willing to discuss deeper issues with us. Intensive encounters with emotions and relationships take place - hopefully in a sufficiently effective way so that less depression remains.

Most of the instructions serve as a copy template for the patient. Depending on the topic, the patient fills in the page copied for him or her as required during the session or makes a record at home.
The bottom half of the page contains explanations of the practical work or notes on the theoretical background. This gives the therapist confidence in the specific procedure (why and why am I carrying out this intervention?).

Suggestion for the course of the consultation/visit

The PKP manual is placed on the therapist's desk - as a shared workbook**.**

The duration of therapy sessions for PCP is 20 to 25 minutes in clinics and outpatient clinics as well as in psychiatric consultations, and 50 minutes in psychotherapeutic practices. In the 25-minute setting, every minute is precious - while the patient subjectively needs and wants a lot of time. Nevertheless, we try to (strictly) adhere to the time available to us and not overrun by specifying the time frame available for the conversation at the beginning. The patient quickly learns to adapt to this time. Anything that has been left out will be discussed the next time.
Suggest the therapeutic procedure with PKP to the patient in the initial consultation:
I suggest that we see each other more closely for the time being. We can each have a 20- to 25-minute conversation, which is psychotherapy for your depression. We now know that psychotherapy is an essential treatment for depression. Time is very short and we have to make good use of it. That's why we can't just stay with your acute complaints and problems, but must place them in a wider context of depression. In each session, we will work on a therapeutic topic that is very important for overcoming the depression. It is useful to fill out project cards on the respective topic. This will give you mental clarity about your depression and your depression therapy.
Even before our conversation here in the practice/visit begins, fill out a short report or handout (copy of a page from the PKP manual), e.g. a project card, on the current topic by recording everything worth mentioning from the past week/s or the current project. This will get you in the mood for our upcoming meeting and give us a reliable overview so that we don't overlook anything important. At the end of our conversation, I will ask you to do something about your depression every

day if possible between our meetings. If you do nothing, nothing will happen. It may be tedious, but we have to tackle the things that will help to get your depression under control. Do you agree with this approach?"
If the patient agrees, they can already be given a photocopy of instruction 2 "What symptoms do I have? (Simply list all the symptoms. Please name only one symptom per line ...) can be given to the patient to take home.
The patient has therefore completed his homework for the next appointments after the last lesson: he has filled in a short report at home about the events and activities of the last week or the photocopied instructions for action or the relevant project card for the topic.
We normally limit the time for the short homework report to a few minutes. Some topics can be postponed until the next time.
The therapist opens the work with the instruction: "Today's topic is ...." and explains which topic (module/submodule) is involved and discusses the content of the instructions for this topic with the patient. She focusses on positive, non-depressive statements made by the patient. In this way, a shared fantasy can emerge that includes a helpful understanding of the topic and a plan for how the topic can be implemented in the patient's life. At the end of the consultation/therapy session, homework is planned again so that the situation, people involved, day and time are determined as far as possible. The patient is asked to express their decision that they will tackle the project discussed, that it is their firm intention.
The patient deals with the topic until the next session, even if it is only to think about the topic for five minutes a day and recall the shared thoughts. If the topic of the instruction has not yet been completed, the patient continues to work on it in the next consultation, i.e. does not simply rush on.
In the meantime, the patient is actively involved - in thought and action, in accordance with their limited possibilities due to their illness. They are required to make their contribution. They are mobilised emotionally, cognitively and actively and resistance is dealt with in the therapeutic relationship and used for relationship work.

Practical work with the modules

1. **Symptom therapy pillar: Depressive symptoms (Module 1)**

If the patient is not severely depressed, we can talk to them about their symptoms, their illness and its origins:
Metacognitive contemplation or mentalising (for 15 minutes in a 25-minute setting),

- because we have already spent 5 minutes asking what has happened since the last appointment and
- because we discuss with him for another 5 minutes what he will do until the next appointment.

In the 50-minute setting, we have 40 minutes to do this. However, it is not uncommon for two twenty-minute discussions of two topics/manual instructions to take place in these 40 minutes.
If the patient is so severely depressed that they cannot concentrate on exchanging thoughts in order to develop an understanding of the illness, an intervention must be started instead that guides their consciousness away from the depressive state. Resource-orientation is obvious: joy exposure, starting with simple positive activities (see module section on joy exposure).

Mentally organising your own symptoms (instruction 10)
The focus is not on remembering, but on thinking, differentiating and correctly categorising. The patient is given the impulse to briefly step out of the affective experience of depression and "expertly" sort their findings - according to thoughts, feelings, actions, etc.
Again, the **aim** is for the patient to look at themselves from a certain distance or from a bird's eye view, which automatically reduces the depressive symptoms somewhat. He moves from simple (depressive) cognition to (non-depressive) metacognition.

Depression is an affective disorder in which there is moodiness. We explain to the patient the difference between emotion and mood (instruction 13):
Feelings such as joy, anger relate to an event, relate to a person, are a reaction to their behaviour, start quickly and change rapidly, can become very intense and have a short duration (minutes).
Moods are the opposite of everything! They do not relate to any event or person, start and change slowly. Why do they do that? They are supposed to protect us from feelings and their consequences.
We can explain this to the patient (Card 16):
In terms of behavioural theory, depression is an operant or instrumental behaviour.

- *It is maintained by its consequences.*
- *The consequence of depression is avoidance.*
- *To understand depression, we need to find out what exactly is being avoided.*

The aim **is** for the patient to categorise the triggering situation in such a way that they should have been able to defend themselves, but the depression wants to prevent them from doing so (Card 18): Depression avoids fighting back effectively and the feelings associated with it. It is usually anger, pain or sadness.

The aim **is** for the patient to accept the necessity of anger as the basis of a healthy defence. He is taught that he has a duty to his life to allow his anger to be felt so that he can defend himself. Those who do not defend themselves tempt others to become offenders. In social interaction, it is necessary to show the other person that they have crossed my boundaries and that I don't want them to. They need this feedback in order to return to good social behaviour.

When a loss leads to depression (card 22):

- *Depression avoids the transition to the next phase of grief: letting go.*
- *What I don't let go of, I don't lose.*
- *Or: I can't live without it, so I can't let go in grief.*
- *Or: Letting go is so painful - I wouldn't be able to bear the pain.*

The aim **is** for the patient to realise (if this is the case for them) that their depression is helping them to avoid grief, which they do not feel able to cope with. They are offered enough support so that they can face their grief later.

2. Pillar: Skills training: The emotional star = vital pendulum swings (Module 2)

We begin the psychoeducation on the emotional star by emphasising that every person needs these feelings to benefit their vitality (= life force). They help them to react to the world in the best possible way and to take care of their inner well-being (satisfying needs, reducing dangers, overcoming losses, resisting frustration).
The aim is for the patient to recognise the vital necessity of free access to their feelings. Feelings provide orientation, help to do what is necessary, etc.

Depression = upset instead of feeling

"When depression protects against unbearable or seemingly dangerous feelings and eliminates them, vitality is lost. Not only the emotional life is suffocated. Relationships can no longer be organised either. And everyday tasks become very difficult. This is too high a price to pay. There is a lack of motivation and strength to take control of one's life."

The aim is for the patient to be able to see the advantages and disadvantages for their psyche: *"The protection was probably necessary, but the price is too high. There must be another way. Depression is like a black, leaden veil that consumes and crushes a person's vital feelings. You no longer have access to your feelings and your vital energy. You need help to be able to face your feelings again. You need exposure to joy, fear, anger and sadness."*

Depression therapy is therefore emotion exposure and Pillar 1 (symptom therapy) leads directly into Pillar 2 (skills training).

Joy exposure

a) Development of positive activities

Positive activities are activities that have a reinforcing effect.
They brighten the mood or prevent depression.

The steps are:

- Creating an individualised list of small, medium and large reinforcing activities
- Plan the next day's activities
- Log an activity as soon as possible after carrying it out
- Estimate the mood during the activity (0 - 10)
- In the evening, estimate the average mood of the day
- In future, plan activities that are associated with greater mood enhancement more often

b) Exercise and sport

Sport is one of the most important antidepressants.
It is therefore worth persevering and forcing the patient to make a compromise. Even if they don't have the strength at the moment, even if it is tiring, the reward of improving their mood will certainly come.
A type of sport should be chosen that can be practised daily (45 minutes of brisk walking (agree a destination: where to?), 20 minutes of jogging, 30 minutes of cycling). In addition, a real sport should be taken up, ideally a team sport such as volleyball, basketball or, if a partner is available, badminton, tennis. Otherwise swimming).
The therapist should not let up, even if the resistance is difficult**.**

c) Relaxation training

Instruction in the method of progressive muscle relaxation.
Practise relaxation with the patient for several sessions during the therapy hour (initially 20 minutes, later 10 minutes).
Give the patient a CD or an mp3 file on a stick, which they should use to relax twice a day. It is better if they can instruct themselves.

Have the patient write a protocol with details of the relaxation effect
(e.g. reduced from 70 % tension to 30 %) for each exercise.
Show the patient how to use PMR in everyday life.

d) Pleasure training

Patient and therapist bring sensual objects to enjoy during the session. The objects and images are spread out. One sensory organ at a time - 5 minutes each:
Practise soothing visual, auditory, olfactory, gustatory and kinaesthetic perception (collect and expose reinforcing stimuli in all sensory modalities).
Conscious and focussed perception.
What, how? What does it trigger in me? How does it make me feel?
Intentionally retain the memory of it - memorise it well and remember what is pleasant.
Use more and more situations for this concentrated sensory experience.
More and more often, direct your awareness away from brooding and towards perceiving the moment.

e) Indulge yourself

Arrange an hour (e.g. in the evening after dinner) with your carer (partner) as an hour of pampering.
Make yourself comfortable in the shared living room.
The carer comes up with small gestures and gifts that have a pampering effect (a comfortable cushion, a drink, something to snack on, atmospheric lighting, pleasant music, a nice scent, a selection of interesting reading material, a massage (only with consent).
Concentrate on the pleasantness of the gesture or gift.
Say that it is pleasant.
Finally, say thank you for the pampering.

Exposure to fear

a) Self-assertion training

Asserting yourself means two things: being able to say no and being able to make demands.
Record everyday situations with these two topics.

Carry out a situation and behaviour analysis.
Define the desired assertive behaviour.
Practise this in role play.
Determine when and where it will be performed for the first time.
Conclude a behaviour contract.
Record the result.
Discuss in the next lesson: Confirmation and/or
modification of the behaviour. Continue practising until automation.

b) Communication training

Fear of unpleasant feelings or reactions from others prevents open discussion.
Learn the speaker role (first person, concrete, present tense).
Learn the role of listener (encourage speaking out, questions, repeating).
Learn conflict dialogue (feelings, wishes, willingness).
Discuss all important topics with the person concerned (practise difficult conversations in role play beforehand).
Further conversations until the avoidance of communication becomes a joy of communication.
First try it out in the session with a current topic of dispute in which the patient has a concern.

c) Independence training

Those who do not allow anger are often afraid of losing love.
Those who do not allow grief are often afraid of being alone.
Those who do not allow mediocrity are afraid of nothingness.
Practise living without the highest good (e.g. partner, job, children, reputation, success) in order to no longer be dependent.
Build up your own circle of friends without your partner.
Develop your own hobby without your partner.
Develop your own taste.
Do things that others don't easily accept.
Hold an opinion that others don't share.

Learning to be mediocre when I've been the best so far.
Daily practice is important.

d) Pleasure training instead of compulsory training
Those who previously only gained satisfaction/enhancement from performance and fulfilment of duties can now learn to forget duties.
Create a daily log of all the day's activities.
Ask for each activity: Did I do it out of duty? (= P)
Ask for each activity: Did I do it for fun, for pleasure? (= L)
Plan the next day so that there are at least as many fun activities as compulsory activities. Cancel any surplus P activities.
Instead of "out of obligation (P)" as often as possible "want out of responsibility (which is also L)":
Consciously decide for yourself: "Do I want to do this now?"

Grief exposure
Remembering the precious, beloved things I have lost→ Daily remembrance
Grieving means visualising and remembering what you have lost.
This is the beginning of the grieving process.
Those who do not consciously deal with what was valuable, what was loved, do not enter into the process of mourning.
When you lose someone, you remember what was loved. What you didn't like about this person doesn't need to be mourned.
All the memories of good times together are dredged up and looked at (either internal images or photos, videos, stories from contemporaries).

Our psyche automatically tries to quickly eliminate such an immeasurable feeling as the pain of separation. It has all kinds of strategies at its disposal: Great reason, having to take care of others, distraction, being overactive, falling in love again quickly.
Only if you manage to let the pain and grief be there until it dries up on its own will progress be made in the grieving process. Otherwise the process will be postponed again and again.

We also find the opposite: that the psyche brings the grief back again and again in the course of a day in order to work through it in small, manageable doses. That is a good thing.

Exposure to anger

Recognising anger and rage

Realise the significance of the angry event.
Feel the feeling of anger.
Catch yourself fleeing (emotionally or cognitively) from the anger.
Try to get back to the anger.
If you notice that the anger disappears so quickly that you don't defend yourself, you have to get the anger back by becoming aware of what is annoying about the other person's behaviour.

b) Allowing anger

This is the actual exposure to anger.
Select the currently most upsetting situation with an important person.
Visualise the angry, outrageous behaviour of the other person.
Imagine the situation with your eyes closed and feel the feeling of anger.
Feel and allow your own anger to grow.
Imagine defending yourself full of anger, acting out of anger until the anger is gone.

3. Pillar from the dysfunctional survival rule to the permission-giving rule of life (Module 3)

The linchpin of the practical implementation of Psychiatric and Psychological Brief Psychotherapy PKP is the replacement of the dysfunctional survival rule, which conveys commands and prohibitions , with a new permission-giving rule of life. This is the only way to overcome the powerful therapeutic resistances that are part of depression. This module is entirely personal and individual and reaches depths that we are otherwise only familiar with from psychodynamic therapies.
As in the development of Beck's (1979) basic assumptions, the starting point is the patient's learning history in the first four to five years of life. Which child behaviour ensures sufficient positive attention from the parents? And which behaviour significantly endangers it? The child is concerned with the adequate satisfaction of its central needs and the minimisation of central threats/fears. This results in the statement "Only if I am always friendly, for example ... and if I

never show my anger, will I keep myself safe and loved and prevent the loss of parental love and being left alone." The survival rule corresponds to Bowlby's (1975) inner working model, which should primarily ensure sufficient attachment. The third pillar or third module of PKP was later adopted as the second module in another modular psychotherapy: Mentalisation Supporting Behaviour Therapy (MST= Mentalization Supporting Therapy - Sulz 2021). There, the survival rule is overcome in two steps. Firstly, by imagining an inner companion who is given the emotional authority to give permission to act against the dysfunctional survival rule. This permission is internalised so that the patient can finally give themselves this permission.

Review and outlook for depression therapy

At the end of the systematic therapy, therapist and patient look at the result together.
No matter how far the emotional exposures have led, no matter how small or great the progress may be, something has moved. The sentences on the front of the card can therefore be completed individually. Reflection on a metacognitive level directs attention to the resource side.
This creates confidence for the time ahead and satisfaction with what has been achieved.

Pharmacotherapy of depression (Gerhard Laux)

Gerd Laux has presented the accompanying pharmacotherapy very compactly and comprehensively enough in 14 instructions. This makes it very easy to gain an overview and ensure that all criteria are taken into account when selecting the right medication for the patient. The topics are

1. General information and mechanisms of action
2. Classification of antidepressants
3. Selection criteria
4. Tolerability
5. Preliminary examinations - compliance
6. Checklist before starting treatment
7. Dosage
8. Course of therapy

9. Side effects
10. Contraindications
11. Control examinations
12. Recommendations
13. Special cases and bipolar depression
14. Pregnancy

Only a few aspects will be discussed here in brief.

General: The more severe the depressive syndrome, the more important the pharmacotherapy.
Worldwide proof of efficacy compared to placebo.
Antidepressants increase the concentration of the neurotransmitters noradrenaline and/or serotonin in the synaptic cleft either by inhibiting reuptake or by inhibiting enzymatic degradation.
More recent studies show changes in the sensitivity of receptors as well as changes in signal transduction - an explanation for the effect latency.
Recently, activation of neuro-/synaptogenesis has been discussed as a mechanism of action (activation of BDNF etc.).

Classification of antidepressants: A distinction is mainly made between

1. non-selective, older so-called tricyclic antidepressants
2. selective antidepressants
   a selective serotonin reuptake inhibitors (SSRIs)
   b selective serotonin and noradrenaline reuptake inhibitors (SNRI)
3. Monoamine oxidase inhibitors (MAOH)
4. Herbal: St John's wort (hypericum extract)

Selection criteria:

- Previous response to the medication in question
- Acceptance by the patient
- Side effect profile

- Risk factors of the patient
- Current clinical picture: main symptoms sleep disturbance, restlessness, listlessness, obsessive-compulsive symptoms
- Severity of the illness

Escitalopram, venlafaxine, sertraline and mirtazapine were found to have the best efficacy/acceptance/tolerability ratio in meta-analyses (e.g. Cipriani et al)

Preliminary examinations

- Physical status (weight; risk factors)
- Laboratory, ECG, pregnancy test if necessary (GP)
- EEG (older people, patients at risk)

Differential diagnosis: e.g. bipolar depression, schizoaffective psychosis, dementia; somatic diseases, hypothyroidism, anaemia, Parkinson's disease

Antidepressants only work after 2-3 weeks of regular use!
Generally only prescribe 1 antidepressant

Dosage

- The required dose may vary from person to person
- St John's wort Minimum dose 900 mg per day
- E.g. citalopram 20-40 mg, sertraline 50-200 mg, venlafaxine 75-225 mg, amitriptyline 50-150 mg, valdoxan 25-50 mg, mirtazapine 15-45 mg per day
- Generally lower doses for older people

Course of therapy

Acute treatment

- Individual symptoms such as disturbed sleep, restlessness should improve after a few days
- Return to the doctor after 10-14 days

- If there is no improvement, change in therapy necessary - increase dose, change, combination

Maintenance therapy

- For initial illness for 6-12 months at full dose
- In case of several depressive phases, long-term treatment over years

Compliance: The central problem of long-term therapy is compliance! Approx. 50% of patients discontinue medication (usually without informing their doctor) within 3 months!
Duration of therapy depends on family history, duration and severity of the phases.
Studies show: Recurrence rate under antidepressants approx. 20-30% under placebo 40-60%

Side effects: In the case of older tricyclic antidepressants, dry mouth, constipation, blurred vision, dizziness, lowering of blood pressure, urination disorders in the foreground
With newer selective antidepressants such as the serotonin-selective antidepressants (SSRIs): nausea, restlessness, sexual dysfunction.
Mirtazapine: tiredness, weight gain
Side effects, especially at the beginning of treatment, usually subside during treatment.

Contraindications:
Antidepressants in general: Intoxication, acute urinary retention, mania, delirium
Tricyclics: pyloric stenosis, prostatic hypertrophy, ileus, myocardial infarction, glaucoma
SSRI, duloxetine, mirtazapine: MAO inhibitors, serotonergic substances
Bupropion, maprotiline: epilepsy
Agomelatine, duloxetine: liver diseases
Venlafaxine: cardiovascular diseases

Control tests

Check-ups of blood count, liver and kidney values, blood pressure.
Plasma level monitoring in the absence of effect, unexpected side effects.

Fitness to drive may be impaired or cancelled in cases of severe depression. Successful pharmacotherapy usually restores fitness to drive.
Side effects relevant to driving are sedation, visual disturbances, main risk in combination with alcohol.

Special cases

Bipolar depression

Depression in the context of manic-depressive illness is primarily treated with mood stabilising medication (e.g. lithium). Antidepressants are only added in cases of severe depression.
→ Best results in bipolar depression for lithium augmentation and quetiapine. Antidepressant only in addition, preferably SSRI (lower risk of switch to mania)

So-called. Treatment-resistant depression

Insufficient response to 2 different antidepressants in sufficient dosage and duration.
Special procedure, e.g. combination treatment
→ Best results with treatment-resistant depression (approx. 30%!):
Exclusion of pseudo-therapy resistance (e.g. non-compliance), dose adjustment for tricyclics and venlafaxine, best data for lithium augmentation

Pregnancy

- If pregnancy is planned, risk-benefit assessment, i.e. there is a relative risk of (severe) depression Taking an antidepressant at the lowest effective dose is indicated
- Frequently unplanned pregnancy. Psychopharmacotherapy is not an indication for termination of pregnancy, only if prenatal diagnostics provide clear indications of foetal damage
- There is no substantial evidence of a relevant risk for antidepressants, best data for amitriptyline, sertraline and citalopram.
- No abrupt discontinuation due to pregnancy
- No valproate or carbamazepine ! (mood stabilisers)
- Always discontinue antidepressants gradually in consultation with your doctor
- Sertraline, citalopram, amitriptyline are considered to be the drugs of first choice
- If a pregnant patient is stable on mirtazapine or venlafaxine, there are no arguments in favour of a switch

- Studies show only a slightly increased risk of an increase in the miscarriage rate
- Advice at *embryotox.de*

For more information see Sulz S. (2021c). Kurz-Psychotherapie mit Sprechstundenkarten. Wirksame Interventionen bei Depression, Angst- und Zwangskrankheiten, Alkoholabhängigkeit und chronischem Schmerz. Gießen: Psychosozial-Verlag

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