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Chapter

Psychosomatic Inpatient Rehabilitation for People with Depression in Germany

Ralf F. Tauber, Carola Nisch, Mutahira M. Qureshi, Olivia Patsalos and Hubertus Himmerich

Abstract

In Germany, inpatient therapy for depression mainly takes place in either health insurance-financed psychiatric hospitals, or in pension insurance-financed, psychotherapy-focused, psychosomatic rehabilitation hospitals. In psychiatric hospitals, the diagnosis is made according to the International Classification of Diseases (ICD), and therapeutic attempts are made to achieve remission, whereas in rehabilitation hospitals, the International Classification of Functioning, Disability and Health (ICF) plays an essential diagnostic role. Accordingly, the main German pension insurance, Deutsche Rentenversicherung, has developed a rehabilitation therapy standard for depressive disorders. In this chapter, we focus on the psychotherapeutic inpatient rehabilitation for patients with depression based on an example of a specialized psychotherapeutic hospital. This example illustrates how psychotherapeutic inpatient rehabilitation can be tailored to the individual's needs and may include any of the following therapeutic modalities: Cognitive Behavior Therapy (CBT), Schema Therapy, Cognitive Behavioral Analysis System of Psychotherapy (CBASP), pharmacotherapy, group therapy for comorbid conditions, skills training, psychoeducation, occupational therapy (OT), movement therapy, physiotherapy, music therapy, social work, family work, and self-help groups. People with depression may benefit from this service model of psychosomatic inpatient rehabilitation beyond symptom remission, as it focuses on increasing people's functional level as well as their quality of life.

Keywords: inpatient therapy, psychosomatic therapy, psychotherapy, depression, rehabilitation

1. Introduction

Mental and substance use disorders are the leading cause of years lived with disability (YLD) worldwide, whereby depressive disorders account for 42.5% of YLDs caused by mental and substance use disorders [1]. The health report of the German technicians' health insurance in 2016 [2] found that the number of work absences due to a mental disorder has almost doubled from the year 2000, reaching its highest value in 2015 at 245 sick leave days per 100 insurance years. Patients with depressive illnesses represented the group with most sick days [2]. Cumulative data

for all public and private health insurance companies in Germany are not available, but comparable reports of individual insurances show similar results.

Compared to other diseases whose number of hospital admissions has remained relatively constant over the past few years (e.g., diseases of the circulatory system, the musculoskeletal system, and cancer), the incidence of mental illnesses in the inpatient care system has steadily increased since 1990. While the number of admissions due to somatic diseases has tended to decrease, psychiatric diagnoses have risen from 175 to 350 days per 1000 insured years since 1990. Among these psychiatric diagnoses, substance misuse disorders as well as depressive disorders are by far the most frequent ones [3]. The Federal Health Care Report (Gesundheitsberichterstattung des Bundes) estimates an increase in the direct cost of mental illness from €219 million in 2002 to about €254 million in 2008 [4]. Beyond the financial cost, mental illnesses, and specifically depression, are accompanied by severe suffering, considerable impairment of work performance, and reduced quality of life (QoL) [5].

2. The significance of mental disorders for German pension insurances

In contrast to other health systems such as the public National Health Service (NHS) in the United Kingdom, which is funded by the state, health care in Germany is mainly funded by either public or private health insurances, as well as by pension insurance, taxes, and out-of-pocket co-payments. Public and private health insurances as well as pension insurances are financed by contributions from both the employer and the employee; a percentage of the employee's gross income is transferred to the individual's health and pension scheme. Whereas health care in general is funded by public or private health care insurances, rehabilitation and work reintegration is funded by pension insurances, which also cover the costs of treatment in rehabilitation hospitals.

As a result, mental illnesses are placing an increasingly heavy burden on pension insurance schemes such as the German Statutory Pension Insurance (Deutschen Rentenversicherung; DRV). While only 6.6% of all occupational disability-related illnesses were of a mental nature in 1982, their incidence rose to 42% by 2012. Among women, almost half (48.5%) of sickness leave was due to a mental disorder [6]. In addition, the average age of retirement in patients with mental illness is lower as compared to other diagnostic groups (48.1 vs. 50.4 years) [6]. Consequently, fewer social insurance contributions are generated by patients and their employers (since they are no longer working), and the duration of pension payments increases (since patients retire earlier).

The amount of DRV reimbursement for medical rehabilitation of mental disorders in 2012 was €716 million as reported in their 2016 position paper of the DRV on the Significance of Mental Illnesses in Rehabilitation and Disability Reduction [7]. Against this background, the DRV has a pressing need to reduce the incapacity to work that results from depressive or other psychological disorders.

3. A disease model for the rehabilitative treatment of depressed patients

Acute and long-term treatments of mental illnesses are either directed at the assumed causes of a certain disorder or the presenting symptoms. They are primarily centered on the clinical picture as a manifestation of the disease or

injury and are aimed at treatment response or remission. In the case of disorders with a tendency toward chronicity, prevention of episode aggravation or precipitation of another episode is crucial. The conceptual framework of acute and long-term psychiatric disorders is frequently based on a medical disease model that corresponds to the classification according to the International Classification of Diseases (ICD) of the World Health Organization (WHO) [8]. For example, in Germany a patient with a severe third episode of depressive symptoms is seen by a psychiatrist in their practice, referred and admitted to a psychiatric hospital, diagnosed with recurrent major depressive disorder (ICD-10 code: F33.2) [8], and treated by the multidisciplinary team on the psychiatric ward according to the German national guidelines for the treatment of unipolar depression [9], which advise psychopharmacological treatment with an antidepressant that will continue after discharge. The costs of admission are incurred by the private or public health insurance.

In contrast, medical rehabilitation as practiced in rehabilitation hospitals in Germany is based on the biopsychosocial model of functioning, disability and health. This model has also been introduced by the WHO [10] in their International Classification of Functioning, Disability and Health (ICF) framework. While ICD-10 gives users an etiological or symptom-based framework for the classification, that is, the diagnosis of a disease, disorder, or health condition, the ICF classifies functioning and disability as associated with health conditions. The ICD-10 and ICF are therefore seen as complementary to one another [10, 11].

In the biopsychosocial model of functioning, disability and health, impairments take place on three levels: (1) body structures and functions, (2) activity, and (3) participation. Health is seen as embedded in the context of “functioning.” A person is therefore “functionally healthy” when:

- Their physical functions including that of the mind and body are of accepted standards,
- They can perform all levels of activities that are expected of a person without a health problem, and
- They are able to develop their participation in all areas of life that are important to them, in the manner and extent that is expected of a person without impairment of body structures, functions, or activities (i.e., a level of participation in all spheres of life).

This model conceptualizes health and disease as a result of the interlocking of physiological, psychological, and social processes (see **Figure 1**). The type and extent of functional health of a person are therefore also dependent on the circumstances or the background of the person’s life. These contextual factors consist of personal factors (e.g., age, sex, and lifestyle) and environmental factors (e.g., family, residential situation, and work situation). These factors can either exert a favorable influence (positive context factors) or have a detrimental influence (negative context factors or barriers) on the overall prognosis, recovery, and reintegration into work and society. **Figure 2** gives an example of how this model can be applied in the case of a patient with a depressive episode. By considering these context factors, it is ensured that in addition to any medical diagnoses, personal and/or social conditions, the patients’ experience is part of the rehabilitative treatment [11].

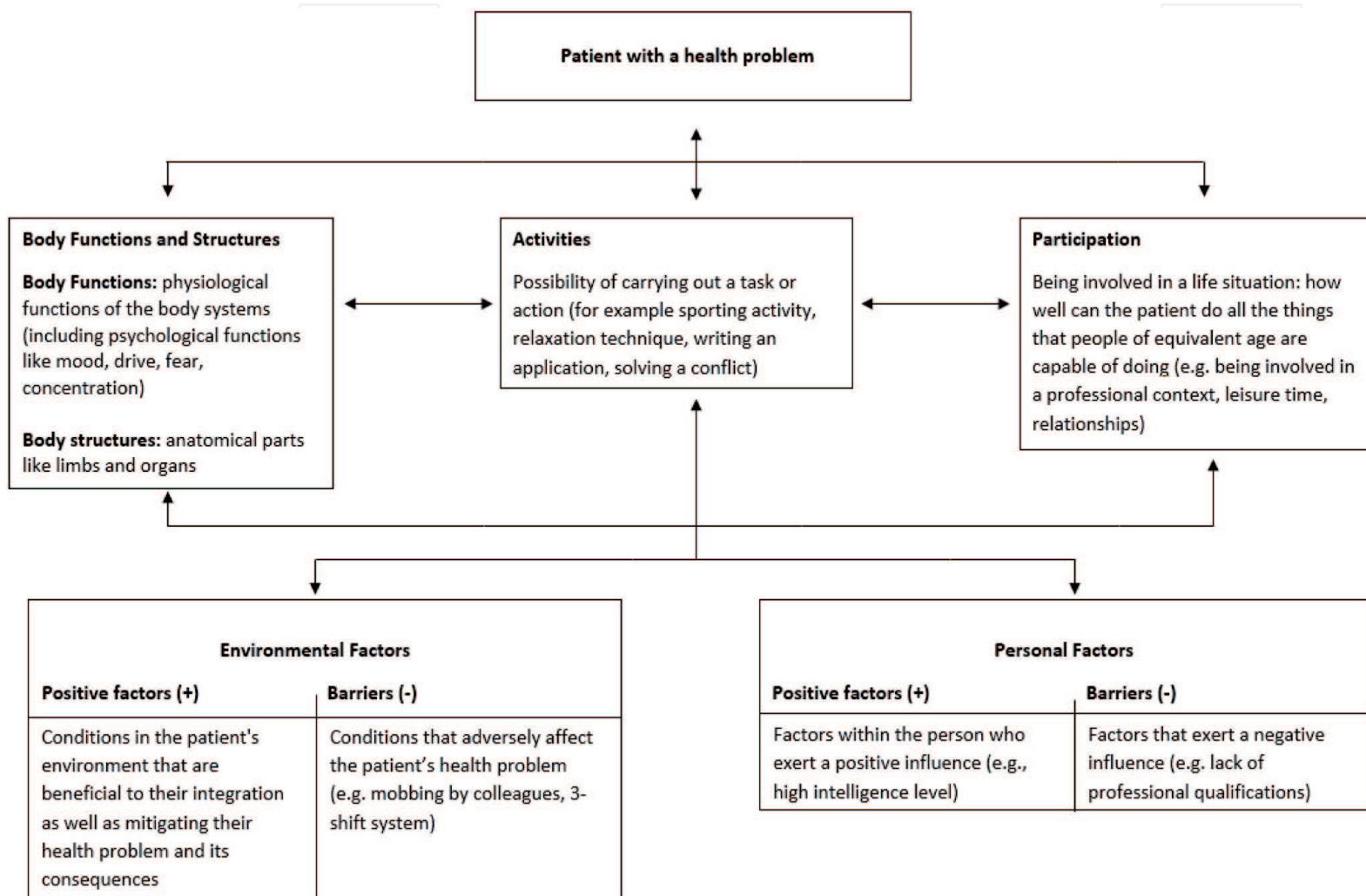


Figure 1. ICF model with definitions of the terms used.

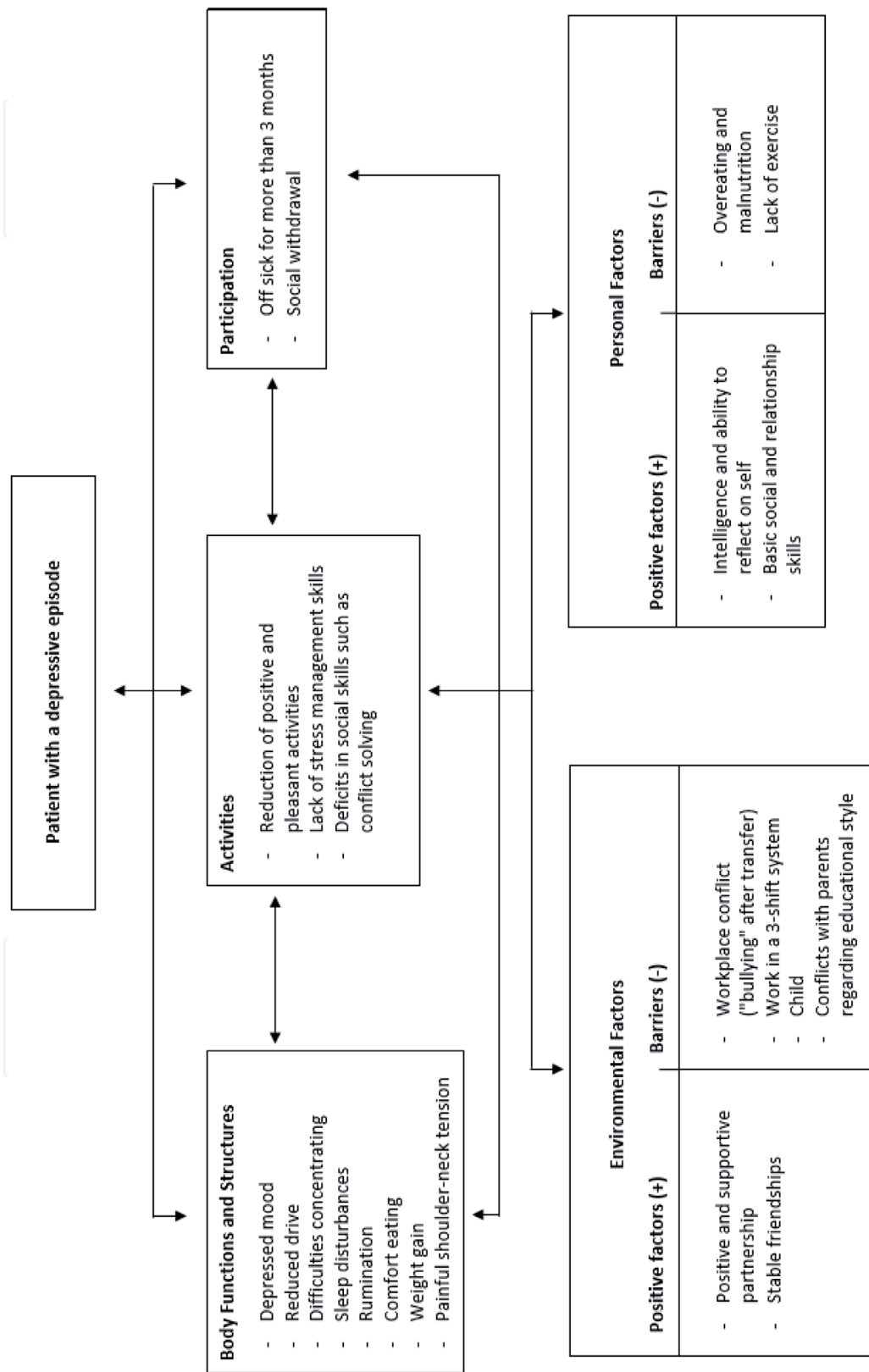


Figure 2. Example of applying the ICF model to a sample patient with depression.

4. The goal of rehabilitative treatment of depressed patients

Against the background of the biopsychosocial model of functional health, the rehabilitation goals of each of three levels of functioning are specified taking into account their respective context factors (**Figure 3** exemplifies these goals for the patient described in **Figure 2**). The aim is to remove or reduce the impending or already manifest impairments of participation or prevent their exacerbation and worsening. The patient is ultimately to be enabled or re-enabled by the rehabilitation to spend their life in a way that is normal within their personal life context.

Participation in their professional life may be of specific interest, even if their job has not been the trigger of a depressive episode. For example, a depressive episode following the death of a close relative may require psychosomatic rehabilitation, because it may impact on the capacity to work and subsequent disability. Therefore, it is in the interest of the cost-bearers such as the pension insurance to prevent such depressive disorders at an early stage.

In psychosomatic rehabilitation for depression, the acute psychiatric treatment is usually not yet completed by the time of discharge from hospital. In some cases, the rehabilitation hospitals are the first treatment providers and thus must provide acute care including psychoeducation, psychopharmacological and psychological therapy. Thus, good psychosomatic rehabilitation encompasses elements of acute psychiatric treatment in addition to the core rehabilitation goals of enhancing the individual's resources, removing barriers, and improving the overall performance to compensate for remaining restrictions and disabilities.

5. The therapeutic standard for rehabilitation in depressive disorders

In recent years, several national and international clinical guidelines have been developed, which provide an optimal, up-to-date therapy or action algorithm as a guidance for the practicing physician. In Germany, the national guidelines for the treatment of unipolar depression [9] constitute the central systematic summary of the current scientific status on the acute treatment and care for people with depression. In addition to this guideline, the DRV has developed a therapeutic standard for rehabilitation (RTS) of depressive disorder [12]. In this standard, the so-called "evidence-based therapy modules" (ETMs) derived from rehabilitation research are defined. The RTS clarifies the specific therapies that constitute an ETM, as well as their duration and frequency. In turn, the therapies provided by the psychosomatic rehabilitation hospital are listed, described, and coded in the German Classification of Therapeutic Procedures [13].

The documentation of applied therapies according to the KTL system is regularly communicated to the funders, for example, a pension insurance, for each patient individually. This can then be used to determine annually to what extent the RTS was implemented by the hospital. We will depict the practicalities of rehabilitative treatment of depressive illnesses in psychosomatic hospitals by using our own hospital, the Psychosomatic Department of the Sachsenklinik Bad Lausick, as an example. This will illustrate not only the application of the aforementioned guidelines, but also the freedom that exists within this framework to implement hospital-specific cognitive-behavioral approaches or novel concepts such as schema therapy [14] or Cognitive Behavioral Analysis System of Psychotherapy (CBASP) [15].

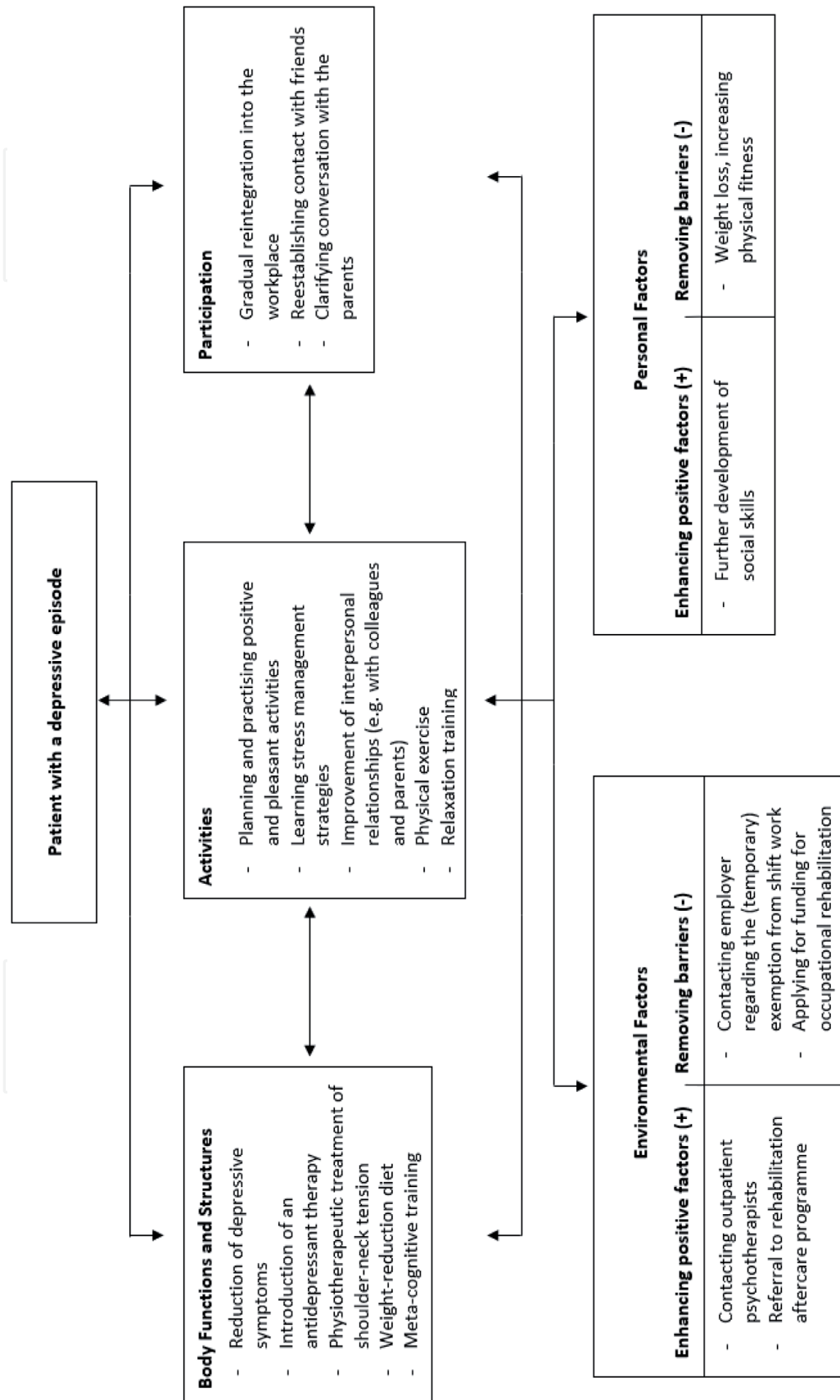


Figure 3. Rehabilitation goals and therapeutic measures according to the ICF model for a patient with depression.

6. Example of psychosomatic inpatient treatment for depression

Psychotherapeutic and medical treatment: In the Psychosomatic Department of the Sachsenklinik Bad Lausick, a treatment concept is applied that places special emphasis on the high quality and density of specific psychotherapeutic interventions. The clinic currently comprises of 100 beds, which are allocated to six wards with multidisciplinary teams (MDT). Each MDT is divided into two thematically specialized sub-teams. Psychological and medical staff are permanently assigned to these sub-teams. **Table 1** depicts the structure of the Psychosomatic Department of the Sachsenklinik Bad Lausic in more detail. In each sub-team, approximately eight to nine patients are assigned and treated by their reference therapists within this family-like group. This allows frequent patient-centered contacts with the reference therapists. There are, in principle, three disorder-specific group therapies (90 min each) as well as at least one individual interview. Thus, the patients are guaranteed a total of at least 20 psychotherapeutic contacts with their reference therapist within a 5-week stay. Nine of the sub-teams of this department are specialized in treating depressive patients. However, there are conceptual differences between the sub-teams (see below).

For patients with psychiatric comorbidities, disorder-specific group therapies are offered, which are applied across all the teams and can thus be attended by those patients referred to by their sub-teams. According to cognitive-behavioral treatment principles, manualized group therapies are facilitated for people with anxiety disorders, pain disorders, obesity, binge eating disorder, obsessive-compulsive disorder, and tinnitus. In addition to these symptom-oriented skills, training is also offered according to the Dialectic Behavioral Therapy (DBT) created by Linehan [16]. These groups take place once or twice a week and each has a duration of 90–120 min per week.

In addition to the groups for the treatment of existing mental illnesses, further non-disorder-specific group therapy is offered. In these groups, patients are trained in general life skills (which are relevant at the ICF level of activities) geared toward coping with difficulties and not necessarily related to a specific psychiatric disorder. Examples include stress management, enjoyment training, social competences training, and imagination groups. In addition, there is a metacognitive training (MCT) group based on metacognitive therapy techniques, in which patients learn a new way of dealing with rumination or worrying thoughts.

Within this context, two separate groups are offered, which have a special working reference within the framework of medical-occupational rehabilitation (medizinisch-berufliche rehabilitation). One group, the so-called professional competence group, is designed to recognize, solve, and avoid workplace conflicts and interpersonal problems, such as bullying. The other group is known as the work-related motivation group. In this group, special focus is given to building up the systematic motivation necessary to take a proactive position and to (re-)enter professional life. Above all, the therapeutic community with other affected people can also be used as a resource to reduce the often-present despair or the sometimes-exaggerated concerns of returning to the workplace. The disorder-specific groups each have a timeframe of about 60–120 min per week.

In addition to goal-oriented therapeutic interventions for the reduction of unhelpful behavior and symptoms, resource-oriented approaches are also used to tap into previously unused potential and abilities of the patient. These well-prepared, high-quality, therapeutically guided cognitive-behavioral group therapies are not simply about psychoeducation or group participant interaction. Instead, in these groups, the therapeutic process between the individual participants and the therapist can be advanced and expanded, especially after appropriate preparation

Medical Director												
Consultant Psychiatrist 1						Consultant Psychiatrist 2						
Consultant Psychologist												
TEAM 1		TEAM 2		TEAM 3		TEAM 4		TEAM 5		TEAM 6		
Team 1A	Team 1B	Team 2A	Team 2B	Team 3A	Team 3B	Team 4A	Team 4B	Team 5A	Team 5B	Team 6A	Team 6B	
Medical Indication: Depressive disorders Old-age depression	Medical Indication: Recurrent depressive disorders Personality disorders	Medical Indication: Somatic symptom disorders Pain disorders Migraine and chronic headache	Medical Indication: Somatic symptom disorders	Medical Indication: Anxiety Disorders Somatic symptom disorders Trauma-related disorders	Medical Indication: Obsessive-compulsive disorders Eating disorders Dissociative disorders	Medical Indication: Burnout-type depression Disorders related to conflicts at the workplace	Medical Indication: Burnout-type depression in workers	Medical Indication: Bereavement - and loss-type depression Adaptation disorder	Medical Indication: Chronic depressive disorder	Medical Indication: Burnout-type depression in managers	Medical Indication: Burnout-type depression in academics and helping professions	
Therapeutic concept: Cognitive behaviour therapy for depression	Therapeutic concept: Schema therapy	Therapeutic concept: Cognitive behaviour therapy for pain disorders	Therapeutic concept: Cognitive behaviour therapy for depression and pain disorders	Therapeutic concept: Cognitive behaviour therapy for depression and pain disorders	Therapeutic concept: Exposition-focussed cognitive behaviour therapy	Therapeutic concept: Cognitive behaviour therapy plus stress training Social competences training	Therapeutic concept: Cognitive behaviour therapy plus stress training	Therapeutic concept: Cognitive behaviour therapy for depression plus interventions for anxiety and bereavement	Therapeutic concept: Cognitive Behavioural Analysis System of Psychotherapy	Therapeutic concept: Cognitive behaviour therapy plus stress training and coaching	Therapeutic concept: Cognitive behaviour therapy plus stress training	
Psychologist 1	Psychologist 2	Psychologist 1	Psychologist 2	Psychologist 1	Psychologist 2	Psychologist 1	Psychologist 2	Psychologist 1	Psychologist 2	Psychologist 1	Psychologist 2	
Ward Doctor		Ward Doctor		Ward Doctor		Ward Doctor		Ward Doctor		Ward Doctor		

Table 1.
 Structure of the Psychosomatic Department of the Sachsenklinik Bad Lausick, Germany.

during individual therapy. Furthermore, these therapies provide opportunities to exchange experiences, to learn from other patients as well as the group leader, and test new behaviors in a protected environment, guided by the group therapist. Group psychotherapy is particularly well suited for the treatment of disorders that manifest predominantly in a group context [17, 18]. The experience gained in the group, the acquired knowledge, and the acquired abilities can be further strengthened in individual therapy. Overall, patients receive an average of 40–50 psychotherapy hours during their stay.

Although the main emphasis is on psychotherapy, drug treatment is also an important part of the overall treatment. As the name would suggest, in the biopsychosocial approach, drug therapy is seen as an equally important treatment modality. Based on the latest evidence available, a combination of psychotherapy and antidepressant medication seems to be of most benefit for patients with depressive disorders [19], specifically with regard to QoL.

Another treatment modality available to medical professionals is light therapy. This treatment has been successfully used in seasonal depression and is scientifically recognized as an effective biological treatment methodology. Given its successful application in SAD, light therapy can also be utilized for other types of depression, where indications that this type of chronobiologic therapy could be beneficial are present [20].

Ultimately, the use of biofeedback is a treatment approach worthy of consideration. Patients could greatly benefit from being trained in this domain as disorder symptoms could potentially be reduced via feedback of otherwise unconsciously running processes controlled by the autonomic nervous system [21].

Complementary therapies: Occupational therapy (OT) includes classic OT, project-oriented OT, and expression-centered OT, within which patients learn different creative techniques. Thusly, patient resources and capabilities are rediscovered or reactivated. Participation in OT is thought to help in building up positive activities and lead to further insights that may be important for psychotherapy such as realizing one's own perfectionism.

In addition to this, specific measures of the medical-occupational rehabilitation are assessed using standardized tests. These could include workplace and concentration training, stress tests in the artisan or office work area, as well as targeted work-related skills tests. Examples of these are the “Diagnostic Instrument to Assess Work Skills” (IDA—Instrumentarium zur Diagnostik von Arbeitsfähigkeiten) and the “Psychological Traits Profiles for the Integration of Disabled People to Work” (MELBA—Psychologische Merkmalsprofile zur Eingliederung Behinderter in Arbeit). For patients with office jobs, workplace training is also offered for ergonomic sitting and working.

Art therapy, a predominantly non-linguistic therapeutic method, is a suitable open and direct emotional approach, which can be very beneficial to patients who have very limited contact with their emotions. In the Psychosomatic Department, art therapy is based on the concept of schema therapy.

Physiotherapy and sports therapy offer a wide range of therapeutic measures ranging from active sports therapy, to specific individual physiotherapy, to interaction-centered groups and, to medical training. The medical-occupational rehabilitation model also utilizes body-oriented workplace training along with problem-specific function-related physiotherapeutic tests and assessments. Furthermore, passive and relieving therapy measures, such as relaxation baths and massages, are also used where necessary, especially at the beginning of the therapeutic process.

The main relaxation technique, which is taught and practiced in our department is Progressive Muscle Relaxation (PMR) as described by Jacobson [22].

Alternatively, the Autogenic Training according to Schultz [23] is used. In addition, as a further relaxation measure, mindfulness and body-centered procedures such as yoga, TaiChi, QiGong, and specific exercises focusing on body perception are offered.

Dietary and nutritional therapy is an integral part of the therapeutic concept in patients with comorbid problematic eating behaviors. A dietary consultation is offered to all patients who have experienced nutritional or weight-related problems such as obesity or binge eating disorder.

Social therapy, which is usually facilitated by a social worker, consists of counseling on various issues relating to social law and participation in working life. This may include getting in contact with external institutions such as integration services, employment or pension agencies, as well as other appropriate services. In addition, social services also provide support with contacting the employer to plan a stepwise return to work, or to adjust the work plan or job description so that reintegration into the workplace can be as smooth as possible. Additionally, within this framework of the medical-occupational rehabilitation approach, social services can organize and support external stress tests in either a simulated or the actual working environment of the patient.

Special consideration of clinical subtypes of depression: Depressive disorders can show a variety of symptom clusters. Thus, it makes sense to have sub-teams that can offer more tailored approaches for each of the following specific symptom clusters:

- Chronic forms of affective disorders like dysthymia, chronic depression, and double depression.
- Depressive forms with predominant exhaustion and, in some cases, workplace-related conflict situations, which are often also referred to as “burnout syndrome.”
- Depressive disorders after loss and death, which may be similar to the symptom pattern of stress-related disorders or grief disorder.
- Depressive forms complicated by specific personality traits, the so-called maladaptive schemata [14].
- Chronic or ever-flaring depressive pictures that can be described as post-traumatic embitterment [24], where there is a strong correlation between the individual’s biography and certain traumatic experiences or failed adaptive performance.

In the context of psychosomatic medicine, therapies can be individually tailored with the intention of improving their effectiveness and generating a better subjective understanding among patients. The assumptions and techniques of classic cognitive behavioral therapy (especially the development of activities and cognitive restructuring) form the basis of these therapies, since CBT has shown the most efficacy in these disorders, and its high efficiency and long-term effects are empirically well documented [25, 26].

Through the systematic development of positive activities, which, in addition to leisure activities and enjoyment, can also include duties, work or other tasks, the patients are brought back into a more proactive position, thereby reducing “learned helplessness” as described by Alloy and Seligman [27]. For many patients, positive activities must be discovered or rediscovered and systematically practiced. As part of further treatment, the focus is on emotional perception and cognitive acceptance

of the positive activities, which can be promoted by additional use of “mindfulness” and mindfulness techniques (according to Linehan [16]). Furthermore, a so-called “euthymic therapy,” also referred to as genus training, is deemed to be very useful in this context [28].

In cognitive therapy, patients are guided toward dealing with negative cognitions in a systematic manner. The depressed and exaggerated negative character of the thoughts is examined against reality, and an attempt into modifying these thoughts into more helpful ones is made [29–31]. In addition, according to Wells, metacognitive therapy can also be used to improve mood and cognitive processes [32]. This is deemed to be particularly helpful in patients with constant negative thoughts and rumination. In the following paragraphs, we will explain the therapeutic focus relevant to each sub-team.

Focus on “Burnout” type: Burnout had originally been characterized by a pronounced physical, mental, and emotional exhaustion due to occupational stress and repeated frustration in caring professions. Over the years, the concept has expanded to include depressive syndromes, which are closely related to occupational or private stress [33]. Important therapeutic aims for these patients (treated by a specialist sub-team) could be to rediscover the positive aspects that originally gave meaning and pleasure to their work, to learn how to deal with frustrations, to clarify responsibilities at work, to identify stress-aggravating thoughts, to identify resources available to them, and to formulate achievable goals.

Focus on loss, grief, and adjustment processes: Patients whose depressive symptoms are related to a loss are allocated to a specific sub-team. This includes patients who are bereaved, those who have experienced separation or divorce, loss of home or property as well as those who are suffering from a physical illness. For all these situations, the common thread is the necessity for fundamental reorientation. Typical dysfunctional assumptions must be addressed (e.g., “If I stop mourning, it means that it (the loss) did not mean anything to me.” or “The more you have loved a person, the longer you mourn”). Thus, patients need guidance to develop new and more realistic beliefs that enable them to view their life in a positive light. The specialized sub-team endeavors to achieve this by applying wisdom therapy [34] and Worden’s Tasks of Mourning [35]. It also considers the role of avoidance or excessive work engagement as being a potentially unhealthy and harmful coping strategy (according to Rosner et al. [36]).

Focus on personality traits: Recurrent depressive disorders are frequently accompanied by unhelpful personality traits or personality disorders, which contribute significantly to the maintenance of the depressive disorder and therapy resistance [37]. These disturbances are treated in the Department of Psychosomatic Medicine using schema therapy developed by Jeffrey Young.

Using the Young Schema Questionnaire (YSQ) [38], the maladaptive cognitive and emotional schemata of the patient are identified, and personality-related problems are communicated to the patient in a transparent and friendly way that motivates the patient to cooperate [39]. Changes are achieved by imaginative, emotion- or relationship-oriented, or cognitive behavioral therapy [40]. In the Psychosomatic Department, weekly group exercises take place in the context of imagination exercises, in which the patient’s injurious and traumatizing experiences of childhood are re-scripted by the introduction of a protective and helping person (in part the therapist, ideally the patient in the “healthy adult mode” themselves).

In addition, during weekly individual and group therapy sessions, specific exercises are employed. Any changes in the experience of the exercise and any accompanying behavior change are discussed, and appropriate responses are practiced. In this way, common, everyday scenarios are evaluated on memo cards and healthy adult behavior patterns are worked out and practiced.

Focus on chronic depression: Chronic forms of depression like persistent depressive disorder (formerly known as dysthymia), major depressive disorder (MDD), and double depression are a challenge to clinicians as these patients often do not respond to common psychotherapeutic or pharmacological treatment [41]. However, for patients with these presentations, a specialized psychotherapy treatment that shows satisfactory response rates is available. The Cognitive Behavioral Analysis System of Psychotherapy (CBASP) developed by McCullough and Negt et al. [15, 42] postulate that chronically depressed patients remain at the stage of preoperational thinking (according to Piaget) due to their specific learning history that took place during their cognitive-emotional development. Thought is therefore characterized by a global, pre-linguistic style, a strongly egocentric view, and the inability to feel authentic interpersonal empathy [43]. Moreover, their ability to regulate their mood is severely restricted; they experience constant depressive mood independent of external factors or influence, which they perceive as completely unchangeable. In the context of CBASP, these patients are guided to develop their thinking style from preoperational thinking to formal operational thinking, and to establish more appropriate responses to external influences, including the therapist. Hence, CBASP is a method used to teach patients how to gradually reach the formal operational stage of cognitive thinking and to break the psychic barrier between themselves and their environment.

In addition to individual therapy, there are two further core elements of CBASP: situational analysis (according to McCullough) as well as a social competence training specifically tailored to the CBASP model. In situational analysis, real-life occurrences on the ward are thought about and analyzed. This is an essential technique of CBASP that teaches patients to recognize their own impact on the course and quality of their life. The social competence training serves to make patients aware of the influence of their behavior on others by means of exercises in the group context, and to jointly work out the desirable behavior in role-play situations with the aid of video feedback.

7. Conclusion

Taken together, we have outlined how the increasing incidence and prevalence of mental disorders, and specifically depressive disorders in Germany, has led to an escalating burden on public and private health, and pension insurance.

Consequently, pension insurance companies, such as the German Statutory Pension Insurance, are supporting therapy and rehabilitation in psychotherapy-focused psychosomatic rehabilitation hospitals. We have further explained that in these rehabilitation hospitals, the ICF and rehabilitation therapy standards play an essential diagnostic and therapeutic role. To explain how medical-occupational rehabilitation works in practice, we have used the Psychosomatic Department of the Sachsenklinik Bad Lausick as an example to illustrate how patients are treated with medical-psychological and complementary therapies by taking their specific depressive subtype into account. This article raises further questions about how the care and rehabilitation of patients with depression should be financed and commissioned, how diagnostic approaches can meet the needs of the patients, whether we can distinguish clinical subtypes of depression with certainty, and how much evidence we have for the specific therapies currently available.

In principle, there are four main ways to fund treatment for mental health problems. Patients can pay privately for their treatment, a public or private health insurance covers the cost of treatment, a pension insurance, or pension fund sponsor the treatment, or costs are covered by the state. To fund treatment for

mental health issues such as depression privately can be difficult or impossible, if people are not wealthy, because low income and indebtedness may have already been a contributing factor for the development of depression [44], and depression might lead to further debts due to medical bill problems [45]. Additionally, one has to consider that treatment time for depression might be unforeseeably long, especially in the case of a recurring or chronic depressive disorder. Public or private health insurances will provide the funding, if they cover mental health. However, they are only obligated to cover treatment costs where the patient has a formal diagnosis according to the ICD-10 [8] or the DSM-5 [46] and where the treatment is proposed according to national guidelines, such as the German national guidelines for the treatment of depression (S3-Leitlinie/Nationale VersorgungsLeitlinie Unipolare Depression) [9]. Consequently, rehabilitation in which the main aim is increasing people's functional level as well as their quality of life, is usually not covered by health insurance. In Germany, this is paid for by pension insurance, if approved. Having different insurance providers dealing with different aspects of the same disorder can be quite challenging. For clinicians, it is sometimes tricky to decide whether the patient needs acute hospital treatment or medical-occupational rehabilitation, since treatment approaches often overlap. At first glance, it might seem more practical and efficient for the state to fund treatment, as is the case in the UK. However, at a closer look one can discern that even in the case of the UK, one has to apply for funding to different funding streams within the NHS (e.g., NHS England, Clinical Commissioning Groups, etc.). Hence, there does not seem to be a funding system to cover mental health costs in place that is generally agreed upon. Nevertheless, from the insurer's, the patients', and certainly the employers' perspective, a pension insurance-funded rehabilitation makes particularly good sense for those with depression who need and want support in order to resume working activities.

Accurately diagnosing mental disorders has always been a challenge, hence the constant revision of diagnostic entities and criteria; the 5th edition of the DSM and the soon to be 11th edition of ICD are a case in point. However, these diagnostic classifications base diagnoses mainly on acute symptoms, and less so on the level of functioning and QoL. As such, the WHO's ICF [10] complements the ICD, providing a more holistic diagnosis. Thus, the emphasis on ICF by pension insurance-financed psychosomatic hospitals for medical-occupational rehabilitation indicates their commitment to a comprehensive assessment of depressed patients.

A perhaps more controversial point worthy of discussion is the decision-making process by which patients are allocated to certain sub-teams in the Psychosomatic Department of the Sachsenklinik Bad Lausick, the case presented. The procedure suggests that certain subtypes of depression are assumed: the burnout, the loss and grief, the complicated personality, and the chronic subtype. However, there is currently no scientific evidence that supports the existence of these subtypes. In fact, diagnostic and genetic research has recently come up with two main subtypes of depression, an anxious subtype that is characterized by decreased appetite and body weight, and insomnia and suicidal ideation, and a metabolic subtype showing increased appetite and weight, low energy, hypersomnia, leaden paralysis, and a poor metabolic profile [47–49]. Despite the research evidence for these subtypes, they seem to be irrelevant for the purposes of treatment, since there are no subtype-specific treatment algorithms available. Another approach would be to define subtypes according to treatment response. This approach has been used in psychiatry since the development of tricyclic antidepressants, and subtypes were suggested according to whether patients responded or not respond to tricyclic antidepressant treatment [50]. This strategy seems natural from a practical point of

view, and this line of thinking is the basis of how patients are assigned to specialized sub-teams who offer a specific psychotherapeutic focus. The question whether wisdom therapy [34] and the Worden's Tasks of Mourning model [35] are the best approach for people suffering from bereavement and loss, whether schema therapy according to Jeffrey Young [39] is most effective to treat patients with personality difficulties, whether CBASP is most efficient in patients with chronic depression, and—last but not least—whether inpatient rehabilitation is necessary and superior to outpatient rehabilitation and treatment, however, is beyond the scope of this article.

In summary, this article provides a review of the literature on rehabilitation for depression in psychosomatic hospitals in Germany. It highlights the importance of thinking beyond the clinical diagnosis by taking the level of functioning and QoL into account during assessment and therapeutic goal setting. It also explains the practicalities of medical-occupational inpatient rehabilitation for depression by reference to the Psychosomatic Department of the Sachsenklinik Bad Lausick. Questions which remain unanswered are how to fund rehabilitation for depressed patients in the best way possible, how to define subtypes of depression in order to provide an individually tailored therapy for people with depression, and what therapies and in what settings they are most effective.

Based on the example of how psychosomatic inpatient rehabilitation for people with depression is delivered at the Sachsenklinik Bad Lausick, this article reflected on the following principal ideas about psychosomatic and psychiatric diagnoses, individually tailored care as well as care provision and funding.

- Disease models can be based on the etiology, the pathophysiology, symptoms or symptom clusters, diagnoses, the level of functioning, activities and participation, and QoL. Thus, in practice, a holistic diagnostic approach should not only make use of a disease classification but should also comprise an assessment of functioning, disability, and overall health.
- Therapies should be individually tailored; this can be achieved taking patient characteristics, personal and environmental factors, the diagnostic subtype, the profile of symptoms and impairments, the availability of therapies, and individual preferences of the patients and their therapists into account.
- Psychosomatic medicine aspires to holistic treatment approaches that consider a variety of therapeutic modalities such as psychoeducation, psychotherapy, pharmacotherapy and other biological therapies, OT, art and music therapy, skills training, movement therapy and physiotherapy, social work, family work, and self-help.
- Potential sources of funding for psychosomatic treatment include public institutions, private assets, and public or private health or pension insurances.

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