



Depressive Störungen bei Personen mit körperlichen Erkrankungen

- Neue Entwicklungen in Diagnostik und Behandlung -

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Abteilung für Klinische Psychologie und
Psychotherapie

Reha-Update 29. April 2016
Psychologie in der medizinischen Rehabilitation

Patientenbeispiel

58-jähriger Winzer, verheiratet, 3 Kinder, AHB

Seit 16. Lj.
Nikotinabhängigkeit

17. Lj. – 26. Lj.
Alkoholmissbrauch

Aktuell
depressive
Episode

20

30

40

50

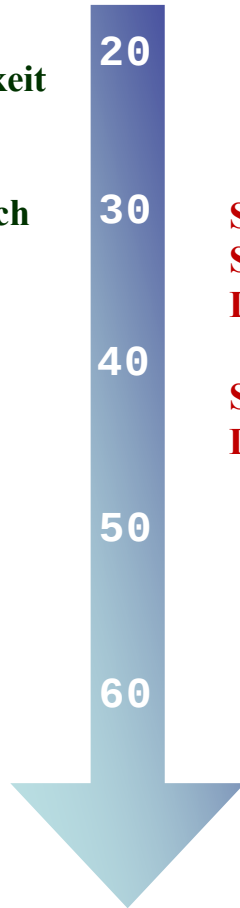
60

Seit 37. Lj.
Schmerzen im Nacken- und
Lumbalbereich

Seit 47. Lj.
Diabetes Typ II

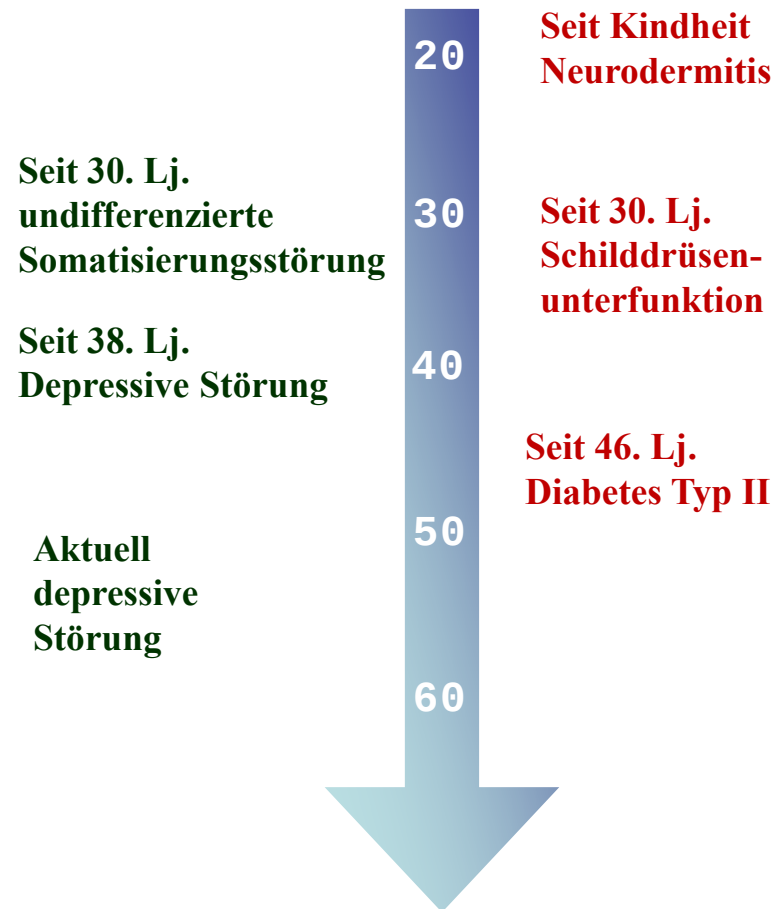
52. Lj.,
Erster Herzinfarkt

Aktuell
Zweiter Herzinfarkt

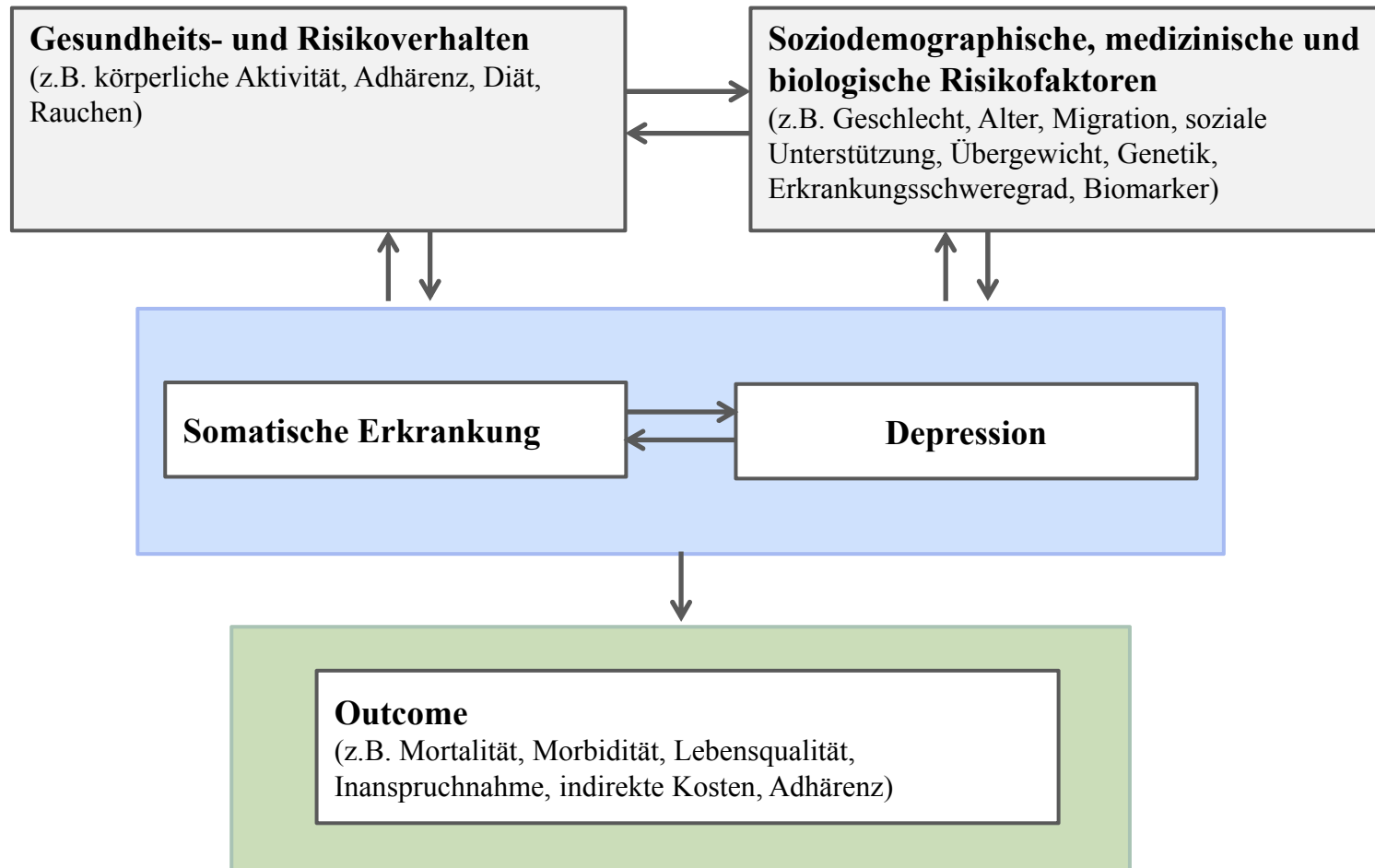


Patientenbeispiel

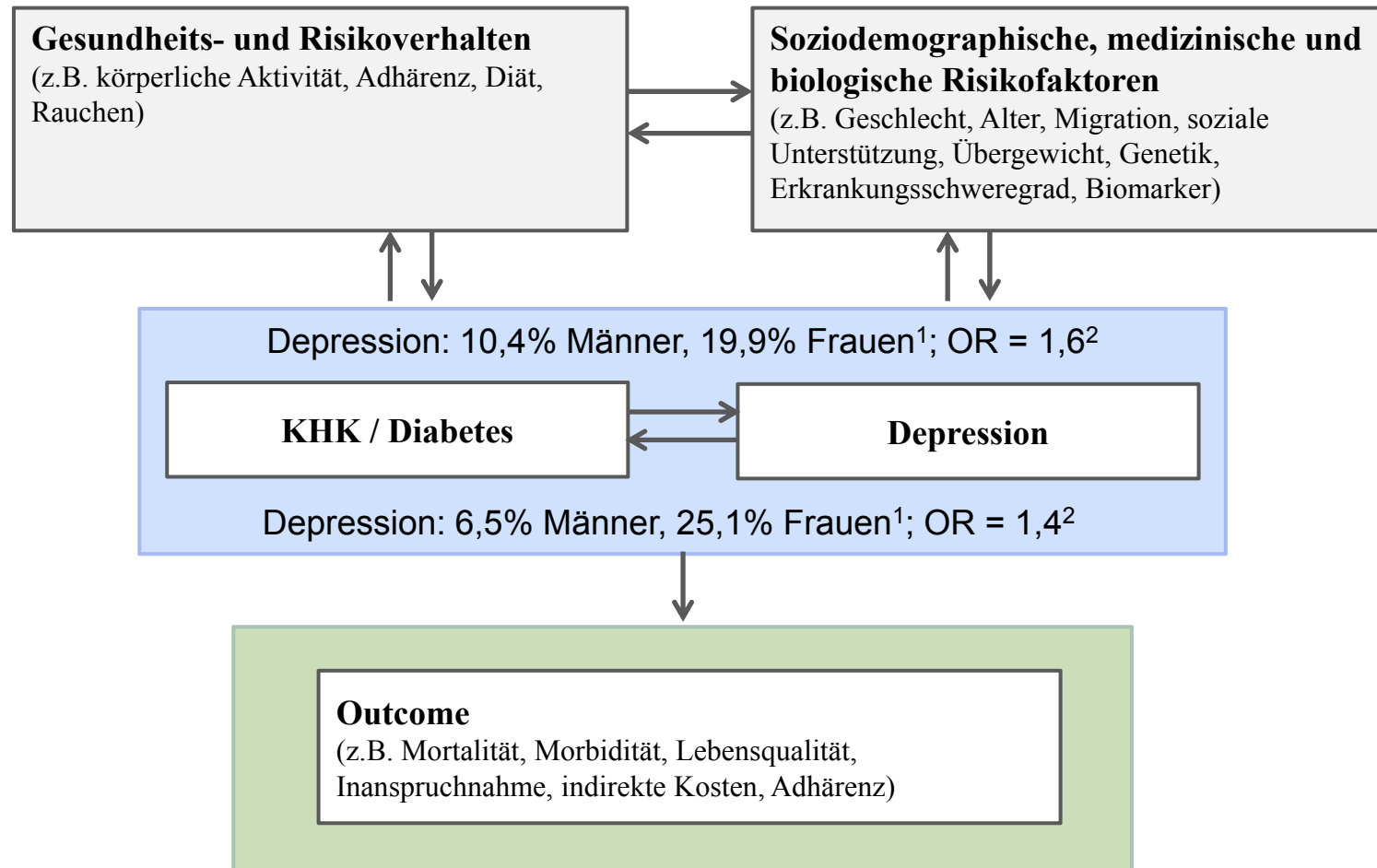
52-jährige Lehrerin, geschieden, 2 Kinder



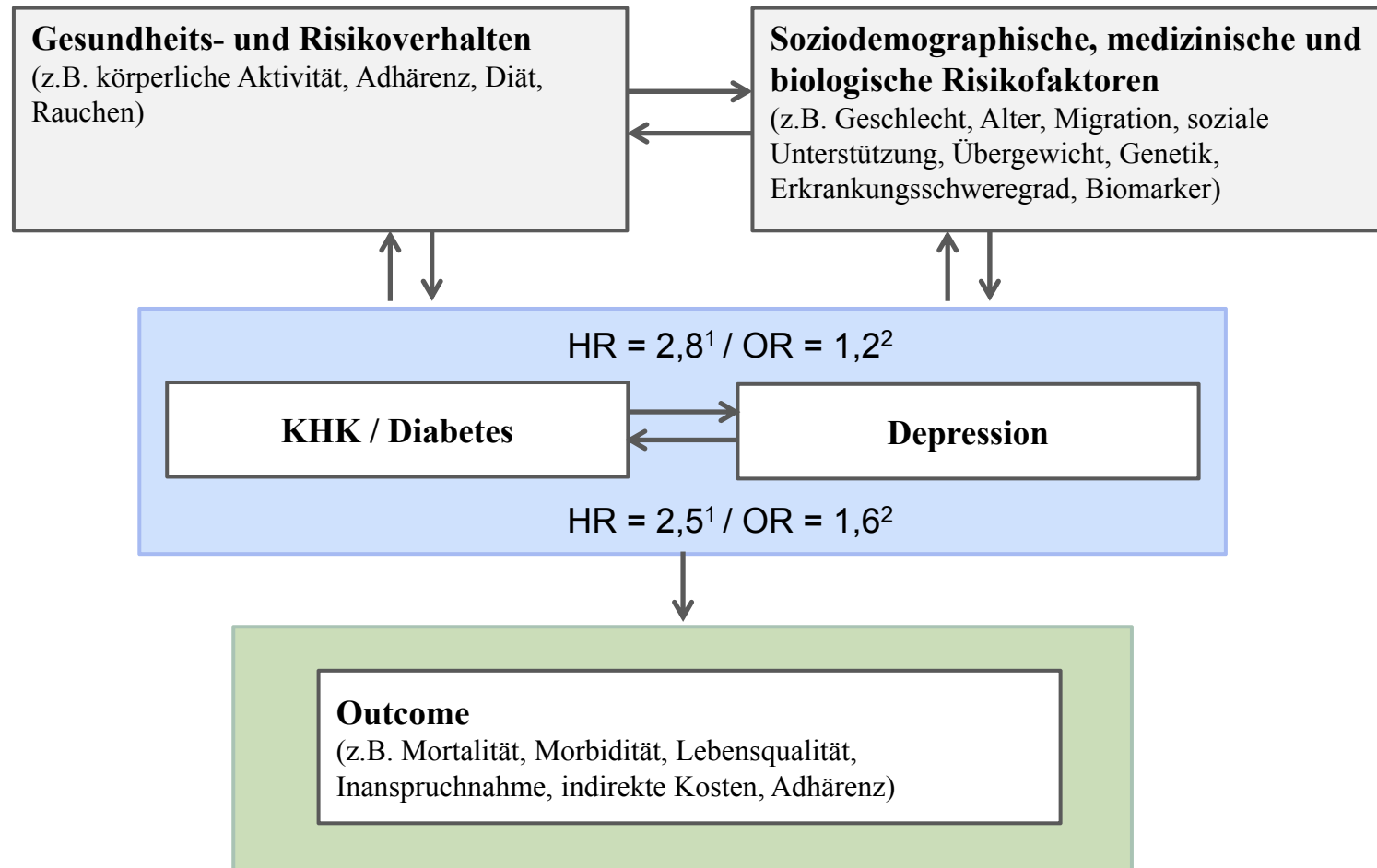
Vereinfachtes Kausalmodell



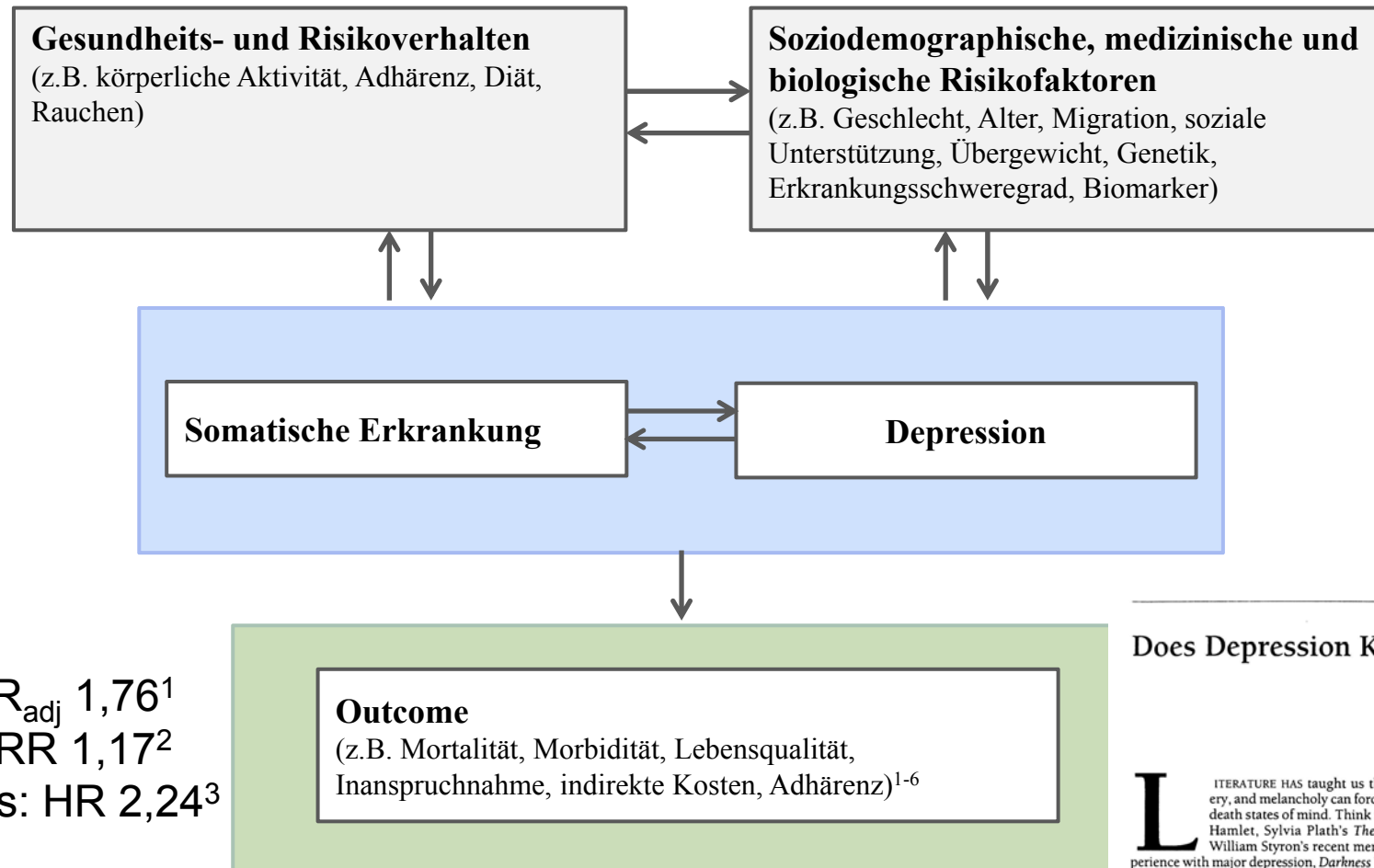
Vereinfachtes Kausalmodell



Vereinfachtes Kausalmodell



Vereinfachtes Kausalmodell



KHK: $HR_{adj} 1,76^1$
 Tumor: $RR 1,17^2$
 Diabetes: $HR 2,24^3$

EDITORIAL

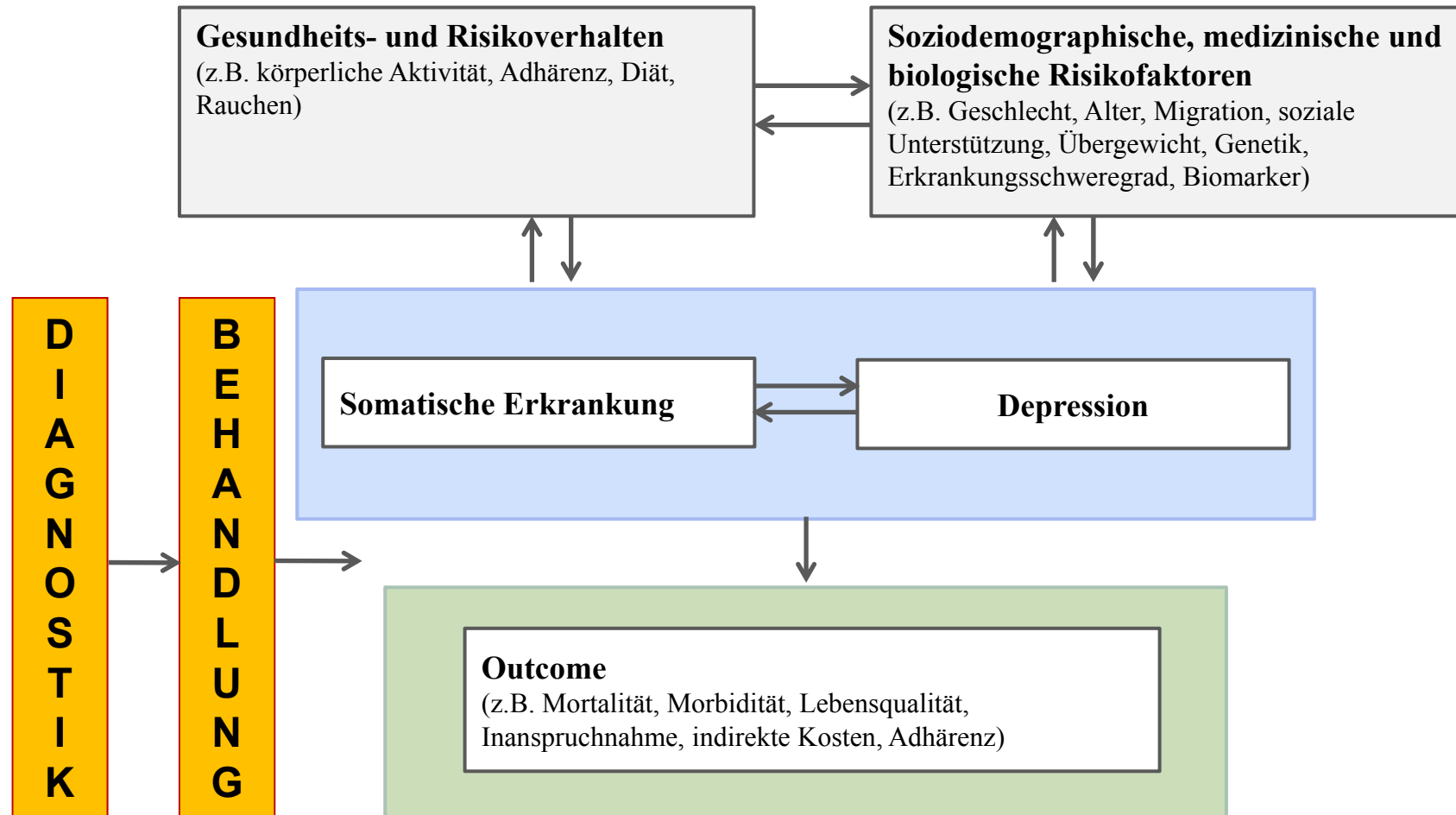
Does Depression Kill?

LITERATURE HAS taught us that grief, misery, and melancholy can force us into near-death states of mind. Think for example of Hamlet, Sylvia Plath's *The Bell Jar*, and William Styron's recent memoir of his experience with major depression, *Darkness Visible*. But ex-

In ad
 good stud
 mortality
 finding is
 toms at ba
 cause moi

1 Barth et al., Psychosom Med 2004; 2 Pinquart & Duberstein, Psychol Med, 2010; 3 Sullivan et al, Diab Care 2012; 4 Baumeister et al., Psychother Psychosom 2011; 5 Baumeister et al., J Psychsom Res, 2012; 6 Hutter et al., Diabetologia 2011

Vereinfachtes Kausalmodell

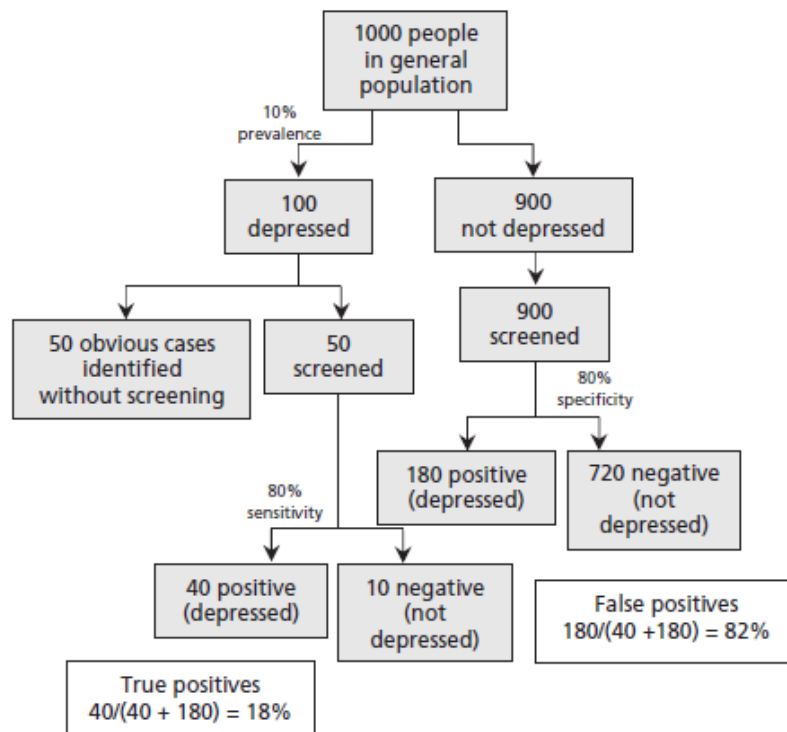


Diagnostik

- Settingabhängig
- Leitlinienempfehlungen: **Routine-Screening** bzgl. Depression bei Patienten mit körperlicher Erkrankung¹⁻³
 - Hoher Aufwand und geringe Anwenderfreundlichkeit
 - Psychometrische Einschränkungen
 - Klinisch nützlich?

Screening

- American Heart Association: all patients with heart disease should be routinely screened for depression
- Kritik an Routine-Screening bei Thombs und Kollegen^{1,2,3}



- Kein RCT zur Wirksamkeit
- Patienten mit leichter bis mittelgradiger Depression profitieren ggf. nicht
- Nebenwirkungen von Antidepressiva
- Fragliche Allokation von Ressourcen

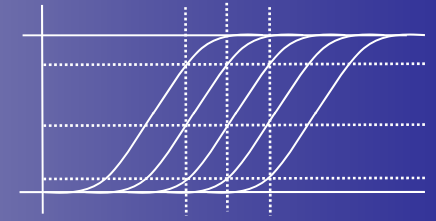
Diagnostik

- Settingabhängig
- Leitlinienempfehlungen: **Routine-Screening** bzgl. Depression bei Patienten mit körperlicher Erkrankung
 - Hoher Aufwand und geringe Anwenderfreundlichkeit
 - Psychometrische Einschränkungen
 - Klinisch nützlich?

⇒ Entwicklung Computer-basierter Testverfahren

⇒ Entwicklung Computer-adaptiver Testverfahren

CAT-Projekte



Gefördert durch: DFG, START-Nachwuchsprogramm & Zarnekow-Stiftung



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DIPF

Bildungsforschung
und Bildungsinformation



**Pädagogische
Hochschule
Freiburg**

Schmerzerleben					
Vermeidend-Selbstunsichere PS					
Zwanghafte PS					
Funktionsfähigkeit im Beruf					
Funktionsfähigkeit im Alltag					
Angst					
Depression					
	Psyche	Kardio	Ortho	Neuro	Onko

Computer-adaptiver Test (CAT)

Ziel ist die Konstruktion eines „maßgeschneiderten Tests“ für jeden Patienten

Vorteile

- Verkürzung der Testdauer
- Hohe Messpräzision
- unmittelbare Auswertung

Grundlage: IRT-basierte, eindimensionale Itembanken

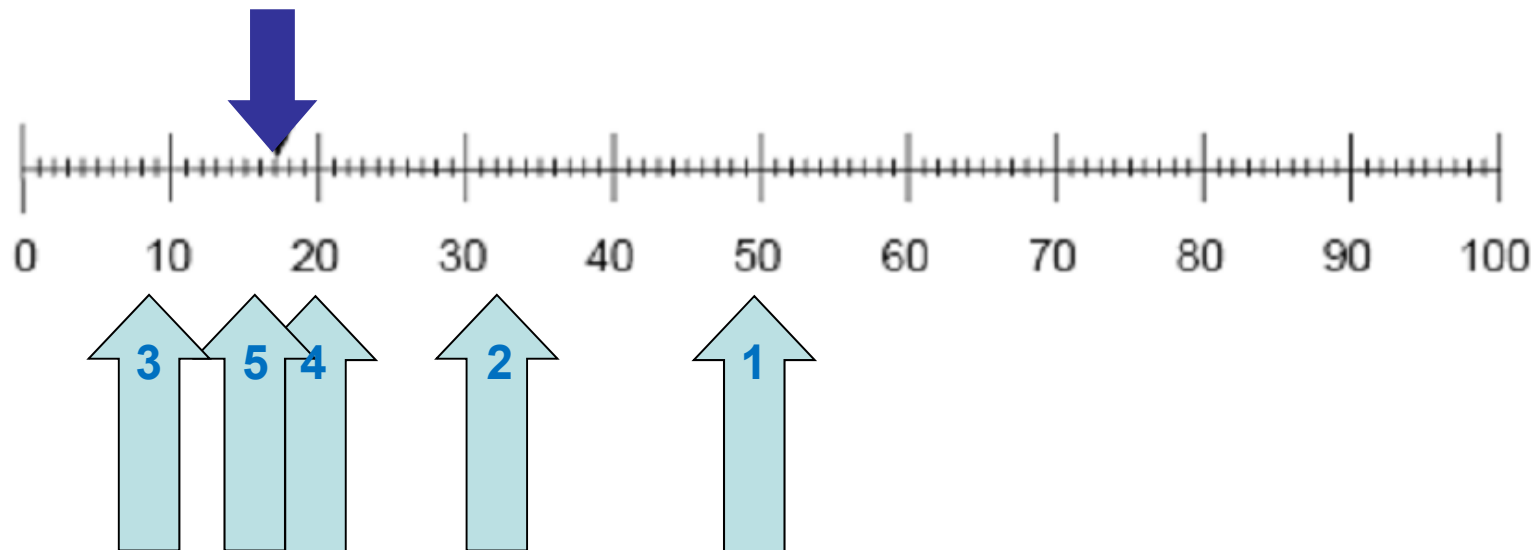
- ↳ Depression:¹ - Itembank mit 36 Items
- 4-13 Items je nach Abbruchkriterium
 - AUC = .788

Computer-adaptiver Test (CAT)

hoch

Depressivität der Person

gering



gering

Schwierigkeit des Items

hoch

Computer-adaptiver Test (CAT)



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Freiburg

Implementierung einer Computer-adaptiven Erst- und Verlaufsdagnostik zur Erfassung der funktionalen Gesundheit in der orthopädischen und kardiologischen Rehabilitation

Baumeister H, Bengel J, Kröhne U, Böcker M, Forkmann T, Wirtz M



Deutsche
Rentenversicherung

Bund

Depressionsbehandlung

Behandlungen depressiver Störungen bei Patienten mit körperlichen Erkrankungen entsprechen im Wesentlichen der Behandlung depressiver Störungen im Allgemeinen

Psychotherapeutische Besonderheiten

Krankheitsbewältigung Behandlungsmotivation Trauer, Tod und Sterben



- Psychotherapie ($d=.29-.57$) und Antidepressiva ($d=0.27$) verbessern die Depressivität von Patienten mit KHK oder Diabetes und Depression^{1,2}
- S3-Leitlinie/Nationale VersorgungsLeitlinie Unipolare Depression:³ Teils Empfehlungen für Psychotherapie und SSRIs (TZA bei Schmerzerkrankungen, aber nicht bei ischämischen Erkrankungen)

Aber:

- nur kleine bis mittlere Effekte und ungünstige Cost-Benefit Ratio bei leicht bis mittelgradig depressiven Patienten⁴
- Bias-Quellen führen wahrscheinlich zu einer Überschätzung der Effekte^{1,2}

Externe Validität klinischer Studien

- 404 HF-Patienten aus der Routineversorgung
- 60.4% der Patienten mit einer diagnostizierten Depression mit zumindest einem Ausschlusskriterium klinischer Studien

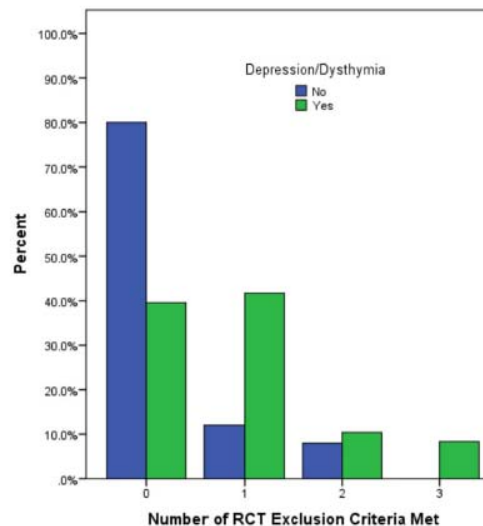


Figure 2. Proportion of standard RCT exclusion criteria met by HF patients according to depression status (yes vs. no).
doi:10.1371/journal.pone.0085928.g002

The Real World Mental Health Needs of Heart Failure Patients Are Not Reflected by the Depression Randomized Controlled Trial Evidence

Phillip J. Tully^{1,2,3,4*}, Gary Wittert¹, Terina Selkowitz¹, Harald Baumeister^{1,2}

¹Department of Rehabilitation Psychology and Psychotherapy, Institute of Psychology, University of Freiburg, Freiburg, Germany, ²Medical Psychology and Medical Sociology, Medical Faculty, University of Freiburg, Freiburg, Germany, ³Fremantle Foundation Centre for Men's Health, Discipline of Medicine, School of Medicine, The University of Adelaide, Adelaide, Australia, ⁴Heart Failure Support Service, The Queen Elizabeth Hospital, Woodville, Australia

Abstract

Introduction: International depression screening guidelines in heart failure (HF) are partly based on depression treatment efficacy from randomized controlled trials (RCTs). Our aim was to test the external validity of depression RCT criteria in a sample of real-world HF patients.

Methods: HF patients admitted to 3 hospitals in South Australia were referred to a HF psychologist if not already receiving current psychiatric management by psychologist or psychiatrist elsewhere. Screening and referral protocol consisted of the following: (a). Patient Health Questionnaire ≥ 10 ; (b). Generalized Anxiety Disorder Questionnaire ≥ 7 ; (c). positive response to 1 item panic attack screener; (d). evidence of suicidality. Patients were evaluated against the most common RCT exclusion criteria: personality disorder, high suicide risk, cognitive impairment, psychosis, alcohol or substance abuse or dependency, bipolar depression.

Results: Total 81 HF patients were referred from 404 HF admissions, and 73 were assessed (age 60.6 ± 13.4 , 47.9% female). Nearly half (47%) met at least 1 RCT exclusion criterion, most commonly personality disorder (28.5%), alcohol/substance abuse (17.8%) and high suicide risk (11.0%). RCT ineligibility criteria were more frequent among patients with major depression (76.5% vs. 46.2%, $p < .01$) and dysthymia (26.5% vs. 7.7%, $p = .03$) but not significantly associated with anxiety disorders. RCT ineligible patients reported greater severity of depression ($M = 16.6 \pm 5.0$ vs. $M = 12.9 \pm 7.2$, $p = .02$) and were higher consumers of HF psychotherapy services ($M = 11.5 \pm 4.7$ vs. $M = 8.5 \pm 4.8$, $p = .01$).

Conclusion: In this real-world sample comparable in size to recent RCT intervention arms, patients with depression disorders presented with complex psychiatric needs including comorbid personality disorders, alcohol/substance use and suicide risk. These findings suggest external validity of depression screening and RCTs could serve as a basis for level A guideline recommendations in cardiovascular diseases.

Citation: Tully PJ, Wittert G, Selkowitz T, Baumeister H (2014) The Real World Mental Health Needs of Heart Failure Patients Are Not Reflected by the Depression Randomized Controlled Trial Evidence. *PLoS ONE* 9(1): e85928. doi:10.1371/journal.pone.0085928

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Introduction

Depression has gained widespread research attention with respect to prognosis of heart diseases including heart failure (HF) [1]. A meta-analysis by Rutledge et al. [2] suggested that the prevalence of clinical depression was 22% in HF, thus substantially higher than community prevalence estimates for populations free from heart failure [3]. It has been consistently shown that depression doubles the risk of major cardiac events and death in patients with documented HF [2,4,5], increases healthcare costs [6], significantly impairs quality of life [7–9], impairs self-care ability [10] and impacts upon participation in HF disease-management strategies [11]. Consequently, depression identification and management is emphasized in international cardiology

guidelines [12–15], HF treatment guidelines [16] and HF self-management recommendations [17].

Though a number of studies have applied routine depression screening protocols to improve recognition of depression [18–27] a paucity of information exists regarding the ensuing mental health management strategies initiated within cardiology settings from a positive depression-screen [22,28–31]. Thoms and colleagues systematic reviews confirm that a number of issues regarding routine screening remain unclear [28,29]. As the utility for depression screening alone in reducing depression and cardiovascular morbidity has not been established [22], randomised, controlled trials (RCTs) provide Level A empirical evidence to guide clinical practice for depression management in HF [2,32]. For example, the Safety and Efficacy of Sertraline for Depression

Fazit I

- Psychotherapie ($d=.29-.57$) und Antidepressiva ($d=0.27$) verbessern die Depressivität von Patienten mit KHK oder Diabetes und Depression^{1,2}
- S3-Leitlinie/Nationale VersorgungsLeitlinie Unipolare Depression:³ Empfehlungen für Psychotherapie und SSRIs (TZA bei Schmerzerkrankungen, aber nicht bei ischämischen Erkrankungen)

Aber:

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- Bias-Quellen führen wahrscheinlich zu einer Überschätzung der Effekte^{1,2}

=> Behandlungsalternativen?

Neue(re) Interventionsansätze bei der Behandlung depressiver Störungen bei Patienten mit körperlichen Erkrankungen

1. Collaborative Care Ansätze ^{1,2}
2. Prävention ³
3. Neue pharmakologische Ansätze (Anti-Inflammatorische Medikamente, Vitamin D, Omega 3...)?⁴⁻⁷
4. Internet-basierte Interventionen⁸

Collaborative Care

J Clin Neurosci 2007;10:75, Total no. of pages: 10

YCO 2007/75

REVIEW



Collaborative care for depression in medically ill patients

Harald Baumeister and Nico Hutter

Purpose of review

Depression is common in medically ill patients and associated with a negative prognosis. Recent findings indicate that single interventions have little effect on outcomes in these patients. Alternatively, complex interventions based on a collaborative care model are promising. This review summarizes recent findings regarding collaborative care in medically ill patients with comorbid depression.

Recent findings

Recent trials provide evidence for a significantly beneficial effect on depression outcomes with moderate effect sizes regarding depressive symptoms (standardized mean differences [SMDs]: -0.46 to -0.74, $n=5$) and depression response (odds ratios [ORs]: 1.29-4.75, $n=6$). Psychological quality of life (SMDs: 0.09 to 0.54, $n=5$) and satisfaction with care (ORs: 2.55-7.43, $n=3$; SMDs: 0.05 and 0.2, $n=1$) were increased in intervention patients compared with usual care, whereas physical quality of life (SMDs: -0.17-0.06) was not. The evidence regarding medication adherence and somatic, disease-specific outcomes is sparse and conclusions cannot be drawn so far.

Summary

Collaborative care interventions are efficacious in medically ill patients with depression. However, there is no data concerning their cost-effectiveness. Furthermore, as trials on collaborative care comprise a heterogeneous set of components, the most effective characteristics should be identified. Moreover, these interventions should be adapted to other healthcare systems than the United States.

Keywords

collaborative care, comorbidity, depression, medical disease

INTRODUCTION

Depressive disorders are common in patients with medical diseases [1-6] and associated with a negative prognosis in terms of increased mortality [7,8], morbidity [9] and healthcare costs [10,11], as well as decreased adherence to treatment regimen [12,13] and reduced quality of life [14,15]. Effective interventions to improve depressive symptoms in medically ill patients are thus of high importance for healthcare research and practice. However, recent systematic reviews report merely small to moderate beneficial effects of psychological and pharmacological stand-alone interventions on depression outcomes as well as further medical and psychosocial outcomes in patients with medical diseases [16-18]. These findings indicate that single interventions might not be sufficient for the complex treatment of medically ill patients with comorbid depression. As an alternative, multifaceted interventions for treating depressive disorders in medically ill patients based on a collaborative care model have been

proposed [19]. Collaborative care interventions are designed to improve the quality of depression care and are characterized by a heterogeneous set of methods such as interdisciplinary cooperation between mental health specialists, primary care physicians and care managers or nurses, routine monitoring of outcomes and proactive follow-up contacts, provision of pharmacotherapy and/or psychological treatments, self-management training and support for patients, supervision of care managers and decision support for primary care physicians [19]. Evidence from recent systematic reviews indicates that collaborative care

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Curr Opin Psychiatry 2012; 25:000-000
DOI:10.1097/YCO.0b013e31824886d3

0951-7367 © 2012 Wolters Kluwer Health | Lippincott Williams & Wilkins

www.co-psychiatry.com

Charakterisiert durch ein heterogenes Set an Methoden: **Interdisziplinäre Zusammenarbeit**; Routine-Monitoring des Outcomes; Proaktive Follow-up Kontakte; Interventionsempfehlungen; Selbstmanagementtraining und Patientensupport; **Supervisionen** für die Case-Manager, **Entscheidungshilfen** für Ärzte

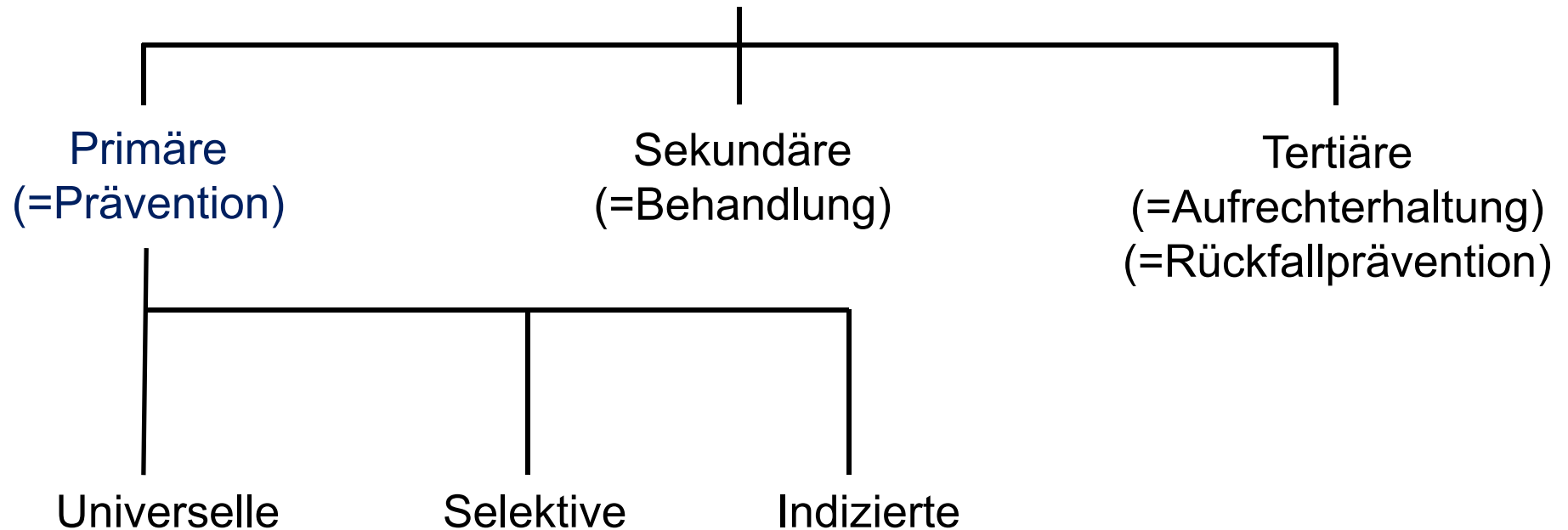
Bekannte Beispiele: **PATHWAYS Study**, Katon et al., Arch Gen Psychiatry 2004; **Bypassing the Blues**, Rollmann et al., JAMA 2009

Signifikante psycho-soziale Effekte: z.B. Depressionsschweregrad (SMDs: -0.46 to -0.74, $n=5$)

Keine Effekte bzgl. körperlicher QoL

Fehlende Evidenz bzgl. medizinischer Outcomes

Prävention



Prävention

- Prävention bei Depressionsbehandlung im Allgemeinen wirksam und kosten-effektiv^{1,2}
- Nur eine Präventionsstudie zu KHK³ und eine Rückfallpräventionsstudie zu Diabetes⁴
- Prävention bei Patienten mit körperlichen Erkrankungen (vorläufige Daten)^{5,6}:
 - SSRIs (N=11): IOR = 0.41 [0.27, 0.62] => NNT = 10
 - Psychologische Interventionen (N=3): IOR = 0.38 [0.23, 0.64] => NNT = 7

Fazit:

- Prävention auch bei körperlich Erkrankten wirksam
- Forschungsfokus auf psychopharmakologische Prävention
- Kosteneffektivere, nebenwirkungsärmere Behandlungen notwendig

Depressionsintervention für Diabetes



Harald Baumeister | Benutzerprofil | Abmelden

Nobis et al. *BMC Psychiatry* 2013, 13:306
http://www.biomedcentral.com/1471-244X/13/306



Programm > Get.On Diabetes und depressive Beschwerden > 1.Lektion: Einführung und Ziele

Start

✓ Aufgaben

📧 Nachrichten

👤 Kontaktpersonen

Programm

Get.On Diabetes und Depression

Diabetes Depression neue Version

Get.On Version Dezember 2012

Get.On Diabetes und depressive Beschwerden

Tagebuch

🗒 Stimmung

Begleitet durch: Stephanie Nobis

Weiter: 1. Programmaufbau und -ablauf

🔊 Text anhören

1.Lektion: Einführung und Ziele



Herzlich willkommen!



Schön, dass Sie hier sind

Sie haben sich dazu entschieden, etwas gegen Ihre depressiven Beschwerden zu unternehmen. Herzlichen Glückwunsch zu diesem Entschluss!

Zwei Gesundheits-Experten werden Sie durch dieses Training begleiten

Frau Prof. Dr. Becker und Herr Prof. Dr. Berking werden Sie in diesem Programm begleiten. Schauen Sie sich die Videos an und lassen Sie sich willkommen heißen!

STUDY PROTOCOL

Open Access

Efficacy and cost-effectiveness of a web-based intervention with mobile phone support to treat depressive symptoms in adults with diabetes mellitus type 1 and type 2: design of a randomised controlled trial

Stephanie Nobis^{1*}, Dirk Lehr^{1,2}, David Daniel Ebert^{1,2}, Matthias Berking^{1,2}, Elena Heber¹, Harald Baumeister³, Annette Becker⁴, Frank Snoek⁵ and Heleen Riper^{1,6,7}

Abstract

Background: A diagnosis of diabetes mellitus types 1 or 2 doubles the odds of a comorbid depressive disorder. The combined diseases have a wide range of adverse outcomes, such as a lower quality of life, poorer diabetes outcomes and increased healthcare utilisation. Diabetes patients with depression can be treated effectively with psychotherapy, but access to psychological care is limited. In this study we will examine the efficacy and cost-effectiveness of a newly developed web-based intervention (GETON Mood Enhancer Diabetes) for people with diabetes and comorbid depressive symptoms.

Methods/Design: A two-arm randomised controlled trial will be conducted. Adults with diabetes (type 1 or type 2) with increased depression scores (> 22 on the German version of the Center for Epidemiological Studies Depression Scale (CES-D)) will be included. Eligible participants will be recruited through advertisement in diabetes patient journals and via a large-scale German health insurance company. The participants will be randomly assigned to either a 6-week minimally guided web-based self-help program or an online psychoeducation program on depression. The study will include 260 participants, which will enable us to detect a statistically significant difference with a group effect size of $d = 0.35$ at a power of 80% and a significance level of $p = 0.05$. The primary outcome measure will be the level of depression as assessed by the CES-D. The secondary outcome measures will be: diabetes-specific emotional distress, glycaemic control, self-management behaviour and the participants' satisfaction with the intervention. Online self-assessments will be collected at baseline and after a 2 months period, with additional follow-up measurements: 6 and 12 months after randomisation. The data will be analysed on an intention-to-treat basis and per protocol. In addition, we will conduct an economic evaluation from a societal perspective.

Discussion: If this intervention is shown to be cost-effective, it has considerable potential for implementing psychological care for large numbers of people with diabetes and comorbid depression in routine practice and improve health outcomes.

Trial registration: German Clinical Trial Register (DRKS); DRKS00004748.

Keywords: Diabetes, Depression, Guided web-based self-help, Internet, Randomised controlled trial, Efficacy, Cost-effectiveness

Depressionsprävention und -behandlung bei Rückenschmerzpatienten



Informationen

Jede Lektion erhält für Sie Informationen zum Thema



Übungen

Sie werden mithilfe verschiedener Übungen Ihre eigene Situation betrachten und die vorgestellten Techniken im Alltag einsetzen. So werden Sie selbst aktiv.



Beispielpatienten

Sophia, Markus und Maria werden Ihnen über ihre Erfahrungen berichten und Sie durch das Training begleiten. Wahrscheinlich können Sie sich in ihren Berichten mal mehr mal weniger wiedererkennen.



Feedback

Im Verlauf des Programmes werden Sie nach jeder Lektion von einem Online-Coach innerhalb von zwei Werktagen Feedback zu Ihren Übungen erhalten. Das Feedback ist nur für Sie persönlich bestimmt und nur von Ihnen einsehbar.



SMS-Coach

Sie können mithilfe des SMS-Coach bestimmte Übungen und Aufgaben durch SMS-Anleitungen immer wieder ausführen.



Achtsamkeitsübungen

In jeder Lektion werden Sie eine Achtsamkeitsübung kennenlernen. Diese können Ihnen dabei helfen, schwierige Situationen leichter zu akzeptieren.

Programm: Studien in der Versorgungsforschung



Bundesministerium für Bildung und Forschung

WARD-BP

PROD-BP

Evidenzbasierung

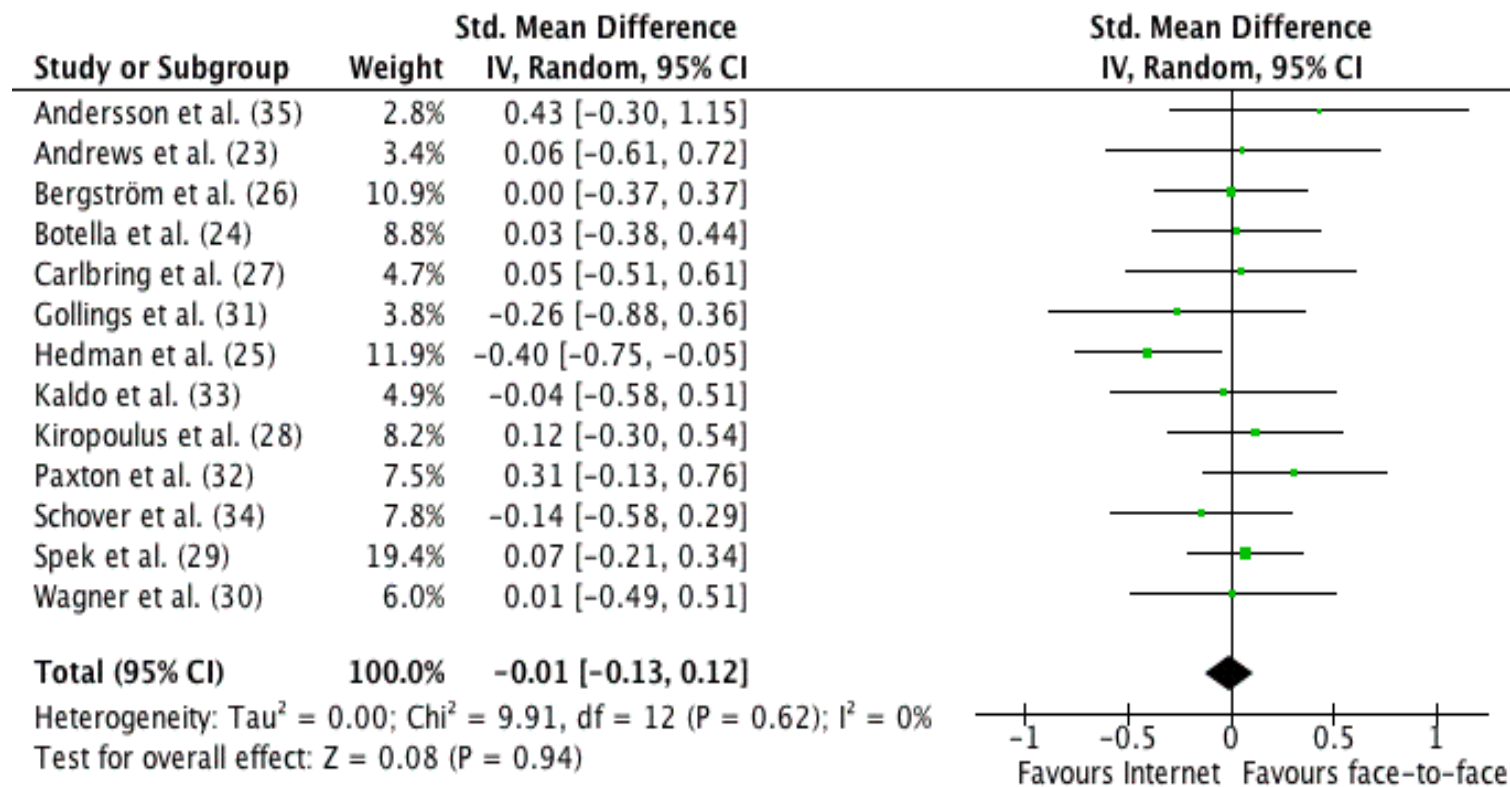
Zielpopulation	SMD	[95% KI]	N
Depressive Störungen	0.56	[0.41-0.71]	19
Panikstörungen	0.83	[0.45-1.21]	6
Soziale Phobie	0.92	[0.74-1.09]	8
Generalisierte Angststörung	1.11	[0.76-1.47]	2
PTBS	1.23	[0.83-1.63]	6
Essstörungen	0.97	[0.63-1.30]	5
Schlafstörungen	0.86	[0.53-1.18]	2
Alkoholmissbrauch	0.20	[0.13-0.27]	16
Zwangsstörungen	1.02	[0.66-1.38]	2
Schmerz	0.29	[0.15-0.42]	11
Alkohol	0.39	[0.23-0.57]	7
Rauchen	0.14	[1.13-1.72]	9
Körperliche Aktivität	0.14-0.37		34
Gewicht	MD: 0.49kg	[0.95,0.03]	5

aus Baumeister et al., Enzyklopädie der Medizinischen Psychologie im Druck; Paganini et al. Neurotransmitter 2015

Evidenzbasierung: Internet vs. face-to-face (f2f)

Internet vs. f2f

Internet = f2f $d = -0.01$ $[-0.13; 0.12]$



Fazit II

- Mit Collaborative Care Ansätzen, präventiven Maßnahmen und internetbasierten Interventionen liegen vielversprechende Möglichkeiten zur Behandlung depressiver Störungen bei Patienten mit Diabetes und KHK vor...aber
- Kaum Evidenz zu Behandlungseffekten jenseits von Depressionsschweregrad und Depressionsremission
- Bias-Quellen führen wahrscheinlich zu einer Überschätzung der Effekte
- Zweiter Blick auf das Konstrukt „Depression“ notwendig?

Subtypen depressiver Störungen

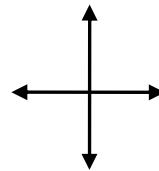
Baumeister H, Parker G. Meta-review of depressive subtyping models.
Journal of Affective Disorders 2012; 139:126-40.

Ätiologiebasiert:

- Anpassungsstörung
- Reproduktive Depression
- Organische Depression
- Early trauma depression
- Perinatale Depression
- Substanzbezogene Depression

Symptombasiert:

- Melancholie
- Psychotische Depression
- Atypische Depression
- Angstbezogene Depression



Time of onset-basiert:

- Early onset Depression
- Late onset Depression
- Saisonal Affektive Depression

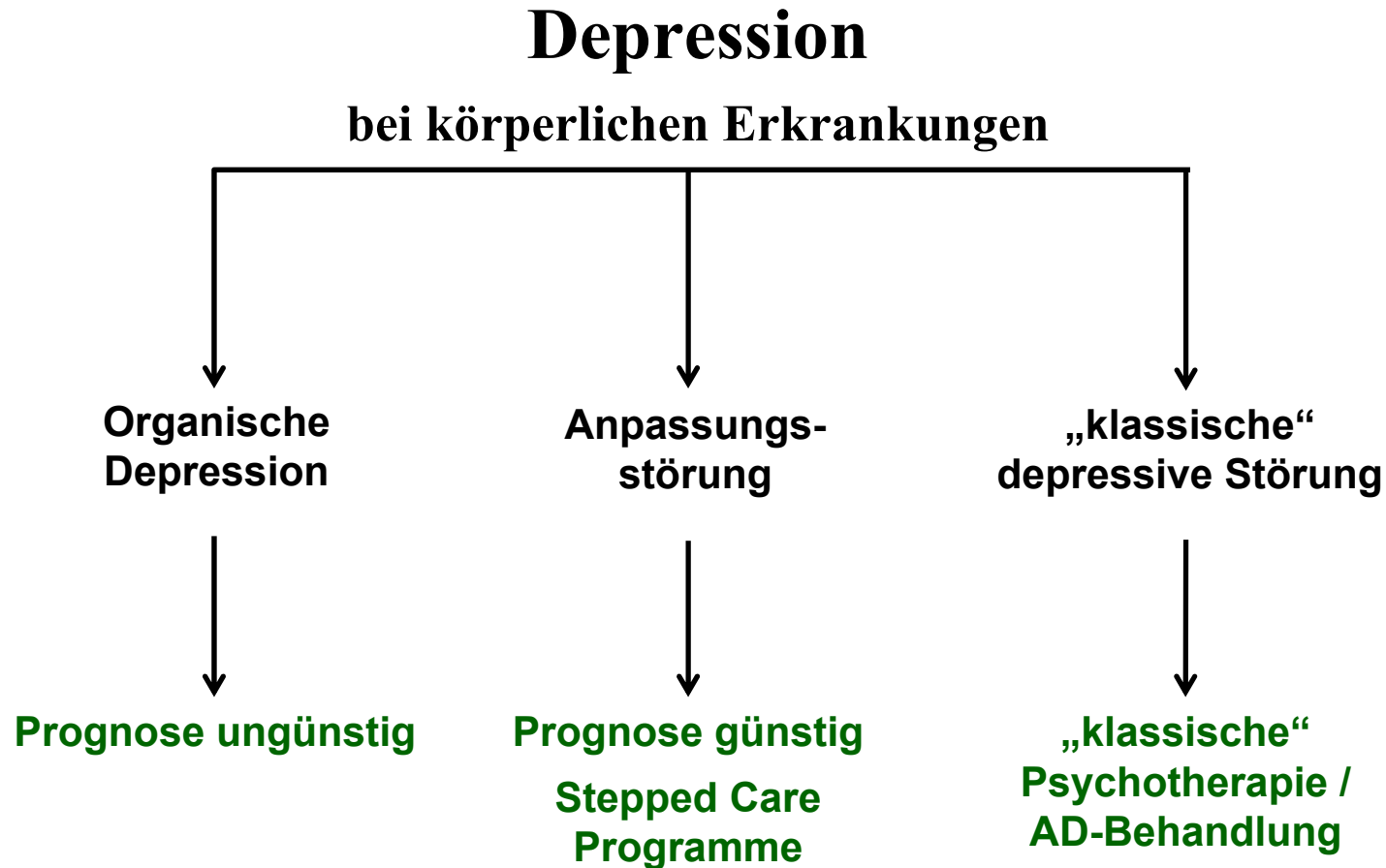
Geschlechtsbasiert:

Weibliche Depression

Behandlungsbasiert:

- Behandlungsresistente Depression

Subtypen depressiver Störungen



**Vielen Dank für Ihre
Aufmerksamkeit!**