Inpatient Psychosomatic Psychotherapy
An Integrative Approach in the Treatment of Stress-Determined Illness

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Cultural Diversity, Social Change and Mental Health in China
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Affiliated Hospital of Ulm Medical University
Incidence of Mental Health and Psychosomatic Disorders

ca. 30% pts. in a general hospital
ca. 35-50% pts. in a general practice

Suffer from mental health problems
or psychosomatic complaints

**but:** up to 80% of these pts.
initially present a somatic symptom
when they meet their doctor
 Patients with Masked Mental Health/Psychosomatic Disorders…

- Often suffer from unclear and frightening discomfort (problem: low or non-improvement of symptoms)
- Do not receive early detection of the problems (problem: insufficient diagnosis)
- Are often unhappy with their treatment (problem: low patient satisfaction)
- Are insufficiently treated for their problems (problem: Underserved but Overserviced)

... occupy, as so-called „High Utilizer“ Patients, significantly more medical resources as any other patient group
Provision of Outpatient Psychotherapeutic Care in Germany

**Outpatient care**

**By physicians & psychologists**

- Therapists mostly work in their own stand-alone practice.
- The preferred psychotherapy setting is Individual Therapy (cognitive behavioral therapy cbt or psychodynamic therapy).
- If a pre-treatment report is accepted, health insurance covers 40 – 100 visits of 50 min. on average (based on a fee of 85 € per visit).
- Medical psychotherapists must be either subspecialists for psychosomatic medicine, or adult-psychiatry or child- and adolescent-psychiatry.
- Psychological psychotherapists need a degree as adult- or child- and adolescent-psychotherapist.
Provision of Inpatient Psychotherapeutic Care in Germany

**Inpatient care**

*Clinics for psychosomatic medicine and psychotherapy at general hospitals*

4,000 inpatient beds and day-clinic placements provide psychotherapeutic/psychosomatic care for a population of 50 Mio. adults aged 18-65 y.

*Clinics for psychosomatic rehabilitation*

Nationwide 13,000 beds in rehab-clinics in Germany

- Health insurance covers all cost of treatment
- Treatment cost varies from 130 – 200 € per day
- Duration of stay differs from 39 – 65 days on average
- Team-oriented, interdisciplinary treatment plans

Hospitals and rehab. clinics regularly are not permitted to provide ambulatory care
**Essentials of Inpatient Psychotherapeutic Care**

**Integrative Treatment Plans**

* Team-oriented multiprofessional procedures
* High intensity care with 25-30 hours therapy per week
* Multimodal approach with combination of

- Different therapeutic settings
  (Individual Therapy, Group Therapy, Couple and Family Therapy)
- Proportions of different therapeutic `schools´
  (Cognitive Behavioral Therapy (CBT), Psychodynamic Therapy, Systemic Therapy)
- Verbal and active therapeutic offers

**Need-Based Therapies and Settings**

* Syndrome specific treatment
* Flexible transfer between inpatient-care (ward) and day-clinic
ICD 10 – Diagnoses
Treated in Psychotherapy or Psychosomatic Medicine

**Somatic Complaints Without Organic Results**
(subclinical health problems, med. unexplained symptoms MUS)
e.g. somatoform cardiovascular dysfunctions like rhythm problems, functional angina pectoris, palpitations, vertigo etc., somatoform dysfunction of digestive system, pain disorder, urogenital dysfunction

**Physical Illness with Strong Psychosocial Impact**
e.g. heart rhythm problems, hypertension, asthma, chronic inflammatory bowel disease, tinnitus, neurodermatitis etc.

**Eating Disorders**
binge eating disorder, bulimia, anorexia

**Coping Problems with Chronic Physical Diseases or Severe Health Problems**
e.g. diabetes, cancer, multiple sclerosis etc.

**Notice:**
Diagnoses have to make sense to the patient, otherwise they are useless for sufficient therapy!
Distribution of Diagnoses in OAK-Hosp.

N = 853 pts.  424 ward / 429 day-clinic
Multi-Leveled Aspects of Conditional Clauses, Interaction and Circumstances of Mental Health and Psychosomatic Problems

- Physical Complaints
- Emotions / Affects
- Cognitions (Health-) Beliefs
- Interaction
- Behavior

Symptom

Contextual Conditions

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The Meaning of Psychological or Psychosomatic Symptoms Depends on the Perspective of Different ‘Therapeutic Schools’

Psychodynamic Perspective

Cognitive - Behavioral Perspective

Systemic – Contextual Perspective
Psychodynamic Perspective

What are the sub-conscious fears and conflicts surfacing through the symptom and what purpose does the dysfunction have with respect to the patient's inner balance?
Cognitive – Behavioral Perspective

What empirical and learning deficits contribute to the symptom?
In what way does the *interaction between emotions (e.g. anxieties)*
cognitive factors (e.g. introspection, internal dialogs, etc.)
and behavior affect the degree of the psycho-physiological response?
The Meaning of Psychological or Psychosomatic Symptoms Depends on the Perspective of Different `Therapeutic Schools´

Systemic – Contextual Perspective

Which *system-oriented or contextual forms of behavior and interaction* are prone to maintain the symptoms/problems and which ones can increase the chances of the symptom disappearing again? What are the *effective relationship elements* of the symptoms with respect to the partnership, family relation, place of work etc.?
The Meaning of Psychological or Psychosomatic Symptoms Depends on the Perspective of Different `Therapeutic Schools´

Today, inpatient psychotherapy combines and integrates different school approaches to realize multi-modal and syndrome-oriented treatment plans.
Syndrome – Specific Treatment Focuses Not Only on the Symptom, but Primarily on Characteristic Clinical Traits of the Patient

Patient’s structure and personality?

Patient’s stability, resources or abilities?

Symptom

(Neuro-) biological proportions?
Acute / chronic course?
Medication necessary?

Patient’s motivation and courage for change?
Exposition (e.g. Anxiety and Obsessive-Compulsive Disorders)

Promoting Motivation (e.g. Somatoform Disorders, Eating Disorders)

Stabilizing (e.g. Trauma Victims)

Support and Relief (e.g. Adjustment and Stress Disorders)

Revealing (e.g. Depressive Disorders)

Experience Centered (e.g. Persistent Pain Disorders)

Conflict Centered (e.g. Depression and Anxiety Disorders)

Therapist Approach Determined by the Disorder
Exposition
(experience and respect own limits, improve self-efficacy, focus on things that work)

Supporting and activating
(Encourage self-confidence during periods of conflict-stress and loss of control)

Educating
(Modify attribution and self-concept of illness)

Verbalizing
(Verbalize hidden feelings of guilt, insult, or fear of failure)

Promoting motivation for change
(relationship-behavior, symptom-behavior etc.)

Assessing personality
(review the patient’s structure and conflict ability)

Problem-Oriented and Solution-Focused Strategies and Approaches of the Psychotherapy

Promoting self-experience
(discovering links between emotions, cognition, behavior and pain)

Conflict focusing
(uncovering maladaptive conflict behavioral-patterns)

Balancing
(finding a suitable balance between individual care and overdoing activities)
e.g.: Syndrome-Specific Treatment Groups

Group A
Depressive Disorders
9 pats. (ward and day-clinic)

Group B
Anxiety Disorders
Eating Disorders
9 pts. (ward and day-clinic)

Group C
Somatoform Disorders
Chronic Pain Disease
9 pts. (ward and day-clinic)

Group D
Traumatic Stress Disorders
9 pts. (ward and day-clinic)
Syndrome-Specific Treatment Divisions in an Integrative Psychosomatic Clinic

Group A - 9 Pat.  Patients with Depression

Group B - 9 Pat.  Patients with Anxiety and Panic Disorders
Patients with Psychogenic Eating Disorders

Group C - 9 Pat.  Patients with Chronic Pain
Patients with Somatoform Disorders

Group D - 9 Pat.  Patients with Adjustment Disorder resulting from General Medical Condition
Patients with Traumatic Stress Disorders

Team A/B

Team C/D
## Treatment During Inpatient/Day Clinic Psychotherapy
### (ca. 25 – 30 hrs/week)

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Frequency</th>
<th>Additional Treatments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Psychotherapy</td>
<td>2-3 x/Week</td>
<td>Art, Music- or Body-oriented therapy (Group) 3 x/Week</td>
</tr>
<tr>
<td>Psychodynamic Group</td>
<td>1 x/Week</td>
<td>Art, Music- or Body-oriented therapy (Indiv.) 1 x/Week</td>
</tr>
<tr>
<td>Role Play Group</td>
<td>1 x/Week</td>
<td>Training Sense of Pleasure (Group) 1 x/Week</td>
</tr>
<tr>
<td>Psycho-Education Group</td>
<td>1 x/Week</td>
<td>Couple and Family Therapy</td>
</tr>
<tr>
<td>Psychosomatic Rounds</td>
<td>1 x/Week</td>
<td>Spec. Trauma Therapy/ EMDR</td>
</tr>
<tr>
<td>Qi Gong und PME-Group</td>
<td>2 x/Week</td>
<td>Spec. Pain Therapy</td>
</tr>
<tr>
<td>Patient Feedback Group</td>
<td>1 x/Week</td>
<td>Exposition Training</td>
</tr>
<tr>
<td>Patient Focus Review</td>
<td>1 x/Week</td>
<td>Nutrition Counseling</td>
</tr>
<tr>
<td>Stress training Group</td>
<td>1 x/Week</td>
<td>Crisis Talk</td>
</tr>
<tr>
<td>Physiotherapies</td>
<td>as indicated</td>
<td>Fitness Training</td>
</tr>
<tr>
<td>Nordic Walking</td>
<td>1 x/Week</td>
<td>Grief Therapy</td>
</tr>
<tr>
<td>Patient-Triad</td>
<td>5 x/Week</td>
<td>Bio Feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Job counseling</td>
</tr>
</tbody>
</table>
The Multi-Professional Team of the Psychosomatic Clinic

- Occupational Therapist
- Physicians and Psychologists
- Music-, Body-Oriented-, Dance- and Art Therapists
- Physiotherapists
- Nutrition Consultant
- Psychosomatic Nurses
- External Supervisor
- Consultants for non-psychosomatic medical problems
However:

It‘s less the working method but 
the relationship between 
the Patient and the Therapist 
that is the crucial factor in the success of a Therapy …..
... so, the continuous reflection and review of the interactions between the patient, the therapist and the team members constantly stands as the middle point of the therapeutic work

- 2 x/day 30 min reflection within the team
  (led by the head doctor of the station or the clinic director)

- 1 x/week 120 min consultant ward round and treatment planning within the team
  (led by the head doctor of the station or the clinic director)

- 2 x/month 240 min external case and team supervision
  (led by external supervisor)

- 1-2 x/week internal (individual) meetings of case supervision
  (with the head doctor of the station or clinic director, respectively)
Day-clinic or Ward?

18 Therapy places

18 Therapy beds
Decision Making for the Assignment of Inpatient or Day-Clinic Treatment

**Differential Criteria for Inpatient Accommodation** (depending on frequency)

1. Relief in psychosocial conflict situations
2. Relief of everyday activities and obligations
3. Distance from home is useful
4. Persistent structure is necessary
5. Ward as a field for exercise
6. Outpatient care would be an excessive demand
7. Outpatient care is insufficient
8. Acute decompensate

**Differential criteria for Day Clinic Accommodation** (depending on frequency)

1. Promoting the transfer to daily life
2. Motivation exists for receiving only outpatient care
3. Increasing exposition in the home environment is useful
4. Remaining in the home environment as resource
5. Daily contact to the social sphere is important and necessary
25-Year-Old Patient

- Recurrent depression, currently severe and Bulimia nervosa
- The patient received further outpatient psychotherapy since her last stay in the clinic. However, an extreme increase in depressive symptoms, including thoughts of suicide, appeared after a period of school exams.
- Therefore she was admitted to the ward as a crisis intervention
Example of a Syndrome-Specific Therapy Offer for Patients with Eating Disorders

- Systemic Family Therapy
- Occupational Therapy
- Pleasure and Senses Training
- Body-Oriented Therapy (KBT)
- PMR from Jakobsen, Qi Gong
- Psychotherapy Individual and Group
- Music Therapy, Art Therapy
- Nutrition Counseling
- Networking for outpatient Aftercare
- As indicated, Consultation by an Internist
- Behavior Therapy Eating Disorders Group

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Course of Treatment

- Quickly stabilized due to the ward‘s structured days
- Pat. Patient herself saw the risk of regressing and changed for 6 weeks to the Day Clinic after two weeks on the ward
- Putting the new eating behavior into practice in the evening, finding daily rhythm.
- „I‘m alone at home and the pressure already hits me when I enter the hallway!“
38-Year-Old Patient

- PTSD resulting from a mugging
- Day Clinic due to severe social anxiety; home environment is a resource.
- Due to suicidal impulses, switched to the ward.
- In order to care for her children, she switched back to the Day Clinic.
Example of a Syndrome-Specific Therapy Offer for PTSD

- Individual and Group Psychotherapy
- Music Therapy, Art Therapy
- Training Psychoeducation
- Trauma Therapy Stabilisation Group
- EMDR
- Resource Work
- PMR from Jakobsen, Qi Gong
- Body-Oriented Therapy
- Systemic Couple and Family Therapy
- Occupational Therapy
- www.psychosomatik-aalen.de
Inpatient/Day-Clinic Treatment Phase Model

**Initial Phase**
- Bio-psycho-social diagnostic.
- Promote motivation
- Clarify goals

**Work Phase**
- Multimodal therapy plan with verbal and active therapy elements

**Transfer Phase**
- Integration of new experiences into everyday life
- Starting to look at the work situation

**Goal:** Cultivate and encourage patient’s competence and skills, allowing him to discover individual solutions

**Motto:** Use the patient’s resources to active his synapses
Clinical Indications for Inpatient Psychotherapeutic MUS-Care

**High Utilizer Behavior**
* More than 15 visits within 3 months at their GP’s practice
* Repeated visits in the hospital’s emergency room
* Unable to follow behavior agreements
* Severe health anxiety

**Referral by GP´s with PBC – Training or by psychol. Psychotherapists or Psychiatrists**

**As a result from Psychosomatic Consultation Service**
Psychotherapy Objectives of MUS

- Express realistic objectives for the therapy: Better coping, less impairing
- Improve the control about the symptoms, reduce helplessness, stimulate agency
- Learn to make distinctions between subclinical health problems and real (severe) illness symptoms
- Recognize and cope with symptom-causing and symptom-maintaining psychosocial conditions and burdens of life history
- End avoiding- and rest-behavior
- Promote physical fitness, healthy life conduct and social activities

Kruse, Henningsen
Psychotherapy Objectives of MUS

- Reducing the awareness for body sensations, reminding of automatic thinking
- Withdrawl checking behavior
- Learn how to handle physical and emotional limits of encumbrances
- Learn to make distinctions between symptoms and emotions (particularly in former or present relationships)
- Reduction of doctors consultations and checking up (e.g. repeated ecg´s) in favor of developing own coping strategies
- Preventing chronification through repeated medical diagnostics and risky forms of therapy

Kruse, Henningsen
Mrs. F. is a 32 year old, married business manager MA. Before getting sick, she worked 60-80 hours per week. Because of her ambition, she has chances of making a brilliant career.

The headache began during a violent relationship (1998-2001) where she felt physically and emotionally threatened. She’s tried “nearly everything to improve the situation”, but she had to lower her performance to 50 % within the last two years.

Her mother was very concerned about the rape which occurred in Mrs. F.’s partnership. Although Mrs. F. had no symptoms of PTSD, her mother insisted that psychotherapy should be done. So Mrs. F. took part of a 1-year therapy with EMDR and hypnosis. Unfortunately, the therapy had no effect on the headache.

Since she has a new partner, she feels very safe, happy and satisfied; she got married in 2005.

Beside pain she suffers from other side effects: neck-shoulder tension, exhaustion, tiredness, poor concentration, constipation and increase of body weight (15 kg).
She is a single child of her parents, father is a 56 year old director of a bank, mother is a 45 year old high school teacher. “I love my parents, they always took care of me. Mom and dad never argued with each other. Mother suffers hard as a result of my chronic pain, so we call each other 3-5 times every day.”

Mother reports, that her daughter always was a lovely girl, they never had any trouble with each other. During puberty the parents often secretly hoped that she would once come home late, but she never did.

Mrs. F. reports, that she never wanted to discomfort her parents but always please them. Mother had never said her expectations openly, “but anyway, I always knew what she wanted. If she was ever mad at me, she never showed her anger openly but lifted one eyebrow at the most and everyone knew what's going on!”

Mrs. F. looked for help from 50 doctors, having more than 200 visits during 1999-2005, but there was no somatic reason found for her complaints.

She feels very exhausted, frustrated and hopeless. She has low expectations for the psychosomatic therapy. “I only come because my pain therapist is at a loss.”
# Health Care Utilization by Pat. F.  Part I

176 Doctors Appointments from Nov. 1999 – May 2004

<table>
<thead>
<tr>
<th>Termin</th>
<th>Arzt / Behandlung (Name)</th>
<th>Anzahl</th>
<th>Bemerkungen</th>
</tr>
</thead>
<tbody>
<tr>
<td>25.11.1999</td>
<td>Augenarzt (Dr. Ziegler)</td>
<td>1</td>
<td>Kontrolluntersuchung wg. Kopfschmerzen (ohne Befund)</td>
</tr>
<tr>
<td>18.01.2000</td>
<td>Internist (Dr. Eulenburg)</td>
<td>1</td>
<td>Blutwerte (ohne Befund)</td>
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<tr>
<td>31.01.2000</td>
<td>Neurologe (Dr. Lehmann)</td>
<td>2</td>
<td>EEG (ohne Befund); Jacobson-Entspannungstechnik</td>
</tr>
<tr>
<td>17.06.2000</td>
<td>Hausarzt (Dr. Axter)</td>
<td>8</td>
<td>Bestrahlungen Rücken (ohne Erfolg)</td>
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<tr>
<td>28.06.2000</td>
<td>Physiotherapeut (H. Miorin)</td>
<td>6</td>
<td>Krankengymnastik (ohne Erfolg)</td>
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<tr>
<td>31.06.2000</td>
<td>Frauenarzt (Dr. Langar-Glock)</td>
<td>1</td>
<td>Kontrolluntersuchung wg. Kopfschmerzen (ohne Befund)</td>
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<tr>
<td>08.08.2000</td>
<td>Physiotherapeut (Fr. Godel-Reichert)</td>
<td>1</td>
<td>Behandlung nach Dorn-Methode (Wirbelblockaden schonend losen) (nur wenige Stunden Besserung)</td>
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<tr>
<td>01.09.2000</td>
<td>Zahnarzt (Dr. Schreiber)</td>
<td>1</td>
<td>Kontrolluntersuchung wg. Kopfschmerzen (ohne Befund); Aufbisschiene ausprobiert (ohne Erfolg)</td>
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<tr>
<td>02.11.2000</td>
<td>Physiotherapeut (H. Rambach)</td>
<td>18</td>
<td>Meridian-Behandlung, Akupunktur (ohne Erfolg)</td>
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<tr>
<td>03.01.2000</td>
<td>Orthopäde (Dr. Wald)</td>
<td>2</td>
<td>Röntgenbilder, Besprechung der Kernspin, Krankengym. Versorgung</td>
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<td>05.01.2000</td>
<td>Kernspint (Dr. Feiling)</td>
<td>1</td>
<td>(ohne Befund)</td>
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<td>11.01.2000</td>
<td>Physiotherapeut (Fr. Nasseriedine)</td>
<td>15</td>
<td>Schlingentisch-Behandlung + Massagen (ohne Erfolg)</td>
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<td>21.03.2000</td>
<td>AIDS-Test</td>
<td>1</td>
<td>(negativ)</td>
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<tr>
<td>01.06.2000</td>
<td>Allg. Arzt (Dr. Simon)</td>
<td>6</td>
<td>Gesprächsberatung</td>
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<tr>
<td>24.04.2000</td>
<td>Frauenarzt (Dr. Langer-Glock)</td>
<td>10</td>
<td>Flunisotid 5 von ct-Klagau - Migräneattacken (ohne Erfolg)</td>
</tr>
<tr>
<td>19.06.2000</td>
<td>Chiropraktiker (Dr. Eikerling)</td>
<td>1</td>
<td>(ohne Befund)</td>
</tr>
<tr>
<td>13.09.2000</td>
<td>Masseur (Praxis Dr. Eikerling)</td>
<td>1</td>
<td>Schlingentisch-Behandlung + Massagen und Fango verschrieben wg. Verspannungen</td>
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<tr>
<td>08.11.2000</td>
<td>Allg. Arzt (Dr. Deuss)</td>
<td>1</td>
<td>(ohne Erfolg)</td>
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<tr>
<td>24.10.2001</td>
<td>TENS-Kurs</td>
<td>1</td>
<td>(ohne Erfolg)</td>
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<tr>
<td>16.06.2002</td>
<td>Neurologe (Dr. West)</td>
<td>1</td>
<td>(ohne Erfolg)</td>
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<tr>
<td>03.09.2002</td>
<td>Schmerztherapeut</td>
<td>1</td>
<td>Amitriptylin zurückgefahren, da stark zugenommen und kein Erfolg (am 08.10. abgesetzt)</td>
</tr>
<tr>
<td>04.09.2002</td>
<td>Schmerztherapeut</td>
<td>1</td>
<td>TENS-Gerät</td>
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<tr>
<td>11.09.2002</td>
<td>Schmerztherapeut (Dr. Böck)</td>
<td>1</td>
<td>2 Vioxx 25 mg für 12 Tage (3 Tage fast schmerzfrei, danach ohne Erfolg)</td>
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<tr>
<td>02.10.2000</td>
<td>Schmerztherapeut (Dr. Böck)</td>
<td>1</td>
<td>2 Tranquil-Dolo-Kein N3 für 17 Tage (ohne Erfolg)</td>
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<tr>
<td>14.10.2002</td>
<td>Gi-Gong-Kurs (Praxis Dr. Böck)</td>
<td>10</td>
<td>(ohne Erfolg)</td>
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<tr>
<td>13.11.2002</td>
<td>Biofeedback (Praxis Dr. Böck)</td>
<td>10</td>
<td>(ohne Erfolg)</td>
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<tr>
<td>04.02.2003</td>
<td>Traumaspezialist (Dr. Kallinke)</td>
<td>40</td>
<td>Beh. mit EMDR - erste Sitzung; danach für ca. 30 min. das Gefühl aus dem Nebel aufgetaut zu sein</td>
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<tr>
<td>13.08.2003</td>
<td>Traumaspezialist (Dr. Kallinke)</td>
<td>1</td>
<td>Amitriptylin neuraxpharm - bis 50 mg</td>
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<tr>
<td>03.11.2003</td>
<td>Traumaspezialist (Dr. Kallinke)</td>
<td>1</td>
<td>Amitriptylin zurückgefahren, da stark zugenommen und ohne Erfolg (am 08.10. abgesetzt)</td>
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<tr>
<td>03.11.2003</td>
<td>Traumaspezialist (Dr. Kallinke)</td>
<td>1</td>
<td>1 1/2 Zoloft 50 mg für 3 Wochen (abgesetzt am 21.11.03, da kein Erfolg)</td>
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<tr>
<td>25.05.2004</td>
<td>Allgemein Med. (Dr. Hagleauer)</td>
<td>6</td>
<td>2. Versuch Amitriptylin 60 mg für 4 Monate (abgesetzt am 10.06., da kein Erfolg)</td>
</tr>
</tbody>
</table>

Typical Relationship Problem with the Medical System: Pat. F. Is overserved but underserved.
Health Care Utilization by Pat. F. Part II

38 Doctors Appointments from May 2004 – August 2005

<table>
<thead>
<tr>
<th>Termin</th>
<th>Arzt / Behandlung (Name)</th>
<th>Anzahl</th>
<th>Bemerkungen</th>
</tr>
</thead>
<tbody>
<tr>
<td>27.05.2004</td>
<td>Internist (Dr. Eulerburg)</td>
<td>1</td>
<td>Blutwerte (ohne Befund bis auf &quot;leicht erhöhten&quot; Schilddrüsentestwert)</td>
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<tr>
<td>02.07.2004</td>
<td>Allgemein Med. (Dr. Lehmann, Freiburg)</td>
<td>1</td>
<td>Chiropraktische Beh., intrakutane Infusionen bds., intrakutane Infusionen und Niederfrequenz-Reiztherapie am Kopf</td>
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<tr>
<td>10.07.2004</td>
<td>Masseurin (Fr. Lazar)</td>
<td>3</td>
<td>Energiemassage, Blockaden lösen durch Messagen, Fußreflexzonenmassage, keine Erfolg</td>
</tr>
<tr>
<td>22.07.2004</td>
<td>Schmerztherapeut (Dr. Böck)</td>
<td>3</td>
<td>Stellatum Ganglion: bei erster Behandlung 1 1/2 Tage kaum Schmerzen, dann weniger ( \text{Erfolg)}</td>
</tr>
<tr>
<td>03.08.2004</td>
<td>Schmerztherapeut (Dr. Böck)</td>
<td>2</td>
<td>Stellatum Katheter (ohne Erfolg)</td>
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<tr>
<td>11.08.2004</td>
<td>Augenarzt (Dr. Ziegler)</td>
<td>1</td>
<td>Kontaktuntersuchung vgl. Kopfschmerzen (leichter Schielwinkel, keine wesentlichen Schäden)</td>
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<tr>
<td>12.08.2004</td>
<td>Schmerztherapeut (Dr. Böck)</td>
<td>1</td>
<td>Voruntersuchung für Anwendung von Botulinumtoxin (nicht durchgeführt)</td>
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<tr>
<td>18.08.2004</td>
<td>Heilpraktiker (H. Kege)</td>
<td>9</td>
<td>Craniosteoosteopathie, Frakturnähliche symptomatische Behandlung, kein diagnostischer ( \text{Erfolg)}</td>
</tr>
<tr>
<td>27.10.2004</td>
<td>Internist (Dr. Eulerburg)</td>
<td>1</td>
<td>Blutwerte mit Befund: TSH 0,074 mmol/l (Aussage: 'LThyroxin beibehalten falls keine Nebenwirkungen, ansonsten reduzieren auf 112,5 mg/m3')</td>
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<td>09.11.2004</td>
<td>Endokrinologe (Dr. Klein)</td>
<td>1</td>
<td>Verordnung: TSH 0,074 (Aussage: 'LThyroxin beibehalten falls keine Nebenwirkungen, ansonsten reduzieren auf 112,5 mg/m3')</td>
</tr>
<tr>
<td>14.01.2005</td>
<td>Endokrinologe (Dr. Klein)</td>
<td>1</td>
<td>Blutwerte: Befund TSH 0,074 mmol/l (Aussage: 'LThyroxin beibehalten falls keine Nebenwirkungen, ansonsten reduzieren auf 112,5 mg/m3')</td>
</tr>
<tr>
<td>27.01.2005</td>
<td>Zahnarzt (Dr. Schumacher)</td>
<td>1</td>
<td>Kontrolle mit Röntgenbild: In mehreren Zahnzahnsäumen starke, bisher unerkannte Kariesbildung</td>
</tr>
<tr>
<td>02.02.2005</td>
<td>Internist (Dr. Eulerburg)</td>
<td>1</td>
<td>Blutwerte: Befund TSH 0,074 mmol/l (Aussage: 'LThyroxin beibehalten falls keine Nebenwirkungen, ansonsten reduzieren auf 112,5 mg/m3')</td>
</tr>
<tr>
<td>10.02.2005</td>
<td>Endokrinolog, Ambulante (Uniklinik HD)</td>
<td>1</td>
<td>Blutwerte: Befund TSH 0,074 mmol/l (Aussage: 'LThyroxin beibehalten falls keine Nebenwirkungen, ansonsten reduzieren auf 112,5 mg/m3')</td>
</tr>
<tr>
<td>01.04.2005</td>
<td>Internist (Dr. Strenz)</td>
<td>2</td>
<td>Hashimoto bestätigt, HbA1c-Test: positiv (26 bei Grenzwert 15), Behandlung mit Depyrimidin-Basis, 1 Tabletten pro Tag</td>
</tr>
<tr>
<td>31.05.2005</td>
<td>Internist (Dr. Strenz)</td>
<td>1</td>
<td>TSH: 3,42 (nach 4 Wochen 100 mg): Steigerung auf 112,5 mg T3 und LThyroxin</td>
</tr>
<tr>
<td>05.07.2005</td>
<td>Internist (Dr. Strenz)</td>
<td>1</td>
<td>Blutwerte: Befund TSH 2,52 (nach 4 Wochen 112,5 mg): Steigerung auf 125 mg T3 und LThyroxin (reines T3, Vermutlich Funktioniert Umwandlung in T3 nicht richtig, FT4 die 1,53 und FT3 die 2,70</td>
</tr>
<tr>
<td>03.08.2005</td>
<td>Schmerztherapeut (Dr. Böck)</td>
<td>1</td>
<td>TSH: 3,42 (nach 4 Wochen 100 mg): Steigerung auf 112,5 mg T3 und LThyroxin</td>
</tr>
<tr>
<td>16.08.2005</td>
<td>Osteopath (Fr. Hauser)</td>
<td>1</td>
<td>starke Verspannungen, Umstellung der Anordnung etc.; Viszeral-Behandlung</td>
</tr>
</tbody>
</table>

Who’s responsible for the over-use of medical resources: the Patient or her Medical Providers?
The chronic pain syndrome, the exhaustion, the overuse of healthcare services and the vegetative complaints indicate that Mrs. F’s internal balance of her basic needs is strongly disturbed.
Syndrome – Specific Treatment Focuses Not Only on the Symptom, but Primarily on Characteristic Clinical Traits and the Satisfaction of the Pt´s. Basic Needs

Patient´s Structure and Personality

Patient´s Stability, Resources and Abilities

Symptom

Patient´s Motivation and Courage of Change

Satisfaction of Basic Needs
Individual Characteristics of Pat. F.

Structure and Personality

Stable bonding experiences during childhood.
Many positive experiences of love, care and interest in her family (overprotection?).
Successful in her profession, very performance-oriented.
But: Little experience being exposed to or managing conflicts.
Low feelings of self-worth and a tendency towards a guilty conscience if she expresses her own needs.
Avoids disagreeing with or opposing her parents, strong tendency towards seeking peace.
Individual Characteristics of Pat. F.

Stability, Resources and Skills

Although the chronic pain has greatly affected her emotional stability, she still develops ideas and fantasies about what must happen in order for her to get better. Although she doesn’t have concrete plans, she is considering giving up her job for a few years in order to discover what she really wants to do with her life. Her husband thinks it is a great idea and supports her plans but her parents are appalled/horrified.

Resources: Creative (Painting and Pottery), Working with Flowers
Activating Resources

- Each opportunity to which a person has access which satisfies their basic needs (Attachment/Autonomy, Self Esteem, Control, Pleasure, Competence)

- To the question, how can the problems best be solved, the resources are likely more important than the problems themselves

(Indication and Treatment Grawe 1999)
Motivation and Courage of Change

Little motivation or courage to actively change the situation. Expectation of external solutions ("I think you know what is good for me")

She is afraid to take responsibility for creating distance between her and her parents. ("They’ll think I’m unloyal if I distance myself from their care!")

The parent’s understanding of her illness implies that her sickness is an expression of her dependence, which she experienced during the violent relationship from 1999-2001.
Good emotional structure. Strong relationship experiences but little ability to handle conflict (at home and later, in her first partnership). Mrs. F. compensates for doubts and low self-confidence with high professional commitment. But the pain interrupts this vicious cycle, forcing her to find out what she really wants to do in her life.
Integrative Treatment Plan of Mrs. F

- Admitted to the Ward
- Conflict-Centered Treatment
- Promote the Perception of Affect/Body Response
- Development of a Psychosomatic Cause of the Illness
- Psychoeducation For Pain
- Early Switch to the Day Clinic
- Involvement of the Parents (Conflict Level)
- Involvement of the Partner (Resource Level)
- Integration of the Outpatient Pain Specialist
- Stepwise Discharge via Day Clinic
The multi-modal treatment leads to a well-balanced Mind-Body-Soul triangle. Mrs. F has had no symptoms for three years, works as a florist, visits her parents once a month and enjoys her pregnancy.
Thank You for Your Attention!