Inpatient Psychosomatic Psychotherapy

An Integrative Approach in the Treatment of Stress-Determined Illness

International Conference on Transcultural Psychiatry

Cultural Diversity, Social Change and Mental Health in China

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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

<u>but:</u> **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 psycho-therapeutic/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

Notice:
Diagnoses have to make sense to the patient, otherwise they are useless for sufficient therapy !

P
e.g. [illegible] traumatizing, sexual abuse, hostage taking, accidents, disasters, after ICD – therapy, after emergency or intensive care experience

Acute Loading Reaction in a Crisis Situation
e.g. acute crisis (after a threatening diagnosis or bad news) or by experiences of loss and separation; mobbing-stress
ICD 10 F 43.0, 43.1

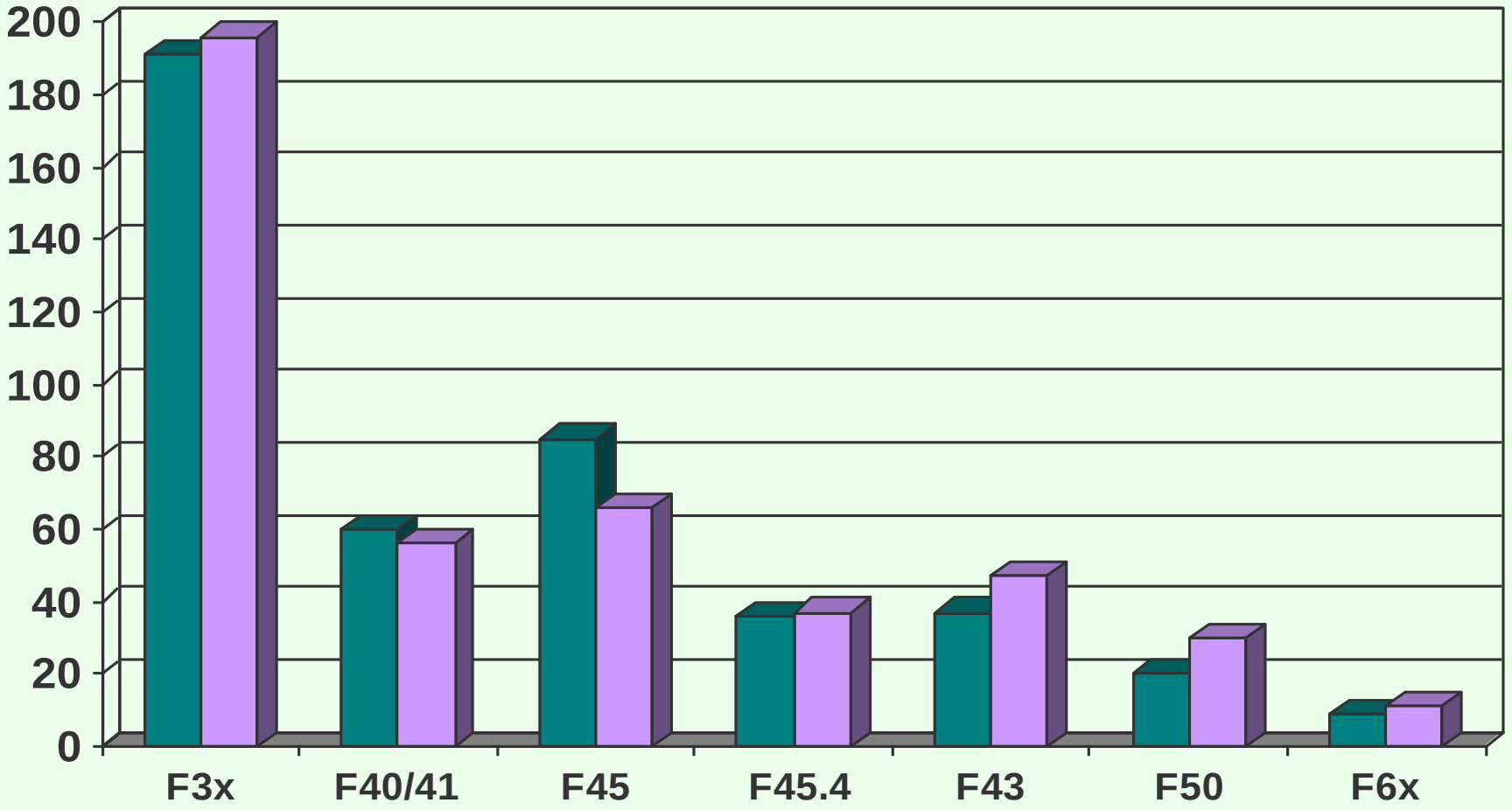
Affective and Personality Disorders
personality disorders, compulsive disorders
ICD 10 F 60, 61, 42

e.g. heart rhythm problems, hypertension, asthma, chronic inflammatory bowel disease, tinnitus, neurodermatitis etc.
ICD 10 F 54

Coping Problems with Chronic Physical Diseases or Severe Health Problems
e.g. diabetes, cancer. multiple sclerosis etc.
ICD 10 F 43.2

Distribution of Diagnoses in OAK-Hosp.

N = 853 pts. 424 ward / 429 day-clinic



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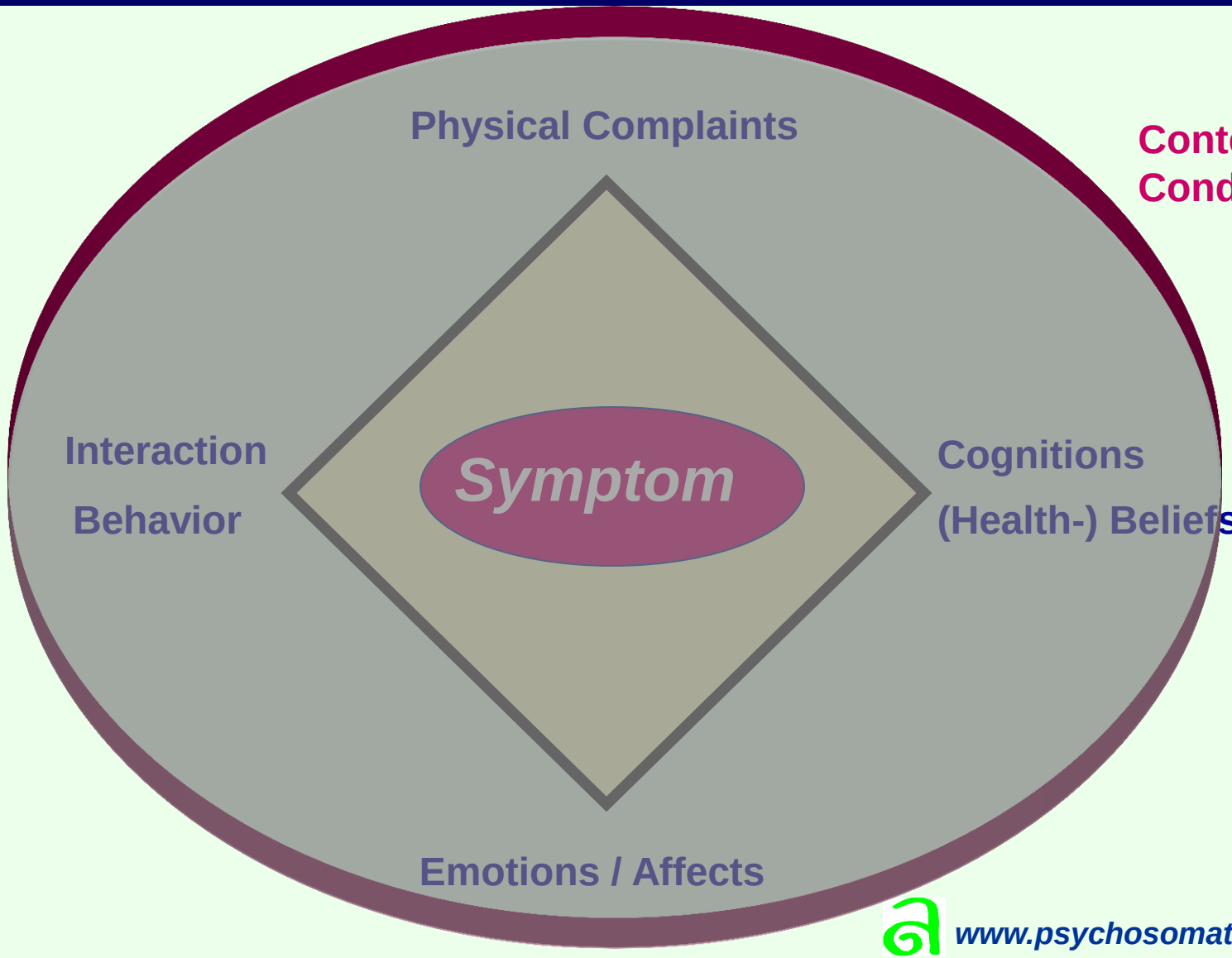
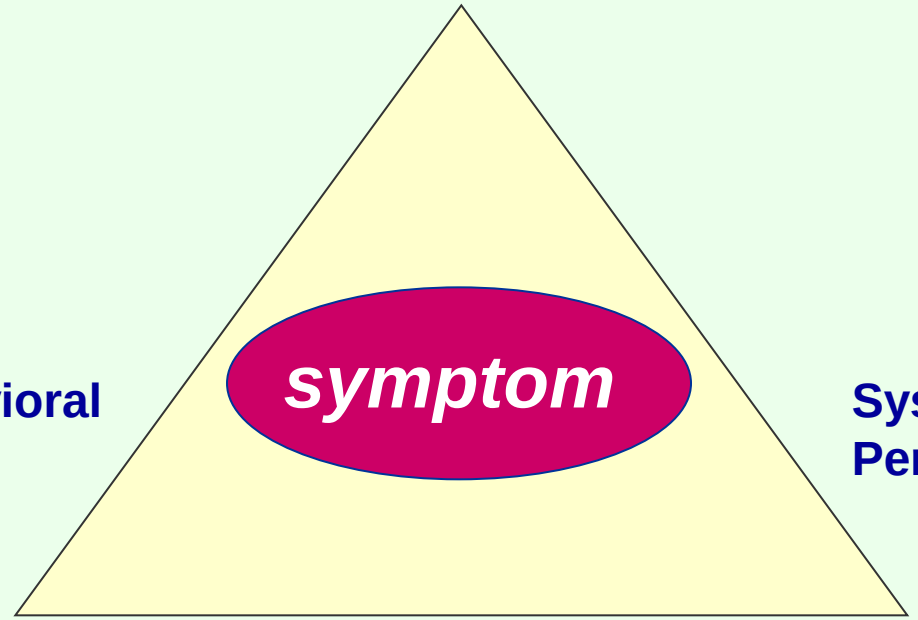
Multi-Leveled Aspects of Conditional Clauses, Interaction and Circumstances of Mental Health and Psychosomatic Problems



The Meaning of Psychological or Psychosomatic Symptoms Depends on the Perspective of Different `Therapeutic Schools´



The Meaning of Psychological or Psychosomatic Symptoms Depends on the Perspective of Different `Therapeutic Schools´

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?***

The Meaning of Psychological or Psychosomatic Symptoms Depends on the Perspective of Different `Therapeutic Schools´

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

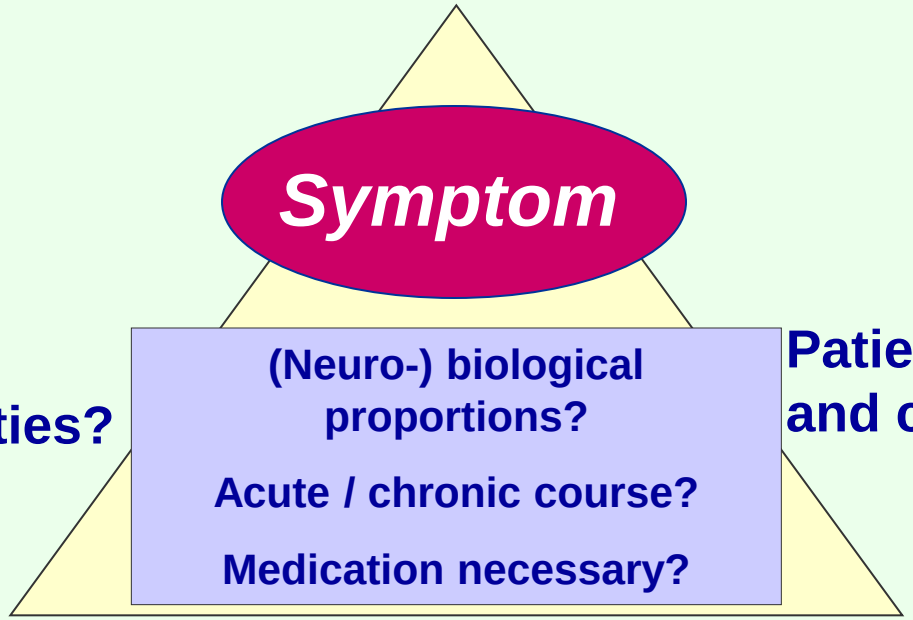
*Which **system-oriented or contextual forms of behavior and interaction** are prone to maintain the symptoms/problems and which ones can increase the chances of the symptom disappearing again?*
*What are the **effective relationship elements** of the symptoms with respect to the partnership, family 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?

Patient´s motivation and courage for change?


Promoting Motivation
(e.g Somatoform Disorders, Eating Disorders)
Exposition
(e.g. Anxiety and Obsessive-Compulsive Disorders)
Support and Relief
(e.g. Adjustment and Stress Disorders)
Therapist Approach Determined by the Disorder
Stabilizing
(e.g. Trauma Victims)
Experience Centered
(e.g. Persistent Pain Disorders)
Conflict Centered
(e.g. Depression and Anxiety Disorders)
Revealing
(e.g. Depressive Disorders)
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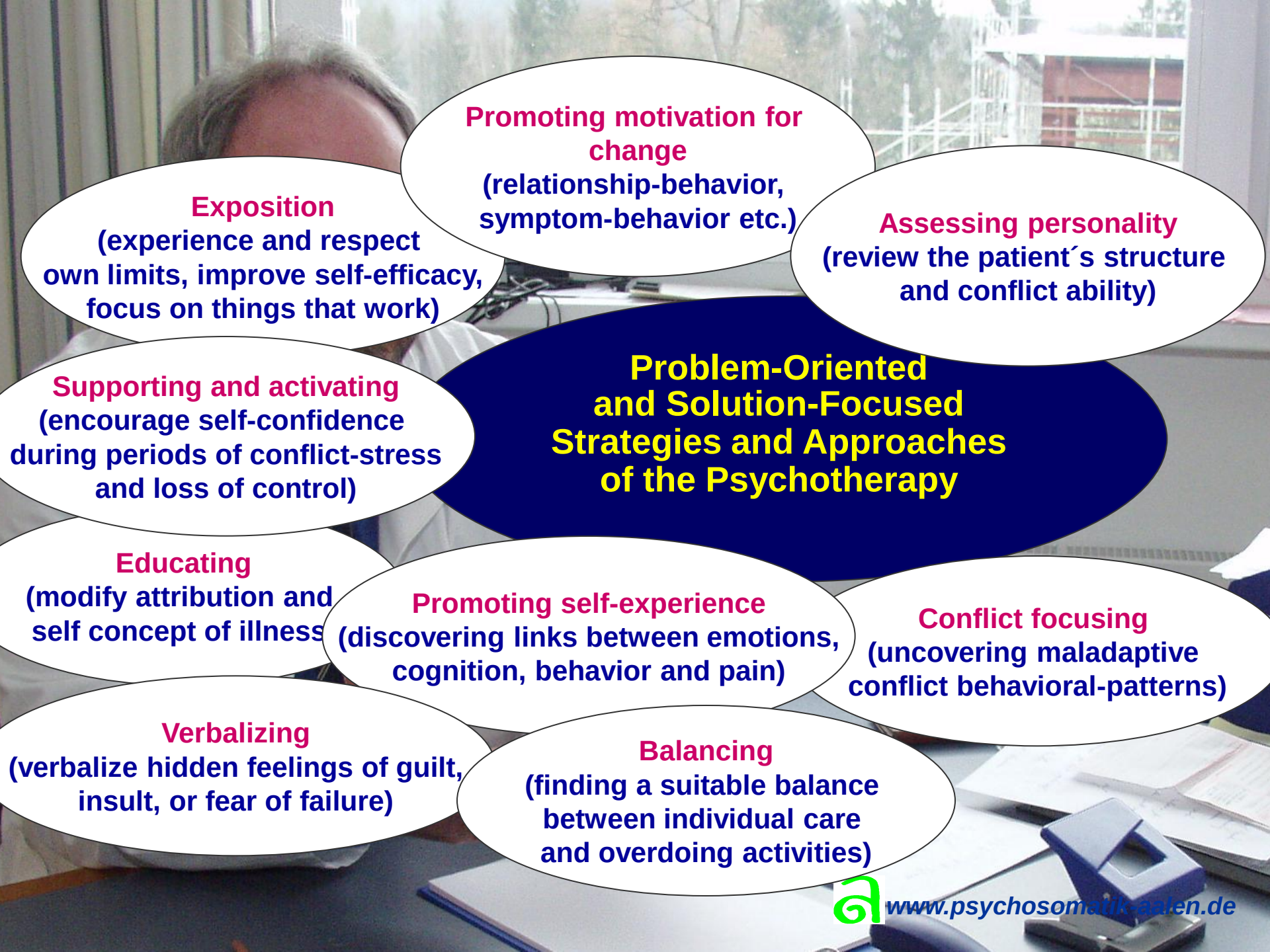
Promoting motivation for change
(relationship-behavior, symptom-behavior etc.)
Exposition
(experience and respect own limits, improve self-efficacy, focus on things that work)
Assessing personality
(review the patient´s structure and conflict ability)
Problem-Oriented and Solution-Focused Strategies and Approaches of the Psychotherapy
Supporting and activating
(encourage self-confidence during periods of conflict-stress and loss of control)
Educating
(modify attribution and self concept of illness
Promoting self-experience
(discovering links between emotions, cognition, behavior and pain)
Conflict focusing
(uncovering maladaptive conflict behavioral-patterns)
Verbalizing
(verbalize hidden feelings of guilt, insult, or fear of failure)
Balancing
(finding a suitable balance between individual care and overdoing activities)
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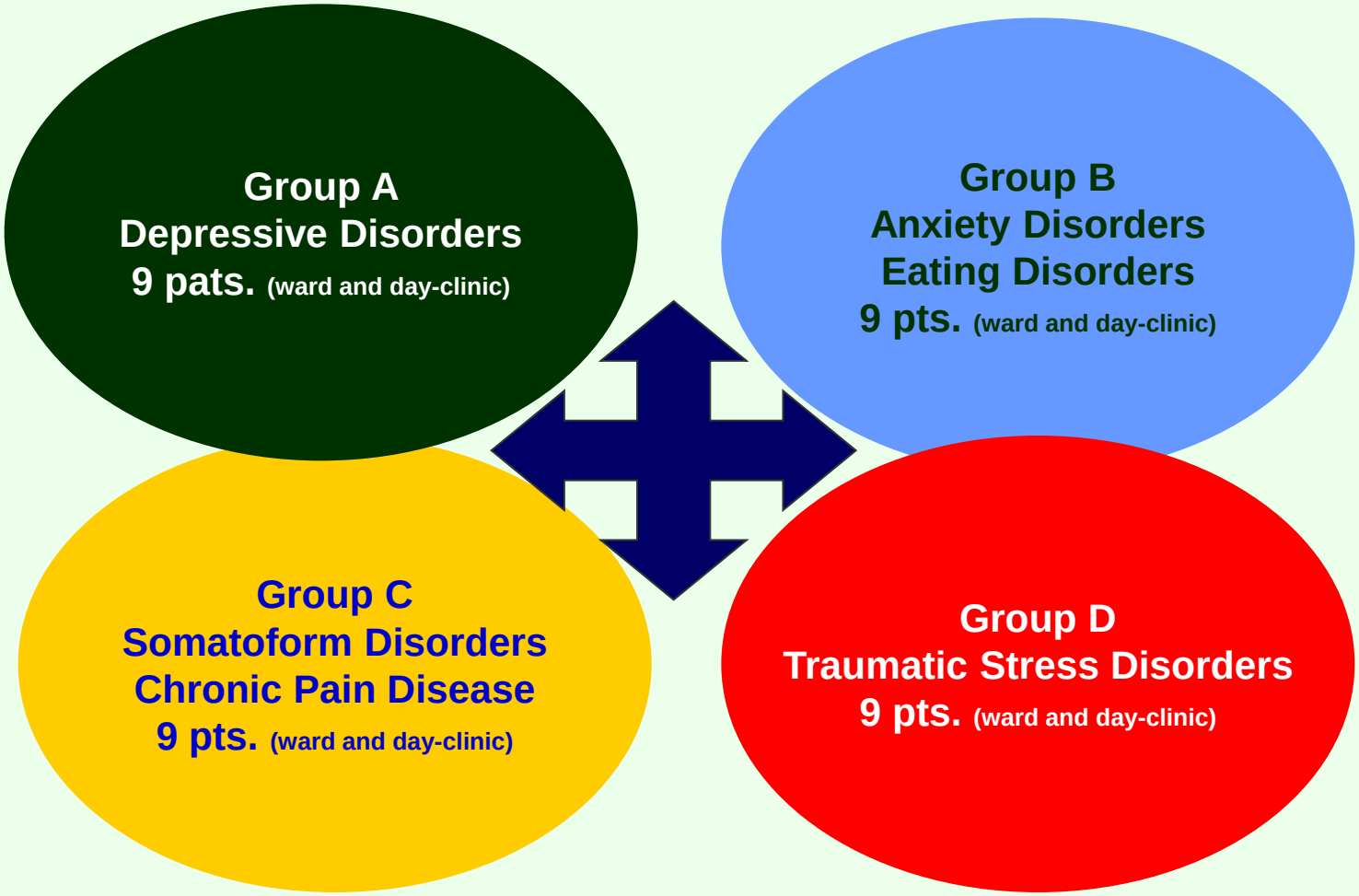
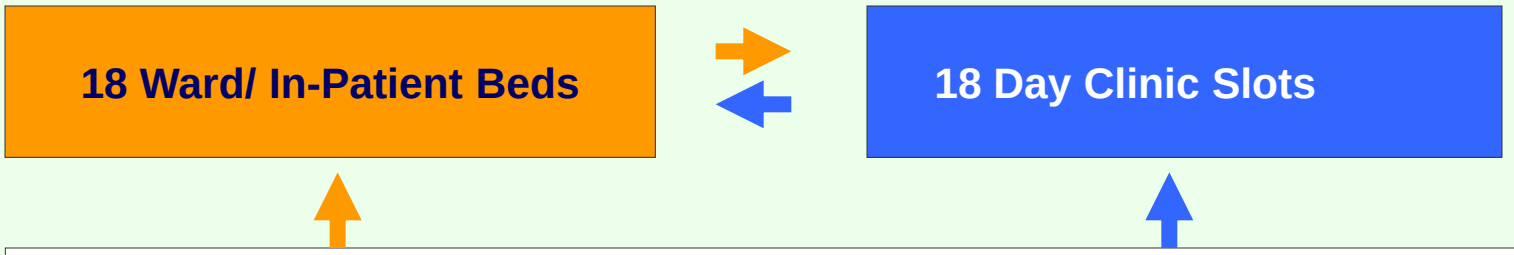
e.g.: Syndrome-Specific Treatment Groups



Syndrome-Specific Treatment Divisions in an Integrative Psychosomatic Clinic



Team A/B	Group A - 9 Pat.	Patients with Depression
	Group B - 9 Pat.	Patients with Anxiety and Panic Disorders Patients with Psychogenic Eating Disorders
Team C/D	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

Treatment During Inpatient/Day Clinic Psychotherapy

(ca. 25 – 30 hrs/week)

Individual Psychotherapy	**2-3 x/Week**	**Art, Music- or Body-oriented therapy (Group)**	**3 x/Week**
Psychodynamic Group	**1 x/Week**	**Art, Music- or Body-oriented therapy (Individ.)**	**1 x/Week**
Role Play Group	**1 x/Week**	**Training Sense of Pleasure (Group)**	**1 x/Week**
Psycho-Education Group	**1 x/Week**	**Couple and Family Therapy**	**as indicated**
Psychosomatic Rounds	**1 x/Week**	**Spec. Trauma Therapy/ EMDR**	**as indicated**
Qi Gong und PME-Group	**2 x/Week**	**Spec. Pain Therapy**	**as indicated**
Patient Feedback Group	**1 x/Week**	**Exposition Training**	**as indicated**
Patient Focus Review	**1 x/Week**	**Nutrition Counseling**	**as indicated**
Stress training Group	**1 x/Week**	**Crisis Talk**	**as indicated**
Physiotherapies	**as indicated**	**Fitness Training**	**as indicated**
Nordic Walking	**1 x/Week**	**Grief Therapy**	**as indicated**
Patient-Triad	**5 x/Week**	**Bio Feedback**	**as indicated**
		Job counseling	**as indicated**


Occupational Therapist
Music-,
Body-Oriented-, Dance-
and Art Therapists
Physicians
and Psychologists
Physiotherapists
The Multi-Professional Team
of the Psychosomatic Clinic
Nutrition Consultant
Psychosomatic
Nurses
External Supervisor
Consultants for
non-psychosomatic
medical problems
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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


PMR from Jakobsen,
Qi Gong
Psychotherapy
Individual and Group
Systemic
Family Therapy
Music Therapy,
Art Therapy
Occupational Therapy
xample of a Syndrome-Specific
Therapy Offer for Patients wit
Eating Disorders
Nutrition Counseling
Pleasure and Senses Training
Networking for
outpatient Aftercare
Body-Oriented
Therapy(KBT)
As indicated, Consultatio
by an Internist
Behavior Therapy
Eating Disorders Group

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.


Individual and Group Psychotherapy
Music Therapy, Art Therapy
PMR from Jakobsen, Qi Gong
Body-Oriented Therapy
Example of a Syndrome-Specific Therapy Offer for PTSD
Training Psychoeducation
Systemic Couple and Family Therapy
Trauma Therapy Stabilisation Group
Occupational Therapy
Resource Work
EMDR
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Inpatient/Day-Clinic Treatment Phase Model

Initial Phase	Work Phase	Transfer Phase
Bio-psycho-social diagnostic. Promote motivation Clarify goals	Multimodal therapy plan with verbal und active therapy elements	Integration of new experiences into everyday life What (problems) will I leave behind?

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 activites

Kruse, Henningsen

Psychotherapy Objectives of MUS

- Reducing the awareness for body sensations, reminding of automatic thinking
- Withrawl 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 relationsships)
- 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

MUS - Case (Somatoform Chronic Pain Disorder ICD 10 F 45.4)

- 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).

MUS - Case cont. (Somatoform Chronic Pain Disorder ICD 10 F 45.4)

- 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 an 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

Termin	Arzt / Behandlung (Name)	Anzahl	Bemerkungen
25.11.1999	Augenarzt (Dr. Ziegler)	1	Kontrolluntersuchung wg. Kopfschmerzen (ohne Befund)
18.01.2000	Internist (Dr. Eulenburg)	1	Blutwerte (ohne Befund)
31.01.2000	Neurologe (Dr. Lehmann)	2	EEG (ohne Befund); Jacobson-Entspannungstechnik
17.06.2000	Hausarzt (Dr. Axter)	8	Bestrahlungen Rücken (ohne Erfolg)
28.06.2000	Physiotherapeut (H. Miorin)	6	Krankengymnastik (ohne Erfolg)
31.06.2000	Frauenarzt (Dr. Langer-Glock)	1	Kontrolluntersuchung wg. Kopfschmerzen (ohne Befund)
08.08.2000	Physiotherapeut (Fr. Godel-Reichert)	1	Behandlung nach Dorn-Methode (Wirbelblockaden schonend lösen) (nur wenige Stunden Besserung)
01.09.2000	Zahnarzt (Dr. Schreiber)	1	Kontrolluntersuchung wg. Kopfschmerzen (ohne Befund); Aufbissschiene ausprobi… ohne Erfolg)
02.11.2000	Physiotherapeut (H. Rambach)	18	Meridian-Behandlung, Akupunktur (ohne Erfolg)
03.01.2000	Orthopäde (Dr. Weldi)	2	Röntgenbilder, Besprechung der Kernspin, Krankengymn. Versch… …gen
05.01.2000	Kernspin (Dr. Fehling)	1	(ohne Befund)
11.01.2000	Physiotherapeut (Fr. Nasseredine)	15	Schlingentisch-Behandlung + Massagen (ohne E…
21.03.2000	AIDS-Test	1	(negativ)
01.06.2000	Allg. Arzt (Dr. Simon)	6	Gesprächstherapie
			Flunarizin 5 von ct-Ka…
			Migränerton… Nebenwirkungen (Angstzustände)) (ohne Erfolg)
24.04.2000	Frauenarzt (Dr. Langer-Glock)	10	Aku…
19.06.2000	Chiropraktiker (Dr. Eikerling)	1	…; Massagen und Fango verschrieben wg. Verspannungen
13.09.2000	Masseur (Praxis Dr. Eikerling)		…/4
08.11.2000	Allg. Arzt (Dr. Deuss)		…ionstechnik (wenige Tage Besserung, danach ohne Erfolg)
24.10.2001	vhs-Kurs		…gressive Muskelentspannung)
16.06.2002	Neurologe (D…		…tylin - 10 mg: 10 Tage; 20 mg: 10 Tage; 30 mg: 21 Tage; 40 mg: 9 Tage
03.09.2002	Schmerzther…		Amitriptylin zurückgefahren, da stark zugenommen und kein Erfolg (am 08.10. abgesetzt)
04.09.2002	Schmerzthera…	1	TENS-Gerät
			Vioxx 25 mg für 12 Tage (3 Tage fast schmerzfrei, danach ohne Erfolg)
11.09.2002	Schmerztherap… …öck)	1	2 Vioxx 25 mg (verteilt auf morgens + abends) für 8 Tage (ohne Erfolg)
02.10.2000	Schmerztherapeut (Dr. Böck)	1	2 Trancopal-Dolo-Kapseln N3 für 17 Tage (ohne Erfolg)
14.10.2002	Qi-Gong-Kurs (Praxis Dr. Böck)	10	(ohne Erfolg)
13.11.2002	Biofeedback (Praxis Dr. Böck)	10	(ohne Erfolg)
04.02.2003	Traumaspezialist (Dr. Kallinke)	40	Beh. mit EMDR - erste Sitzung: danach für ca. 30 min. das Gefühl, aus dem Nebel aufgetaucht zu sein
13.08.2003	Traumaspezialist (Dr. Kallinke)		Amitriptylin neuraxpharm - bis 50 mg
			Amitriptylin zurückgefahren, da stark zugenommen und ohne Erfolg (am 08.10. abgesetzt)
03.11.2003	Traumaspezialist (Dr. Kallinke)		1 1/2 Zoloft 50 mg für 3 Wochen (abgesetzt am 21.11.03, da kein Erfolg)
			2. Versuch Amitriptylin 60 mg für 4 Monate (abgesetzt am 10.05., da kein Erfolg)
			wenig Schmerzen im Skiurlaub, danach aber wieder kein Erfolg
25.05.2004	Allgemein Med. (Dr. Hagelauer)	6	Testung, Mundakupunktur, Eigenbluttherapie, Bachblüten, MRT-Behandlung, Injektionen m. Betäubungsmittel
			in Höhe der Kieferhöhlen und Stirn
			Medikamente: Lymphdiaral, Zentramin Bastian, Hylak plus, Schüsslersalze (Magnesium phosphoricum D6,
			Calcium phosphoricum D12, Kalium sulfuricum D6) BMT Komplex, Antimigren, Zincum valerianicum Hevert

Typical Relationship Problem with the Medical System: Pat. F. Is overserviced but underserved.

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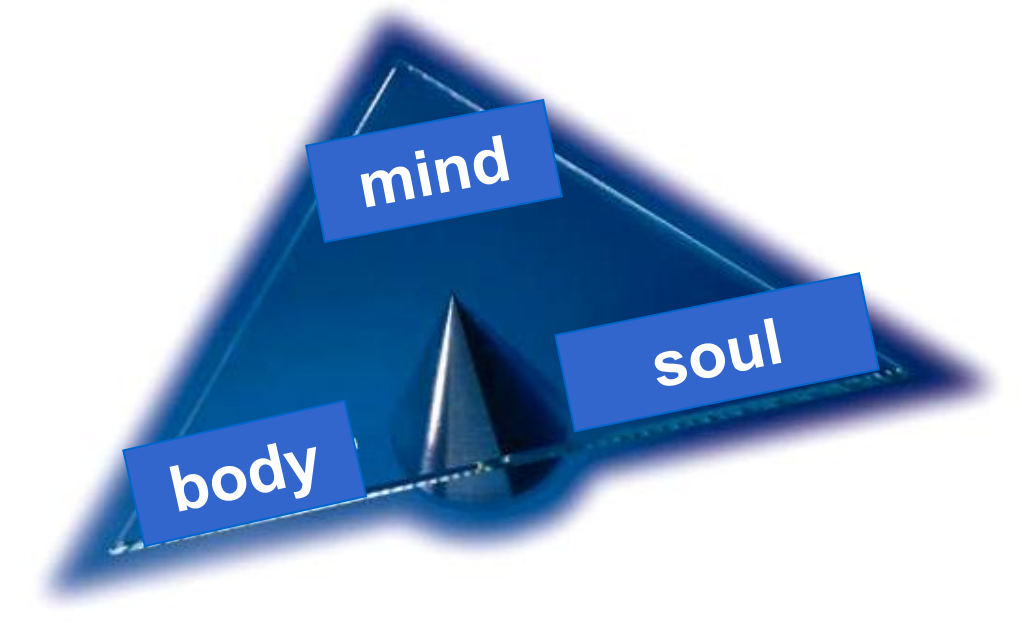
Health Care Utilization by Pat. F. Part II

38 Doctors Appointments from May 2004 – August 2005

Termin	Arzt / Behandlung (Name)	Anzahl	Bemerkungen
27.05.2004	Internist (Dr. Eulenburg)	1	Blutwerte (ohne Befund bis auf "leicht erhöhten" Schilddrüsenwert)
02.07.2004	Allgemein Med. (Dr. Lehmann; Freiburg)	1	Chiropraktische Beh., Injektionen supraorbitalis bds., infraorbitalis bds., Niederfrequenz-Reiztherapie am Kopf
			medikamentöse Infiltrationsbehandlung, Nervenblockade im Bereich der Schädelbasis Ggl.
			Pterygopalatinum bds. (ohne Erfolg)
10.07.2004	Masseurin (Fr. Lazar)	3	Energieflussbehandlung, Blockaden lösen durch Massagen, Fußreflexzonenmassage (ohne Erfolg)
22.07.2004	Schmerztherapeut (Dr. Böck)	3	Stellatum Ganglion; bei erster Behandlung 1 1/2 Tage kaum Schmerzen, dana[illegible]rfolg
03.08.2004	Schmerztherapeut (Dr. Böck)	2	Stellatum Katheter (ohne Erfolg)
11.08.2004	Augenarzt (Dr. Ziegler)	1	Kontrolluntersuchung wg. Kopfschmerzen (leichter Schielwi[illegible]en auslösen)
			Empfehlung: Prismenbrille (nicht ausprobiert)
12.08.2004	Schmerztherapeut (Dr. Böck)	1	Voruntersuchung für Anwendung von Bot[illegible] (nicht ausprobiert)
18.08.2004	Heilpraktiker (H. Kegel)	9	Cranial-Ostheopathie, Pränatal-R[illegible]sen von Blockaden (ohne Erfolg)
27.10.2004	Internist (Dr. Eulenburg)	1	Blutwerte mit Befund: TS[illegible] 125 (Normalwert 100)
			Diagnose: Schil[illegible]oditis (Autoimmunerkrankung), Behandlung mit
			Thyron[illegible] mg erhöhen (Erhöhung wöchentlich um 25 mg)
			[illegible]er klein"
09.11.2004	Endokrinologe (Dr. Klein)		[illegible]n und schwarze Stellen; Blutuntersuchung TSH 3,15 und Antikörper 1:1280
			[illegible]ren irrelevant"): Ergebnis: Hashimoto Thyreoditis, daher kein Jod in Medikament:
			[illegible]g (direkter Umstieg), jeden Morgen 30 min vor Frühstück (ab 22.11.04 eingenommen)
14.01.2005	Endokrinologe ([illegible])		[illegible]e: Befund TSH 0,074 (Aussage: "LThyroxin beibehalten falls keine Überfunktionssymptome, ansonsten
			reduzieren auf 112,5 mg")
27.01.2005	Zahnarzt (Dr. Sch[illegible])	1	Kontrolle mit Röntgenbild: In mehreren Zahnzwischenräumen starke, bisher unerkannte Kariesbildung
02.02.2005	Internist (Dr. Euler[illegible])	1	Butwerte: Befund TSH 0,02; freies T3 5,38, freies T4 2,65, TAK 497, TRAK 1,2 (13 Uhr, ohne Einnahme Thyroxin)
10.02.2005	Endokrinolog. Amb[illegible]z (Uniklinik HD)	1	Butwerte: Befund: TSH - deutlich in Überfunktion, nicht mehr messbar (ohne Medikamenten-Einnahme)
16.02.2005	Augenarzt (Dr. Thomas)	2	Befund: etwas verdickte Sehnerven, trockene Augen, Sehstärke stimmt nicht mehr (neue Kontaktlinsen),
			ansonsten ohne Befund. Neue Kontaktlinsen: keine Besserung der Sehstörungen.
01.04.2005	Internist (Dr. Strienz)	2	Hashimoto bestätigt, HPU-Test: positiv (26 bei Grenzwert 15), Behandlung mit Depyrrol-Basis, 1 Tablette pro Tag
			TSH-Wert: 11,7 (nach versehentlich 4 Wochen 25 mg LThyroxin - Packung vertauscht): Steigerung auf 100 mg
31.05.2005	Internist (Dr. Strienz)	1	TSH: 3,42 (nach 4 Wochen 100 mg): Steigerung auf 112,5 mg LThyroxin
02.06.2005	KH Trudpert Innere (Dr. Weber)	1	Beurteilung des bisherigen Krankheitsverlaufs: Es besteht noch keine Diagnose. Hashi reicht nicht aus für meine
			Symptome. Vorschlag: Auf Multiple Sklerose untersuchen, da bisher noch keine Liquor-Untersuchung erfolgt ist
			und MS sehr vielfältig auftreten kann. Endokrinologisch ist lt. Weber alles abgeklärt und ohne Befund.
05.07.2005	Internist (Dr. Strienz)	1	Blutwerte: Befund TSH 2,52 (nach 4 Wochen 112,5 mg): Steigerung auf 125 mg LThyroxin + 200 mg Selen +
			10 mg Thybon (reines T3). Vermutlich funktioniert Umwandlung in T3 nicht richtig. FT4 1,53 und FT3 2,70
03.08.2005	Schmerztherapeut (Dr. Böck)	1	
16.08.2005	Osthepatin (Fr. Hauser)	1	starke Verspannungen, Umstellung der Ernährung etc.; Ursache-Beziehung

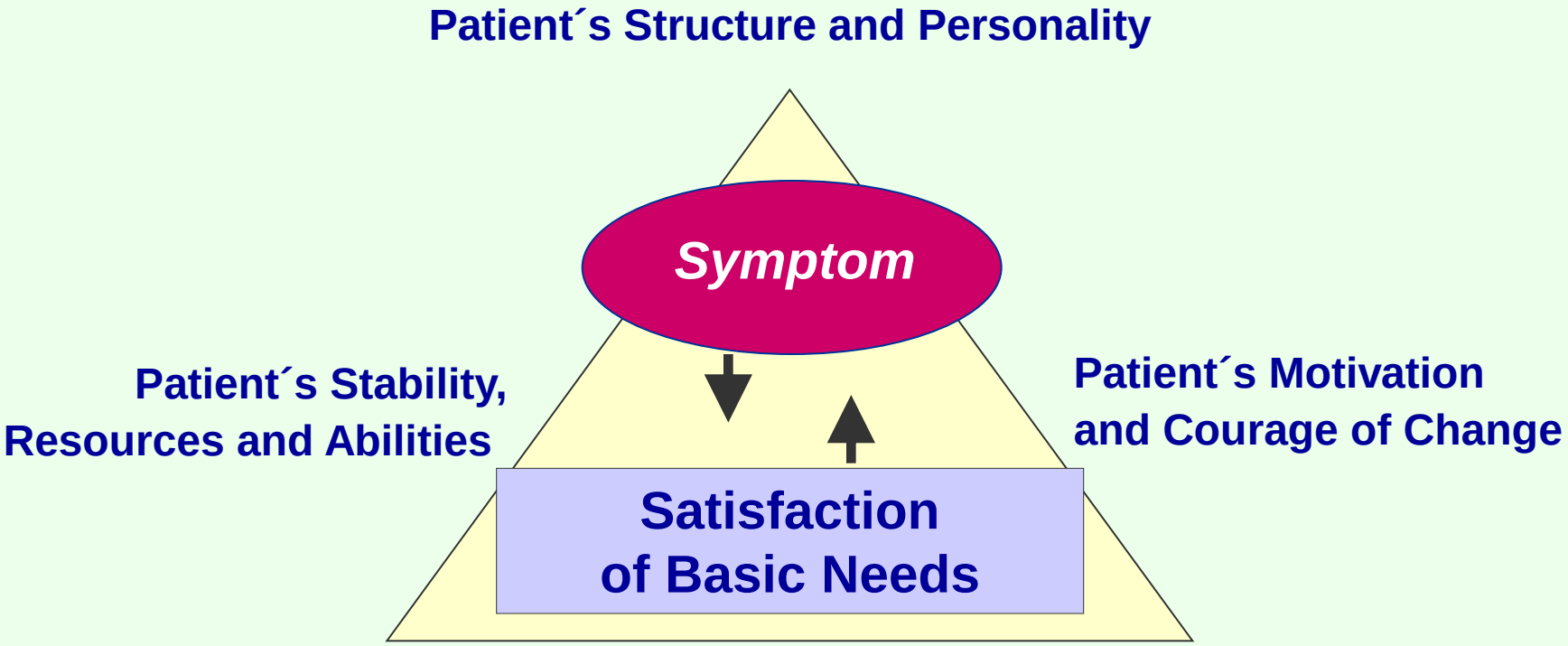
Who's responsible for the over-use of medical resources: the Patient or her Medical Providers?

Conclusion



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



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


Visions, Goals, Ideas
Appearance
Competency
and Skills
Hobbys and Interests
Attitudes
Mental Approach
Friends
and Neighbors
Memories
Resources
Significant Other,
Family Members
Work
Free Time
Relationship
to the Therapist
Economic Stability
Health
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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

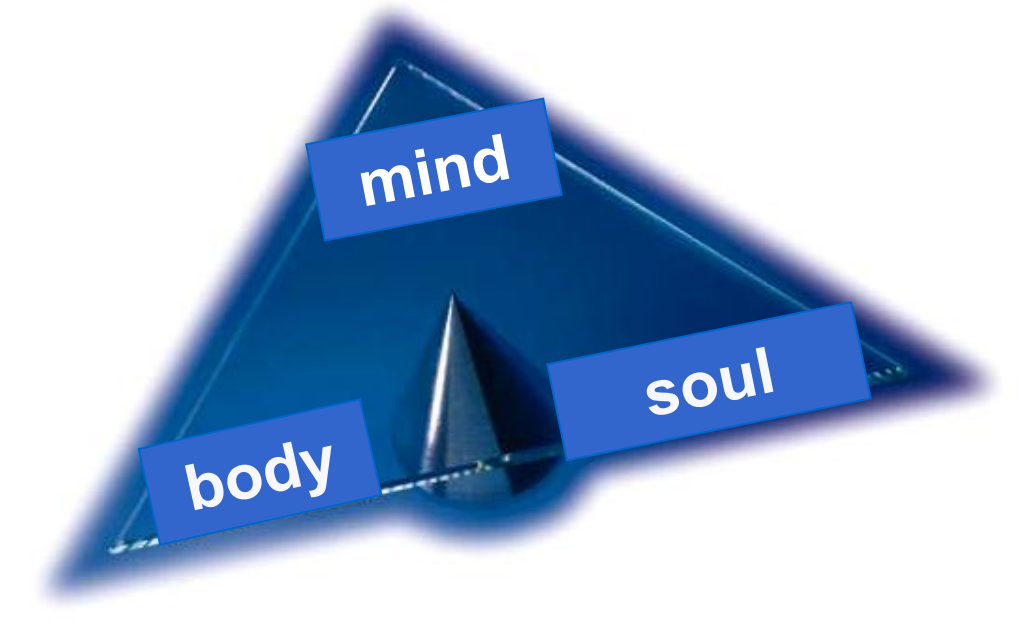
(Indication and Treatment Grawe 1999)

Individual Characteristics of Pat. F.

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

Psychodynamic Hypothesis about the Meaning of the Symptom



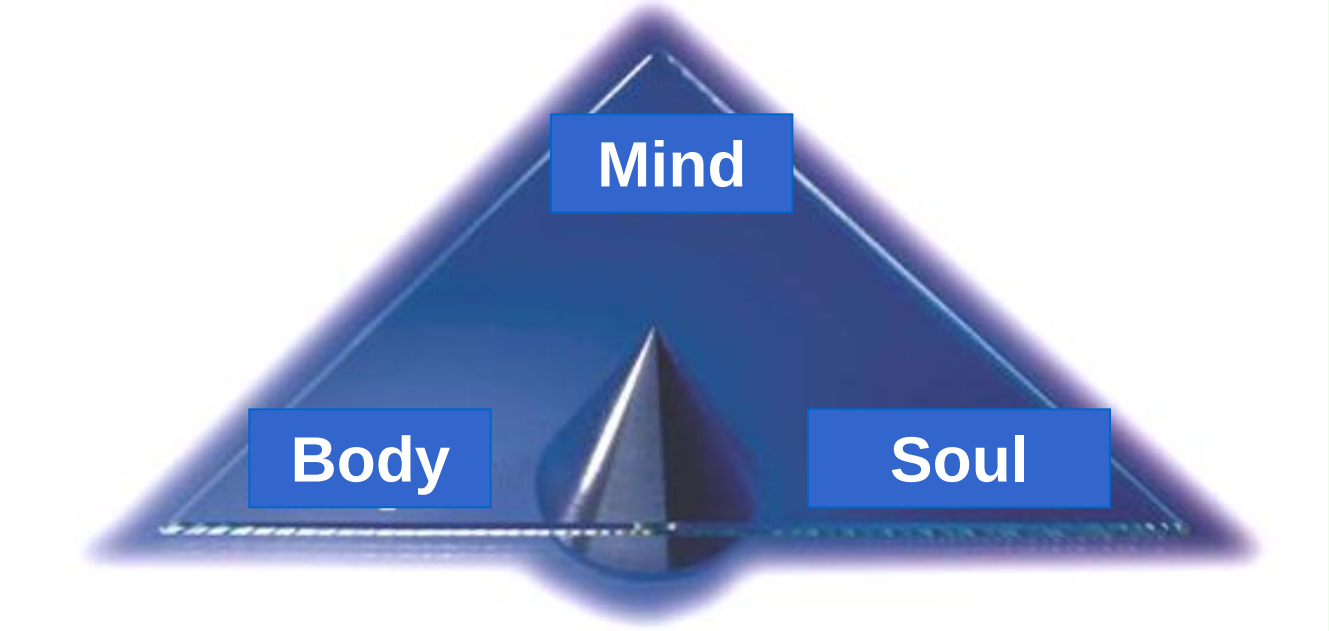
Good emotional structure. Strong relationship experiences but little ability to handle conflict (at home and later, in her first partnership). Mrs. F. compensates for doubts and low self-confidence with high professional commitment. But the pain interrupts this vicious cycle, forcing her to find out 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

Summary



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!