

Psychosomatic Medicine

An International Guide for the
Primary Care Setting

Kurt Fritzsche
Susan H. McDaniel
Michael Wirsching
Editors

Second Edition

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To Geneviève Plasson

Preface to the 1st Edition

In 1978, representatives from 134 countries convened in Alma Ata, calling for “health care for all by the year 2000.” (*Declaration of Alma-Ata* 1978) This was a turning point for global mental health care, as this declaration emphasized the importance of health care near people’s homes, health promotion and disease prevention services alongside curative medical service delivery, and mental health as an integral component of health. Thirty years later, Barbara Starfield elucidated the evidence to prove that countries with the best morbidity and mortality figures and overall health were linked to health care systems based on a strong foundation of primary care (Starfield et al. 2005).

In 2007, the *Lancet* published a series on global mental health, which identified the gaps in mental health care services, particularly in low and moderate income countries. Key works in this *Lancet* series (Movement for Global Mental Health 2007), followed by the movement for global health launched on the 2009 World Mental Health Day, provided the momentum and backing to work toward mental health care for all (World Federation for Mental Health 2009). WHO and the World Federation for Mental Health have now joined forces to advocate for policies and practices to reduce stigma and integrate mental health into primary care systems.

In 2008, the World Health Organization (WHO) and the World Organization of Family Doctors (Wonca) published a report that delineates the need, describes best practices, and identifies 10 common principles for successful integration of mental health care into primary care (WHO and Wonca 2008). This document, along with the works of Patel, Schirmer and colleagues provides tools, strategies, and best practices for mental health and behavioral health integration into primary care in low and moderate income countries (Patel 2003; Schirmer and Montegut et al. 2010).

Since 2001, the Department of Psychosomatic Medicine and Psychotherapy of the University Medical Center, Freiburg, Germany, maintains exchanges with the Asian countries China, Vietnam, and Laos, with Iran, with African countries such as Sudan and Uganda, as well as with colleagues in other European countries and the USA and Australia. Ongoing classes in Psychosomatic Medicine and psychotherapy are held especially in Asian countries and Iran. In their feedback, hundreds of doctors, from young professionals to highly experienced doctors, reported to have

benefitted tremendously from the courses both professionally and in their personal relationship with patients. The experiences we gained in these last 10 years with respect to the content, and pedagogical and methodological design of the courses are included in this book.

This book was written for curious doctors who wish to gain and develop knowledge and skills in Psychosomatic Medicine. The main question is therefore: How can I learn Psychosomatic Basic Care? Psychosomatic Medicine is a multidisciplinary subject involving extensive knowledge. It is not possible to treat all clinical manifestations in one class and in this textbook. Therefore, basic ways of thinking and approaches in the most common diseases are presented. The book is organized according to the three objectives of basic psychosomatic care:

1. Recognizing psychological and psychosomatic conditions and disorders
2. Limited personal consulting and treatment services
3. If necessary, targeted referral to and cooperation with mental health specialists.

The book is divided into a general part and a part with specific clinical manifestations. The general part addresses topics that are relevant to all clinical manifestations such as the interaction between mind and body, doctor–patient relationship, doctor–patient communication, the family interview, and the Balint group. The second part addresses specific clinical manifestations that are most frequently encountered in primary care, including depressive disorders, anxiety disorders, somatoform disorders, posttraumatic stress disorder, alcohol dependency, and psychosomatics of life threatening diseases such as cancer and coronary heart disease.

Each chapter is divided into diagnostics, treatment, and pitfalls. In each chapter, typical case studies are used to demonstrate the diagnostic and therapeutic steps. As a result, the book has a high practical relevance, and can also be used directly as a course book in training in Psychosomatic Basic Care.

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Preface to the 2nd Edition

According to the current studies and the criteria of ICD-10 (10th revision of the International Classification of Diseases), between 10% and 20% of the world's population develop a mental disorder at least once a year. The most common symptoms are anxiety disorders, depression, and somatoform disorders. The majority of these mental disorders manifest in childhood and adolescence, a point in life at which the course for a life-long history of suffering is set. To this day mental disorders are often not recognized at an early stage and, above all, are not adequately treated. If left untreated, mental disorders take a chronic course with enormous suffering for patients and often also severe effects on their social environment, while causing enormous costs in the health care system.

The impulse for a new edition of our textbook comes not only from the necessity to offer new scientific and practical findings in the field of psychosomatic medicine and psychotherapy also for non-psychiatrists, but also from the rise of a meanwhile new generation of medical doctors in many different countries and fields, who are very open-minded towards psychosomatic thinking. A generation of physicians has emerged who know that the predominant biomedical disease and treatment model is only one way of practicing medicine and who are increasingly disillusioned by the economization of modern scientific medicine. Psychosomatic medicine as human medicine is “subversive” in this sense, since it undermines the theory and practice of mechanized medicine and teaches doctors a holistic approach to medicine. Psychosomatic medicine in this sense is not only a special subject but an integral part of every medical field. We are pleased that the interest in psychosomatic medicine continues to grow and were happy to face the content-related, methodological, and didactic problems that had to be solved during the conceptualization of the new edition of this textbook.

Courses for the qualification in psychosomatic primary care were held by us in many different countries continuously for the past 30 years. Several thousands of physicians, from beginners to experienced doctors, gave us the feedback on the classes to the extent that that they had learned a lot from the courses, especially in their personal way of dealing with their patients. It seemed that by attending the

courses both patient satisfaction and the doctors' satisfaction with their own daily work improved.

The Textbook

Containing several new chapters and featuring extensively updated contributions from experts in the field, this title takes a uniquely global approach in laying the foundations of psychosomatic basic care and provides relevant information about the most common mental and psychosomatic problems and disorders. An extension of the cultural aspects of the individual clinical pictures and new contributions from China, Latin America, Russia, Iran, India, Africa, and Myanmar also about migration and mental health accompany this revision.

This book is divided into four sections and begins by explaining the relationship between psychosomatic medicine and primary care. The next part outlines the best practices for diagnosing the most common psychological and psychosomatic problems and disorders and mastering the most frequent communication challenges (e.g., biopsychosocial anamnesis, breaking bad news, dealing with difficult patients, family and health systems, communication, and collaboration). The following section delves into more specific psychosomatic problems such as depressive disorders, posttraumatic stress disorder, addiction, the terminally ill patient and eating disorders, amongst others. The final section focuses on developing psychosomatic medicine in international settings. Every chapter integrates basic theoretical background and practical skills and includes transculturally sensitive material, important for the work with patients in different nations.

Kurt Fritzsche

Freiburg in July 2019

Acknowledgments

We would like to express our sincere gratitude to the thousands of medical colleagues who have attended our courses in Germany and many other countries all over the world during the past 30 years. You have provided us with valuable feedback that improved the content and teaching methods of our courses and consequently of this book. The vision to motivate you to continue on your way to an integrated psychosomatic medicine has inspired us in our work over all these years.

The completion of this project could not have been accomplished without the dedicated and enthusiastic support of my colleague Catharina Marika Dobos. She excellently managed the communication between the authors and the publishing company, compiled the chapters, revised contributions where necessary, and finally formatted the book, which I am very thankful for.

Our thanks also go to our research assistants Johanna Löhlein, Fabian Fachinger, and Sarah Thomas for their patient and painstaking work on proofreading.

We would like to acknowledge the contribution of Gertrud Frahm to the first edition of this book. We were deeply saddened by her passing away.

It was a great joy to carry out this book project with Sheik Mohideen of Springer publishing company, who brought the book to a close with his friendly, tireless, patient, and efficient manner. We also thank Miranda Finch of Springer publishing company for providing her support in the completion of this book.

For the sake of readability, in the present work, terms such as patient or doctor are referred to with him or her alternately; however, all genders are encompassed equally.

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Part I
Introduction

Chapter 1

What Is Psychosomatic Medicine?



Kurt Fritzsche, Farzad Goli, and Catharina Marika Dobos

Case Study

Initially, a 59-year-old female patient is hospitalized for removal of benign polyps. During hospitalization, in the context of a thromboembolism in the right leg, a gangrene of the right toe develops. Other complications such as poor wound healing and infection lead to emergency amputation of the lower leg. After surgery, the patient is alert and responsive but appears to be distraught and feeling helpless. After a few sentences, she starts to cry. She tells the doctor that when she was being transferred to the ward, she heard the nurses say that they were overwhelmed by her case. She feels left alone and has little hope for improvement. She feels like “a funnel into which something is poured at the top, but everything comes out again at the bottom” (to be continued).

The Biopsychosocial Model

The theoretical basis of psychosomatic medicine is the biopsychosocial model (Engel 1977). This model describes the interactions between the biological, psychological, and social processes that are involved, to various extents, in every disease (see Fig. 1.1.).

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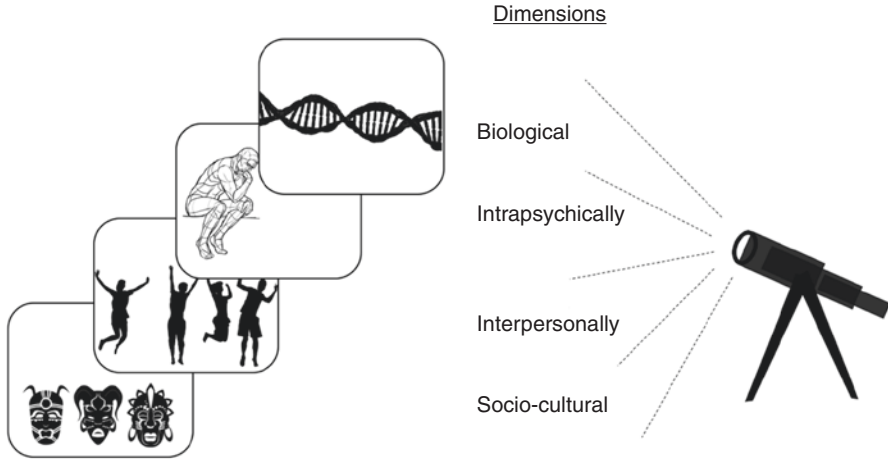


Fig. 1.1 Dimensions of the biopsychosocial model

Physical, emotional, and social factors, in varying proportions, play a role in every illness. The doctor's task is to recognize not only the organic components but also the psychosocial processes involved in the disease and to take these into account. Only in the framework of a psychosocial anamnesis, psychosocial stressors can be identified by the doctor.

Example 1: “Bronchial Asthma”

Psychosocial factors may co-elicite the onset of an allergy-related bronchial asthma. Conversely, the bronchial asthma of a child often affects the whole family. For example, a sibling may develop anorexia nervosa to claim his share of attention; or the mother could suffer a depressive crisis as a result of the great strain the illness of the child puts on her.

Example 2: “Duodenal Ulcer”

Until 20 years ago, a duodenal ulcer was understood to be the consequence of stress and specific personality traits, such as passivity and dependence. With the discovery of the *Helicobacter pylori*, a somatic explanation was found for the occurrence and chronification of duodenal ulcer and its eradication by antibiotics. But in fact, 60% of people over the age of 60 are *H. pylori*-positive, but only 2% of them develop a duodenal ulcer. Therefore, the development of a duodenal ulcer after an infection may also have a psychosocial cause.

Example 3: “Coronary Heart Disease”

Congenital and acquired dispositions and risk factors, elicitors (“Why now?”), and maintaining factors influence one another: coronary heart disease in the family, cardiovascular risk factors like smoking, elevated blood lipids, hypertension, fear of job loss, partnership conflicts with acute irritation, vital exhaustion, lack of social support, and depression.

Excursion: Biosemiotics

How do the material body and symbolic mind communicate with each other? How are molecules and cells translated into thoughts and intentions and vice versa? Having a mind-body model is very important for clear and accurate clinical thinking and reasoning. One of the main concepts which psychosomatic medicine has developed from is the phenomenal world. Jakob von Uexküll (1982) showed that each organism creates its own world around itself based on the structure of its receptor and effector organs. Thus, each organism represents reality as a specific system of meaning which manages its life in environment. Each organism reacts to stimuli which have meaning for itself. Therefore, living systems make their own inner world and experience and behave to others within this field. Von Uexküll and Wesiack (1979), Thure von Uexküll (1981), and von Uexküll and Pauli (1986) elaborated on the biosemiotic model in the form of the situational circle model. They illustrated how meanings assign (perception) and utilize (behavior) through the inner world of ideas (Fig. 1.2). This model shows that life is a meaning or functional system. The signs in the form of matter (e.g., atoms, molecules, cells), energy (e.g., electrical signals in nervous system), symbols (e.g., words, images, machine codes), and reflections (e.g., mindful moments, metacognitions) can be interpreted and translated into each other (Goli 2016; Goli et al. 2016). So, there is no gap between body, emotion, cognition, and behavior but a multilingual complex body. Based on this biosemiotic model, we realize how beliefs, relations, and experiences can modify the nervous system, the immune system, and gene expressions.

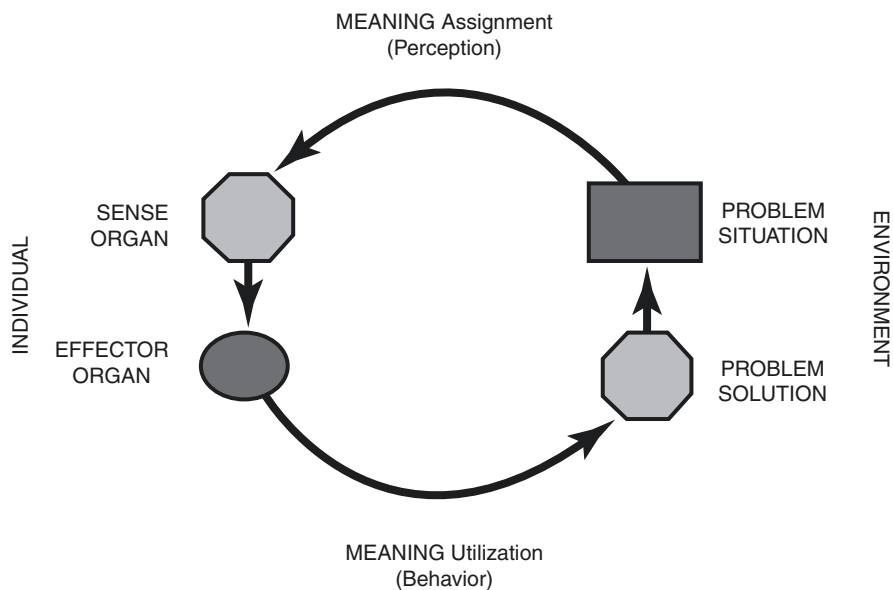


Fig. 1.2 Thure von Uexküll's situational circle

Case Study (continued)

While talking in the evening, the ward's doctor first sets the stage for the discussion. He has about 15 minutes to collect information on the health and life history of the patient. The patient tells the following: Her father was killed during the Second World War; she has no memories of him. The mother was overwhelmed with raising the patient and her two sisters and had become an alcoholic. The patient moved to her grandmother whom she experienced as very strict and emotionally cold. At the age of 23, she married and bore two daughters herself. Over the course of the marriage, the husband also became an alcoholic and later died of cirrhosis of the liver. The patient had separated from her husband, found a new partner and opened a restaurant with him. This partnership, however, also failed. The restaurant was carried on by her daughters but was later closed down. Last year, her older sister was diagnosed with cancer and died shortly thereafter. The patient took over the responsibility and care for her sister's son who is paraplegic. (to be continued)

Bonding Experience

Any infant holds the inherent need for attachment to another human being and clings to this individual. There is a primary need for human contact in any human being, independent from the need for nutrition, which is as crucial as the need for nutrition and shelter (Bowlby 1969). The need for *emotional bondage* is congenital. The aim is the creation of emotional closeness and security, especially when the child is tired, ill, insecure, or feels abandoned. Positive bonding experiences influence the mentalization of the brain. Mentalization includes the understanding of emotions, thoughts, wishes, and fantasies of another person, but at the same time, it also means perceiving the own mental states during the interaction with other human beings (Fonagy et al. 2003).

The life history of the patient is characterized by negative bonding experiences. In healthy development, there is constant balancing between the attachment and the exploratory behavior (Fig. 1.3). Bonding behavior is activated in discomfort and stress, exploration behavior in well-being. *Bonding research* confirms the importance of early experiences for the physical and emotional health of a person. Uncertain, impaired early bonds decide over whether a person can also withstand serious stress (*resilience*) or becomes ill (*vulnerability*). The first 3 years of life are decisive for the development of the person's attachment style.

If the infant or small child has a mother or another main attachment figure who responds *sensitively* with quick and appropriate mimicry and gestures to the child's reactions, oxytocin is excreted, which enables the infant to experience social interactions and feelings as being pleasant. A *secure bonding behavior* is promoted in this way. The brain, especially the amygdala, the hippocampus, and

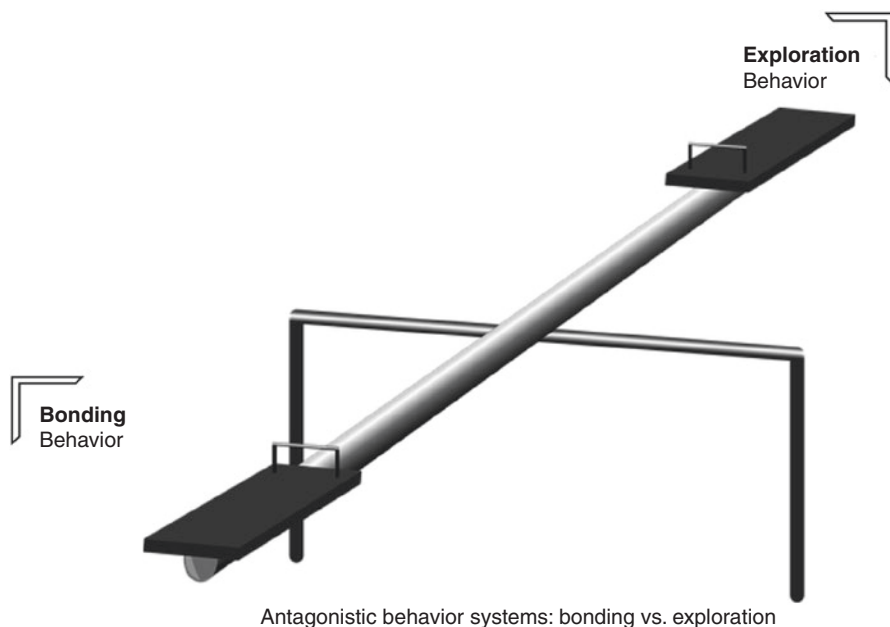


Fig. 1.3 Bonding versus exploration allostatic load (McEwen 1998)

the prefrontal cortex are protected against damage in consequence of excessive glucocorticoid excretions in stress situations. Secure bonding contributes to an elevation of the stress threshold and dampening of the stress response. However, if the mother rejects the child's bonding needs, the result is an *insecure-avoidant* bonding style in the child. If the maternal responses to the child's signals are contradictory and unpredictable, the child develops a so-called *insecure-ambivalent* bonding style.

Psychosocial Stress

A mother who suffers from serious depression after the birth of her child cannot respond adequately to the child's bonding needs or empathize sufficiently with the child. This lack of *sensitivity* later leads to impairments in the development of the stress-coping system. Activation of the hypothalamus-pituitary-adrenal (HPA) axis by increased corticotropin-releasing hormone (CRH) excretions or a lack of cortisol inhibition leads to an increased cortisol level and a resultant damage to the hippocampus. Children who suffer great physical or emotional trauma develop a hyperreactivity of the HPA and locus coeruleus-norepinephrine (LC-NE) axes. Psychosocial stress in childhood may thus lead to a dysfunction of the stress-coping system with elevated stress vulnerability in conflict situations.

Long-Term Effects

Often alcohol, drugs, aggressive behavior and social withdrawal are used in order to cope with stress. In the long run, the associated common risk behavior such as smoking, physical inactivity, malnutrition, sleep deprivation, frequent switching of partners and workplaces lead to physical and psychological illness. Long-term studies show that the influence of psychosocial stress in childhood increases the probability of acquiring a psychological or psychosomatic illness by the 5- to 20-fold as grown-ups. The more stress factors (as shown in Table 1.1) a child is exposed to (accompanied by negative bonding experience), the higher the risk of acquiring physical or psychological illness as a grown-up. One single factor, however, will not increase the health risk (Felitti et al. 1998).

Homeostasis is the maintenance of equilibrium within a narrow framework, e.g., oxygen in the blood, pH value, and body temperature.

Allostasis is the maintenance of balance despite adversity, such as the ability to cope with extreme stressors such as prolonged sleep deprivation, isolation, hunger, or extreme external temperature fluctuations.

Stress denotes the state of a threatened biological homeostasis or allostasis, which can be caused by both physical damage or psychosocial burdens. Stress response or stress reaction is the body's attempt to reinstate biological homeostasis or allostasis by means of change and adaptation processes at the neuronal and endocrine levels and in behavior (Fig. 1.4). When the stress is over, the adaptation processes are deactivated again (McEwen 1998).

Table 1.1 Psychosocial protective factors and stressors in childhood

Psychosocial protective factors	Psychosocial stressors
Ongoing good relationship to primary attachment figure	Ongoing emotionally bad relationship to primary attachment figure
Big family	Work stress of both parents from early childhood on
Adequate early childhood bonding between parent and child	Continuous disharmony in the family/with abuse
Good substitutional care after loss of parents, for instance, by grandparents	Frequent abuse (i.e., beating, spanking)/sexual abuse
Above average intelligence	Divorce/separation of parents
Robust active temperament	Mother or father physically ill/handicapped
Female	Mother or father mentally ill/alcohol or drug abuse
Social fostering, supportive caring environment	Death of a parent

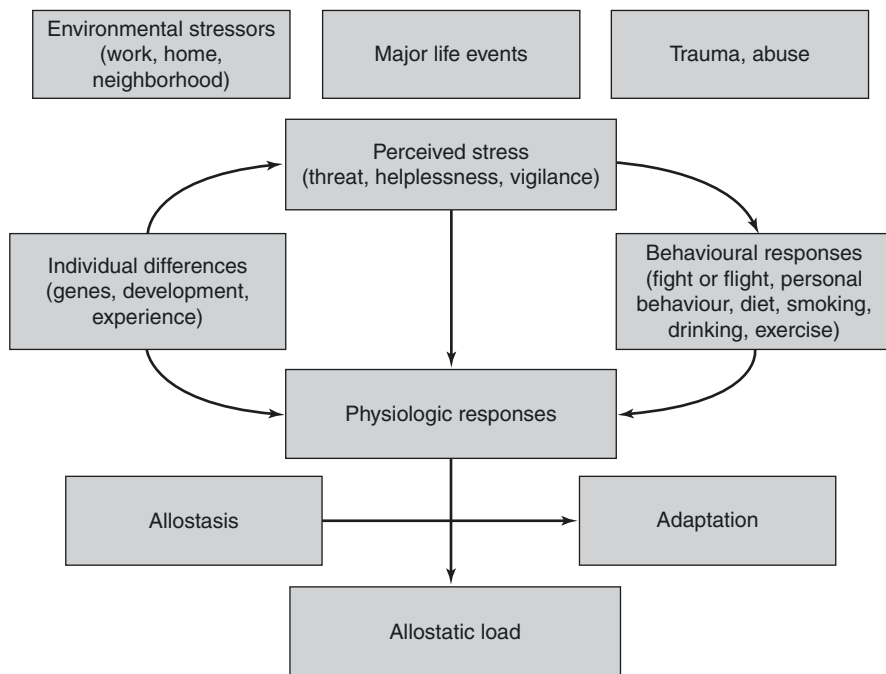


Fig. 1.4 The stress response and development of allostatic load (McEwen 1998)

The mediators of this allostatic adaptation reaction are the stress hormones cortisol and adrenalin/noradrenalin and the messengers of the immune system, the cytokines. An increased release of these hormones has the following immediate protective and adaptive effects:

- Enhancement of cardiovascular functions.
- Mobilization and renewal of energy reserves.
- Strengthening of immune functions.
- Improvement of cognitive functions.

This stress reaction enables the adaptation to stress situations by influencing the gene regulation and expression of cells and tissues through mediators. But the same mediators can also damage the body if they are secreted too frequently, too long, or too strongly. The regulatory adaptation thus becomes an “allostatic load” with increasing duration.

In the event of inadequate or excessive activation, stress mediators cause pathophysiological changes in the cardiovascular system, glucose and fat metabolism, immune system, and nervous system. These pathophysiological changes can

develop into manifest diseases such as high blood pressure, arteriosclerosis, obesity, diabetes, infectious diseases, tumors, and dementia under continuous stress (McEwen 2007).

In certain situations, stress reactions protect us because they are essential for our survival. However, too much stress can have a negative impact on us and can be the cause for disease.

Case Study (continued)

The development of thrombosis with embolization in the right leg, development of gangrene at the right toe, poor wound healing, and recurrent infections may have been an expression of allostatic overload in the patients' body. In addition, she might have an increased stress vulnerability due to negative childhood experiences. (to be continued)

Psyche and the Immune System

Negative life events (e.g. death of a life partner, separation, or divorce) can lead to temporary loneliness, depression, and anxiety that, as stressors, affect the immune system. The immune system sends feedback to the nervous system in the form of cytokines. As part of an infection, they activate the HPA axis in order to curb the infection-induced immune activation. This produces the familiar feeling of illness in the form of fatigue, pain, loss of appetite, and body aches.

Overall, stress can promote or suppress the immune system. Short-term stress responses enhance the innate immune response. Satisfactory interpersonal relationships, physical well-being, and positive personal valuations strengthen the immune system. Permanent psychosocial stress such as job loss or loss of a significant other, an accident with long-term consequences, chronic anger, or a chronic health condition results in a reduction of T-lymphocytes, reducing the activity of natural killer cells, monocytes, and macrophages leading to a less effective immune response.

Stress and Illness

Research has shown that the outbreak and course of diseases are influenced by psychological stress, because it affects the immune system. The negative effect of stress on respiratory infections has been documented, also the influence of stress on multiple sclerosis, bronchial asthma, rheumatoid arthritis, and allergies has been studied.

Stress which goes on for days or months leads to a persistent increase on the LC-NE axis and HPA axis activity and at first to functional and then also to structural damage of the brain, the cardiovascular, and the immune system. The hippocampus plays a significant role. Continued overload in this region leads to the dysregulation of the HPA axis and to cognitive impairments.

Example: Taking Care of a Relative

A person taking care of his or her by Alzheimer's disease affected spouse will develop strikingly less antibodies after an immunization and is more susceptible to illness for years to follow. In this case an increased amount of interleukin-6 (IL-6) circulates in the bloodstream, IL-6 activates the hypothalamic-pituitary-adrenal axis, cortisol is released, and the immune system is inhibited.

Example: Stress and Cardiac Arrest

In some cultures the vernacular says "the heart stops after a shock" or "the heart breaks or aches after the separation from a loved one." This phenomenon has been confirmed in studies with patients who were admitted to the clinic after severe excitement with infarct-like symptoms. The patients had suddenly learned of the death of a close person (partner, child, or friend), had been attacked on the open road, or had suffered massive financial losses in one fell swoop. What they all had in common was a feeling of extreme powerlessness and helplessness. The catecholamines in the blood were over 30 times higher than in healthy people. The cardiac pumping function was massively restricted. Currently this picture is classified as "stress-related cardiomyopathy" or "Takotsubo cardiomyopathy."

Example: "Autoimmune Diseases"

The nervous system, endocrine system, and immune system form a unit. When one system does not respond adequately to a stressor, another system responds in the form of counter-regulation. If, for example, the cortisol excretion is no longer possible in response to a stressor, the inflammatory parameters like cytokine, which is normally inhibited by cortisone, increase in compensation. The negative consequence of a persistent excessive inflammatory response is a greater susceptibility to autoimmune diseases. Examples of reactions to a underregulated HPA axis are fibromyalgia, chronic fatigue syndrome, or atopic dermatitis.

Learning Experience and Cognitions

Fundamental assumptions about one's self and the world are especially relevant for the patient's health cognitions. Every person has certain basic convictions, the so-called patterns. These patterns have their origin in early childhood relationship experiences and are further formed by cultural and family influences as well as personal experiences. Thoughts and convictions are not only a consequence of emotional well-being, but can also trigger positive or negative emotions. There is a high level of interdependence. This has been shown in studies on the role of cognition in prolonged depression. The focus of the cognitive theory is the assumption that the patient's convictions are important to his behavior, his emotions, and also his physical reactions. The therapeutic work with the patient consists in evaluating the cognitive patterns that lead to the disruptive behavior, distressing emotions, and related pathological physical responses and then replacing them with more adequate patterns.

Example: Learning Experiences “Suppression of Emotions”

Many patients have learned their way of dealing with emotions from a family climate in which feelings and conflicts are not expressed and irritation, rage, disappointment, and sadness are not even recognized. The affects go “inward”; they activate the attendant psychophysiological processes, whereby the patient appears passive and withdrawn on the surface. The psychophysiological reactions lead, however, to an activation of the HPA axis with increased cortisone excretion, inhibition of the immune system, and activation of its back-coupling processes to the central nervous system. Suppression of emotional experience and the related initial avoidance of conflicts has a transient relief function, but in the long-term, it promotes anxiety, depression and unclear physical complaints, including chronic pain.

Case Study (continued)

For her, the hospital situation triggers a reactivation of early childhood loneliness and abandonment. She was originally admitted because of a harmless lesion and then experienced one unsuccessful intervention after another, until finally an amputation of the right lower leg became necessary. She was accustomed to fighting and getting back on her feet. Now this active path seems to be cut off. The ward doctor understands that the patient had always been caring for others and now suddenly feels left alone with no hope. He summarizes the conversation in his own words, showing his emotional understanding and assures the patient that he will be there for her. The patient feels relief after the conversation and can start smiling a bit again and with adequate pain medication spends a quiet night. (to be continued)

Salutogenesis and Resilience

Whether a person falls ill with a mental disorder or not depends on the interactions between stress factors and protective factors. Protective factors can balance out the negative experiences in the child’s development and lead to a strengthening of the emotional *resilience*. Since the neuronal linking in the brain is immediately related to the first 3 years of the upbringing and socialization of the child, deficits in brain development can also be offset at this point in time.

Case Study (continued)

The medical history interview revealed that the patient, despite the current hopelessness, has good resources of her own in terms of her fighting spirit and social skills. After a period of mourning over the loss of her leg, she is very actively involved in the mobilization. The adaptation of a prosthesis is achieved without difficulties. The patient agrees to attend a rehabilitation clinic. Three weeks later at discharge from the hospital, the patient is cautiously optimistic regarding her future and is very grateful for the professional and emotional support by the ward doctor. The ward doctor also feels appreciated for his efforts and relieved.

In researching the *development of health* (salutogenesis), Antonovsky (1987) sought conditions which enable a person to remain physically and emotionally healthy in difficult life situations, such as death of a close person, an accident, or an emotional crisis, or to regain health. By examining holocaust survivors, Antonovsky reached the conviction that salutogenesis depends on a *sense of coherence*, that is, stressful life events are perceived by the person as comprehensible, manageable, and meaningful. Antonovsky considers the *sense of coherence* a basic, life-preserving resource, which the person develops during his life by coping with and overcoming problems. *Resource activation* connects to the patient's positive characteristics, capabilities, and motivations in organizing his life and his interpersonal relationships. If, for example, the anamnesis reports past or current traumatic events, the physician can speak directly about the patient's resources that have enabled him to cope with such events in the past or could enable him to do so in the future. The question is not only "What has made you ill?" but above all "What do you need now to cope with the difficult situation or to become healthy?" and questions such as "Why did you become ill only now or what has protected you from an illness up to now?"

Sense of coherence includes the capability of:

- Experiencing stressful events as comprehensible (*comprehensibility*).
- Feeling able to manage these events (*manageability*).
- Attributing meaning to these events (*meaningfulness*).

Psyche and Genes

Genes and Environment

The regulation of gene activity is largely subject to psychosocial influences. Genetic reaction patterns can be formed through experiences. Organisms, environment, and genes form a unit. The question "genes or environment?," which is rarely disputed anymore, is outdated: both influence each other. Mental health or illness are not predetermined but develop as a result from our interpersonal relationships, experiences and their influence on the regulation of gene activity.

Gene Regulation

The regulation of gene activity and thus the production of proteins are the decisive control variable for the cardiovascular system, hormone system, immune system, and nervous system. The regulation of gene activity is carried out for each gene separately by regulatory sequences that are upstream of the gene. So-called transcription factors bind to these regulatory sequences, thereby regulating the activity of the gene and the downstream gene. Whether genes are activated via transcription factors thus depends on signals that reach the gene from outside. These signals can come from the cell itself, from the entire organism, or from the environment. The regulation of

numerous genes in the brain is also permanently influenced by signals from the outside world that modulate neuronal networks in the cerebral cortex. The limbic system combines this information with emotional and cognitive experiences, evaluates it, and converts it into biological signals. Mental experience is thus “translated” into biological signals, in which transcription factors are activated and genes regulated within the framework of the signal chains triggered in this way. For example, the brain transforms dangerous situations into specific biological signals that activate genes in the alarm systems of the brain stem and the hypothalamus and thus trigger anxiety reactions. The activation of so-called stress genes has an effect on the cardiovascular system and the immune system and can have a direct damaging effect on nerve cells in the hippocampus during prolonged stress, as described above.

Coping

The outcome of a disease or life crisis is less determined by the type and severity of a stressful event than by how the patient evaluates the disease and the available coping resources for crisis management (see Fig. 1.5).

Three main types of coping processes can be distinguished:

- *Cognitive processing:* finding explanations for the disease in books, magazines, or the internet, minimizing the threat with sentences like “It can’t be that bad, others have survived it as well”, but also exaggerated self-observation, maximum attention to all symptoms and sensations.
- *Affective processing:* moods, affects, and emotions ranging from normal fear or grief reaction to severe psychopathological states such as panic attacks, depressive withdrawal with suicidal tendencies, or aggressive behavior.
- *Processing at the behavioral level:* taking action, looking ahead, actively approaching doctors and other people, surrender and avoidance, and retreat.

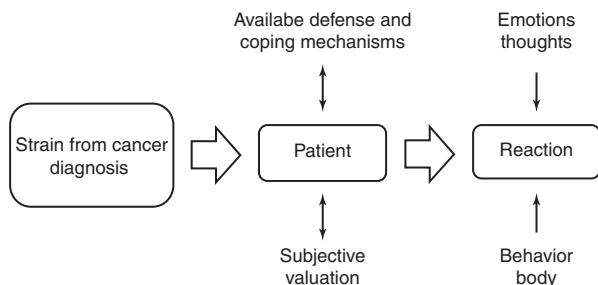


Fig. 1.5 Coping

Factors influencing the processing of the disease can be:

- The *severity of the physical illness* and the resulting impairment.
- The *personality of the patient*. Does the patient view his/her own life and the events and stresses that occur in it as understandable, significant, and manageable.
- The *concept of control convictions*. Does one's own behavior has an influence on life events (internal control) or are life events predominantly experienced as externally determined (external control)? Successful coping with earlier life-threatening events or illnesses increases the ability to cope with stress; whereas "learned helplessness" (repeated experience of no control and helplessness over challenging life events) reduces the ability to cope with stress.
- *Social support*. Most important is the social support *perceived* by the patient, e.g., through close caregivers, in the doctor-patient relationship, or through hospital care.

Psychosomatic Medicine in Primary Care

The theoretical basis of psychosomatic medicine is the biopsychosocial model (Engel 1977). This model describes the interactions among the biological, psychological, and social processes that are involved, to various extents, in each disease. In many Western countries, basic knowledge about recognizing psychological and psychosomatic disorders and problems, counseling and providing emotional support, and providing referrals to health specialists are included in the training of medical students and postgraduate doctors. The objectives of the psychosomatic approach are to build bridges between the various clinical disciplines to overcome the mind-body dichotomy and to stress the importance of understanding the interactions among biology, psychology, and social factors in every patient, independent from the primary pathology that is treated. These objectives imply both a system-based perspective and individual knowledge of the biological, psychological, social subsystems, and their interactions. The psychosomatic approach focuses on the doctor-patient relationship and on an integrative strategy for diagnosing and treating patients. Educating somatic clinicians in integrating psychosomatic aspects of medical care into their daily work has become a well-accepted priority for medical training and research.

Psychosomatic medicine in primary care has primarily been influenced by psychoanalysts and internists who emulated Michael Balint's (2000) approach, which stressed the integration of psychosomatic and holistic perspectives into the medical practice.

This integrated biopsychosocial treatment includes the following advantages:

- The physical examination is integrated into the consulting hour. Beginning with the patient's presentation of complaints, the doctor assesses both somatic and emotional concerns. As a result, both physical and psychosocial problems are addressed in diagnosis and treatment.

- Many patients do not feel as embarrassed about conversations regarding their mental or interpersonal conflicts in the primary care setting compared to a separate session with a mental health professional.
- Conversations in the primary care setting usually occur in the context of long-standing, trusting doctor-patient relationships. Such relationships have been shown to be important factors in the healing process. Family conflicts and past crises of a patient are usually familiar to the doctor who treats the entire family. When a new conflict or symptom arises, it can be placed in a personalized context.

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Chapter 2

Objectives of Training in Psychosomatic Medicine in Primary Care



Kurt Fritzsche and Catharina Marika Dobos

Primary Care

The aim of psychosomatic primary care is to overcome the dualism in medicine and health care by making overall diagnoses. Physical and psychological symptoms, as well as subjective experience and its processing, are described in the context of present and past relationship experiences and, above all, in the current doctor-patient contact where their significance for the current symptoms is assessed. The basis of this process is a trusting and empathic doctor-patient relationship. Further goals of the basic therapy are solution-oriented problem clarification, help in overcoming life crises, specific treatment for various psychological disorders including psychopharmacotherapy, and preparation and initiation of further psychotherapeutic treatment in an inpatient or outpatient setting.

A very special communicative competence is necessary for the diagnostic process and for all the basic therapeutic services within the framework of psychosomatic medicine. The primary goal of communication is not the record keeping of facts but the creation of a common reality between the patients and their helpers. In a successful doctor-patient relationship, a common reality emerges through mutual permanent coordination processes. Everyday life in medicine looks rather different; patients regularly complain about the communication deficits in therapeutic relationships in hospitals and medical practices. Compliance is understood one-sidedly as adherence to medical instructions by the patients.

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The targeted skills of psychosomatic medicine in primary care include the recognition of mental disorders, basic interventions, and collaboration with mental health specialists.

Targeted Skill: Recognition of Mental Disorders

Mental disorders and psychological problems should be identified by using the psychosocial anamnesis.

The selection of mental diseases to be taught in medical training depends on the frequencies of these diseases. The following diseases have been deemed most important: (1) various forms of depression; (2) anxiety disorders; (3) somatoform disorders; (4) adjustment disorders to severe life-threatening diseases, such as cancer and coronary heart disease; (5) posttraumatic stress disorder (PTSD); and (6) dependence syndrome.

Targeted Skill: Basic Interventions

- Promoting a helping alliance among the doctor, patient, and family members; this skill also includes identifying possible barriers on the part of the doctor, patient, or family and stressing the core skills of empathy and sensitivity.
- Improving the patient's problem-solving skills, including providing information about self-help groups, supporting the management of adverse life events (e.g., severe illness, loss, separation, or divorce), and avoiding unnecessary medication, diagnostic procedures, and surgery.

The basic therapeutic approaches integrate psychodynamic approaches, cognitive-behavioral models, systemic family therapy, and communication skills, such as empathy, unconditional positive regard, and congruence, to develop good doctor-patient relationships (Rogers 1997). Examples of the use of cognitive-behavioral models include the vicious circle model in the area of anxiety disorders and the influence of negative thinking and avoidant behaviors in depression. In the treatment of patients with somatoform disorders, the disease model of the patient, which has traditionally focused on physical causes, is gradually expanded to include alternative concepts of illness, and the attention is refocused on potential psychosocial stressors. In systemic thinking the interaction between the patient and his/her social systems (family, partnership, coworkers at the workplace) replace reductionist notions of cause and effect.

The teaching of doctor-patient communication skills includes learning interview techniques that are both doctor centered and patient centered, allowing time for the patient to talk at the beginning of the interview, not interrupting the patient, asking open questions, offering verbal and nonverbal encouragement to encourage the patient to keep talking, summarizing what has been said in your own words, and reflecting emotions.

An ideal method for understanding doctor-patient interactions is the Balint group, in which the focus is placed on difficult interactions between the doctor and the patient.

The goals of the interventions in psychosomatic basic care are:

- Creating a viable doctor-patient relationship.
- Promotion of patient autonomy through the focus on his/her resources or those available in his/her environment.
- Solution orientation through problem clarification, acceptance, or coping.
- Symptom relief or healing.
- Informing the patient (psychoeducation).
- Prevention of unnecessary measures such as non-indexed medication intake, doctor consultations, surgical interventions, and inpatient stays.
- Assistance in overcoming life crises such as serious illness, loss, and separation.
- Specific treatment of various mental disorders including psychopharmacotherapy.
- Preparation and initiation of indicated further specialized therapy (specialist psychotherapy, psychiatric treatment, psychosocial counselling centers).
- Cooperation with self-help groups.

Targeted Skill: Collaboration with Mental Health Specialists

Motivating patients for psychotherapeutic treatment and referring them to experts. Additional skills in this area include collaborations around consultations and case management with psychotherapists and other psychosocial service providers.

The fourth learning objective involves referrals to mental health specialists and cooperation with mental health services. Even in countries with well-developed support systems, these collaboration processes are not optimal. Primary care physicians have an important guiding function in the mental health-care system. They must decide whether basic psychosomatic care is sufficient or expert assistance should be requested. They also have to decide which expert is best suited to address the patient's problem. The primary care physician should inform the patient of the need for more intensive psychotherapeutic and/or psychopharmacological treatment. He/she should also motivate the patient to accept such an offer and should refer him/her to the appropriate physician or facilities.

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Chapter 3

Traditional Medicine and Psychosomatic Medicine



Kurt Fritzsche, Catherine Abbo, Hamid Afshar Zanjani, and Farzad Goli

Traditional Chinese Medicine

Traditional Chinese medicine (TCM) is one of the oldest healing systems. Most of the principles of TCM originated in the philosophical ideas that contributed to the development of Taoism and Confucianism. In TCM all natural phenomena are categorized into yin and yang (the dualistic principle) and the five elements (wood, fire, earth, metal, and water) and the universe as well as the human body is constantly changing towards dynamic balance or harmony. This knowledge was applied to understand, prevent, and cure diseases.

TCM includes chinese herbal medicine, acupuncture, moxibustion, massage therapy, nutritional therapy, and physical exercise (such as shadow boxing). It is estimated that 40% of health care in China is based on TCM, with a higher

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proportion in rural areas. Every city has a hospital practicing TCM, and the government plans to have one in every county in China as well. In 95% of hospitals practicing Western medicine, there are departments of TCM, most of them have patient beds. When patients arrive at the outpatient department, they can choose between Chinese and Western treatment. In Western medicine hospitals, around 40% of the treatment is traditional. TCM herbs are used much more frequently than acupuncture (Tang et al. 2008).

According to TCM, disease occurs as a reaction to a disturbance in yin-yang and flow of qi or blood or because of disharmony in the organs caused by personal (e.g., sadness, joy, and lifestyle) and climatic factors (dampness, heat, cold). The treatment aims at expelling or suppressing the cause and restore balance.

The integration of TCM in Western medicine has been widely promoted and studied in China and in Western countries. Eventually, integration aims at combining these two systems. Physicians who have received training and passed the examinations can treat patients in both disciplines. Over a third of the training which students receive in TCM schools concerns knowledge about Western medicine. But also Western medicine schools offer some training in TCM. Globally seen, this has been taken a step further by the World Health Organization's inclusion of TCM in its 11th revision of International Statistical Classification of Diseases and Related Health Problems (ICD) for the first time (<https://icd.who.int/browse11/l-m/ene>). The ICD 11 includes TCM diagnoses such as liver qi stagnation, damp heat, and qi deficiency, amongst others. This move may improve recording of epidemiological data regarding disorders of ancient Chinese medicine in parts of the world like China, Korea, Japan, and in many other countries. The ICD 11 was presented to the World Health Assembly in May 2019, but this move has not gone without criticism from others: *Scientific American* describes the step as a “bad idea” and blames the WHO for legitimizing TCM practices which they consider as being not evidence-based.

The WHO, however says, incorporating is not a judgment on the validity of a condition or the efficacy of treatment but is an important aspect of mapping how humans live and the types of health care they receive.

Research is needed to determine which illnesses are best treated by one approach or the other. In China, Western medicine is often regarded as being more effective in an acute situation or in cases in which the etiology of the illness is known, whereas TCM is more effective for immune disorders, chronic illnesses, or illnesses with an unknown etiology.

Psychosomatic Aspects in TCM

TCM has a holistic view on the body and mind and accepts that somatic presentation of emotion is common. This is a similarity to modern psychosomatic approaches (Tseng 2001). The heart was thought to house the superior mind, the liver to control

the spiritual soul, the lungs to host the animal soul, the spleen to host ideas and intelligence, and the kidney to host vitality and will.

According to TCM, when vital air (qi) is concentrated in the heart, joy is created; in the lungs, sorrow; in the liver, anger; in the spleen, worry; and in the kidney, fear. Thus, it is considered that various emotions are stirred through the visceral organs. In accordance with these medical attributions, in daily life, many organ-related sayings are used in common language such as an “elevated liver fire,” “losing spleen spirit,” “hasty heart,” “angry liver,” or “exhausted kidney,” to describe emotional states.

TCM has some special features in the treatment of psychological and psychosomatic symptoms:

1. TCM patients prefer a holistic view of their illness and do not like the separation of physical and psychological causes.
2. Even if patients are aware of psychosocial stress being an underlying cause of their condition, they rather choose a more somatically oriented way to describe and treat their symptoms.
3. Patients expect the doctor to ask about their physical symptoms, perform a physical exam, and take their pulse. They feel uncomfortable when doctors ask them about psychosocial aspects of their illness.

Ayurvedic Medicine

The term “Ayurveda” comes from Indian Sanskrit and is composed of the words *Ayus* (life) and *Veda* (knowledge). Ayurveda claims a holistic approach in that human health and disease are seen as the interaction of physical, mental, emotional, and spiritual aspects (Kutumbiah 1962).

Different temperaments or vital energies called *Doshas* are distinguished:

- *Vata* (wind, air, and aether), the concept of movement.
- *Pitta* (fire and water), the concept of fire and metabolism.
- *Kapha* (earth and water), the concept of structure.

In a healthy organism, the *Doshas* should exist in a harmonious equilibrium. In a consultation the doctor will determine the current relationship between the *Doshas* for the patient by means of pulse diagnosis and with the help of the patient’s horoscope. To balance the *Doshas* and to drain accumulated waste, certain cleansing procedures (*Panchakarma*) are employed. These *Panchakarma* procedures include fasting, baths, enemas, vomiting, and bloodletting, and also massages, yoga and breathing exercises, color and music therapy, and the use of Ayurvedic medicines.

The goal of Ayurvedic medicine is to prevent serious disease by trying to understand the cause of a disease and to eliminate unhealthy habits. The diagnosis is made after taking the result of an examination of the whole body (including pulse check, urine tests, and an examination of tongue and eyes) into account.

Ayurvedic medicine also includes special dietetics. Food is considered to be information for the *Doshas*. Ideally, this information is converted into *Ojas*, an intangible superfine substance that is also produced when making positive experiences. *Ojas* strengthens the body's natural defenses and connects the body and mind.

Diseases are divided into three groups: physical, accidental, and mental. *Physical disease* arises from abnormal conditions of the body. *Accidental diseases* are caused by the action of spirits, poisons, wind, fire, and violence experienced by the body. *Mental diseases* are caused by unsatisfied basic emotional needs. Pronounced anger, sadness, fear, and anxiety are an expression of a mental imbalance. In Ayurvedic medicine it is clearly apparent that emotional distress is recognized as a cause of disease. In addition to treatment with herbs and drugs, Ayurvedic medicine includes a detailed description of psychotherapeutic techniques for the treatment of mental disorders.

Mental health is seen as an integral part of life. Firmly rooted is also the notion that emotional ties, love, and affection of closely related persons are just as or even more effective in the treatment of mental disorders than doctors and their treatment methods.

Possibly, parts of the Ayurvedic theory and some drug preparations have been adopted from the Greek medicine. In Plato's system, health is based on a harmonic balance between the three elements *Pneuma* (air or *Vata*), *Chole* (bile or *Pitta*), and *Phlegm* (or *Kapha*). On the other hand, the Greek medicine has influenced the Galenic-Islamic medicine.

Ayurveda got lost almost completely with the fall of the Vedic culture and was only recently since the 1950s revived by the Government of India. In Sri Lanka, it has been consistently applied and preserved until today. Sri Lanka is not the only country that offers state-funded Ayurvedic medicine as a complete health-care system. In India, too, Ayurveda plays an important role in public health care. It is – arguably the most important – one of the seven Indian systems of medicine officially endorsed by the Ministry of AYUSH. In many Western countries, Ayurveda is used as an alternative and complementary therapy.

Iranian Traditional Medicine

There were three schools of medicine in Iranian traditional medicine: methodism, empiricism, and dogmatism. The *methodists* focused on symptomatic treatment, and they did not care about etiology and pathology. The *empiricists* claimed that management plans should be obtained through experience and concrete observation. They emphasized a disease-oriented approach and believed that each therapy which had been effective in a patient evidently would be effective for other patients with the same disease. This school of medicine is the origin of modern biomedicine. The *dogmatists* believed that there was no doubt that sense and experience were the facts, but they had to be derived through thought and analogy. In spite of the empiricists, the dogmatists did not believe in generalization of management plans to all

cases of a disease. In addition to signs and symptoms and nosological classifications, dogmatists carefully mentioned illness experiences, individual differences, humoral and psychological states, family support, and occupational and environmental parameters in their management (Ibne-I Hindu 1989). Evidently, this approach is a precursor of psychosomatic medicine.

The traditional medicine of Iran is based on *Unani* medicine and was developed by the great physicians of the Middle Ages such as Abu Zayd al-Balkhi (850–934), Razi (865–925), Ibn-e Sina (Avicenna) (980–1037), and Jorjani (1042–1137). Like most of the comprehensive traditional medicine systems, it relied on the concept of “equilibrium” of nonlocal natural forces and qualities (humors; Bannerman and Bannerman 1983). Disease is defined as an imbalanced outcome of internal/external forces. Treatment in this approach is not focused on the removal or alternating of the local pathogenesis but is organized around managing the natural forces of the body and environment.

There is no dualistic border between mental and physical illness in this healing system, and both of them are analyzed as systemic imbalance of the natural forces. Moreover, *psyche* is nothing but the function of the *soma* which can act independently and is autogenous in some way.

The “health calendar” of Ibn-e Botlan (2003) is a typical example of this view on the world. According to this calendar, each person, illness, part of the body, food, remedy, mental or physical activity, time, place, color, and order has its special temperament, and we should conduct these natural forces prudently into our life to maintain and promote our dynamic equilibrium of the forces.

For maintaining and promoting mental health in Iranian traditional medicine, you should first recognize the temper of the brain and then the temper of the disorder, and then you can manage the health condition. For example, a person with a warm and wet brain is supposed to be prone to headache and nightmares. Their wits are not so blunt, they sleep deep and long, and they have difficulties in obtaining and retaining information. So, wet and warm foods, remedies, and weather resonate this. Furthermore, in this system, each disorder has its own specific nature (Ibn-e Botlan 2003). For example, it is believed that two main deviations from a normal and balanced brain are anxiety restlessness and depression weakness; the first one arouses from excessive warmth and/or dryness, and the second one is caused by coldness and/or wetness of the brain (Jorjani 1966).

Phobia, worry, impulsivity, and paranoia signify warmth of the brain, and one is supposed to manage these conditions by consuming cold foods and drinks, as well as mental and physical activities. One of the ways in which one can diagnose the brain temperament is by dream analysis. For instance, a colorful dream signifies humor; red spectrum is induced by blood, yellow by bile, and white by phlegm.

In Iranian traditional medicine, the heart is the place for mind and emotion regulation. Hence, physicians must have a deep knowledge of the pulse and its states so that they can understand functions of the body as well as tune and balance of the psyche. Therefore, knowing music is one the basic skills of healers because they should distinguish about 50 normal and abnormal pulses as Avicenna explained in *canon* and *resalat fi nabz* (Morewedge 1973). Various musical modalities of pulse were explored

as rhythm, frequency, range, tension, color, and harmony, and evidently, in such a medical model, music therapy plays a very important role in reorganizing both mental and physical disharmonies. During a traditional music therapy session the main cue for the adjustment of the music to obtain ultimate psychosomatic balance is the monitoring of the pulse. In addition to remedy-based interventions and lifestyle modification for balancing mal-temperament (*so-e-mizaj*), some founders of Iranian medicine utilized psychosomatic methods systematically; among them was Abu Zayd al-Balkhi, known as the first psychosomatic physician (Deuraseh and Abu Talib 2005), who employed psychotherapy and emotion regulation to treat patients.

Religious and Spiritual Healing in Africa

In most African societies, healing goes beyond the alleviation of individual history and includes mending of social divisions which exist both within and between communities. Health is traditionally defined as harmonious relationships between human beings and their natural surroundings, between them and their ancestors, and among themselves and illness as encompassing relations between the universe, ancestors, and God.

The social world (comprising the spirits and the living) and the physical world are united within a larger cosmology. If this harmonious state breaks down, it is seen as a result of malevolent intervention or a sanction by the ancestors and/or God for incorrect or inappropriate social behavior. Although a large proportion of Africans have converted to Islam and Christianity, these two world religions have been assimilated into African culture, and many African Christians and Muslims maintain traditional spiritual beliefs. Furthermore, African cultural practices contain elements of indigenous religion. Thus, traditional African cosmologies and beliefs continue to exert significant influence on Africans today. The power of spiritual entities remains paramount in the causation and treatment of mental disorders. It is by means of spiritual understanding that people can restore meaning and a sense of balance to their lives following traumatic experiences (see Chap. 13). Appeasing the spirits, for example, is a mechanism for redressing the wrongs of the past and restoring well-being.

Religious/spiritual practices that can be of benefit to the health worker's medical practice and well-being:

- Open prayer (ecumenical prayer): This can be held with clients in the patients' waiting room each morning before formal treatment begins.
- Personal reflection (on personal life, life of others, nature).
- Promotion of humanitarian service (give back to humanity).
- Forgiveness or self-forgiveness.
- Acceptance that some of the problems are beyond your control and that you need to surrender them to a "higher being".

- Adaption of some of the spiritual rituals/practices such as singing and dancing.
- Undertaking physical exercise and self-care.
- Promotion of positivism, self-efficacy, and self-actualization.

Attitudes Toward Indigenous Healing Practices

Some medical doctors regard folk healing as merely “superstitious” and “primitive,” insisting that such out-of-date practices should be discouraged or prohibited. Other doctors consider these folk practices to be interesting subjects for academic study. They want to examine the therapeutic elements that they utilize and why such supernaturally orientated therapeutic exercises are still popular among some groups. Other doctors or community health workers believe that due to shortage of professional personnel available in the community, the existence of “folk” therapies should be supported (Tseng 2001). The joint declaration on primary health care made in 1978 by the World Health Organization and the UNICEF at Alma Ata, Kazakhstan, led to international recognition of the positive role of indigenous practitioners. Any folk healing practice that proved to be helpful to the client and useful to the community deserves the support and encouragement of clinicians as well as administrators. The collaboration of indigenous healers and modern clinicians should be encouraged to provide maximal mental health services for the community.

Cultural Responsibility and Humility

Every physician should be “culturally responsible” when dealing with a patient with emotional problems from a different cultural background. Cultural responsibility starts with cultural competence—that is, one’s ability to work with people from different cultural backgrounds. Cultural responsibility means going beyond cultural competence and taking responsibility for the way we view culture. It means that people of all cultural backgrounds work together respectfully and effectively with knowledge and awareness. It includes attitudes, behaviors, skills, policies, and procedures.

Cultural responsibility might include:

- Understanding and/or learning from the cultural group you are dealing with.
- Building links between health services and culture-based community organizations or other organizations that serve a specific community and recognizing the experiences and expertise of cultural organizations and leaders in our communities.

- Providing helpful, tailored information in a language that is understood by the patient.
- Recognizing the role of cultural, medical, or health practices.
- Considering importance of religion and spirituality in the management and treatment of mental disorders.
- Considering extended family network in the management and treatment of mental disorders.
- Looking at the whole person beyond cultural or any other borders.
- Looking at the bigger picture and recognizing that it is difficult to separate mental problems from larger concerns, like poverty or lack of housing.

Cultural humility can be conceptualized as the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the other person. Aspects of cultural humility that may be useful for the clinician include:

- Lifelong commitment to self-evaluation and-self critique.
- Being able to fix power imbalances where they should not exist.
- Developing partnerships with people and groups that advocate for others.

Summary

Medical tradition often has its origin in a religious world view, which assigns gods the power to afflict illness on people. During the fifth century before Christ, Greek medicine tried to understand illnesses based on the laws of nature. The teachings of the four elements and the four humors were created, and an independent medical science developed therefrom. The basis of all life is seen as an equal interconnectedness of the four elements or basic substances: fire, water, air, and earth. Any living being and the entire universe is made of these. This holistic perspective shows parallels to Chinese medicine, to Ayurveda, and the Persian-Islamic medicine. It is obvious that there has been a far-reaching cross-cultural parallelism of traditions for more than two millennia. In addition, medical science is closely tied to the societal and economic conditions of life and how people view life, as Paul Unschuld aptly described in his book *What is Medicine? Western and Eastern Approaches to Healing* (Unschuld 2009).

Over the millennia, the knowledge of the power of the gods, our ancestors, and demons have largely determined human actions in all cultures. This type of thought was alive and is still alive parallel to the development of modern life sciences.

Until this day, many ideas of holistic medicine are found in home remedies and folk medicine of Western countries. There are departments for natural healing at universities. Additional study programs are offered in homeopathy and an independent approach to healing that is based on a religious world view such as the medical anthroposophic medicine.

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Part II
The First Contact: Basic Interventions

Chapter 4

The Doctor–Patient Relationship



**Kurt Fritzsche, Sonia Diaz-Monsalve, Catherine Abbo, Farzad Goli,
and Catharina Marika Dobos**

Doctor as a Contact Person

If the doctor is perceived as trustworthy and helpful by the patient, a good foundation for any following medical treatment is formed. If we define communication as sharing meaning, relationship is the context and framework of communication. It is evident that this intersubjective context, which profoundly depends on the doctor's and the patient's emotions and traits, can determine the meanings of illness and treatment. Doctor–patient communication and interventions are focused more on acting as a therapist, while doctor–patient relationship is focused on being a healer. Often the basic care physician is the only expert with regular and frequent contact

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to the patient. He is told about interpersonal conflicts, fears, and needs, people of all age groups, social classes, and nationalities are burdened with as a result or cause of physical or mental suffering. The quality of the doctor–patient relationship is the decisive factor for the treatment success. Doctors who combine empathy with an reassuring demeanor and comprehensible information have better treatment outcomes compared to doctors with a more distant and formal demeanor.

Basic Attitudes

Carl R. Rogers' humanistic psychotherapy describes three basic attitudes that promote successful relationship formation: empathy, congruence (authenticity), and unconditional appreciation (Rogers 1951).

Empathy

Empathy means being able to gain an understanding of how another person feels or thinks; putting oneself into the other person's shoes. In the medical setting it means *listening attentively*, pausing, and waiting. Empathy means understanding why someone cries, why someone does not consent to an operation, or why someone prefers natural treatments. Empathy means showing the patient that the doctor is interested in him and that he wants to understand the personal experience of the patient and his motives.

This interest is shown through expressions such as: "I would like to understand this better." "What do you associate it with?" "Can you explain to me where your opinion comes from?"

Authenticity

Authenticity in therapy means finding a professional attitude that does justice to one's own personality. This attitude answers questions such as: "May I cry with the patient when their fate makes me sad?" "May I show my worries even if I actually want to leave the decision about the treatment up to the patient?" "How do I deal with feelings of disgust towards a patient's behavior?" Authentic therapists do not necessarily have to hide these reactions. It is the doctor's duty, however, not to let his/her own emotions become the basis for the decisions on treatment-relevant questions. The doctor is responsible for the course of the conversation and for the treatment process and should always return to the factual treatment level. Professionalism and humanity belong together.

Unconditional Appreciation

Unconditional appreciation means signaling to others that they are still valued and taken seriously as a person, even if they do not meet their own or others' expectations in some areas. Unconditional appreciation does not mean to share or approve of the patient's opinion. It simply means respecting that there are valid reasons for patient's opinion or behavior. For example behind a xenophobic opinion might lie a fear of losing one's job.

The Doctor as a Diagnostic Instrument and as a Drug

Every doctor has had the experience that his or her presence already does more good for the patient than the medicine itself. The perception of the doctor himself/herself as a drug is a key task in dealing with patients. The doctor tries to understand how the patient's behavior affects his/her reactions and vice versa. This division of attention between dealing with the patient and the doctor's own arising emotional reactions and their impact on the doctor's behavior towards the patient is an unusual task, which requires patience, concentration, and constant training. The doctor himself/herself facilitates to a great extent, whether the patient will be able to open up, talk about himself/herself, or whether he/she is withdrawing and only provides monosyllabic answers to questions (Balint 2000).

Just as a doctor uses a stethoscope to examine the heart and ultrasound to examine the abdomen, his own emotional reactions can tell him something about the patient that no other diagnostic method can tell him. His own state of mind, his thoughts, and his fantasies are like the sound of a resonating body, which is made to vibrate by the conversation.

Feelings, that arise in the doctor as a reaction to the patient, influence his behavior toward the patient. It is impossible to be a neutral observer: *One's own subjectivity shapes the course of the conversation*. If the doctor thinks the patient is sympathetic, he will react differently than if he feels annoyed and attacked by him/her. He will take up topics offered by the patient, reject them, or overlook them. He will ask questions or hold back. He will feel inspired or paralyzed by the patient. He will find that the patient's behavior or problem remains unclear or that he reacts nervously, insecure, or bored in conversation with the patient. This means that the doctor will experience that his behavior is susceptible to the impressions the patient makes on him.

These, often unconscious interactions between doctor and patient, can be explained by the psychoanalytical concept of transference and countertransference:

- *Transference* refers to all the thoughts, feelings, fantasies, and behaviors of the patient in the relationship with the doctor. The doctor asks himself: "How does the patient treat me? Is there a connection to the patient's life story? Who do I stand for?"

- *Countertransference* refers to all thoughts, feelings, fantasies, impulses, and behaviors that the patient triggers in the doctor: “Why does the patient make me so angry? Why do I feel such a strong tiredness? Why am I not interested in the patient? Which person in my own biography does the patient remind me of?”

Case Study

An elderly patient in poor nutritional and general condition is ventilated in the intensive care unit due to pneumococcal sepsis. She develops an anxiety disorder and refuses to be weaned by ventilation. The anesthetist on duty feels helpless during the night shift and turns off the ventilator with the feeling of “I will force her to breathe.” Then the patient panics, becomes cyanotic, and has to be intensively ventilated again quickly. The small advances in weaning that had been made before were thus destroyed.

Michael Balint, a Hungarian psychoanalyst who later trained GPs in psychosomatic medicine in England, called the doctor’s alignment to the patient “tuning-in.” When the doctor discovers that he can listen to his patient and capture the unspoken, he will begin to listen to himself in the same way and see himself as a diagnostic instrument. Such a change of attitude takes time. It requires the doctor to be willing to be touched and stimulated by the patient and his/her story. One way to better understand the doctor–patient relationship is to participate in a Balint group (see Chap. 16).

Types of Doctor–Patient Relationships

Because of the doctors’ professional knowledge and training and due to their respective roles, the relationship between doctor and patient is asymmetric at the core. The asymmetry intensifies with rapid advances in medicine, but it also reduces with new information sources (such as the internet) arising and is less pronounced in patients with a high level of education. Therefore, the doctor needs to be highly flexible and must have a very good intuition for adapting his/her behavior to each individual patient’s needs. Thus accessibility of knowledge, severity and acuteness/chronicity of illness, attachment style, and timeframe predetermine the form of relationship between patient and doctor. Evidently, chronicity, secure attachment, and lesser time limitation reduce the asymmetry.

The Paternalistic Model

The paternalistic model arised from hippocratic thinking. Accordingly, the doctor, by virtue of his (paternal) authority, is in the position to make decisions for the patient (who is deemed incompetent), for the benefit of the patient. According to this model, the doctor is viewed as being the expert who knows what is best for the

patient. He/she violates the autonomy of the patient, based on the conviction that this is happening to the patient’s benefit.

In the conversation between the doctor and patient, the doctor determines the topics. The interview is used to query diagnostic criteria that cannot be directly observed in the examination. It focuses on somatic findings. Often, the complaints are registered through closed or standardized questions. In this model, the doctor may be guided optimally by the best scientific standards when treating a patient. The doctor’s contribution to the conversation is his/her medical expertise. The patient is merely told about the treatment plan that is derived from the findings. The patient’s compliance with medical instructions is assumed.

Case Study

A 36-year-old patient is in a cardiac outpatient clinic to discuss the findings of an examination the the attending physician.

Physician: “According to the findings, it is a high-degree aortic stenosis which absolutely requires surgery within the next few weeks. I already scheduled an admission date at the surgical clinic for February 13. In the meantime, please refrain from any physical activity. Continue to take your medication. After surgery, you will be staying in the intensive care unit. When in stable condition, you will move to the floor. Subsequently, we will request a rehabilitation therapy for you.”

This approach has advantages (especially in specific urgent situations) and disadvantages which are listed in Table 4.1.

The Service or Consumer Model

Medical care becomes a service, the doctor is seen as the service provider and the patient as the consumer. In this model, the doctor is an expert, but the decision-making authority remains with the patient. The physician’s role is limited to

Table 4.1 Advantages and disadvantages of the paternalistic model

Advantages	Disadvantages
Diagnosis is brief, factual, guided by closed questions	By focusing only on somatic information, additional diagnoses or other important informations are overlooked
With a definite diagnosis the patients get the best treatment in a short time frame	Lack of compliance of patients. Most patients build trust only when they feel seen as a person and not just as a sick body
Suitable for patients who expect a paternalistic doctor and come with great confidence in the doctor’s expertise	–

providing the patient with the necessary information and to carry out the decisions made by the patient. Since the doctor is liable for the treatment, the rules of medical science must be followed. Not everything that the “patient as the customer” may desire is carried out by the doctor.

In the doctor–patient consultation, patient satisfaction is paramount. The attitude of the patient is characterized by mistrust, which the doctor is looking to overcome by friendliness and expert advice. The doctor thus satisfies the needs of the patient for freedom and independence and of being informed, respected and receiving professional attention. The patient has the right to make demands; the physician, however, should remain friendly even if the patient exaggerates.

Case Study

61-year-old patient with severe aortic stenosis and aortic aneurysm.

Physician: I can tell that you are not thrilled about the news about the necessary surgery. I can assure you that we will operate carefully and with utmost professionalism. Foregoing surgery, however, leads to a high health risk that you would have to bear.

Patient: The scheduled date, 3 weeks from now, is too early. I’m traveling on a business trip and would like to go on vacation afterward. Can we reschedule the surgery for a later date?

Physician: This is difficult; according to the findings, the surgery should be carried out soon. Of course, you can wait; in the meantime, we reduce the health risk with the help of drugs; however, a significant risk remains that you would have to bear.

Advantages and disadvantages of this model are listed in Table 4.2.

The Partnership Model

The partnership model is based on the cooperative effort between two equal partners. Only if both work together and complement each other, the treatment can lead to a successful outcome. The patient is respected as a mature person who makes life decisions autonomously (principle of autonomy). The doctor is the expert. His/her mission is to inform the patient so that he/she is capable of making reasoned decisions. In this model, the patient can, may, and should contribute his/her own questions and positions to the conversation with the doctor. They work together to find the best possible solution (shared decision-making). The patient has the right to refuse any treatment, if done in full awareness of the consequences of doing so. The doctor has to accept this. In this negotiation process, doctors and patients are collectively responsible for all decisions. This is true even

Table 4.2 Advantages and disadvantages of the service model

Advantages	Disadvantages
Patient satisfaction; the patient can talk about worries and problems that are not disease related	Risk of carrying out treatments which are not indicated
Doctor satisfies social needs of the patient to a greater extent	Often, the doctor must confront patients against their will with unpleasant but necessary decisions. The patient possibly turns to another doctor, who fulfills his/her wishes. Many patients expect emotional involvement
Compliance problems are rare	–
People with severe need for autonomy are satisfied with this type of relationship	–

if one or both had envisioned something different or considered something else as being more desirable.

Case Study

Coronary artery bypass grafting surgery

Physican: I have shared the results with you and would now like to know your thoughts and whether you agree with the suggested decision of my colleagues.

Patient: For once I am shocked that I have to undergo surgery immediately; I would have preferred having a bit more time.

Physican: Yes, I see that the finding is very surprising to you and you still have to get used to the situation. I would be happy to explain once again the advantages of an early surgery and the risks of waiting.

Patient: Please go ahead.

Advantages and disadvantages of the partnership model are listed in Table 4.3.

The goal of *shared decision-making* is a jointly made decision of two, in principle, equal partners. To achieve this, both sides must be willing to share relevant information, come to a joint decision and accept it.

For the patient it is important to obtain the following information:

- Basic information about the disease and giving an idea on the prognosis
- Information on the course of examinations and possible treatments (suggested treatment and alternatives)
- Information on the consequences of examinations and treatments (in some cases including the most relevant side effects)
- Available support (within the health care system/support groups) and ways the patient can support his/her own healing
- Ways to avoid complications

Table 4.3 Advantages and disadvantages of the partnership model

Advantages	Disadvantages
Patient takes responsibility; compliance problems are avoided	It is difficult to inform the patient in a manner so that he/she will be able to take the full responsibility
Doctor is relieved of some of the pressure of decision making because he/she does not have to decide on ethical questions on behalf of the patient	Takes more time; this way of communication might result in unpaid additional efforts
Subsequent treatment might be shortened because the patient already built trust in the doctor	–
Especially useful during prolonged monitoring of patients	–

The doctor may ask the patient to explain his/her decision in his/her own words. Supporting graphics can be used, which serve both the perceptual information and the clarification of risks.

It is the decision of each doctor to what extent he/she includes the models described in his/her professional identity. The partnership model requires the doctor to be highly flexible and to be able to listen. Psychological or social problems are often addressed only reluctantly and in disguised form. If the doctor does not notice the hints of his/her patients, psychosocial issues are increasingly being excluded from their conversation. The decision to walk the more difficult path of being more flexible toward the patient will be rewarded with more grateful patients and an increased job satisfaction in the long run.

Characteristics of a “Good Doctor” in Psychosomatic Basic Care

- Considers not only the somatic findings but also the patient’s life and disease history
- Is aware of the importance of the doctor–patient relationship and has the ability to constructively solve difficult doctor–patient interactions
- Has a high level of communicative competence and can pause and listen actively
- Is aware of his emotional reactions to stressful experiences (such as being confronted with the life-threatening disease of a patient, death and dying) and can process them
- Can recognize, analyze, and constructively solve social conflicts within the treatment team
- Is aware of his/her own limitations and the inevitability of mistakes. He/she can admit mistakes and asks patients, relatives, and colleagues for forgiveness
- Recognizes his/her own limitations on handling stress and ensures timely physical and mental compensation

Pitfalls

- Doctors may have high expectations on themselves to implement the above models perfectly, but the attitudes described are ideals that can rarely be matched one-to-one. Therefore, go ahead and experiment with these models.
- The expectations of patients for autonomy, trust and security are being considered too one-sided. The doctor should not forget his/her own needs as well as physical and mental constraints.

Cultural Aspects

While in much of the Western world a family doctor is the first contact who, if necessary, will refer the patient to a specialist, “doctor shopping” takes place in many parts of the world. In case of dissatisfaction, doctors will be switched, or various practitioners will be consulted parallelly. This does not foster sustainable care and may result in misdiagnoses. Depending on the cultural background, patients show different attitudes toward proposed treatments. Doctors should reflect on their own system of values as well as that of their patients in order to be able to deal with possible deviations.

Asia

In the USA, a cooperative doctor–patient relationship, based on the values of individualism, autonomy, and service, is predominant. In contrast, in many Asian societies, the doctor–patient relationship is structured according to the model of a hierarchical relationship (Nilchaikovit et al. 1993). Here, the doctor is the virtuous authoritarian figure, caring, and responsible for the welfare of the patient. In return, he/she receives a high level of respect. If an Asian patient is treated by an American doctor, it may result in cultural misunderstandings due to the different interpersonal models the encounter is based on. If, for example, certain expectations are not met, the patient will probably not tell the doctor outright. The doctor might even get the impression of a passive–aggressive, non-compliant patient. Often, therapies are prematurely terminated, and the patient starts “doctor shopping.”

Latin America

Medical doctor–patient interactive practices in the Latin American continent are marked by a strong oral tradition rooted in the native indigenous inhabitants’ oral culture. This creates a high expectation and demand on the oral interaction in any profession. Thus, the doctor is expected to be very empathetic, and it would, for example, be considered rude if the health professional were too direct and too straightforward in the announcement of certain illnesses. Among the poorer, less-educated individuals, the doctor is still taken as being somebody of unquestionable higher knowledge, and he/she is considered to have a certain superior capability to sort out any kind of physical or mental health problem; here the belief that what the doctor says is “right” (Garaffa and Albuquerque 2001) prevails.

The Private and the Public Health-Care System

Doctor–patient relationships are also affected by the type of health-care system. There are mainly two types: the private and the public one. Public health care means free medical care for all. This overloads the public system and promotes serious deficiency of quality in the public sector. This situation promotes a rapid expansion of the use of the private sector, already reaching 25% of the population in Brazil, for example. Evidence shows both systems are putting doctors and other personnel under stress with time constraints and low salaries, which is resulting in more and more cuts in the time doctors spend with each patient. Consequently, in a culture that relies mostly on orally oriented practices, this brings a reasonable amount of dissatisfaction affecting the interaction quality between doctor and patient significantly.

New Media

Patients' easy access to information is resulting in an increased number of patients who come to the doctor with self-diagnosed illnesses and ready-made solutions for their treatments. This, at times, has proven to be strenuous in cases where there is no real need of prescribed medication or where the diagnosis is very different from the one supposed by the patient.

Africa

In Uganda, there are barriers that may restrict the clinician to just one model—the *paternalistic model*. The dominant health-care system in Uganda is the Western or modern health care; the Western-trained doctor has the Western views of health and disease, while the patient has cultural views or beliefs about health and disease. Any model that gives powers to the patient is undermined when the patient and the doctor have different views or beliefs about the problem, and yet the dominant health-care system favors the views/beliefs of the Western-trained doctor.

There is low health literacy and generally low education. This puts the doctor in such a high and powerful position as compared to the patient who may be poor and has low education and a poor social status. The doctor is therefore seen as being omniscient. Any attempts to try and devolve power to the patient is met by remarks such as “Doctor, you are the one who knows best.” The situation of a heavy burden of communicable diseases such as HIV, malaria and other parasitic diseases, pneumonia, diarrhea, and tuberculosis coupled with a very limited number of doctors persistently leaves the doctor with no choice but to be paternalistic in the relationship with the patient.

In a collective society, there is minimal focus on individual psychological functioning, a lesser focus on individualized human rights, and the associated tendency toward overriding patient autonomy, as, for example, a wife will at best wait for her husband to make decisions that affect her own health; or even the whole clan could have a say in her medical matters.

On the other hand, the few urban educated patients with access to the internet may consult with Google diagnosis and management. Establishing trust and a therapeutic relationship may be a challenge as they come with information that have been tinted from the media.

Table 4.4 The BATHE technique (McCulloch et al. 1998)

Background (What is going on in your life?)	Redirects patient from somatic to emotional issues; this elicits life circumstances and potential stressors
Affect (How do you feel about that?)	Helps patient to talk about feelings
Trouble (What about the situation troubles you most?)	Focuses on the meaning of the situations for the patient
Handling (How are you handling that?)	Provides an assessment of functioning and what the patient has done including googling
Empathy (That must be difficult for you. No wonder you are feeling that way and are looking for answers)	Normalizes the patient’s reactions and demonstrates the clinician’s understanding

Below are suggestions of how the clinician can handle the situation:

- Validate their efforts by acknowledging it.
- Use the BATHE technique (see Table 4.4) to help them verbalize their feelings.
- Build on their understanding of what the problem is.
- Suggest additional resources that can guide them in correcting false information and improving their knowledge.
- If as a clinician you have limited knowledge, acknowledge your limitation.
- Psychoeducate them about the dangers of self-diagnosis.

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Chapter 5

Doctor-Patient Communication



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The Importance of Medical Consultation for Diagnostics and Therapy

Words were originally magic and the word has retained much of its ancient magic power to this day. Through words a person can make others happy or despair, through words the teacher transfers his knowledge to the students, through words the speaker takes the audi-

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ence with him and determines their judgments and decisions. Words evoke emotions and are the general means of influencing people among themselves. So we will not disdain the use of words in psychotherapy and we will be satisfied if we can be listeners to the words exchanged between the analyst and his patient (Freud and Strachey 1953).

A patient's cooperation and thus the success or failure of medical treatment depends on the quality of the doctor-patient communication. The most important diagnostic and therapeutic tool of a doctor is the medical interview. In the course of his career, a doctor conducts up to 200,000 interviews with his patients and their families. In most specialties, one-third of the doctor's time is taken up by interviews. Seventy percent of all diagnoses can already be correctly made based on the anamnesis interview only.

Frequent Deficiencies and Errors in the Doctor-Patient Consultation

The following list shows common mistakes and deficiencies in the doctor-patient discussion:

- Interruption of the patient's description, on average after 18 seconds.
- Lack of structuring of the conversation.
- Restriction of the patient by suggestive questions and closed questions.
- Failure to respond to emotional remarks.
- Unclear and misleading explanations of examination findings, disease diagnoses, and therapeutic recommendations.
- Vertical communication: The physician in his function as teacher – adherence to orthodox medical knowledge.
- Too rapid psychologization of the problem with out psychosomatic disease understanding of the patient's disease.

Patient-Centered and Physician-Centered Communication

For a successful and satisfactory doctor-patient conversation, it is necessary as a doctor to know and be able to apply different forms and phases in order to guide the discussion. In the first part of this chapter, the basics of a patient-centered and a doctor-centered interview are presented. In a patient-centered conversation, the guidance is given to the patient, and he/she can develop descriptions of complaints, concerns, worries, or questions, while the doctor "only" has the role of supporting and listening. Especially for the collection of a biopsychosocial anamnesis, a patient-centered conversation is important to start with, also in conversation situations in which a patient is very stressed or psychosocial topics and problems are addressed. Conversely, a patient-centered conversation enables the patient to address the stress or psychosomatic aspects of a disease in the first place.

On the other hand, it is important that the physician then takes the lead again to ask for details of the symptoms and/or the biography of the patient or to structure the conversation as required in a doctor-centered conversation. Depending on the topic of a conversation (anamnesis, visitation, information, couple and family conversation) or

the setting (doctor's room, patient's room, emergency room, home visit), a more doctor-centered or a more patient-centered conversation may be necessary. Both partners, doctor and patient, should participate in the course of the conversation comparable to a joint dance, in which sometimes the patient and other times the doctor takes the lead.

In the second part, the application of these interview techniques will be presented using the example of biopsychosocial history and dealing with aggressive and demanding patients.

Patient-Centered Interview

Clarification of Task

Approximately 30% of the patients in a general practitioner's practice want a purely somatic, disease-oriented treatment and do not want to talk about psychosocial stress. These are mainly patients with acute complaints and relatively minor limitations. 70%, however, signal more or less clearly to the doctor that they would like to talk about psychosocial problems in addition to physical complaints. In order to clarify what the patient wants to talk about and whether this can be done within the scope of the medical consultation, the doctor should be clear about his mandate.

Case Study

Clarification of the Task

Mr. K. has been suffering from tension headaches for a long time. Recently, the attacks of pain have increased. If the pain is particularly severe, his family doctor prescribes a painkiller. As consultations have become more frequent recently, the doctor suspects psychosomatic involvement. He wants to clarify whether the patient agrees on giving an extended treatment contract.

Doctor "You've been here a lot lately because of the headaches. Have you ever thought about the reason for this?"

Mr. K. "I don't know, but you say it's muscle tension. Maybe I sit in front of the screen too much."

Doctor "Mhm, you sit in front of the screen a lot?"

Mr. K. "Yes, I've had my new office for three months now. Since then, I've often had to work until late at night and spend most of my time in front of the computer."

Doctor "This means that the conditions at work could aggravate the headaches?"

Mr. K. "Yes, there is a lot of stress at work, although I am also very happy not to be in the field anymore. So the worst thing is sitting at the computer."

Doctor "It can also be that you tense up because of too much stress, worry, or strain and then you get a headache. Can you imagine that this also has an influence on you?"

Mr. K. “Well, there’s this stress at work, but I’ve always had it. But what has now been added are the planned rationalization measures, which will result in the loss of 300 jobs. I’m already afraid of that.”

Doctor “Would you like to tell me more about it?”

Mr. K. “It is difficult for me to talk about it. I immediately notice how I begin to sweat on the subject and everything cramps up on me. Well, I am a trade union representative on the works council...”

The doctor suspects a psychosomatic connection, which the patient does not take up at first but explains by sitting at the computer. After a further cautious offer from the doctor, the patient then begins to talk about his/her professional burdens. Only now can both agree on a psychosocial treatment contract.

Active listening is the most important method in patient-centered interviews. The doctor plays the role of the listener, but is definitely not passive. He/she concentrates on the question of what contents are relevant for the patient. The doctor is also active, since he/she makes it clear to the patient with listener signals (“mhm,” “yes”) and postures that he/she is following the narrative. This style is recommended in the first part of the interview and especially in emotional situations, or if the patient himself talks about psychosocial stress.

Active listening is part of the conversational psychotherapy according to Rogers (Rogers 1951). Rogers names three basic attitudes of the therapist/doctor which help the patient to grow, heal, or unfold: an unconditional appreciation or acceptance of the patient; an empathic understanding of his problems; and an “authenticity of the doctor” in speaking and behavior. These attitudes in humanistic psychotherapy are of great relevance for the medical conversation, as they create a space in the doctor-patient relationship in which the patient can express him/herself and his complaints and feel understood. The doctor-patient relationship itself realized in this way is effective in healing and supports the patient in coping with the illness.

The techniques of patient-centered interviews, which will be explained in more detail below, are:

- Let the patient finish talking.
- Use open-ended questions.
- Pause.
- Encourage the patient to continue talking.
- Paraphrase.
- Summarize the contents.
- Reflect the patient’s emotions.

Let the Patient Finish Talking, Give Space

Studies show that doctors interrupt patients for the first time after 15–20 seconds already. Usually an open-ended first question (like “What brings you here today?”) signals the patient that there is space to speak. It has been found that patients

are more cooperative, keep their comments shorter, and only talk about relevant things, if the doctor lets them finish speaking first. The average patient speaking time at the beginning of an interview is 92 seconds, and 78% of patients stop within 2 minutes (Langewitz et al. 2002). During the investigation, the doctors were asked not to interrupt their patients. Only 7 out of 335 patients spoke for more than 5 minutes. According to the attending physician, however, the given information was so relevant that it was worthwhile not to interrupt. Patients have a positive experience of being allowed to explain. In addition, the patient's complaints and symptoms are discussed more fully in a coherent narrative, and seemingly unimportant aspects can be relevant for the patient's diagnosis. This particular knowledge of the patient is often difficult to acquire in a doctor-centered conversation.

Open-Ended Questions

Open-ended questions are those that cannot be answered with a simple yes or no (closed questions) or a single word (half-open questions, alternative questions). Open-ended questions invite the respondent to report comprehensively on everything that is relevant to the subject in question.

Example

Doctor "How would you describe the pain?"

Instead of

Doctor "Is it a stabbing pain?"

By using open-ended questions, the doctor provides space to the patient and signals that he is interested in the patient's point of view. The more reflected, structured, and communicative a patient is, the more questions can be asked openly. If, however, the patient cannot find the right words, it can be useful to help him with closed questions (e.g., lists of adjectives to determine the quality of pain). No additional questions or explanations should be added after an open question has been asked, since the question will then lose its supportive, patient-centered function.

Pause

During breaks in conversation, the doctor often feels embarrassed, as if he doesn't know what to do next. Together with the high time pressure, this makes the use of these techniques more difficult. A short pause of about 3 s has been found to be effective. In short periods of silence, the patient may remember something he/she had previously forgotten to mention. The pause allows the patient to continue speaking if there is something to add. The patient may express thoughts he/she had hesitated to address. The pause lowers the inhibition threshold for speaking about psychosocial matters. The deliberately used pause signals the patient to continue telling if there is anything to add. During the pause, the doctor emphasizes by listener signals ("hmm," "yes") and by his/her posture that he/she is listening to the patient and wants to give

the opportunity to continue speaking. Contrary to the fear that pauses might be interpreted as incompetence, pauses act as a relief. It is pleasant to be able to think about something briefly. The doctor appears interested, calm, and secure.

Case Study

“Pause”

Doctor You briefly mentioned stress at work; can you tell me more about that?

Patient Hmm, yes. The problem is that the company is not in a very solid position. And now there was a large recall action that had to be dealt with quickly to prevent further damage. This meant we all had to work overtime; that takes a lot out of you.

Doctor Hmm... (3 s pause).

Patient ...to be honest, I just can't go on. I have trouble dragging myself out of bed in the morning and trouble falling asleep at night. And there often are arguments with my wife. And I can't blame her. When I come home at night, I'm often irritable and don't have energy to do much of anything. Actually, I could do with a week's vacation, but that's impossible at the moment.

Encourage the Patient to Continue Talking

Nonverbal signals like nodding, when the patient hesitates, indirectly encourage him to continue speaking. Eye contact signals attention and interest and also encourages patients to continue speaking. Posture facing the patient emphasizes the doctor's presence. Through eye contact, you can also see whether a patient wants a speaker change or is still thinking about a question or a topic. A change of speaker is usually initiated by eye contact, while thinking about personal topics is usually accompanied by looking down. Verbal possibilities to encourage the patient to speak are short expressions like “mhm” or “ah yes.”

Case Study

Patient “I had to go to the toilet and had blood in my stool.”

Doctor “Ah yes.”

Patient continues “And that reminds me...”

Echoing

Echoing is another way to encourage further speaking. Here, individual words are taken up and repeated literally. The function is very similar to a simple “mhm,” but it draws more attention. However, there is no interpretation of the contents, as there is deliberately no search for other words.

P In addition to my stomach ache, I also lack the drive at the moment. I always feel tired.

A Constantly tired.

P Yes, I mean I drink hardly any alcohol and usually go to bed early, but I sleep very restlessly and usually feel as if I've been on the move all day. The worst time is in the morning when I want to get up.

Applied as a “technique,” echoing sometimes seems artificial to the doctor himself. However, the other person usually does not notice this but feels encouraged to continue talking.

Paraphrase

Paraphrasing means repeating what has been said by the patient in one's own words. The doctor takes on the patient's point of view and only focuses on the patient's key messages. Using paraphrases is a good way to support the patient in emotional or personal topics. Questions tend to disrupt. Paraphrasing often offers the patient new perspectives that lead to what can be astounding solutions.

Case Study

“Paraphrase”

Patient Couldn't we postpone the next chemotherapy cycle?

Doctor You would like to have a longer pause?

Patient Yes. You see, it's like this: My sister lives in the USA and is coming for a visit in 2 weeks. I can't visit her at the moment, and the medications make me so tired. Well, it would be really dumb while she is here.

Doctor Ah yes, you don't want to be hampered while your sister is here?

Patient Yes, that's it. Actually, I don't want her to realize so much that I'm sick. I mean, she knows it, of course, but she shouldn't have to be confronted with it.

Doctor Mhm, you don't want your sister to see you as sick.

Patient Yes, I don't want her to pity me. You see, I'm the older one and I was always there when she needed me.

Doctor OK, I understand. You don't want pity and help from your little sister.

Patient Well, if she helps a little that's OK, but no pity.

While the first paraphrase focuses on the treatment, the doctor then addresses the stress and the patient's personal background. Often, the patients themselves will then come to a new solution. If this is not the case, the doctor can help.

Doctor Could you imagine telling her that you don't want pity?

Patient Actually, it's silly. I'm still strong enough to deal with my sister's sympathy and I can tell her that I don't want her to pity me.

Summarize the Contents

With paraphrasing, the doctor only picks up on the most important parts of the message, whereas summarizing covers a larger segment of the discussion. The doctor repeats in his own words what he/she has understood. The patient can then add information he had forgotten. This leads to agreement between the doctor and the patient. The doctor checks whether he/she has understood what the patient said.

Summaries are also a suitable means of transition to a new discussion or to announce the end of the conversation by summarizing the most important contents. In this way, it is also a doctor-centered communication technique.

The physician can further increase the patient's involvement by reassuring him/herself after the summary by asking the following question: "Have I understood this correctly?"

Reflecting the Patient's Emotions

Reflecting emotions is very similar to paraphrasing. However, it refers primarily to emotional contents. Sometimes, these emotions are addressed directly. Sometimes, the response to emotions is based on an observation of body reaction or refers to what is said between the lines.

The patient's emotional expressions should be taken up in the sense of a proposal that does not restrict the patient, but can be rejected or corrected by him.

Case Study

"Reflecting Emotions"

Patient I'm afraid it could be a malignant tumor.

Doctor You are anxious and worried about what the examination will reveal.

Patient My mother had a fatal accident 8 years ago (cries).

Doctor You become very sad when you think of your mother's accident.

The doctor then waits to see whether the patient permits the doctor to pick up on his emotion. In the pause, he/she can reflect on his/her own feelings. Once the doctor has described the feeling, the patient has the possibility to talk further or change the subject.

After an intensive emotional statement, it is especially important that the doctor pauses and does not immediately soothe the patient or change the subject. This initially represents a considerable stress test. For the patient, it is important that he does not feel dismissed but rather gains the doctor's interest and sympathy. He experiences that emotions are acceptable and don't have to be answered by immediate defensive maneuvers. The sympathy can be supported by small gestures, such as handing a handkerchief when the patient cries. For example, at the bedside of a seriously ill patient the doctor can hold the patient's hand.

Doctor-Centered Interview

The physician is responsible for the time and organizational framework of the interview. He/she has to focus on certain topics and details for the diagnosis and to steer and control the conversation and has to inform the patient about certain aspects and provide well-structured information. Therefore a doctor-centered interview includes many structuring techniques. They help to focus and streamline the interview.

Transparency

The basic instrument for keeping within time limits is the transparency of the interview contents, the time frame, and the transitions between various interview phases. The transition to a new interview phase should be clearly emphasized. Important techniques for providing transparency are:

Transparency of content

- Provide information about the treatment steps that you have planned for this appointment.
- Provide the necessary technical information.

Transparency of the environment

- Point out potential difficulties.
- Provide information about the timeline of the interview.

Transparency of the interview phases

- Make it clear if you expect from your patient long explanations or short answers.
- Indicate transitions between a patient-centered and a doctor-centered interview.
- Announce the end of the interview well in advance.

Case Study

In the patient-centered phase of the anamnesis, the patient talks about being burdened by her job and children, and that she receives little support from her husband. Against this background, the lower abdomen complaints may represent this strong burden.

Doctor “OK, I understand that you are very busy with your children and your work. You are also a little frustrated that there is hardly any support from your husband. And now there’s the pain, too.”

Patient “Yes, exactly.”

Doctor “In order to better classify your pain, I would like to ask you a few questions about your complaints. I proceed on the basis of this anamnesis sheet. If you come up with anything important that goes beyond that, we will have time to clarify it afterwards. Is this procedure OK for you?”

Patient “Yes of course, I would like to know what I have.”

Questions in a Doctor-Centered Interview

Table 5.1 lists the question types that serve to structure a doctor-centered interview.

Case Study	
“Counter Questions”	
Doctor	In my opinion, general anesthesia is suitable for your child because she is too young to remain calm under a local anesthetic.
Patient (slightly aggressive)	Would you do the same to your own child?
Doctor	I’ll answer your question in a moment; first, can you tell me beforehand what’s behind your question? (<i>Counter question</i>).
Patient	I would like to know if the risk is really justifiable, you see. If you are not personally affected, such decisions may be too simple.
Doctor	I have children of my own and would do the same for them also. But for me it is more important to know, which risk can you yourself justify? (<i>Alternating the level of discussion</i>).

Table 5.1 Question types to structure a doctor-centered interview

Closed-ended questions	Questions that can be answered with yes, no, or a short statement Allows to query specific information “Are you vaccinated against tetanus?”
Alternative questions	Already provide a list of potential answers “Is the discharge green, brown, or yellowish?”
Knowledge questions	A doctor can provide more targeted information when he queries the knowledge of the patient in advance “Have you yourself looked for information about how one can cure your pain?”
Opinion questions	Find out about belief systems Problems can be anticipated; priorities regarding the course of treatment may be set “How do you feel about taking medication?”
Counter questions	In case of patient questions with unclear intention Provide more information before you answer Often particularly useful in case of aggressive, difficult patients
Leading questions	The interviewee is given a specific answer “You certainly also don’t want to feel any pain?” Overall these questions should be avoided, only if it is considered to be appropriate after careful weighing, for trying to convince a patient
Behavioral questions	Request the patient to do something specific “Can you summarize this in your own words once again?”

Interrupting

Over the course of the interview, it may be necessary to stop the flow of speech of some patients in order to stay focused. Interrupting is usually perceived as impolite and must be done in a way so that the patient can accept it and will return to the topic.

The Four Elements of Interruption

- *Direct interruption*
The doctor addresses the patient by name, directly looking at him/her, while maybe even touching his/her arm and in this way draws the patient's attention.
- *Summarizing*
The doctor signals that he/she has understood that the topic is important to the patient, even if the discussion cannot be continued at the current moment.
- *Repeat interview goal*
The doctor repeats the goal of the interview.
- *Obtain agreement*
At the end, the doctor asks if the patient agrees to the planned procedure. This makes it possible for him/her to remind the patient of the agreement if other interruptions occur.

Example

Doctor Mrs. Dunhill (direct interruption), I hear it is very important for you to report very detailed on all your complaints (summarizing). It would be important to me, however, that you answer my questions as briefly as possible, as otherwise there would not be enough time to ask all the necessary questions (repeat interview goal). Do you agree that we should continue like this (obtain agreement)?

The first element, the direct interruption, is very important; it's practically a wake-up call. In situations where patients talk incessantly, they lose contact. The doctor first has to reestablish this contact; he/she in a way has to tear the patient out of the monologue. The second element, summarizing, then makes the interruption socially acceptable. By signaling that he/she understands the patient, the doctor remains in an empathic, appreciative mindset towards the patient. Thirdly, by repeating the interview goal, the physician benefits from the transparency that has been achieved so far. If he/she has already pointed out the contents and goals of the conversation, it becomes more easy to remember. The fourth element, obtaining the agreement, is particularly important when looking towards the future. Once an agreement has been made, it can then be repeated again and again: "Mrs. Dunhill, now we have gone into great detail again, may I remind you of our agreement?"

Metacommunication Comments

Metacommunication comments are comments about the way the interview is being conducted. The content or how something is being talked about (process) are addressed. It can refer to verbal and nonverbal information.

The aim of any metacommunicative comment is to reflect on the way the conversation is being conducted in order to correct it. Since such utterances are usually only used in very problematic situations (“I will not be spoken to like this!” “I ask you to speak to me in a different tone!”), it is particularly important to keep the utterance neutral and to formulate it as an “I”-message: “I experience the conversation as being very tense.” There should be no reproach in the voice; otherwise the relationship will quickly become strained. The use of metacommunicative comments can help structure an interview, but it requires a clear distance from one’s own feelings, since the reason for metacommunicative messages is usually associated with anger, impatience, or rejection. If the aim of the interview is also mentioned (“I would like to return to a factual exchange in order to complete the information”), its effect as a regulative is intensified.

Metacommunicative Comment on the Topic

Metacommunication via content is the simplest form. Here it is emphasized which contents are particularly in the foreground or which contents may hardly be addressed.

If the metacommunicative utterance mainly serves the purpose of structuring, it is advisable, as with the interruption, to finally obtain an agreement for the structure.

Case Study

“Metacommunicational Comments”

Doctor It occurs to me that we got side-tracked, although I had expected that the subject would be at the center of our conversation. (Metacommunication with mention of the goal of the conversation)

Patient Well, yes, it’s true. I’m also pretty nervous just thinking about it.

Doctor Shall we postpone the interview? (Closed question)

Patient No, at some point we have to discuss it.

Doctor Well, if you notice that it’s too much for you, please tell me. We would also have the opportunity to end the conversation tomorrow morning. (Transparency on the framework)

This form of comment is particularly suitable for patients overflowing with information. In this case it should not be questioned why the conversation behavior is shown, as this would further escalation. With these patients it is important to offer and keep a structure.

The advantage of metacommunicative comments in conversations with extremely talkative persons is the surprise effect. It almost always leads to an irritation for a short period of time, because the change of the level of conversation comes unexpectedly. The first reaction is therefore usually a rather short answer. This pause in the flood of words can be used to make the structure clear. If this technique is repeated, the surprise often turns into a humorous reaction, which makes the process much easier.

Doctor Now we are talking about diseases of other people (metacommunication).

Patient (Laughs) You're right, I really am a little confused. What was the question again?

Metacommunicative statement on positions

If patients take up other positions than their physician, these are not always expressed directly, but show up in nonverbal communication. Since these are also contents, this form is less problematic. On the contrary, patients are often grateful when the doctor recognizes their reluctance and takes it seriously.

Doctor I have the impression that you react very hesitantly to the suggestion of taking antibiotics (metacommunication).

Patient Yes, what you have noticed is true. I'm reluctant because I've just taken a cure to regenerate my intestinal flora, and now it's all going to be destroyed again?

Doctor Ah yes, I see, you have the impression that you are doing yourself more harm than good (metacommunication).

Pitfalls

- Several questions are asked at once.
- The transition from one topic to the next is unclear.
- The interruption occurs too late; the doctor's anger at the patient becomes apparent.
- Metacommunication comments are phrased as allegations rather than observations.

Depending on the situation and the patient's personality, the interview style may be more patient-centered or more doctor-centered. In a medical emergency, the doctor must obtain an overview of the situation and make a tentative diagnosis by asking the patient specific short questions: "Are you in pain? Are you a diabetic? What medications are you taking?". In situations of emotional crisis, the doctor provides the patient with an opportunity for emotional relief, summarizes what he/she heard in his/her own words, and reflects the emotions of the patient. The following two typical interview situations are presented, where both patient-centered and physician-centered interview techniques are necessary in a balanced manner.

The Biopsychosocial Anamnesis

The anamnesis is the most frequent discussion form in the hospital and practice. A different procedure is needed in emergency admissions in a hospital than in the family doctor's office. The phases presented here are based on the case in which the doctor has hardly any previous information about the patient and there is no immediate need for treatment (as for example in acute pain). Depending on the task at hand, the doctor is forced to choose certain phases or to omit them entirely and come back to them later.

Greeting

The greeting gives the impression of how attentive and interested the doctor is in the patient. Does he/she greet the patient with a handshake and name; does he/she look him/her in the eye; does he/she look inviting and cordial or does he/she hide behind a file or the computer screen and seem inapproachable; or does he/she read the name from the file card? For the doctor, it is a professional routine, but for the patient, the appointment is connected to a number of hopes and fears. An increase in blood pressure in the doctor's office ("white coat hypertension") is not unusual. Some brief *small talk* facilitates the first contact. One or two sentences about the family, the weather, and the trip from the patient's home to the hospital or office bridge the feeling of strangeness and provide the physician with some information in a format that is comfortable for the patient and family. It is also part of the greeting that the doctor briefly introduces him/herself and his/her function.

Patient-Centered Phase of the Anamnesis

The patient describes his matter. With the patient-centered interview, the doctor supports the patient's presentation. He should not interrupt in this phase, unless something is unclear. In this phase, the doctor receives information about the complaints, the patient's personal circumstances, and quality of life and how this has changed due to the illness. Finally, the doctor can learn something about the patient's personal understanding of how the disease came about and is maintained and about the resources available to the patient to cope with the disease.

The doctor can ask, for example:

- "Where do you think your complaints come from?"
- "Why do you think you got sick at this point in your life?"
- "What are your worries, fears, and anxieties about the disease?"
- Have you already thought about certain treatment measures yourself?

In this way it is possible to reconcile one’s own ideas about diagnostics and therapy with those of the patient or to identify and name discrepancies.

If the patient in this phase makes hints about psychosocial burdens without further elaborating on them, he/she is probably uncertain whether they are allowed to give this information.

Case Study

“Patient-Centered Anamnesis”

Doctor You have just indicated that it’s not easy for your children to deal with your illness. I’d be interested to know more about this.

The patient may be irritated, since it has been his/her experience that doctors block such topics. He/she may react as follows:

Patient I don’t know. There’s nothing I can do about it anyway.

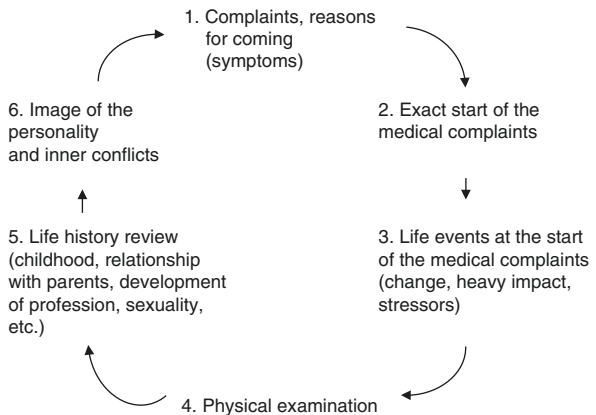
The doctor can then explain why he/she thinks it’s relevant and leave it to the patient whether he/she wishes to further speak about it.

Doctor I don’t know whether we can change anything about it. But it’s important to me that you have as little stress during the treatment as possible. If you want to, you can tell me more.

Psychosocial Anamnesis

In an initially somatic-directed anamnesis, information about the life history, such as serious illnesses or hospitalizations in childhood or stress from the illness or death of a parent, may be expressed (see Fig. 5.1). This information enables the doctor to form first hypotheses about a relationship between early stress and the current complaints:

Fig. 5.1 Biopsychosocial anamnesis modified from Bräutigam:



- Psychosocial topics.
- Individual anamnesis.
- Family.
- Family environment: parenting style of the parents, emotional climate, relationship between the parents, relationship among siblings, etc.
- Diseases, disease risks, disease management, and health behavior in the family.
- Early childhood development: specific diseases, hospitalizations, etc.
- Typical threshold situations like graduation, moving out of the parents' home, choice of profession, marriage, retirement, etc.
- Current life situation, for example, job, family changes in occupational and professional life.
- Forms of coping with disease, such as active or depressive coping, denial of the severity of the symptoms.
- Subjective understanding of the cause of disease.
- Consequences, expectations regarding treatment and course.

Doctor-Centered Phase of the Anamnesis

In the doctor-centered phase of the anamnesis, the doctor asks specific closed questions in order to obtain the information he/she needs to make the diagnosis as quickly as possible. The commonly used check lists help to ask all the questions necessary and signals the altered interview style to the patient. If a patient is still talking very verbosely during this phase, it is helpful to make the changed form of conversation transparent to the patient.

Doctor “I notice that you answer my questions in great detail. I still have some questions for you and would like to ask you to answer them briefly and concisely. If there is anything else you would like to talk to me about, I would like to take the time to do so when we are at the end of the anamnesis. Do you agree?”

Physical Examination

Even in the physical examination, there are verbal and nonverbal exchange processes between the doctor and the patient. Touching during the physical examination can be experienced as an advance by a stranger which violates bodily limits and is intimate and/or penetrating. For example, in an examination of the abdomen, the degree of tension needed depends on the examiner's sensitivity and the trust the patient has in the situation. The patient may experience feelings of resistance, fear, shame, or pain.

Practical Tip

Sharing of the doctor's perception of the patient's reactions during the physical examination may help the patient to relax, gain trust, and feel that the doctor understands him/her.

"I notice that you tense up your stomach when I touch it. Is being touched on this spot unpleasant to you?"

Treatment Planning

The goal of treatment planning is to together with the patient find a treatment strategy that combines the patient's wishes with medical necessities to the greatest extent possible (*shared decision-making*, also see Chap. 4). What we know of compliance is sobering. In family practice, only 33% of the patients take their medications correctly. So, it is highly relevant whether the patient can and wants to follow the treatment at all.

Example

Doctor "There are different treatment approaches that are possible. If you wish, I will inform you about them, and we will then decide together what is best for you. If you like, I can also make the decision for you from my expert's point of view."

The answer could be:

Patient "You're the expert, you should decide."

Or:

Patient "Yes, it would be nice to hear about the alternatives."

Conclusion

The concluding phase serves as a review. The doctor again summarizes, bringing together the topics that were discussed and the most important points. Here, the patient has the chance to add anything important. The doctor then decides whether the additions should be clarified immediately or at a later date. Only if the new information is highly relevant, the treatment can be changed or clarified very briefly should the doctor include it immediately. Otherwise, it makes more sense to keep to the schedule and make a new appointment.

Doctor "Today we talked about your continuing complaints. We agreed to draw blood again and whether the blood values do not indicate anything against starting with the medication. You also talked about the problems with your wife/husband. We will make a new appointment during the next few days to discuss this. At that time we will also discuss the blood values. Are there any questions that we have forgotten now?"

Pitfalls

- Switching between patient-centered and physician-centered approach is not announced. This can irritate and confuse the patient, because he/she may not understand the interview structure.
- The doctor does not end the interview in time. Right before the conclusion of the interview the patient brings up another important topic for discussion. The doctor addresses it and exceeds the time frame.

Dealing with Negative Emotions (Fear, Anger, Rage)

Dealing with angry or agitated patients is a particular challenge in everyday medical life. In the following a model is presented, which can help to understand and to relieve such emotionally loaded situations beyond the already presented patient-centered discussion guidance.

Interviews with Challenging and Aggressive Patients: The CALM Model

Case Study

“Mr. G”

Mr. G. is summoned to the doctor’s office of the cardiology department. He is facing junior doctor Dr. B.; Mr. G. pauses, looking questioningly at Dr. B., then around the room, then back at Dr. B. Dr. B. asks Mr. G. to take a seat. In response, there is only a clearly impatient and rude question: “Where is Prof. K.? I had an appointment with her.” Quickly and apologetically, Dr. B. answers, “Prof. K. is attending an international conference at which she was invited to give the opening speech.” Dr. B. cannot finish the last sentence, because Mr. G. bursts out, and with a reproachful, loud voice he complains, insults the clinic, the lack of organization, and, eventually, Dr. B. who feels more and more uncomfortable.

The CALM model is a graduated model which is used to de-escalate conflict-prone discussions. Generally, the stages should be run through in ascending order. The two lower stages conserve or strengthen the relationship, while the two top stages are agreements that constitute a compromise in the form of a lowest common denominator between the clinician and the patient. If the stages are implemented skillfully, the top of the pyramid is only reached in rare cases (Fig. 5.2). Usually the first step is enough to return to a constructive working relationship. In some cases it can happen that the lower levels no longer correspond to the escalation level and are

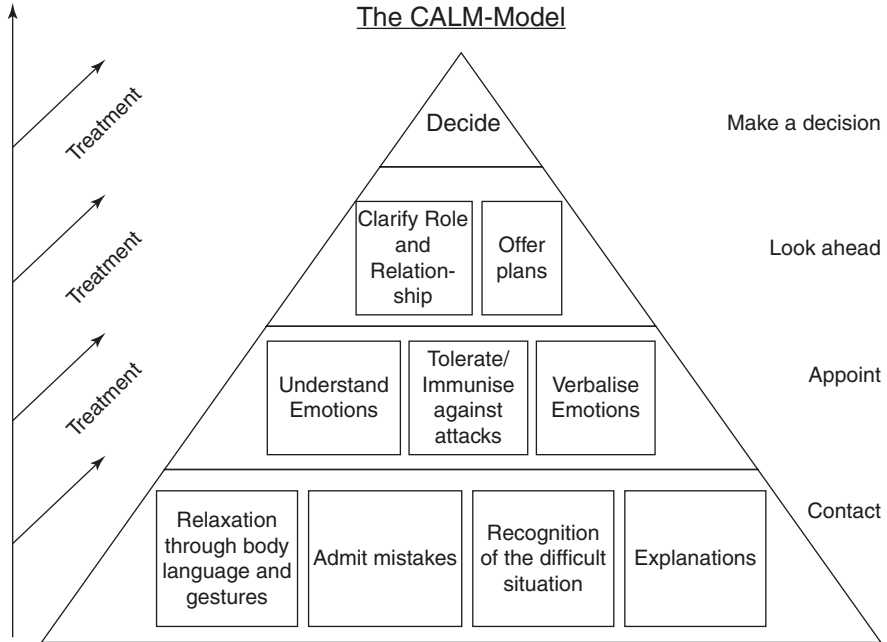


Fig. 5.2 The CALM model

immediately entered at level 3 or 4. Here it is up to the doctor to weigh up the situation. The first two levels can only be achieved if the patient’s behavior respects certain limits of the doctor.

Stage 1: Contact

The purpose of Stage 1 is to maintain contact with the patient in spite of his/her aggressive or degrading behavior. In doing so, it is essential to keep the aggressions at bay and to remain calm and objective. Initial aggression should be allowed to surge and ebb away like a wave, and it should under no circumstances be suppressed. It may be helpful to accept the fact that the patient is in a difficult situation or else he/she would not behave in such an inappropriate way. They may launch bitter accusations at you, but the initial focus should be on the patient’s situation, and no excuses should be made. The body language is particularly important to allow the aggression to surge. A relaxed posture and facial expressions, possibly even friendly body contact, can relax the situation. Afterwards possible mistakes can be admitted. It should be emphasized that the patient’s concerns are understood and will be considered. The interrelationships that led to the unpleasant situation for the patient should be explained as far as possible.

These procedures are usually sufficient to appease the situation. Should this not be the case, follow up with Stage 2.

Case Study**“Contact”****Patient**

That really is the limit. I have a serious heart condition and drove 200 km to get to this clinic, and then you tell me that everything is in vain? Last time, everything was so urgent, and now we are canceling the appointment just like that? Do you think I drive this far to see just any doctor that is available? Are you even a real doctor?

Doctor (quiet and approachable)

Mr. G., I’m very sorry; I thought you had been informed that Prof. K. is out of town. Let’s have a seat.

Patient (a little calmer)

Hmm (louder again), this hospital is a case of the right hand not knowing what the left hand is doing.

Doctor

Please have a seat; then, I would like to explain everything, as far as I can.

Patient (breathes and then sits down)

But don’t think that this matter can be resolved easily.

Stage 2: *Appoint*

The purpose of the second phase is to name the observed emotion directly. The anger, the frustration, and the disappointment are addressed directly (e.g., “You are angry.”). Often, directly addressing the emotion causes a temporary aggravation of the latter. However, you should be aware of this and “ignore it.” The level of the emotionality will then quickly drop considerably. This is the time to focus on the patient’s self-revelation and to address the emotions responsible for the aggressive behavior. Raw emotions are usually the result of fears or worries. If the latter are addressed, the quality of the discussion can rapidly change. From incomprehensible rage becomes appropriate dismay, and afterwards inadequate demands and fears emerge. In rare cases, patients refuse to cooperate on this level. If this happens, you will have to move to Stage 3 and look for the lowest common denominator to carry on the collaboration.

Case Study**“Appoint”****Patient**

You think you’ll just get away this? You are absolutely wrong. I have many influential friends and contacts with hospital management. I’ll let them know what’s going on here.

Doctor	I understand that you are very outraged.
Patient	Outraged, yes, you can say that. I am outraged, yes.
Doctor	Hmm... (Brief pause).
Patient (a bit calmer)	I have every reason to be. This is about my health, perhaps, even about my life, and I simply expect the best treatment. Do you think I would come here otherwise?
Doctor	There is also a lot of fear. I wonder what should happen next.
Patient (now thoughtfully)	Yes, that's no easy task when it comes to the heart. You see, I have confidence in Prof. K. because I know I am in good hands.
Doctor	That is what this is about, that you feel safe with her.
Patient	Yes, at least I felt this way. Prior to this incident.
Doctor	Yes, your trust is shattered for now.

Stage 3: Look Ahead

The next stage is designed to emphasize the professional relationship between the clinician and the patient. The relationship has a goal and this should be considered again. This stage is about clarifying how the collaboration should proceed. The key in this phase is to make the patient aware of the common goal and to make him/her an offer that will be upheld, irrespective of his/her frustration. The limits are specified and the rules of the encounter established making a collaboration possible. It is essential that this is done without resentment.

Case Study "Look Ahead"

Doctor	I realize how angry you still are. To me, the question arises, how do we proceed from here.
Patient	Proceeding. Proceeding, how...?
Doctor (interrupts)	I would like to point out once again that Prof. K. has told me all the findings. I am well prepared for the consultation with you, and I would like to walk you through the findings. At the next appointment with Prof. K., you can discuss the operation before deciding on a treatment option. Thus, your trip would not be in vain, and you could still discuss all relevant steps with Prof. K. I would be glad if this approach could resolve this issue at least to a small extent.

Stage 4: Make a Decision

During this phase, the patient will be presented with a “contract” he/she may or may not sign. Consequently, the patient is put in charge of his/her further treatment, and he/she will have to make his/her own decision. Reaching this stage means that the escalation has progressed to an advanced stage. It is not easy for the patient to realize and accept that the physician is not going to go into the content of the accusations or demands, but expects a decision. Therefore, it may be helpful to offer the patient time for reflection, by taking a walk or by sleeping over the decision.

Case Study

“Decision-Making”

Doctor Mr. G., I think any further discussion won’t lead us anywhere. I would like to offer you to discuss the findings with you, but you must decide whether you would like this or not.

Patient What do you mean by deciding? How should I decide? I don’t even know you.

Doctor I think I’ve told you all I can say. If you need some more time, you may take a seat in the waiting room or take a walk. When you come back, I’ll see you as quickly as possible.

Patient Okay, a walk might be a good idea, but you better not make me wait for long.

Doctor Please see the receptionist; I’ll let them know to notify me immediately.

Attitude

It requires some practice to adopt a different attitude and – as described above – not to oppose aggression, but to let it expire. The best way to do this is to consciously try to pay attention to the patient’s self-revelation. There is a reason for aggression and this is usually understandable. Counterattack or justification then quickly becomes understanding.

Pitfalls

- The doctor fails to distance himself/herself from his/her own troubles. While being superficially friendly, a hidden sharp tongue is apparent in his/her comments. This is enough to complicate the interview even more. It is therefore important that one’s anger is actually overcome.
- The switch to level 3 is too fast without having recognized or resolved the issues of the emotional level sufficiently. This increases the likelihood of discontinuation of treatment on the part of the patient.

Cultural Aspects

The manner in which patients present their symptoms initially depends largely on their cultural background and the associated patterns and norms as to how to talk about diseases and mental health issues in general. In many cultures, emotional issues and personal feelings are considered a personal matter. Talking about them is equivalent to publicly exposing oneself. Even family conflicts are widely regarded as internal matters which are not communicated externally. To ask for sexual habits and difficulties presents a particularly large hurdle for doctors. In Asian countries, the anatomical terms “penis” and “vagina” are largely avoided and replaced with coded phrases. Even the sexual act is described with different expressions and disguises depending on the culture. Male impotency is a taboo for most lower educated patients. Patients tend to avoid addressing the problem directly. In these cases, doctors have to be very skilled to address such culturally delicate matters.

Other taboos include death and dying. For example, in Micronesia asking about the reason for the death of parents involves the fear of punishment. It is also important not to discuss mistakes and omissions of the parents in front of children, because this could hurt the image of parents as authority figures.

Also, questions about the financial situation, costs of certain purchases, or even age can hurt the image of the person being questioned.

Latin America

A survey and ethnographic study on doctor-patient interactions, developed by the University of Sao Paulo Medical School, evidenced that doctors still rely mostly on oral orientations (only the prescription of medicine is written), regardless if it relates to a first visit of the patient or not. The study identified two main modes of doctor-patient interactions; in one mode, doctors spend some of the time talking about trivial matters with the patient within a frame of the doctor’s friendly attitude, which in the survey has also shown a high score of satisfaction by the patient. In the other mode, doctors adopt more objective procedures of interaction with exclusive concentration on physical examinations and history, strictly focused on the problem presented by the patient; this mode has also evidenced high satisfaction by patients. As regards to the communication skills used by the doctors, the study observed that doctors have been careful in making themselves understood to the patient, using an adequate language in the explanation of more specific medical issues such as exams’ interpretations, also making use of colloquial language with less educated patients. As for the time spent with the patient, it is as low as 4 min with each patient (Kiyohara et al. 2001).

The cultural trend of lack of assertiveness in general habitual everyday communication tends to make doctors take a more paternalistic attitude by adopting smaller steps in the communication of certain illnesses; depending on the case, the doctor even opts to talk to the nearest relative(s) or guardian first. It even creates certain *tabus* mostly in the more primitive cultures, which can be traced back to the original native inhabitants’ beliefs that certain illnesses have a kind of “sacred aura” that

must be preserved and/or taken into account; thus, at times, instead of saying the name of the illness, there is abundant use of paraphrasing. Studies have evidenced the relevance of the bond established between doctor and patient and relatives for the effectiveness of doctors' work; for this empathy demands are crucial, for which some themes related to doctor-patient relationship were pointed out as follows: use of adequate communicating skills, establishment of adequate bond between the doctor and patient, adequate therapeutic approach, family inclusion in the interaction, consideration to the suffering status, and the differences in communication abilities (Silva et al. 2011).

Iran

At the moment there is no certain curricular course for doctor-patient communication for medical students and residents in Iran. There are only some continuing medical education (CME) programs and some topics on communication and clinical reasoning. Using proper didactic tools such as live interview, role plays, and case discussion are not common in clinical education. In recent years, many studies have been done in this field in Iran, and almost all the physicians saw the need and realized its influence on patients' satisfaction, adherence, and effectiveness (see Yazdi et al. 2008; Zamani et al. 2004). On the other hand, patients currently are more sensitive to communicative aspects of care and want to have more participation in decision-making (Asghari et al. 2008). In parallel to these positive changes toward development of communicative rationality in the health system, utilizing electronic health records (EHRs) made some barriers between family physicians and patients (Ajami and Bagheri 2013; Ayatollahi et al. 2014). We should possibly think about new communication skills by including the computer as an independent character in our practice scene. According to these trends in the clinical discourse in Iran, it seems that realizing the inclusion of communication skills not only as a curricular course but also as a part of clinical training in all settings is not so far away.

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Chapter 6

Family-Oriented Primary Care



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Case Study

Family A

Mrs. A., 33 years old, married to Mr. A., 36 years old, is a mother of a daughter (age 9) and a son (age 11). She is diagnosed with Hodgkin's disease, stage CS IV. At the beginning of the illness, the family stuck together closely: The husband canceled all leisure activities, was very committed to the children, and visited his wife regularly during her hospital stays. Complementary relationship patterns were evident: When Mrs. A. showed signs of weakness, her husband demonstrated strength by assuming the role of a primary caregiver and filling in. The children also responded to the mother with a noticeable upbeat attitude, providing her with cheerful children's drawings. Conflicts were played down, and harmony and stability were stressed. Ten months after the initial diagnosis of cancer, the family dynamic changed: The 11-year-old son was becoming increasingly aggressive and experienced a drop in school performance. The doctor invited the family to a family interview.

(to be continued)

Definition

“We define family as any group of people related either biologically, emotionally, or legally, i.e., the group of people that the patient defines as significant for his/her well-being. The family-oriented practitioner gathers information about the family relationships, health and illness across generations, emotional connections with deceased and geographically removed members, and significant life events, in order to understand the patient within his/her larger context. In other words, the family-oriented clinician mobilizes the patient's natural support system to enhance health and well-being” (McDaniel et al. 2005, p. 2).

Relevance

Family-orientated primary care and psychosomatic medicine have many similarities in their approaches and methods. Both treat patients while considering biological, psychological, social, cultural, and spiritual aspects. Both have community-based and family-based approaches. Furthermore, when we look at their history, they both have a backbone on system theory.

Relatives of a patient will significantly influence the health and illness behavior of the patient and his/her interaction with the doctor and the health care system. Therefore, the family perspective is an important aspect in the context of a biopsychosocial understanding of disease.

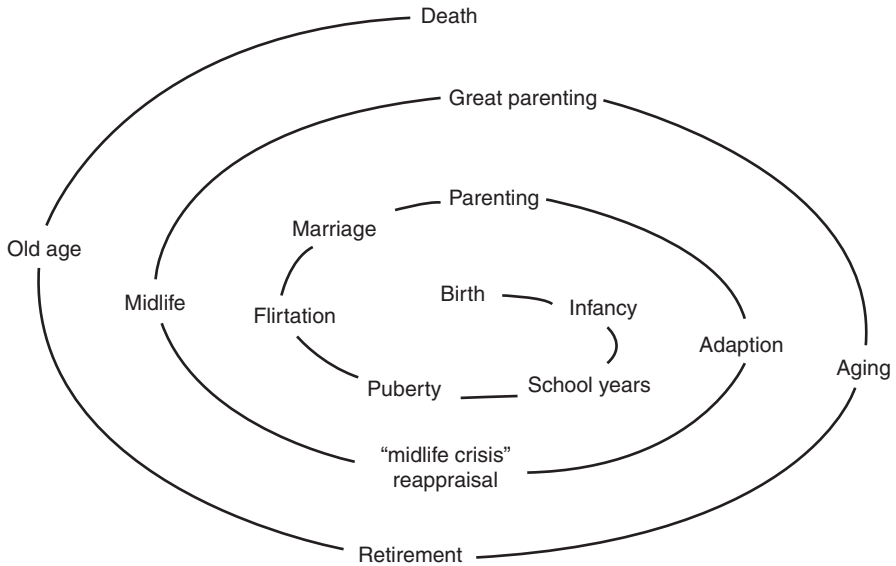


Fig. 6.1 The concept of the life cycle

Theoretical Background

The concept of the life cycle (Carter and McGoldrick 1989) assumes that families throughout their lives go through different phases such as pairing, parenting, aging, etc. (Fig. 6.1). Each of these phases represents a potential threat to the existing organizational structure of the family. New members join through birth, adoption, friendships, or marriages, while others leave the family through separation, divorce, or death. The stages that families pass through are not arbitrary, but can be divided into phases. Each phase has its characteristic problems.

A successful completion of the phases is vital for growth and development in families. The phases that families go through can be divided into stages, having characteristic manifestations with signature issues. The ability to manage such issues depends largely on how successfully previous issues have been managed by the family. Sometimes, when a family has a hard time adapting to changing conditions, a family member develops symptoms and seeks medical attention. It is always helpful to consider the developmental stage of the family at the time of the occurrence of disease in a family member.

The Young Couple

The relationship of a young couple, which is in the process of replacing the family of origin and building a new family system, is often threatened if one partner becomes seriously ill. The affected person can fall back into the dependence and

intimacy of his/her family of origin, who may take care of upcoming decisions without including the new partner adequately.

Families with Adolescent Children

The main task of this phase of development is the gradual but definite separation of the children who turn more and more to their peer group and are looking for their own identity and their own life goals. In such a situation, a serious illness of a family member can easily lead to termination or suspension of the separation dynamics. Regression trends and dependency-autonomy conflicts can result. Individuation efforts are often associated with guilt (the separation guilt).

At Old Age

In the later phase of aging, the spirit of partnership among parents and interaction with their adult children depends largely on how the phase of adolescence and its troubles have been managed. Being separate with a simultaneous feeling of togetherness is very important for this phase of older adulthood. Grandchildren later often take on the function of bringing the generations closer together again. In working with seriously ill elderly patients, the relationship with their grandchildren is often seen as one of the key coping resources, closely linked to the feeling of “still being needed.”

Family as a Resource and Support System

Family-based interventions, such as a change in eating habits or the reduction of cardiopulmonary risk factors, are more successful and cost-effective than programs that focus only on the individual patient. Spouses or significant others have greater influence on health-related habits than any other person, including the attending doctor. In particular, children with diabetes and asthma benefit from therapeutic family interventions (Campbell and Patterson 1995) regarding blood sugar levels, lower seizure frequency, medication reduction, and sick days.

In case of severe disease, the partner and family can play a positive supporting role through the following:

- Experience of being accepted and loved by others despite the disease.
- Experience of being useful and helpful within the partnership or family despite the serious illness.
- New common ground through dialogue and joint activities.

- New emotional closeness.
- Allowing feelings of grief and love.

Family as a Burdened System

The transition from an acute to a chronic disease with the need to care for chronically ill patients both at home and in the hospital places increasing stress on families. Mental diseases as well as severe physical diseases of the parent influence the relationship between parent and child in many ways and can result in lasting damages in the psychosocial development of a child. Particularly in cancer and neurological diseases of a parent, maladaptive coping patterns can be found in up to 50% of the children. In case of a disease, the following stressors can occur in families and partnerships:

- A shift of balance between give and take, and change of the distribution of tasks within the partnership.
- Unresolved conflicts come to light, that can no longer be avoided or suppressed under the burden of the physical disease.
- Feelings of alienation through physical and mental overload of both partners, and behavioral and personality changes in the patient.
- Increased helplessness, aggression, feelings of disgust, and associated guilt in the patient and/or caregiver.

In collaboration with patients and their families within the health care system, we consider families both as a support system and an important resource in managing disease, and as a system burdened by diseases.

The Family Dialogue in the Medical Context: Useful Strategies

In the medical context, McDaniel et al. (2005) suggest the therapeutic strategies listed below for couple or family dialogues.

Disease: An Explanation of the Diagnosis, Treatment, Disease Progression, and Prognosis

The disease and its impact on the family members (rather than the family conflict as in psychotherapeutic interviews) are at the center of the family interview. The physician may begin with an explanation of the disease, its prognosis, and the probable

impact of the disease on the family as a whole. Then psychological and social interactions are related to the medical problems. The therapeutical focus lies in supporting the coping competences and resources within the family.

Inquiring About Medical History

If, as part of a family dialogue, we—the doctors—listen to the medical history of the patient and understand it, we enter the world of the patient and his/her family. Like the autobiographical narrative, the family narrative, as a collection of stories about family experiences in coping with life events and life crises, is a reality construct that shapes the reactions of families to threatening diseases over generations. In addition to the content of these stories, this approach builds trust for joint work with the family. Important questions in a family dialogue include:

- How does the family cope with and overcomes life events and life crises?
- Are there typical patterns within the family on how to deal with illness?
- Is there support across generations in dealing with the illness of a family member?
- Which constructions of reality in terms of etiology, course, and management of disease and successful healing strategies are included in these stories?

Focus on Concerns of the Family

When dealing with a family coping with the stress of a serious illness, it is important not to criticize from the beginning or disqualify their coping mechanisms, even when they appear rather dysfunctional from an outsider's perspective. Instead, acknowledge their attempts to cope with the current situation and the effort of the individuals to support the functioning of the whole family. This approach serves to reduce blame and guilt and causes an immediate emotional relief. It often happens, for example, that some family members put their own life tasks completely on the back burner and put themselves entirely at the service of the sick family member. Others distance themselves and are therefore often condemned as ungrateful and tend to be expelled within the family itself. From a systemic perspective, it may be possible to describe both aspects as important tasks within the family system during the crisis.

Promotion of an Open Communication Between the Parties

Give the family time to process information about the prognosis, the disease progression, and the treatment plan. Offer the opportunity to continue the dialogue, and encourage them to ask critical questions and express any concerns.

It is particularly important to acknowledge that the current issue concerns all family members and to help them to express any possible feelings of dismay. These emotional reactions often induce fears in family members: losing their role within the family, appearing psychologically disturbed, and becoming socially excluded. The shame of not being able to communicate their emotional reaction to others is usually noticeable and leads to thoughts and feelings being held back from both the treating physicians and the own family. Emotional reactions often result in strong uncertainty and helplessness among family members. This is where therapeutic support can help. First, it can help to talk about the process of the emotional reaction. Second, the psychotherapeutic support can convey the significance of the emotional reaction to successful coping. Third, this conversation can help to reinterpret the emotional instability of the patient or other family members as a positive coping aspect. The acceptance and handling of, directly or indirectly expressed feelings, ultimately helps the affected individuals to return from their individual reality to the social reality of the family or the environment.

Dealing with directly or indirectly expressed feelings helps the concerned persons. Confrontational statements should be avoided. The focus is on emphasizing and affirming the strengths and special characteristics of a family.

The Doctor as the Moderator

If the doctor understands his/her role in the family interview as a discussion moderator, without giving advice, an open exchange within the family can be facilitated. The family will feel able to support their loved one's course of therapy in a positive way.

Phases of the Family Dialogue

Phase 1: Joining

Joining means to connect with each family member and to show that each person's opinion is valid and important in this setting. The dialogue starts after the doctor has greeted each family member (even the younger children) with a handshake, asked for their names, and perhaps the age of each of the children.

Case Study (continued)

Joining 1

Doctor "Hello. Thank you all for coming today. I have seen you, Mrs. A., now several times and we have talked about your illness. I thought it might be helpful to talk to you and your family about your situation and see how the disease has impacted all of you. Together we can talk about how all of you can support your mother and each other in this situation."

(to be continued)

As a next step, explain the focus of the conversation and how long it will last.

Case Study (continued)

Joining 2

Doctor “I have known you, Mrs. A., and you, Mr. A., for many years. However, I just barely know your children. Who would like to introduce your family a bit more in detail? Please give me your childrens names and ages again? Maybe each of you can say a few words, about the person sitting next to you.”

(to be continued)

If children are involved in the conversation, the doctor should briefly establish personal contact with them as well. This is important in order to set a sign of equality of all family members from the very beginning. This way smaller children in particular do not get bored and distracted right away. It is also important to have a small play corner in the room or to alternatively ask the parents to bring a toy or painting materials so that the children can keep themselves busy during the conversation. If you directly address the children with questions, you should ask the parents for permission to talk to their children first. Furthermore, you should and grant them a “veto right” in dealing with difficult topics. In family conversations it is easy to touch on topics that the parents do not want to discuss in the presence of their children.

Phase 2: Context and Mission Clarification

Institutional context:

- Especially in the hospital setting, it is important that the doctor who is responsible for the diagnostic and therapeutic process is directly involved in the joint dialogue with the patient’s family. Otherwise there is a high risk of being confronted with varying professional perspectives on the disease and its consequences, which can be confusing and an additional burden to the patient and his/her family.
- Clarification of the suggested treatment plan of the interviewing doctor as well as different health professionals who take care of the family. It should be clarified which other doctors, psychotherapists, and health professionals are involved in the health care of the whole family, and how these other professionals assess the current situation of the family.
- Expectations of the family toward the interviewing doctor.

Case Study (continued)

Context and mission clarification

- “Anna, what needs to be discussed today, for you to feel it was worth while to come here?”
- “For whom was it the most difficult to come here?”
- “Who in the family was most looking forward to, or skeptical of, the idea of a joint family interview?”
- “Paul, how did your father convince all of you to come here today?”

(to be continued)

The questions are intended to encourage direct communication within the family. The initiated family interactions offer the opportunity to closely observe how the family members communicate with each other, who supports or criticizes whom, how is the family hierarchy presented, and who plays which role in the family. It is important that everyone has the opportunity to express his/her needs and expectations as well as fears and worries.

Phase 3: Questions About Family Dynamics and Psychological Resources and Threats – Various Views on the Disease and Its Impacts

Disease

- What has changed within the family since the onset of the illness?
- What has the family tried already in order to help the patient?
- What has helped the most?
- What does the family know about the diagnosis?
- What is your understanding of the therapeutic intervention and the side effects?
- What is your belief about the prognosis?

Threat to Family Relationships and Future Plans

- How are roles, relationships, and communication patterns defined within the family?
- How are decisions made within the family, currently and before the disease?
- What are the objectives and plans of the family, and how does the disease affect them?
- How does each family member view the changes that were triggered by the disease?

Available Resources

- What financial resources are available, for example, if one income is lost?
- What are the resources within the social network of the family: extended family, friends, support groups, etc.?

Previous Experience with Similar Situations

- What are the coping strategies used by the family in previous times of crises?
- What is the family's medical history and the associated experiences in dealing with past illnesses?

Phase 4: Treatment Planning

By joining, continuous assessment of the health problems and the associated relationship realities, an idea about possible change is shaped.

Case Study (continued)

Treatment planning

Doctor “What would be a good final result of our family discussion?
Do you have specific ideas about what could be changed, and how
it could be accomplished, so that all of you feel better?”
(to be continued)

Phase 5: The Conclusion of the Interview

Family therapists take a break of approx. 10 minutes after approx. 60–90 minutes of family interview. During this time they can process the received information, test their own hypotheses, reflect on the impartiality, and develop a final commentary. The therapist can structure the interview by holding the silence during a break in the conversation, summarizing the talking points so far and making agreements on the further course of treatment.

The final intervention consists of several elements:

Positive assessment: Each person will be acknowledged in a positive and appreciative way in relation to the family and to the presented problem and the functioning of the family as a whole. Problematic behaviors should be described in terms of understandable but suboptimal attempts to cope with the situation. The goal is the loosening of rigid behavioral patterns and one-sided views.

Homework: In the final phase, the meeting and the main conclusions are summarized. The family's positive resources and strengths are emphasized. Unresolved issues and topics are named. Specific tasks are distributed among the family members.

Case Study (continued)

Homework

Doctor “At the moment I am under the impression that the illness is permanently looming in your living room—is there a way you could send it for a walk for a few hours?”

The end of the dialogue also includes support and advice, such as:

- Information about local support groups for patients and their families.
- Information on how other families have mastered a serious illness.

During a family interview, the basic attitude is impartiality. The doctor is guided by the assumption that, in principle, there is a range of individually experienced realities in any family. In the course of dialogue, each subjectively perceived reality must be respected, and the doctor should be wary of one-sided assessments and one-sided partisanship.

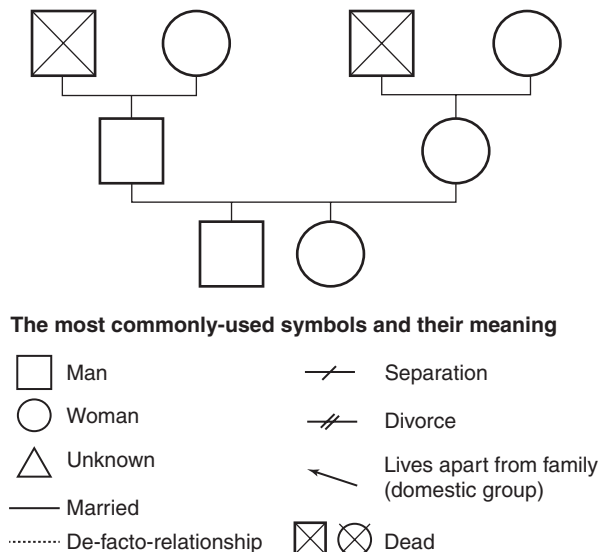
Practical Implementation

The Genogram

The routine use of disease-related genograms proved to be a simple and straightforward technique in the context of family diagnostic and the formation of hypotheses. Genograms are graphic representations of a family constellation spanning across multiple generations. It helps visualize biographical information such as the birth order, deaths, diseases, symptoms, and life events within a family. They are assessed as part of a medical history interview with individuals or families (Fig. 6.2).

The genogram can be introduced by the doctor in the following way: “We have talked in detail about your problem. Now I would like to get an overview of the diseases that have occurred in your family. As you tell me about it, I will take notes so I can remember all the information at a later point.” By constructing a

Fig. 6.2 Genogram



family genogram, there will be numerous opportunities to enter into an in-depth discussion with the patient.

Practical Tip

Questions for the genogram

- Which diseases run in your family?
- What “counts” as a disease?
- Who is affected by these diseases?
- Who takes care of the sick?
- What does the caregiver get in return for helping?
- How did your family deal with illness and death?
- What was the cause of death?
- Which coping strategies does your family use for illness, or grieving?

The creation of the genogram takes place in three steps:

1. All members of a family and their relationships to each other are recorded. It starts with the core family. Then, the extended family is added. Overall, if possible, at least three generations should be included.
2. In the second step, information about the family history is added: age, marriage, divorce, miscarriages, death, and serious diseases as well as critical family events.
3. Finally, the quality of relationships among family members may be particularly highlighted.

Techniques for the Family Interview

A structured interview can be very helpful to the family dealing well with the problematic situation. Different questioning techniques are useful to keep a balance between spontaneous statements of the family and a structured approach. Asking questions not only serves the gathering of information, it also shows new ways of thinking and perspectives within the family.

Direct Disease-Related Questions

Direct questions relate to facts, causes, and ways of behavior and experience that are easily accessible to the individual. Some examples include:

- “When did the first symptoms appear?”
- “Who noticed these symptoms first?”
- “How did your relatives react to your illness?”
- “Who are you talking to about your symptoms? With whom do you rather not about your illness?”

Indirect or Circular Questions

By questioning family members in a circular manner about their own take on the disease and its impacts, interesting information can be obtained. For example, the doctor asks, “Anna, what do you think your father thinks about the disease of your mother?”

Through circular questions, caregivers, but also family members, learn about the different perspectives of each person in a playful way. The questions invite the family members to enter into the mindset of others and to consciously talk about the relationships within the family. Circular questions foster understanding for others’ thoughts and views and realizing the mechanisms of the own family dynamics. So, in addition to their diagnostic value, circular questions can help people to see things differently, reveal unspoken differences in opinion, and take the first steps in resolving conflicts.

Hypothetical Questions

Hypothetical questions are also helpful. They allow the interviewer to introduce new options, try out new narratives, and therefore counteract the fear of change. The new paths playfully addressed in the questions do not have to be realistic in any way, not even feasible, but nevertheless they indirectly strengthen the self-efficacy of the individual family members.

Some examples of hypothetical questions include:

- “Suppose the migraine attacks of your wife would occur much less frequently, what would your wife and your family gain, what would this mean for your relationship in everyday life?”
- “Suppose one of your children would choose to move back home to take care of you. Who would be most likely to do that?”
- “Suppose we met again in 5 years, what do you think, will your parents still be together? What will have changed? What will remain the same? Will Eva choose to stay with her boyfriend? Will Richard still live at home?”

Solution-Oriented Questions

- “How often (how long, when) did the symptoms not occur?”
- “What did you and others do differently during those times?”

Pitfalls

- Confrontational statements usually lead to distrust and withdrawal of the family. Instead, the focus should be on the strengths and special characteristics of the family.

- In the medical context, one should speak of family interview and not of family therapy, since the latter is often misunderstood by family members in the sense of “Oh, now, not only our daughter, but we as a whole family are sick or possibly to blame for her illness!” Such attitudes encourage families to defend themselves strongly against offers of conversation.
- Insufficiently structured interviewing: couples or families reveal communication patterns that have formed in everyday life of the relationship. If the doctor does not structure the dialogue quickly and sets some ground rules for successful communication, there is the risk of old patterns reoccurring, coalitions forming, and individual family members “checking out” mentally from the conversation.

Cultural Aspects

While in Western cultures family members are usually only included in medical cases of children and elderly patients, the involvement of family is a given in many other cultures.

Asia

The Chinese culture is a “high-context culture,” where family members are highly dependent on each other and pay very much attention to taking care of each other. Familism embodies this culture and individualism is a rarely used word in China. A family is viewed as a small state and the state is viewed as a large family. Therefore, interpersonal relations can be reduced to the following basic rules from Confucianism:

- The monarch rules his minister.
- The father rules his sons.

Accordingly, the ruling and ruled people should follow five basic virtues:

- Humanity
- Responsibility
- Courtesy
- Wisdom
- Trustfulness

Confucianism requests a person to control himself/herself and to obey social norms, to respect and take care of other peoples’ interests at any time, to develop and maintain interpersonal relationships with a modest and polite attitude, and to improve himself/herself through continuous practice. Familism is closely bound with moralism.

Outstanding Issues in Modern Chinese Families

Changes of family structure resulted in the nuclear family becoming the main family pattern. Extended family structures have lost their social support functions.

Women have equal legal and economic status in the family. But some families (especially husbands and their mothers) have difficulties adapting to these developments to new gender roles. Traditional values contradict the contemporary social reality, so that the so-called generational gap is very common within families. Anxiety about the uncertain future and fear of unsuccessful parenting makes the parent-child relationship much closer, which impacts the individuation process. A lot of children have to be brought up by their grandparents or institutions instead of their parents. This is a very important factor that influences psychological and behavioral disorders of adolescents, marriage crises, and sexual problems. Stressful lifestyles and dysfunctional coping styles are harmful for the family life. Major burdens are financial problems, finding a job, purchasing apartments, childcare, and managing the childrens' education. There is little time for family life and face-to-face communication.

Examples of Culture-Related Family Problems

Cultural Differences Between Generations

The parents are still stuck with traditional views and behaviors and have difficulties to adapt to the fast-paced changes in consumption and lifestyles in the context of globalization. The younger generation quickly adopts to new lifestyles and values, with a tendency to ignore old viewpoints, or even to despise them. Parents are confused and helpless, do not know how they should behave, and perceive a threat to their parental dominance and disciplinary power.

The Roles of the Daughter-in-Law in Asian Families

In the traditional Hindu family, the focus is the mother-son relationship. The daughter-in-law has a subordinate position within the family. As a result, the daughter-in-law is often abused and punished, both physically and mentally, by the family members of the husband, especially, if she violates the rules of conduct with respect to the mother-in-law.

Violence Against Parents in Japan and China

Often boys are brought up by their mother, while the father is absent due to his work or because he is perceived as weak and vulnerable. Violence against the mother or both parents is understood as an attempt to gain distance, mainly from the mother. As part of the one-child policy, this behavior is observed more and more frequently in China. As a small child, many boys are spoiled by their parents and grandparents, and as a teenager they react with violence if their wants and needs are not met immediately.

Africa

In traditional African societies, extended families and associated social support that comes with it are positive and protective factors against stressful life events. The sense of belonging to the community, the perceived connection to other members of the community, ancestors, and the land, as well as the collective response to suffering, all somehow lift the burden of stressful live events from the individual. With globalization, the communal living seems to be disintegrating, especially in urban areas.

Latin America: The Young Patients

For young patients the doctor-patient relationship is mediated by the nearest relative. Nonetheless, a survey study carried out in the pediatric unit demonstrated that there is a lack of satisfactory communicative relationship between the parents, the patient and the doctor. The study found that there is a need for training to improve doctors' communicational skills as a tool for more ethical behavior (Garrafa and Albuquerque 2001).

Iran

Family physician programs (FPP) had been initiated in 2005 as one of the main policies of the Ministry of Health and Medical Education and are continued up until now. The programs were focused on rural areas and small towns ($\leq 20,000$). But in 2011, Fars and Mazandaran provinces were selected to be the pioneers for implementing FPP at the whole service levels of the province. From 2015 onwards, all medical universities have been asked to launch the integrated health system (SIB) which is applied by family physicians.

Family physicians (FP) should have the necessary skills in screening, diagnosis, treatment, referral, and communication and the ability to analyze biological, psychological, and social aspects of the patients and their families.

Over time, various training programs have been launched to train skillful FPs in Iran. At the moment, there are continuous medical education, modular, and residency programs (Ferdosi et al. 2018).

There is still a great need to improve family physicians' competencies in doctor-patient communication, psychosocial interventions, and family-based management. Fortunately, after a 3-year research and training program which was funded by DAAD (German Academic Exchange Service) and the international congress on family-oriented primary care in 2017, in Isfahan, some educational research training, residencies, and teacher training programs were carried out. Currently, a national program on psychosomatic basic care is being designed by Psychosomatic Research Center of Isfahan University of Medical Sciences and Danesh-e Tandorosti Institute in cooperation with the Department of Psychosomatic Medicine and Psychotherapy, Albert-Ludwigs-University Freiburg.

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Chapter 7

Balint Group



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Frank Kuan-Yu Chen, Jing Wei, and Farzad Goli**

Case Study 1

In the group, a doctor reports that she had been annoyed lately about a patient suffering from diabetes mellitus, who treated her increasingly arrogantly. When entering the doctor's office, the patient already welcomes her with condescension: "Well, how are you today, doctor? Today **you** don't look good." Now, she gets annoyed by just seeing the patient. (to be continued)

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Definition

Balint groups are case studies with particular emphasis on the doctor–patient relationship. A doctor presents case of a patient who is on his/her mind for various reasons. The group reflects on the doctor–patient relationship from various angles. This method allows the doctor to obtain new insight into the patient’s problem through the eyes of others and uncovers interfering unconscious influences as well as his/her own contribution to the problem. This creates a new understanding and a new level of relationship. These new perspectives lead doctors to a better understanding of themselves and the patient and provide the impulse for a more satisfactory course of treatment.

At the centre of medicine there is always a human relationship between a patient and a doctor. (Balint 2000)

What Is a Balint Group?

- Its primary task is to promote further understanding of the relationship between doctors and patients.
- The method is an exploration of the relationship between a particular clinician and a particular patient.
- A Balint group presents the opportunity for an in-depth exploration of a puzzling clinical case.
- It allows for professionals from different backgrounds to get to know and understand each other and their work.

Relevance

A good doctor–patient relationship is the most important factor for a successful and satisfactory treatment. For successful diagnosis and treatment, the doctor has to observe the behavior of the patient exactly but also explore his/her own thoughts, feelings, and behavioral impulses.

Doctors are important attachment figures for the patient, to whom positive and negative thoughts, feelings, hopes, and desires are transferred. The doctor must be aware of this, without interpreting the patient’s thoughts and feelings right away. The patient’s behavior and feelings influence the doctor’s thoughts, feelings, and actions and may, in extreme cases, confuse him/her and make him/her unable to act. The doctor, too, has his/her history of emotional development with strengths and weaknesses, which he/she must recognize.

Positive effects of Balint group include an improvement in the capacity to empathize (Cataldo et al. 2005); a change in conversational behavior, combined with a willingness to listen more when talking to patients; an improvement in psychosomatic skills and self-confidence; fewer brooding thoughts about patients; greater work satisfaction; indications of an improved doctor–patient relationship; as well as a significant reduction of burnout parameters (Benson and Magraith 2005; Rabin et al. 2009; Bar-Sela et al. 2012).

A qualitative study on general practitioners showed that Balint work can improve the doctor–patient relationship, and the doctor’s psychological health (Taghavi et al. 2017).

Theory

Historical Background

Michael Balint was born in 1896 in Budapest as the son of a general practitioner (GP). After studying medicine, he trained as a psychoanalyst. Very early on, he became interested in psychosomatic diseases and focused on the importance of an adequate psychological understanding of these diseases within the medical profession. He wanted to raise awareness in GPs that mental processes also play a key role in disease symptoms. His focus laid on the close observation of the doctor–patient relationship and the desired effects and side effects thereof. In his collaboration with GPs, he wanted to empower them to consciously create relationships with their patients and to use these as a healing method. His best-known book is *The Doctor, His Patient and the Illness*, published in 1957 (Balint 2000).

Basic Principles of Balint Work

1. Most mental processes are unconscious, at first not accessible, but influenceable.
2. It is not a question of what is right or wrong, not of either/or, but of both/and. Contradictory thoughts and ideas can be expressed and it is important to endure these ambivalent feelings.
3. It is not crucial to know everything about the patient. It is what has been forgotten and omitted in the narrative that often has a crucial meaning. Childhood experiences are important. They shape our relationships as adults.
4. Doctors are important reference persons for the patient, to whom positive and negative thoughts, feelings, hopes, and desires are transferred. The doctor should be aware of this.
5. The behavior and feelings of the patient influence the thoughts, feelings, and actions of the doctor and in extreme cases can confuse him/her and make him/her unable to act. Also the doctor has his/her own history of emotional development with strengths and weaknesses, which he should know.
6. Just as words have multiple meanings, so can the patient’s descriptions and symptoms of illness be understood on multiple levels that are not mutually exclusive.
7. The success of a Balint group depends on the sincerity, respect, and mutual support of the members of the group. The content of the Balint group work is confidential. The longer a Balint group lasts (months, years), the stronger the group cohesion and trust in each other becomes.

What Do Doctors Learn in the Balint Group Work?

Case Study 2

The doctor introduces a case from his practice to the group. He talks about a young female patient with severe anorexia nervosa, who drives him to despair and devalues any treatment suggestion. After the group discussed various aspects of the patient's behavior, and also made proposals for treatment, the presenting doctor was included in the discussion again. He then says that all the ideas and propositions were of no use to him. He was convinced that the group discussion did not help him at all. He did not feel understood at all.

These were exactly the words he introduced the patient with initially. Now, he could sense how the patient must feel about her illness and the various treatment attempts. He felt her hopelessness, her insecurity, and her desperation. After taking on the perspective of the patient, he was able to express his wishes to the group and to better accept the proposals of the group.

A parallel process between the presented doctor-patient relationship and the relationship between the presenting doctor and the Balint group took place. The Balint group work made it possible for the doctor to better empathize with the patient as a person with all the accompanying feelings. By experiencing the patient's perspective, the doctor could better understand the patient and the interaction between him and her. The concept of Balint group is specifically targeted at raising awareness on this countertransference phenomenon, the patient initiates in the doctor. The feelings of countertransference are usually also made visible by the group. Feelings of countertransference can be used professionally as valuable information on diagnostic perception and understanding of the patient. This may develop into further therapeutic interventions.

Countertransference

In psychoanalysis, *countertransference* is defined as a form of *transference* that occurs as a result of the influence of the patient on the doctor's thoughts and feelings. Countertransference is present when the doctor directs his/her own feelings, prejudices, expectations, and desires onto the patient. The therapist leaves his/her neutral position. For this reason, in the early days of psychoanalysis, countertransference was considered a disruptive influence the therapist must become aware of and resolve. Modern psychoanalysis sees the feelings of the therapist toward the patient as a "sounding board," by which he/she can gain information about the patient and his/her interpersonal relationship patterns.

Objectives of the Balint Group

- Openness for both interview content and one's own reactions, in the form of feelings, fantasies, and bodily sensations evoked by the interview (e.g. nervousness or sleepiness)

- Practicing listening and patience
- More sensitivity for recognizing emotional disorders or psychosomatic problems
- Loosing the own anxiety in dealing with patients' emotional and social problems
- Reaching a better understanding of the interactions between doctors and patients
- Implementing this understanding in diagnostics and therapy
- Altered attitude and altered behavior of the doctor toward his/her patients
- Better understanding of unconscious processes
- Emotional relief and prevention of burnout
- Recognition of doctor's own feelings toward seemingly "problematic" patients (countertransference)
- The doctor develops a more analytical way of thinking
- The doctor is more aware of his/her personal influence on the patient

Environment and the Course of a Balint Group

A Balint group is made up of 8–12 participants. The group leader is a psychoanalytic psychotherapist, is familiar with group processes and has experience in the management of Balint groups. The group meets on a regular basis (weekly, fortnightly, monthly or even once a year). A session lasts approximately one and a half hours.

The presenting doctor describes a doctor–patient relationship from his/her memory, without using any notes. An impression of the speaker, the patient, and their relationship to each other arises. The other participants then talk about their impressions, their feelings, and their thoughts about what they have heard. This discussion results in a complex picture of the doctor–patient relationship that the speaker can observe quietly from a distance, without intervening in the group discussion. Ideally, he/she gets a new point of view on the problem; blind spots are illuminated. The clinician recognizes his/her effect on the patient and his/her own behavioral patterns. Balint group work enables the doctor to gain self-awareness, but the doctor also learns to not only think about the patients disease, but to keep the patient's entire personality in mind. The treatment then proceeds in a more relaxed atmosphere. The patient and the doctor might become more comfortable with each other.

Procedure of a Balint Group

1. Group leader calls for a case
2. Presenting doctor describes his/her case (without notes)
3. Group has time to ask clarifying questions
4. Now the presenting doctor has time to listen and reflect while the group starts working on the case (the group talks about what might lay underneath the behavior of the patient and how the doctor and the patient might feel and what thoughts they might have)
5. The group leader closes the discussion
6. In the end the presenting doctor gets the chance to comment or ask the group questions
7. Then the group leader summarizes the discussion and marks the end of the session

Tasks of the Group Leader

The group leader's task is to make these ask questions which reveal the thoughts and feelings underlying the presented doctor-patient relationship. The group leader might ask some of the following questions to the group:

- What do you think the patient was feeling at that moment?
- What kind of a person is the patient?
- What do you know about his/her life situation, his/her current family, and his/her family of origin?
- What feelings does this patient elicit in you?
- How does the patient shape his/her doctor to his/her needs and vice versa?
- Is there an underlying "disrupted fit" between the patient and his/her environment and how is this reflected the doctor-patient interaction?
- How do you think the patient sees his/her doctor and what does he/she think of him/her?
- Why did the doctor behave as he/she did in this situation and what did he/she want to achieve with this behavior?
- Is there something the patient is missing in the doctor and perhaps in his/her life as well?

Practice

Tasks of the presenting doctor

- Listen to the group discussion about my presented case, and pay attention to my thoughts, feelings, body perceptions, and fantasies.
- You may feel angry, misunderstood, frustrated and want to say something. Or you feel relieved that you were able to pass this case on to the group, and you are glad that the group is taking so much time for discussing your case.
- You might also develop very intense feelings about how your colleagues deal with your case: in addition to relief, curiosity, worry, anger, fear, despair, and confusion.

Case Study 1, Continued

The group will discuss the annoyance of the fellow doctor about the patient suffering from diabetes mellitus. Is the patient's condescending behavior an unconscious attempt of not having to respond to unpleasant topics? Encouraged by the free discussion in the group the doctor shared her fantasies about the patient: She experienced him like a struggling elderly gentleman. This was, however, quite contrary to the lively and cheerful entrance of the patient into the treatment room.

At the next visit, the doctor was brave enough to show the patient the contradiction: “Amazingly, Mr. Miller, you come in here appearing quite cheerful but at the same time I have in my head the picture of an elderly man struggling to cope with every day tasks.” The patient then got a very wry face and said, “Have we ever talked about my wife, how she constantly tantalizes me with her cleanliness compulsion, and how she is trying to make me part of her cleaning mania?” He also said that he often eats sweets out of frustration, and he was embarrassed to talk about it with the doctor.

At the next meeting with the patient there was a much better atmosphere between doctor and patient.

Family Sculpture in the Balint Group Work

Family Sculpture is a method in couples and family therapy. A family system or work team (e.g., hospital team) are represented by a sculpture consisting of people who are placed in the room. A sculpture of a system enables access to tensions, conflicts, and positive and negative relationships within the system. After presenting a case, the presenting doctor first selects persons from the group as representatives of the most important persons involved in the presented case such as the patient, the patient’s mother, partner, father, child(ren), mother- or father-in-law, boss or colleague, and so on. The symptom/s or the disease can also be represented by a group member. Then the doctor positions the representatives in the room. He/she plays the role of the doctor (respectively him/herself).

The Balint group leader supports this process by asking the positioned participants, “Whom do you see? How do you feel standing there?”. The trainer can intensify the process with further questions about physical and emotional perceptions, by requesting the person to make a typical gesture or to summarize his/her feelings in this role in a sentence. After the presenter has arranged the representatives of his/her case, he/she only acts as an observer. The amazing thing about this method is that from being positioned in the room in a certain way, the positioned representatives can relate to and better comprehend the feelings and relationships of the family (or team members) involved. The goal is to recognize conflicts between the family members (or team members) and find new solutions for them. In the end the trainer encourages all representatives to find a new order in which every person is comfortable in their position.

The family sculpture may be included into the Balint group work as another way to help the group to visualize the family dynamics and facilitate a new perspective on the doctor’s relationship with the patient, as well as the environment of both, the doctor and the patient. The impact of the family, the staff, and the environment plays a crucial role in the relationship and communication between the patient and the doctor and thus in the diagnosis and the treatment or therapy. The environment may be the family and significant relationships of the patient, the patient’s and the doctor’s lifestyle and financial circumstances, and the clinical context of the conversation.

Like Balint group work, sculpting can foster empathy as well as flexibility and plurality of perspectives in the therapist.

Change in the Doctor's Attitude

During continuous Balint group work the participating doctors undergo a change in attitude towards their patients' psychological problems as well as a better understanding of their own psyche. The change in attitude takes place in the context of a longer-term learning process. Although the Balint group is not primarily a therapy group, the Balint group participants also gain considerable knowledge about themselves through their emotional involvement: "Why do I react in this way in this situation? What does this behavior remind me of in relation to previous life events? Why do I always talk about similar patients?". The change of attitude leads to a different way of handling challenging doctor-patient interactions. Over time, the doctor gets to know many difficult doctor-patient constellations and increasingly gains experience and confidence in dealing even with very difficult patients.

Cultural Aspects

Asia

Some of the publishers of this book (Michael Wirsching and Kurt Fritzsche) have started to introduce Balint work in China, Vietnam, Laos, and other countries and have adapted the classical Balint group work into the Asian setting (also see Chap. 20). For the Balint group participants, the introduction of family sculpture as a modifying element of the Balint work enabled a symbolic way of working with thoughts and feelings. Using sculptures led to dissolution of the rigid structures. Introduction of family sculpture into the Balint group work arose from previous experiences in Vietnam and Laos. In these two countries, more than in China, it is not customary to directly talk about personal feelings. This was repeatedly confirmed in the first discussions of Balint group work between participants and their trainers. The participants would feel overtaxed or intruded upon by the instruction to freely express their thoughts, fantasies, and feelings. The situation appeared completely different when sculpting was introduced. The participants became completely absorbed in their roles, spoke of their fears, their anger, and their sadness. Hidden conflicts became emotionally palpable; ideas for possible solutions arose.

Latin America

Balint groups are becoming more and more part of doctors' training programs in Latin America. This is noticeable due to the increase of research on this field and from the amount of advertisement for Balint group training courses offered within and outside the university realms (Missenard et al. 1994).

Balint group is also used for professional development of health care professionals. Balint group work might be considered a beginning of establishing the “*espaço para a palavra*” (space for the word), even in cases where working conditions are not in favor of this possibility (Brandt 2009). The “*espaço de palavra*” (space of the word) creates an adequate group atmosphere and the possibility of the doctor to acquire a differentiated professional status with more respect, more adequate autonomous creativity, and more assertive decision-making capability. The professionals who attended Balint group work showed more autonomy within and outside the working context, with an added quality of a humanistic approach whenever occupying leadership positions. Moreover, Balint group work has shown to be efficient, whenever used in neutral environment without the influence of the working organization, for the development of empathy; thus, promoting prevalence of humanistic ethics. Brandt’s findings evidenced that it is possible to reeducate leaders so as to turn them into democratic humanists to become healthy models of identification as outcome of Balint group work.

Iran

Balint groups in Iran started arising in 2009 in Danesh-e Tandorosty Institute and Psychosomatic Research Center of Isfahan University of Medical Sciences in one of the courses of “Globalization and Health” – an interdisciplinary cooperation project between Germany and Iran. This program included Training of Trainers (TOT) of psychosomatic basic care and postdoctoral and family physician Ph.D. programs. At the moment, there are also Balint programs in Razi Society and Rouzbeh Hospital.

Studies on effectiveness of Balint work on job satisfaction among nurses (Marofi et al. 2017) and on general practitioners (Taghavi et al. 2017) have been conducted. Also an experimental Balint group was performed with a focus on relationship between clinical teachers and medical students (Yazdankhahfard et al. 2018).

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Part III
Recognition and Treatment of Most
Common Clinical Presentations

Chapter 8

Depressive Disorders



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Case Study

Mr. Miller, a 30-year-old law student, visits his general practitioner (GP) because of tinnitus. He complains about chronic fatigue and vertigo for some time. He is complaining about difficulties to concentrate when studying for his final exam. He can only focus for a short amount of time, and then his mind wanders off. He feels like he is not able to finish any single thought, as his mind runs in circles. Mr. Miller also feels restless and cannot sit still. He hardly goes out anymore, is not meeting up with any of his friends lately, is afraid of them asking whether he is making progress with studying, and feels ashamed and is mad at himself. Everything seems to be hopeless to him.

Mr. Miller grew up in a very strict and achievement-oriented home. When he was 14 years old, his father lost his job, a shock his father never overcame. His father started drinking and withdrew more and more from his family and friends. One year later, Mr. Miller found his father dangling from the roof beam where he had committed suicide. Mr. Miller will not talk about this incident, even though he apparently has nightmares about this. In secret, he is reproaching his mother for not being present and caring enough for his father; to him, his father might still be alive if there had been more empathy. (to be continued)

Theory

Definition

As apparent from the case study, depressive symptoms are expressed at various levels (Table 8.1).

Relevance

Depression is the most frequent of all mental disorders. Over time, every sixth person suffers from depression, the risk is twice as high for women compared to men. Depression can negatively affect the treatment success of physical illnesses or can even be the cause for somatization. Despite their high relevance, depressions are scarcely recognized by GPs or consulting physicians. Nearly half of all depressive disorders remain undetected. This is particularly dramatic because of the high risk for suicide.

Symptoms

Some of the symptoms are depicted in Figs. 8.1 and 8.2.

Table 8.1 Depressive symptoms at four levels

Behavior	Feelings	Body	Thoughts
Powerless and bent posture; slow movements; sad facial expression; face sometimes like a mask/stone-faced; speech: soft, slow, and monotonous; reduced activity with limited radius of movement	Dependent; sad; hopeless; helpless; alone and anxious; hostile mood toward others; inner restlessness; feelings of isolation; feelings of guilt	Physical weakness; apathy; loss of appetite; sleeping problems; reactions to weather changes; increased sensitivity to pain; loss of libido; multiple vegetative complaints such as pressure in the head; gastric complaints and impaired digestion	Determined by a negative attitude toward self and the future; pessimism; permanent self-criticism; lack of self-confidence; concentration problems; impaired memory; anticipation of catastrophes; thoughts of hopelessness and purposelessness of own life; suicidal thoughts; expectation of punishment; delusions such as impending poverty; and compulsive high level of expectations on self

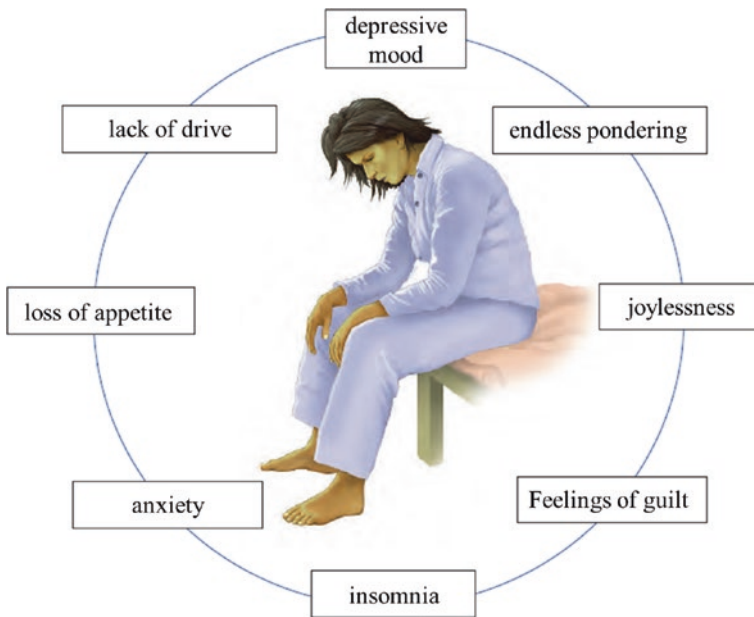


Fig. 8.1 Main and secondary symptoms of depression

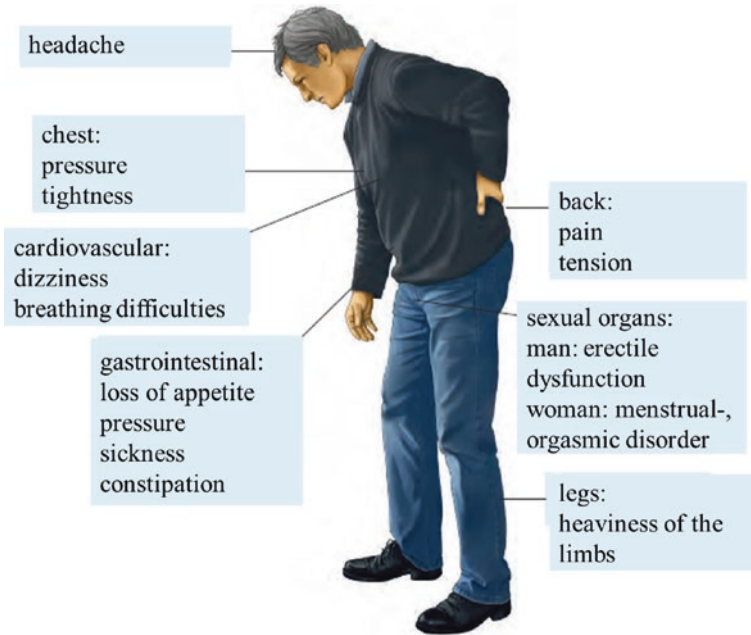


Fig. 8.2 Physical symptoms of depression

Main Symptoms

- Depressive mood
- Lack of interest and/or joylessness, even in situations that are usually perceived as being pleasant
- Apathy, easily exhausted

Secondary Symptoms

- Reduced concentration and attention span
- Reduced self-esteem and self-confidence
- Feelings of guilt and worthlessness
- Negative and pessimistic perspective on the future
- Suicidal thoughts/actions which imply suicidality
- Insomnia
- Reduced/increased appetite

The inclusion criteria for the diagnosis of a depressive episode are met when several of the abovementioned symptoms are present for at least 2 weeks.

Diagnostic Categories

In the international classification systems, depressive disorders are described within the diagnostic category of “affective disorders.”

The most frequent affective disorders are depressive episodes (ICD-10: F32, F33) and dysthymia (ICD-10: F34.1). Manic episodes (ICD-10: F30) and bipolar affective disorders (ICD-10: F31) are described in textbooks on psychiatry.

Depressive Episodes (ICD-10: F32; See Table 8.2)

We can differentiate three degrees of severity: mild, moderate, and serious depressive episodes:

- *Mild*: Two main symptoms and two secondary symptoms (F32.0).
- *Moderate*: Two main symptoms and 3–4 secondary symptoms (F32.1).
- *Serious*: Three main symptoms and ≥ 4 secondary symptoms (F32.2).

The presence of other emotional disorders (i.e., addiction, anxiety disorders, and eating disorders) is a risk factor for chronic depressions and suicidal tendencies.

Table 8.2 Checklist depressive episode (ICD-10 F)

<i>Guiding symptoms</i>	
Depressive mood	<input type="checkbox"/>
Loss of interest and/or pleasure	<input type="checkbox"/>
Decrease of motivation/strong signs of fatigue	<input type="checkbox"/>
<i>Additional symptoms</i>	
Impaired concentration and attention	<input type="checkbox"/>
Impaired self-esteem and self-confidence	<input type="checkbox"/>
Feelings of guilt/worthlessness	<input type="checkbox"/>
Negative and pessimistic future perspectives	<input type="checkbox"/>
Suicidal thoughts and actions which imply suicidality	<input type="checkbox"/>
Insomnia (early wakening)	<input type="checkbox"/>
Decreased/increased appetite and/or weight, decreased libido	<input type="checkbox"/>
<i>Psychotic symptoms</i>	
Delusions (catastrophes, fear of impoverishment)	<input type="checkbox"/>
Hallucinations (accusing/defaming voices)	<input type="checkbox"/>
Psychomotor impairment—stupor	<input type="checkbox"/>

A depressive episode should be diagnosed if a minimum of two of the main symptoms and two additional symptoms are identified and if symptoms persisted for ≥ 2 weeks.

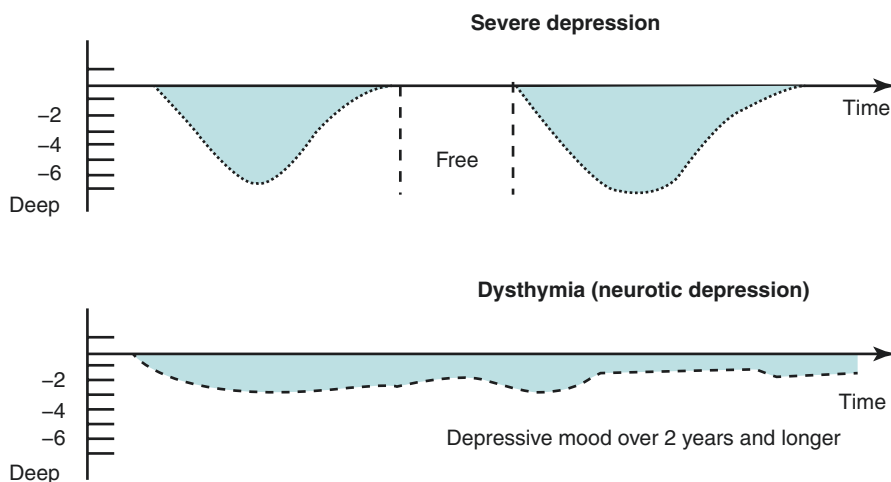


Fig. 8.3 Comparison between severe depression (a) and dysthymia (b) over time

Dysthymia (ICD-10: F 34.1)

This disorder was formerly called neurotic depression. The characteristics are:

- Long-lasting depressive mood which is expressed in a way that the criteria for a depressive episode are not met (Fig. 8.3b)
- Onset in early adulthood. Duration of several years, sometimes lifelong

Typical symptoms: fatigue, insomnia, being easily exhausted, pondering, complaining, and feeling of inadequacy.

Differential Diagnosis

Adjustment Disorders

Depressive symptoms also are found as a reaction to severe psychosocial stress or certain life events, e.g., diagnosis of a life-threatening illness. A difference is made between short *depressive reactions*, which do not last longer than 1 month, and longer depressive reactions, which do not last longer than 2 years (ICD-10: F 43).

Depression/Grief

Sadness or grief is a normal feeling like rage, joy, or fear and belongs to the basic human emotions. The capacity for sadness is biologically designed. Feelings of sadness are usually transient. Sadness or grief is often the result of the loss of a

significant other. Feelings of self-doubt, hopelessness, and helplessness, that are associated with depression, can also occur in grief. As part of grieving, these feelings usually do not have the same intensity, and the loss of self-esteem is usually not as drastic. In contrary to a depression, sadness can often be interrupted by positive feelings and activities. Grief is transient with a hopeful perspective on the future and the capacity to seek help and support from others. Grieving takes time. In a normal grief reaction, the feeling of self-esteem is hardly restricted, and there is no suicidal tendency. Depression can be the result of an unsuccessful, suppressed process of grieving.

Burnout Syndrome

Burnout is a creeping process that develops from work overload or prolonged exhaustion to psychological and physical health consequences (see Fig. 8.4).

Table 8.3 shows how burnout syndrome differs from a depressive disorder.

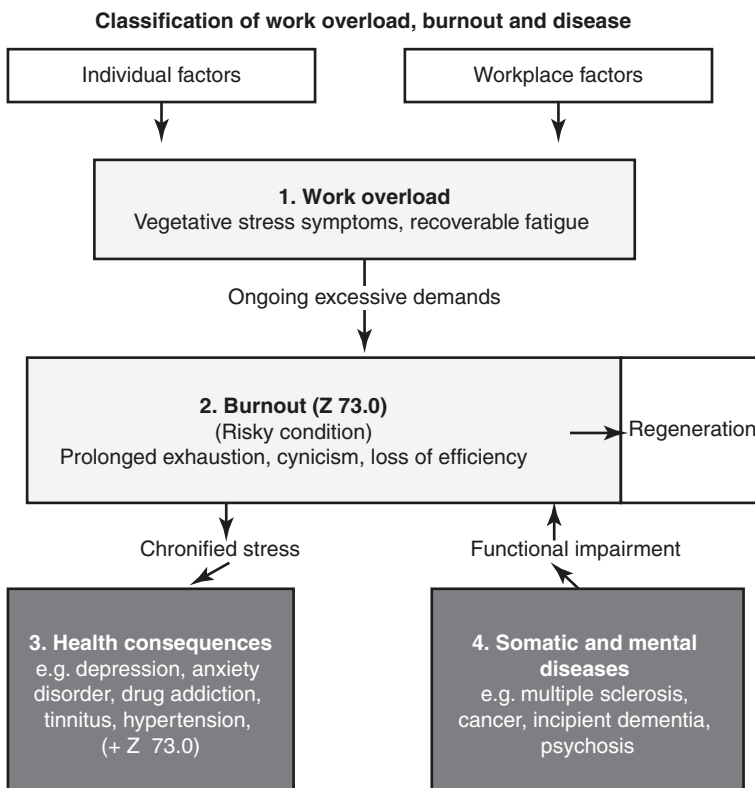


Fig. 8.4 How work overload turns into a disease. (A concept from Berger et al. (2012))

Table 8.3 Differentiation between burnout and depression

Burnout syndrome	Emotional exhaustion	Depression
Work-related mental and emotional exhaustion		Multifactorial genesis
Achievements ↓		Motivation ↓/easily exhausted
Mental distancing/cynicism		Depressive mood
Insomnia		Early awakening in the morning
Gain a sense of status		Loss of status
Maintain self-esteem		Self-esteem ↓
Risk factors		Risk factors
Workload ↑		Genetics, female, single
Imbalance of efforts and rewards		Negative life events
Sence of control at work ↓		Lack of social support
Role conflict		Socioeconomic status ↓

Frequency and Course

According to an European study (Wittchen et al. 2011), affective disorders have a 12-month prevalence of 7.8%. Major depression is the most common affective disorder—6.9% of the European population is diagnosed with major depression every year. 0.9% of affective disorders in Europe fall into the category of bipolar disorder. Severe physical diseases double the risk of developing a depression. Depression varies greatly from person to person. In about half to two thirds of patients, the condition improves in the course of treatment to such an extent that they regain their former quality of life and personality traits. Some complaints may persist. Studies have shown that approximately half of all patients who suffer from depression for the first time experienced another depressive episode within the following years. The probability for another depressive episode after the second episode was 70%, and the probability after the third episode was 90%. The difference between a recurrent depressive disorder and dysthymia is shown in figure 8.3.

Depression has a high rate of comorbid mental disorders (75–90%), especially anxiety disorders, compulsions, post-traumatic stress disorders, eating disorders, substance abuse/dependency, sleep disorders, somatoform disorders, schizophrenic disorders, brain organic disorders, dementia, and personality disorders. The presence of other mental disorders is a risk factor for chronic depression and suicidal tendencies.

Case Study

A 37-year-old doctor, Mrs. W., introduces herself as outpatient in the psychosomatic department through the mediation of her family doctor.

She has had nausea and abdominal pain for 3 weeks. A gastroscopy had resulted only in a slight antrum gastritis. For 2 weeks, she has also felt an abysmal sadness and loneliness. She does not know what is wrong with herself. In addition, there are fears of failure in her profession as an anesthesiologist, problems falling asleep and sleeping through, early waking, and, at

times, tachycardia. She no longer had any appetite and had withdrawn from her colleagues. She could not explain all this to herself; she did not know what was wrong with herself.

She had set herself so many goals, moving from a small town to a big city, the new job, opportunities for career advancement, and a desire for a new partnership after several disappointments in the past.

None of this had been achieved by her. She was disappointed about herself. Others would say that she should reduce her expectations. But she couldn't. She often wakes up early in the morning and then all these thoughts come: "How can I do all this? I no longer function properly. My body no longer reacts adequately. If I had a stomach ulcer, I could understand the nausea and abdominal pain. Something is wrong with me."

Biopsychosocial Model of the Onset of Depressions

According to the biopsychosocial model, several factors are involved in the onset and manifestation of depression (Fig. 8.5), whereby their severity differs depending on the individual.

Genetic Disposition

Depression often occurs in families. If both parents suffer from depressions, the risk of the illness is approximately 50% in the children.

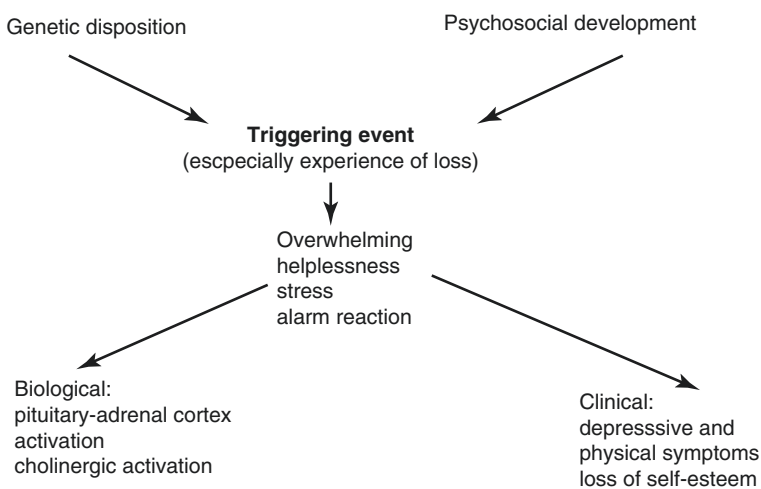


Fig. 8.5 The biopsychosocial model of depression

Neurochemical and Neuroendocrinological Correlating Distress Reaction

The *serotonin theory* assumes that a low serotonin level strongly affects the neural activities of other neurochemical systems and leads to mania or depression. The antidepressive effect of tricyclic and tetracyclic antidepressant drugs and Monoamine Oxidase Inhibitors (MAOI) is attributed to an increase in the availability of serotonin and noradrenalin in the synaptic cleft.

Depression is a potent stressor. It leads to an activation of the hypothalamus-pituitary-adrenal cortex axis with a subsequent excessive *cortisol production*.

Cognitions

Cognitions are all mental processes associated with perception, imagination, memory, learning, thinking, and judgment. Cognitions may elicit feelings and moods. Depressive patients have a pessimistic view of themselves, the world, and the future (*negative triad*). Because of negative life experiences, they have acquired negative convictions and action patterns (schemata), which lead to cognitive distortions in stressful situations, for example, arbitrary conclusions and selective perception.

The *concept of learned helplessness* is cited as an example. In their biographies, there are repeated uncontrollable traumatic events that these patients had to passively accept, with no possibility of developing avoidance and coping reactions. The learned helplessness leads to the expectation that subsequent negative experiences cannot be controlled either. One effect is that the actual given possibilities of influence are not used and that the response is depressive withdrawal. In addition, the patient always looks to himself for the reason of failure.

Psychosocial Stress

Before the first occurrence of a depression, there are usually typical stressful situations: interpersonal conflicts, loss of prestige or insults, threatened or finally accomplished separations, or death of a significant other.

A common characteristic of these events is the *threat* or the *loss of interpersonal bonds*. People who experienced separation more often or a serious endangerment of their predominant protective relationships in the first years of life show a long-lasting sensitization of their biological stress response to conflicts, separations, or losses in adulthood. These people also show an elevated risk for depression. Critical psychosocial stress leads to a greater and longer-lasting alarming of their stress system and also epigenetic changes in the methylation and acetylation processes of DNA (see section “[Psyche and Genes](#)”).

Psychodynamics

Because of the fear of more separations and losses, these people have developed a *high degree of responsibility and sense of duty*, and they expect great things from themselves to satisfy others. So they hope to be needed by others and to offset their love deficit. At the same time, this behavior serves to maintain their self-esteem. The basic conflict is a lifelong longing for unconditional love that has been frustrated since early childhood. These secret desires for recognition and love, however, are not shown or rather shown as reproach towards others and accordingly are not fulfilled. Their own needs, annoyance, rage, and disappointment are initially repulsed and then directed at themselves in self-blame, self-accusation, and attempted suicide.

Communicative Function: The Vicious Circle Model

Besides the appeal for help, depressed people display, the illness also has the evolutionary meaning and purpose of forcing the patient to withdraw from his/her everyday life. Thus this gives him/her the opportunity to say goodbye to conditions and constellations that have been overtaxing and unpleasant for him/her so far and possibly to dare a new beginning.

Case Study, Continued

Psychosocial Anamnesis

The patient was often ill during her school days. When the patient was 5 years old, the mother fell in love with another man and divorced the patient's father. She had a good relationship with her stepfather nevertheless.

The change from school to university was difficult for her. At school there had been personal relationships with the teachers, and she had always been among the five best. The anonymity of the university was a problem for her. The partnerships were unsatisfactory. There had been a lot of fighting and she had suffered a lot.

In the course of her professional activities, she often felt overburdened and overwhelmed by the fates of her patients. Sleep disorders and digestive problems as well as fears had already occurred at that time. She eventually had to give up her actual career aspirations to be an internist with a focus on cardiology due to chronic overstraining. After then completing her further training in anesthesia, she initially worked in a small hospital.

The move to a big city led to tensions between her and her boyfriend at the time and eventually to separation. She tried to balance the associated feelings of failure, worthlessness, and disappointment through increased commitment to her medical work. In the end, however, she was no longer able to disengage from the burdens of the patients and the demands of the head of department. She felt exploited.

Besides anxiety disorders, depression is the most common psychological disorder in the population and in general practitioners. According to the WHO, depression is expected to be the second most common condition after cardiovascular disease in 2020.

The *depressive episode* is mostly phased.

The *dysthymia* is chronic, but it is milder.

More than half of all depressions remain undetected and untreated. Approximately 50% are recognized, and approx. 30% are treated, of which approx. 6% are hospitalized.

The depressive patient is caught in a vicious circle during the depressive episodes (Fig. 8.6). The loss of interest and joylessness as a result of the depression leads to withdrawal and passivity. Friends are neglected; favored hobbies are not appealing anymore. Usually, it is still possible to fulfill duties such as going to work or taking care of children, but all these tasks are performed carelessly and with little engagement. This passivity amplifies the existing feelings of guilt and inferiority; the depressive person observes his/her own behavior but cannot change it. He/she is condemning him/herself for what he/she is doing or rather not doing. The crestfallen mood and hopelessness are thereby increased. The patient might resignedly react to impulses and suggestions from his/her environment, friends, and supporters in an inner dialogue: "You are right, but I'm not worth it that you are spending your time with me, it is hopeless, and I'm not able to do anything reasonable anyway."

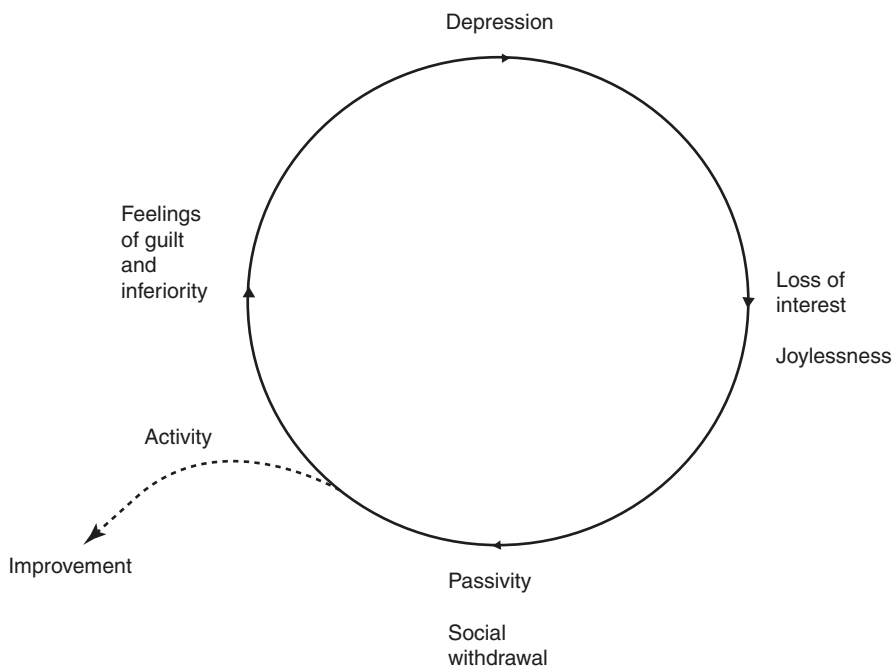


Fig. 8.6 Vicious circle model of depression

Practice

Recognition

Most depressive patients can be identified with two questions. However, there are some patients in which depression is hidden behind physical symptoms.

Practical Tip

Diagnostic Questions for Depression (Arroll et al. 2003):

- “Have you often felt crestfallen, sad, gloomy, or hopeless within the last month?”
- “Have you lost interest and pleasure in things that you normally love to do within the last month?”

The checklist in Table 8.2 sets out the main symptom areas that need to be scanned to detect depression.

Case Study, Continued

“Recognition”

D: “Mr. Miller, you have described a couple of problems to me: chronic fatigue, difficulties to concentrate, and vertigo. I will refer you to an Ear, Nose, and Throat specialist for the tinnitus. These symptoms often are connected to stress though; are you feeling stressed?”

P: “Yes, I’m about to take my exams; at least I’m trying to, but I guess I won’t make it.”

D: “Exams.”

P: “Yes, the state examination, but this is rather difficult; actually, I don’t think I can do it.”

D: “Hmm, you have a lot of stress due to the exam and can’t even imagine anymore that this could work out.”

P: (Looking down) “Exactly.”

D: “What is it like in other areas: friends, hobbies?” (*Diagnostic clarification*)

P: “I’m not doing anything at the moment. If I can, I’m studying, and otherwise, I’m too tired, or I don’t feel like it.”

D: “Thinking of the last month, have you felt crestfallen, sad, gloomy, or hopeless?” (*Screening question 1*)

P: “Yes, sure. Mainly gloomy and hopeless.”

D: “And what about your interest and pleasure in things that you like to do during the last month?” (*Screening question 2*)

P: “I liked to go out with friends in the past, but I think they don’t want to go out with me anymore; I’m just a turnoff.” (to be continued)

If both screening questions are answered in the affirmative, the following questions can be used to distinguish between mild, moderate, and severe depressive episodes:

1. How do you sleep at the moment?
2. Can you currently read a newspaper or a book/watch television?
3. What do you like?
4. What is important to you at the moment?
5. Do you have a tendency to ruminate at the moment?
6. How is your appetite at the moment?
7. Have you noticed any weight changes recently?
8. What is your current sex life like?

The clarification of suicidal tendencies is also an important part of the initial interview. The catalogue of questions by Pöldinger (1982) is a good example (see section “[What to Do in Case of Suicidality?](#)”).

Basic Therapeutic Attitude

Depressive people are so weakened and wounded in their self-respect and self-esteem that they react to any kind of disruption in interpersonal relationships. The physician’s key task is primarily to listen patiently to the patient and accept his/her complaints *without* giving him/her *premature encouragement*. The doctor signals to the depressed patient that he/she is with him/her and that the patient will not be left alone with his/her problems. The patient learns through the behavior of the therapist that the depressive mood is ultimately bearable and surmountable.

The physician must dare to accompany the patient even if this shortly leads to the experience of the depressive person’s entire misery. The paralyzing feeling might be even amplified, and the impulse of wanting to do something might appear. Impatience, admonitions, and shortsighted advice only lead to the patient feeling misunderstood. Thus he/she would be confirmed in his/her depressively distorted view of him/herself and the world. The central problem of the conversation is to keep the balance between accompanying, activating, and informing and not to get involved in a tug-of-war in which the physician is trying to help while the patient is using his/her depression as a defense.

Basic Psychosomatic Intervention

The treatment of depression starts at four points according to the conditions described above:

- The influencing of dysfunctional *patterns of thought and behavior*
- The improvement of *self-esteem*
- The *reduction* of internal and external *demands*

- The creation of a physical balance, e.g., treatment of sleep disorders and sports
- The influence of psychopharmaceuticals on the *neurotransmitter metabolism*

Accompanying-Activating-Informing

How can you approach depressive patients when all well-meaning advice is lost in the whirlpool of hopelessness? Basically, the patient should be *accompanied* at first. The hopelessness is not euphemized but is reflected. So the patient is experiencing something rare: he/she is being taken seriously in an empathic, nonjudgmental conversation, while being signalled, that it is possible to talk about the feelings of heaviness and to bear them—an experience that will make the depressive person feel understood and less lonely. Accompanying a patient usually has an interesting effect: the depressive person will eventually start to reconnect to his/her own resources.

The physician can seize small signals of a minimum of *activity* which need to be acknowledged, supported and emphasized. Another activating conversational method is to strengthen the nondepressive part of the patient's personality. Whenever the patient is talking about his/her former self, this can be emphasized as being the actual personality, but it should always be hereby accepted that this personality is not available at the moment. The possible assumption that the depressive person is 'bad' is overcome by these interventions and the episode character of the disorder is underlined.

If the patient shows to be interested, the physician can start to *give background information* on the illness. It is important to clarify that the symptoms are part of the depressive disorder and that depression can be treated successfully. As depressive patients are usually able to perform tasks that are assigned to them, structuring is helpful. The physician needs to keep in mind that the structure does not include an overstrain, relaxation phases are strictly limited in time, and relaxation is not gained by sleeping but, if possible, by exercise. In discussing the daily routine, the positive activities can be emphasized.

Case Study, Continued

D: "Ok, your friends don't feel like going out with you anymore."
(*Accompanying*)

P: (crestfallen) "Yes, I wouldn't feel like going out with myself either. I'm just spoiling the mood anyway."

D: "Actually nobody can stand you like that." (*Accompanying*).

P: "Yes." (Pause) "Actually, I used to be a pretty entertaining person, but this is all gone."

D: "I understand, you are actually a social person, but you don't recognize this side of yourself anymore right now." (*Seizing on the nondepressive personality*)

P: "Yes, gone, as if it was blown away."

- D: “This side simply disappeared and is gone.” (*Accompanying*)
 P: (Pause) “Do you think I can get it back?” (*Shows activity*)
 D: “When you think about it, the question arises: can I become my old self again?” (*Activating*)
 P: “My old self, I don’t think so, but maybe a little bit of it. You think that will work?”
 D: “Yes, I do. What you are suffering from is a depression; it is an illness which can be treated.” (*Informing*)

Practical Tips for Self-Management

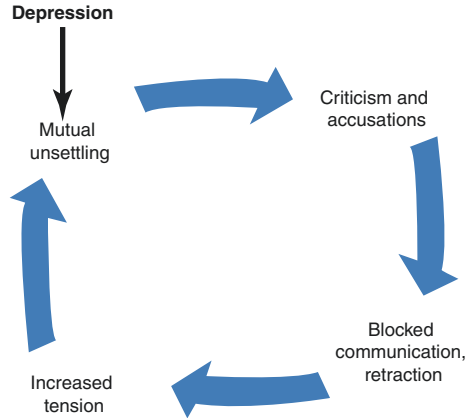
“Green Prescription”

1. Examples of the diverse possibilities that depression can manifest itself include lack of motivation, lack of energy, rapid exhaustion, lack of interest and inability to feel pleasure or joy, guilt, anxiety, feelings of incompetence, lack of appetite, weight loss, insomnia, somatic complaints, and social withdrawal.
2. If you suffer from depression, you are not the only one: About 10% of the population will at some point in their lives go through a major depression.
3. Even if you feel you are losing hope: Depression can be treated successfully with consistent treatment; the chances of healing through a drug treatment and/or cognitive behavioral therapy are good.
4. Avoid prolonged withdrawal with excessive rumination (plan distracting activities), and avoid morning sleep. Try to maintain a regular daily routine.
5. Make sure that you comply with general rules for reducing stress: Stick to sufficient time for relaxation, planning breaks, leisure activities, not too many straining activities at the same time (e.g., moving, changing jobs, etc.), and healthy nutrition (→ doctor).
6. Check whether there were significant changes in your life before you became depressed (professional or private), losses, failure experiences, interpersonal conflicts, excessive demands, relocation, or change of job, and discuss these with your doctor.

Involvement of Family and Close Caregivers

The reactions of family members and close caregivers to a depressed patient can vary: They range from realistic, practical to completely confused, helpless, sometimes even negative action. One of the main problems is that the patient’s pessimistic and negative feelings can be contagious. The patient is often convinced that there is no solution to his/her condition and that the problem will destroy him/her

Fig. 8.7 Vicious circle of depressive communication within the family



and this hopelessness and helplessness can spread to family and friends. Spouses feel hurt by the patient's behavior when they do not react as warmly and empathetically as before. Lack of tenderness and reduced sexual desire lead to frustration in the partnership. Death wishes and suicide threats also frighten relatives (see Fig.8.7).

By informing and supporting the family, the doctor can ensure that the relatives have a deeper understanding of the suffering and are better able to support someone in this difficult phase.

The following measures have proven helpful in working with the family:

1. Inform family members, like patients, about the nature of depression and about treatment options and plans.
2. Relatives should ensure that the patient is taking the medication as prescribed.
3. If there is a risk of suicide, they should keep the patient company and not let them out of their sight.
4. Relatives should help the patient with personal hygiene, take him/her for walks, and keep him/her as busy as possible.
5. If there are changes in the patient's behavior and condition, especially if there are signs of deterioration, the doctor in charge should be informed immediately, even if the patient resists.

Psychotherapy

Psychotherapy is the most important pillar in the treatment of depression, as it can reduce the risk of further depressive phases, especially when depression occurs for the first time (see Fig. 8.8.).

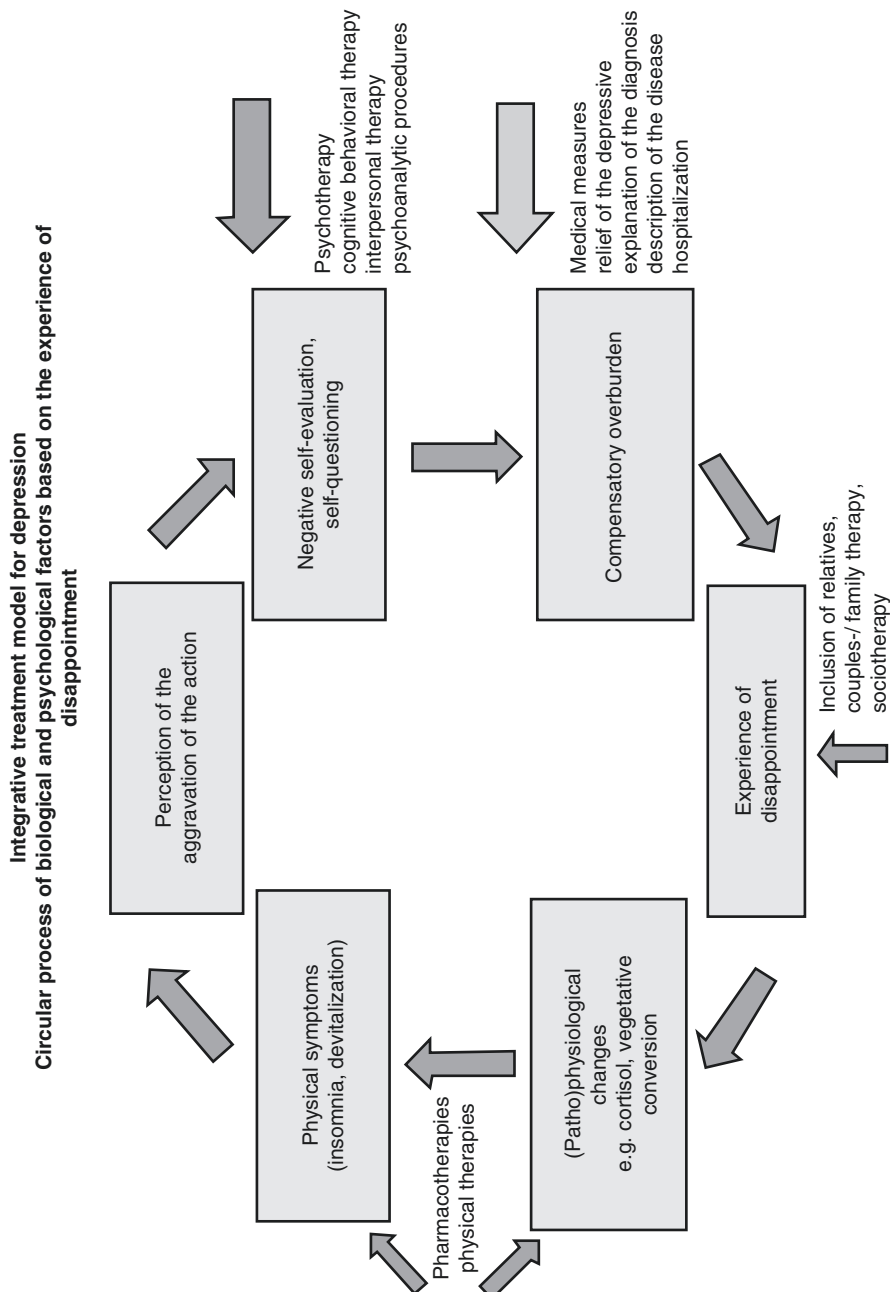


Fig. 8.8 Integrative treatment model for depression

Psychopharmaceutical Treatment

With *mild* depressive episodes (without severe sleep and drive disorders or serious suicidal thoughts), psychotherapy is the treatment of choice after a short wait and see period of spontaneity (maximum 14 days). Exceptions are, for example, explicit patient requests for medication and positive previous experience. The fact is that in the case of mild depression, the placebo effect exceeds the verum effect of an antidepressant medication.

With a *moderate* to severe depressive disorder, psychopharmaceutical treatment may be used as a supplement to psychotherapeutic treatment. However, it has been found that a psychotherapeutic treatment of the initial manifestation reduces the risk of a second depression later, whereas sheer drug treatment of the first depression shows a tendency of an increased risk to suffer another depression later.

In serious cases, treatment with antidepressive psychopharmaceuticals in combination with psychotherapy is indicated. It must be noted that the patient also has to be informed that there is a latency of at least 2 weeks for all antidepressants to show an effect, whereas side effects may occur immediately. Medication should be continued for approximately 6–9 months. In case of recurrent depressions, a long-term prophylaxis is indicated.

The *antidepressants* can be attributed to three groups according to clinical-practical aspects, depending on the active ingredients, and to certain main indications.

- *Energy-increasing* antidepressants such as the selective serotonin reuptake inhibitors (SSRI)
- *Sedating* antidepressants: Mirtazapine, a specific serotonergic antidepressant. *Others* are venlafaxine and duloxetine

The prescription of psychopharmaceuticals requires a trusting doctor-patient relationship, which also serves the purpose of increasing the medication compliance of the patient. Particularly in difficult phases of the treatment, for example, right at the beginning when the desired antidepressive effect is not yet apparent, but side effects occur to impair well-being, it is crucial that the patient feels taken seriously, when he/she, for instance, complains about side effects. The physician also should not take it lightly if the complaints do not match the typical spectrum of side effects.

The efficacy of antidepressive *drug therapy* is particularly well-documented in the acute phase. Psychotherapy is superior to drug treatment in the long term. Antidepressants help in 70–80% of the cases. The average effect latency of 14 days must be considered. Antidepressants have an impact on the central transmitter substances, especially serotonin, noradrenalin, and dopamine.

According to new studies, the narcotic *ketamine* can have an antidepressant effect in patients with severe depression within 24 hours.

<p><i>The doctor should not:</i></p> <ul style="list-style-type: none"> Send a depressive person on a holiday or recreational trip Let a depressive person make important decisions Tell the patient to pull himself together Claim that things will be better (if they're not right) 	<p><i>The doctor should:</i></p> <ul style="list-style-type: none"> Accept the patient and his/her illness Emphasize favorable prognosis of the disease Explain the treatment plan Explain possible side effects of the medicine Prepare for temporary mood swings Set short-term therapy goals for the patient to experience success
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Other Nondrug Therapy Methods

- Sports have a proven antidepressant effect for all degrees of severity, but will not be sufficient as the sole therapy for moderate to severe depressive episodes.
- The sleep restriction therapy can be used because of its rapid, even if only short-lasting effect.
- The indication for light therapy is limited to treating mild to moderate episodes, especially in diseases with a seasonal pattern.
- Electroconvulsive therapy is still considered as last resort.

The Stepped Care Model

Step 1: All known and suspected forms of depression

- Assessment, support, psychoeducation, active monitoring, and referral for further assessment and interventions

Step 2: Mild to moderate depression

- Psychosocial interventions, medication and referral for further assessment and interventions

Step 3: Severe and complex depression

- Combined treatments of high-intensity psychological interventions and medication
- Crisis service
- Inpatient care

What to Do In Case of Suicidality?

Recognition

Suicidality often exists—especially with elderly depressive patients—for months and is considered a taboo to the patient’s social surroundings (“you don’t talk about such things”). While patients mostly will not commit suicide, these thoughts and

wishes are overwhelming and sometimes are experienced as being alien to the patient's personality. Most likely, the patient will be seeking medical help after a suicidal crisis.

Risk Factors for Suicidal Actions

- Patients with chronic progressive painful conditions
- Isolation, confinement, and breaking off contacts
- Recent loss
- Suicidal actions in the past
- Suicide in the family (biological factors and learning history factors, identification)
- Certain emotional disorders (bipolar disorder, melancholic and psychotic depression, schizophrenia)

If a depressive disorder is assumed, the unmentioned symptoms of a depression should also be specifically questioned. Death wishes or suicidal thoughts have to be explicitly questioned.

Typical patient comments are:

- I may as well quit it all.
- There is no point in living anymore anyway!
- I don't know what else to do at home...there is only one thing left to do.
- It would have been better for me to die of this heart attack.

The patient can usually only talk about these shameful thoughts that are a taboo if the physician is indicating that this is a common human subject and that he/she has no issues talking about it at all. It is important to identify suicidality to estimate the suicidal endangerment of a patient. By openly talking about possible suicidal thoughts of a patient, there is a higher chance of preventing suicidal actions.

A limitation of emotions, interpersonal relationships, and his/her scope occurs with a depressive, suicidal person. This limitation is usually noticed by others. Close friends or family members realize a change in behavior; that the person concerned is more and more withdrawn or makes certain insinuations.

Every insinuation has to be taken very seriously. The feeling of endangerment of a patient by him/herself, which the physician experiences during the conversation, has a special character and importance. The opportunity for an open conversation about this difficult and highly ambivalent subject, which is extremely charged with feelings of guilt and shame, is a relief to the patient if this conversation is conducted in an understanding and emphatic way and not like an interrogation. The following question catalogue can serve as an orientation for such an open and impartial conversation.

- Have you recently thought about killing yourself?
- How often?
- Have you had to think about it without wanting to?
- Have suicidal thoughts forced themselves on you?

- Could you ward off these thoughts?
- Do you have concrete ideas or plans about how you would do it?
- Have you made any arrangements?
- Is there something that still makes your life worth living?
- Have you talked to anyone about your intention to commit suicide?
- Have you ever attempted suicide?
- Has anyone in your family or a friend or acquaintance committed suicide?

Doctor-Patient Relationship

The fact that a suicidal person can feel understood is paradoxical, because he/she has just denounced every relationship to others and to him/herself. Thus the taking up of a relationship is already a contradiction to the intention of suicide. Therefore, the therapeutic technique is to hold a person in conversation “before the jump” until the intention to commit suicide slowly fades away.

It is crucial to see the difference between those who want to live and those who want to die. These two sides can be found in every person who is determined to commit suicide—just like in the doctor him/herself. To keep the two sides apart and to take them equally seriously might also be painful to the doctor, but it is part of the empathic, nonjudgmental mindset and a part of life. In the course of the conversation, the doctor can support and underline the life-affirming parts of the patient.

Practical Tips

Ten rules for dealing with the risk of suicide:

1. Anyone talking about suicide must be considered suicidal. Ideas of suicide must never be underestimated.
2. If someone with a face filled with grief and petrified, with a bent posture and slowed psychomotor skills, assures us that he/she is well, we should remember that there might be secret suicidal intentions behind this.
3. If there is depression, don't just rely on your intuition about suicidal tendencies. Ask the patient straight away if he/she has ever thought about taking his/her own life. Such a direct question may make the patient aware of suicidal thoughts much earlier than would otherwise have been the case.
4. An understanding approach to any sign of an aggressive topic is of particular importance. Who offended the patient by what? Whom are the suicidal fantasies directed at? The patient should understand that suicide impulses are usually always directed at someone else.
5. The extent of the suicide risk does not necessarily correlate with the severity of the depression. Patients are particularly at risk when the depressive petrification is relaxed. At this point the drive increases, and only then is there the energy to do something to oneself.

6. You can assure the patient that you know that every depression will subside again. The patients might have strong doubts about this information, but they will absorb it, and it will be important to them that the doctor holds this information and trust in a good outcome.
7. The emotional bond to a reliable person is of decisive importance. This can also be the family doctor. It is essential to find out important persons in the relationship by questioning them. Then ask the patient whether he/she can promise not to hurt him/herself until the next agreed appointment. It will definitely make it easier for the patient if you can assure him/her that he/she can call you around the clock if the thoughts of suicide should increase.
8. If a patient specifies the time and place for his/her planned suicide—i.e., “I will hang myself from a tree on Tuesday”—then he/she should be admitted to a clinic because of the suicidal tendencies. This is a reason for forced admission.
9. In addition, the following applies in principle: If you feel overwhelmed, refer the patient to a psychiatrist or psychotherapist or to the outpatient clinic of a psychiatric clinic.
10. For adolescents with suicidal fantasies: here it is good to know the background of these patients. The most common causes are fights and/or neglect in the family or among peers, insecurity and loneliness in broken home situations, unhappy love, and school and/or exam fears.

The No-Suicide Contract

The medical-therapeutic interview should be completed preferably with a no-suicide contract. A prerequisite for this is that the patient is capable of making arrangements. The doctor can assess this based on the previous conversation:

- How readily does the patient talk about his suicidal intentions and the underlying problems of life?
- Is the doctor able to make an emotional contact with the patient?
- Does the patient have the cognitive ability to reflect on his/her situation?

Practical Tip

Example of wording

D: I would like to ask you to promise, first orally and then in writing, that you will not hurt yourself.

I would like you to say the following sentence aloud while looking into my eyes:

- I declare that I am not going to kill myself neither deliberately nor through negligence, no matter what happens and how I feel. If I have thoughts of death, I will check into the emergency room of the psychiatric clinic. I agree to comply to this agreement until tomorrow morning at 8 o'clock.

After the patient has said these words, the doctor reaffirms the contract with a handshake and clear eye contact. If the patient is reluctant to say these words, speaks indistinctly, is not emotionally involved, and avoids eye contact, the doctor should ask the patient to repeat the sentence with a loud voice and participation from the heart and to look in the eye. If the patient is unable to comply despite verbally assuring otherwise, there is a significant suicidal risk and this is an indication for hospitalization.

As an additional assurance, the doctor can draft a written contract, letting the patient sign it and hand him/her a copy. The wording of the contract depends on the current situation of the patient and should be adapted to the patient's language.

The time frame, in which the no-suicide contract is valid, can be individually negotiated with the patient and can range from several hours to several days. At each meeting in between and before the contract expires, the doctor should assess the acute suicidal tendencies and negotiate a new contract with the patient. The result of the assessment should be written down in the medical records, e.g., "The patient denies any current suicidal intent."

Practical Tips

Example of a written no-suicide contract/commitment-to-treatment contract

- If I am in danger, I will call my doctor/check into the emergency room of the psychiatric clinic.
- I will not kill myself intentionally or by carelessness, no matter what happens.
- I will not kill myself, no matter how I feel.
- I will use every opportunity that will help me in making decisions for continuing with my life.
- If I start to think about death, I will follow the emergency plan.
- I promise to do this until our next meeting.

Emergency Plan

The emergency plan serves the purpose of providing alternatives to suicide in the case of unbearable thoughts of suicide. It can be phrased as follows:

"In case of intolerable inner tensions and suicidal thoughts, I turn to

- My friend Erika
- My family doctor, Dr. Schmidt
- My psychotherapist, Dr. Franz
- To the emergency room of the psychiatric clinic
- To the telephone hot line

"I find relief by telling my dialogue partner that I am in an unbearable state and I am thinking about committing suicide."

The emotional attachment to a reliable person is of vital importance for the prognosis. In addition to the persons close to them, this may also be the doctor, of course.

After clarifying the whole situation and all outstanding issues, it must be discussed with the patient quite specifically, as to how things will continue on this very day and the time afterwards, who will be available to support him/her, and how he/she will contact the doctor if the pressure inside increases. The direct involvement in the conversation of, for example, family members or other trusted persons (if the patient agrees) and a tight scheduling of more appointments are valuable tools.

Hospital Briefing

If the patient is no longer capable of control and consultation and there are serious suicidal intentions, either immediate consultation with a specialist or direct hospital referral is required. If the patient does not agree, the physician who has previously ensured his or her indication should insist on his or her decision and arrange for the referral against the patient's will.

Pitfalls

- Beware not to force activity on the patient which does not come from within the patient him/herself.
- Potential suicidality may be overlooked; that is why this has to be clarified at all times. It is not strange for depressive patients to be asked about suicidal thoughts; such questions do not enlarge the risk of a potential suicidality either.
- Comforting and encouraging the patient with words such as: "Think about how nice life could be...are you forgetting your wife, your children? Treat yourself to some 2 weeks of vacation." Such false comfort or perhaps well-intentioned encouragement is perceived as mockery by a desperate person.
- Actively taking measures without involving the patient (e.g., by prescribing drugs, referral to a psychiatrist), regardless of whether this is what the patient wants or whether the patient can actually tolerate the situation. In this case he/she is in danger of favoring suicide, because of the lack of respect. This frequently happens particularly at the beginning of therapeutic activities. The doctor makes him/herself master over life and death through these actions, without involving the patient him/herself and reaching out for consent.
- Trying to calm down the patient for one's own sake, thus preventing the patient from communicating his/her despair.
- Being guided by the fear and panic of the patient and no longer being able to function as a responsible doctor. If one notices this, one can distance oneself internally by deeply inhaling and exhaling, counting to 10, and reducing the emotional commitment.

Cooperation and Stepped Care

The treatment objective for depressive patients in a somatic-oriented setting is the initiation of a psychotherapeutic or psychopharmacological treatment. The physician should not go beyond giving information in the conversation. To work out subjacent conflicts or cognitive distortions that are associated with a depressive disorder requires a special training.

In any case, the involvement of a psychiatric-psychotherapeutic specialist is required when a depressive symptomatology has reached moderate severity. The following treatment approaches alone or in combination may be considered: cognitive behavioral therapy, psychoanalytically established procedures, and interpersonal therapy.

Cultural Aspects

Although depression could be seen as being universal according to the current mainstream theories, medical beliefs in different cultures influence the recognition, interpretation, and diagnosis of depression as well as the help-seeking behavior of the patients remarkably. The core symptoms of depression, i.e., change of mood, disruption of physiological functions such as sleep and appetite, and hypochondriac symptoms, are the same in Europe and in non-European cultures. Other symptoms such as feelings of guilt and suicidal tendencies show variations in frequency and intensity among cultures (Sartorius et al. 1983).

In the WHO study (Simon et al. 1999), the somatic presentation of patients meeting the criteria for major depression was very different among patients. A somatic presentation was more common at centers where patients lacked an ongoing relationship with a primary care physician than at centers where most patients had a personal physician.

Asia

A literature review published in 2001 confirmed that Chinese tend to deny depression and instead express it somatically (Parker et al. 2001). In Taiwan, social change, introduction of a universal national health insurance system, and the effects of public education about depression increased the treatment rate of depression within recent years (Chien et al. 2007).

Neither physicians of traditional Chinese medicine (TCM) diagnose depression, nor do patients who believe in TCM consider a depressive mood as being an entity on its own and a medical disease in the sense of Western medicine. According to the classical theory of TCM, human beings have seven essential emotions, i.e., happiness, anger, sorrow, concern, sadness, fear, and fright. These emotions correspond with certain organs, respectively (also see Chap. 3, section about “[Traditional Chinese Medicine](#)”). If one of these emotions is imbalanced, e.g., it breaks the harmonious dynamic relations between Yin and Yang, between organs, etc., it could

harm the organ it corresponds with. The TCM physicians see such a condition as a dynamic process instead of a constant status, which needs their continuous efforts to “re-balance” by prescribing herbal drugs. Nevertheless, the interpretation of symptoms and the doctor’s prescription seem to serve as a psychotherapeutic intervention as well.

In such a cultural context, most Chinese psychiatrists in the 1980s preferred to diagnose a depressive syndrome as neurasthenia. It was new to them to see and treat depressive patients. To some extent, this change can be understood as a result of the changes of conceptions about depression since the 1990s, and not as a substantial indicator that Chinese are suffering from depression more than before.

In Vietnam, the development of economics and changes in society and culture lead to lifestyle changes, working environment, and population structure. These factors led to an increase in stress-related depression during the past decade. Depression in Vietnam is still stigmatized and under-recognized in the community, family, and by patients. The patient likes to see general doctors with lack of psychiatric knowledge, resulting in a delayed detection of the illness.

Symptoms of pain, eating disorders, etc. are often seen in depression, especially among elderly patients or female patients going through menopause. General practitioners often do not recognize the depressive symptoms and refer the patients to somatic specialists, instead of psychiatrists. Loss of libido, especially among Vietnamese women, is difficult to detect and is often ignored.

Depression is mainly treated with medication. Implementation of psychotherapy is still limited in Vietnam. Superstitious methods are commonly used in remote and mountainous areas. Alcohol and substance abuse are used as self-medication among patients.

Africa

Although, as mentioned, many symptoms are universal, local idioms are common, e.g., Kufungisisa in Shona in Zimbabwe. Some symptoms like loss of appetite may not be specific because of the abundant physical causes; some of the symptoms are culturally explained, e.g., seeing dead people in dreams calling the individual to join them. Causal attributions include both problems in the relationship and supernatural causes. There is a complex relationship between depression, poverty, and economic deprivation (Fig. 8.9).

In African settings, treatment facilities are different in rural and urban areas, and treatment is often dispensed in unconventional settings and may be combined with traditional methods (Patel et al. 2001). Group interpersonal therapy for depression has been reported to be an effective treatment for adult depression in rural Uganda (Bolton et al. 2003).

Latin America

Escobar et al. (1983) compared depressed inpatients in Colombia and the USA. The results showed higher depression levels in Colombian patients. Mezzich and Raab (1980) compared depressed patients in Peru and the USA. The incidence of endogenous depression was greater in the Peruvian sample. Associated factors in both countries were Mestizo culture, lower educational level, to be female, and married. This confirms the vicious cycle of poverty and depression.

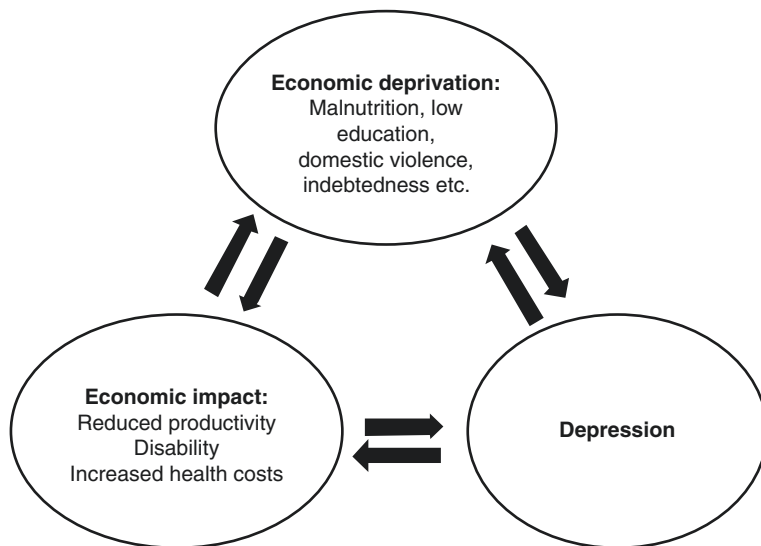


Fig. 8.9 Vicious cycle of poverty and depression

There is a high prevalence of postpartum depression (PPD) in Southern Brazil. Most acute cases and higher frequency are in general related to precarious economic conditions and lack of acceptance of pregnancy. This evidence puts pressure on public health authorities as regards prevention and treatment; demanding integrated follow-up accounting for depression, measures such as home visits, at least to mothers with lower incomes, are seen as being crucial. It is important to emphasize, nonetheless, that poverty is considered one of the biggest barriers for adequate care possibility.

Cultural Differences of Suicidal Behavior

The religious background and social attitudes decide whether suicides are reported or not. Many of the countries which are known for a very low suicide rate include Muslim, Buddhist, or Catholic societies, where suicide is sanctioned by religious morality. Suicide rates have generally been relatively stable for decades; however, sociocultural and political upheavals provide for changes. Motives for suicide vary across different societies. Suicidality in Eastern societies is closely related to mental or physical illness and associated adverse reactions, for example, in the family. In undeveloped and developing countries, conflicts or financial problems are in the foreground. In Western societies, relationship problems or drug abuse plays a larger role.

Family Suicide in Japan

A socially intolerable situation for one or both parents such as financial debt or an incurable disease will be the trigger for family suicide. Several reasons may cause the inclusion of children in the act: One reason is the fear that after the death of the parents, no one will take care of the children and that only parents can adequately

care for them. Another reason is the strong family ties between parent and child; in their view it is better to die as a family, than to leave behind a family member with a family that has been broken apart.

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Chapter 9

Anxiety Disorders and Obsessive Compulsive Disorder



Kurt Fritzsche

Case Study “Agoraphobia”

A 41-year-old female patient develops blurred vision and very unpleasant and rather unspecific dizziness after an acute flu-like infection. She is on sick leave for a fairly long period because of these debilitating symptoms, several attempts to become accustomed to a new job as a legal secretary fail. In particular, she is unable to tolerate working at the computer. A few months previously, she had lost the job she had had for years, because her boss had given up his law practice. Consequently, she had withdrawn more and more, leaving the house seldomly and after causing a slight dent in her car when parking in the garage was afraid of driving. Living in the countryside, this limited her mobility vastly. (to be continued)

Definition

Anxiety is one of the basic human experiences. Patterns of anxiety accompany all emotional and physical illnesses, either openly or in disguise. The disposition to feel fear guarantees individual survival, similarly to the capability of feeling pain. To have no fear at all may be just as unusual or remarkable as having too much fear.

Fear is useful and necessary as:

- Alarm signal with increase of vigilance in response to threatening events
- Preparation of the body to act quickly in case of danger
- Standby mode for escape and avoidance

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Table 9.1 Anxiety symptoms on four levels

Behaviour	Feelings	Body	Thoughts
Avoidance, flight, medication	Feelings of tension, worry, panic, unreality, fear of going crazy, of dying, of losing control, feelings of helplessness and powerlessness	Trembling, sweating, heart pounding, light-headedness, dizziness, muscle tension, nausea, breathlessness, numbness, stomach pains, tingling sensation	Something terrible is going to happen; I have got to get out of here, I am in despair “I am losing control” “I am having a heart attack” (catastrophic thinking)

Fear becomes an illness when:

- It is unreasonably strong.
- It occurs too often and for a too long stretch of time.
- One loses control over it.
- One is compelled to avoid anxiety situations.
- It leads to restriction of daily life.
- It leads to abuse of alcohol or drugs.
- One severely suffers under it.

Other mental disorders such as depression occur with suicidal tendencies. Anxiety involves complex physical and emotional simultaneous episodes, which are reflected on four levels (Table 9.1).

Relevance

In anxiety disorders physical symptoms, as so-called affective equivalents, often are evident instead of the consciously perceived fear. This aspect is particularly important in psychosomatic primary care, since patients experiencing physical symptoms primarily turn to their GP or a specialist. Anxiety disorders are often not diagnosed, misdiagnosed or diagnosed too late and are rarely treated specifically and appropriately. Untreated, anxiety disorders may become chronic, and spontaneous remissions are rare. There are high comorbidities with other mental disorders such as depression and somatoform disorders. Consequently timely detection prevents huge costs in primary care.

Theory

Symptoms

In a large number of patients with anxiety disorders, their feelings are hidden by physical symptoms. Table 9.2 shows an overview of physical symptoms of anxiety, arranged according to organ systems.

Table 9.2 Physical symptoms of fear

Heart	Irregular, rapid or pounding heartbeat to palpitations, left-thoracic sensation of pressure
Vascular system	Pallor or flush in the face and extremities, cold-sweaty hands and feet, hypertension
Muscular	Tremors, weak knees, motor restlessness, muscle tension, feeling of paralysis, pain in the joints, arms and legs, tingling and numbness
Respiratory tract	Hyperventilation, feeling of constriction and shortness of breath, fear of suffocation
Gastrointestinal tract	Lump in the throat (globus sensation) with difficulty in swallowing, swallowing air and belching, vomiting, stomach ache, diarrhoea
Vegetative/autonomic nervous system	Sweating, dilated pupils, need to urinate
Central nervous system	Dizziness and giddiness, tremors, spots in front of the eyes, impaired vision, such as double vision, headache, insomnia, impaired concentration, fatigue, weakness, depersonalisation and derealisation

Diagnostic Categories

Forms of anxiety disorder according to ICD-10:

- **Phobias:** fear of crowds, places, social situations and heights
- **Panic disorder:** Sudden unexpected occurrence, no clear trigger
- **Generalised anxiety:** Diffuse anxieties, worries, fears, sleep disturbances and various physical symptoms that often last for months
- **Hypochondriasis:** Fear of disease

Panic Disorder (ICD-10 F 40.01)

The most essential characteristics are recurrent phases of intensive acute fear, so-called panic attacks. They do not refer to a certain situation and are experienced by the patient usually as spontaneously occurring palpitations, chest pain, feeling of suffocation, severe dizziness and headache, up to a feeling of alienation. In addition, fear of dying or going mad does occur.

Occasionally there are feelings of being alienated from oneself (depersonalisation) or the environment (derealisation).

These intensify within minutes until they reach their peak after 10 min and then subside after about 30 min. Prolonged panic attacks are caused by trying to suppress and control them, thereby maintaining tension.

Frequently, the so-called fear of fear (expectation of fear) also occurs in the fear-free interval.

Case Study: “Panic Disorder”

A 36-year-old patient, mother of three sons, develops severe panic attacks as a response to her husband changing his behaviour—for her unexpectedly and inconceivably. He dyes his hair and announces that from then on, he is going to do his own thing and do as he pleases. In the preceding years, at high personal cost, the two had renovated the house they had taken over from the parents.

The patient is feeling completely overwhelmed, helpless and unable to act and hardly able to cope with the daily tasks of keeping the house. She is repeatedly overcome by great feelings of fear, coupled with palpitations, severe dizziness, sweating and trembling. Often she finds herself on the border of “losing control” or “flipping out”, so her husband sometimes fears that she might be suicidal because of the current pressure of the situation.

After intensive long-term psychotherapy, several months of in-hospital treatment in a special clinic and a temporary use of anxiolytics and antidepressives, step by step, she is able to better cope with her fears, bear unpleasant states of tension and become able to conduct her life again.

A deep underlying rift in the marital relationship is identified and the two finally decided to separate.

Phobic Anxiety Disorders (F40)

In contrast to diffuse anxiety disorders such as panic attacks and generalised anxiety disorder, these anxieties are linked to triggering stimuli and situations that are subsequently avoided. The avoidance behaviour is common to all anxiety disorders and leads to a short-term reduction in tension but in the medium term to a further retreat and increase in anxiety. The phobias are divided into agoraphobia, social phobia and specific phobias.

Agoraphobia (ICD-10: F 40.00 Without Panic Attacks, F40.01 With Panic Attacks)

Many patients with panic attacks come to avoid places in which anxiety attacks occur. The avoidance behaviour may reach a stage in which some are unable to leave their house. Agoraphobia describes not only the fear of open spaces but also, for example, of crowds or the desire to be able to leave a space immediately and to be able to retreat to a safe place. Typical situations these patients avoid or endure only with severe anxiety include department stores, cinemas, restaurants, public transportation, driving a car, lifts or heights. Most patients can endure the feared situation better in company. As a substitute for a fear-reducing trusted person, the patient may take along medications, smelling substances or the doctor’s telephone

number. Agoraphobia may also develop without any preceding acute anxiety attack or panic attacks. These patients often report a rather diffuse feeling of eeriness and threat which comes over them when they leave their familiar environment, the reason being an underlying fear of unexpectedly being alone and helpless while exposed to a possible danger.

Case Study: “Agoraphobia”, Continued

Numerous examinations by specialist and a hospital treatment follow to definitely rule out any possible organic cause of the illness. Her doctor prescribes antidepressive medication. After reading through all the possible side effects in the drug product information, she gets scared of the side effects and decides not to take the medication without talking to her doctor. A 2-month rehabilitation programme in a hospital and an outpatient group psychotherapy are needed to enable her to work at least part-time and to cope with everyday life without more significant limitations.

Social Phobias (ICD-10: F 40.1)

The patient will show an inappropriate fear and avoidance of situations in which he/she has to deal with other people and may be judged (e.g. signing papers, eating, drinking in public). These persons are afraid of failure, being ridiculed or being belittled because of clumsy behaviour. The social phobia may be limited to specific situations, such as eating or speaking in public, or meeting someone whom they do not know very well. The patients express complaints such as blushing, trembling hands, nausea or the urge to urinate.

Case Study: “Social Phobia”

A 25-year-old medical student has increasing problems when eating in the company of others, e.g. in the university cafeteria. In these types of situations, he has the feeling of not being able to swallow or suffering under a severe, almost irresistible urge to gag. By and by, he avoids such situations, which means that he often is alone, and while he can concentrate entirely on his studies, he sometimes is so restless that the eating problem even occurs at home, though in a weaker form. Obviously he often feels insecure in dealing with others, thinking that he is too fat, too sweaty and would making others feel uncomfortable by his presence.

Although he is studying nearly 750 km away from home, he is in very close contact with his family and is often asked for advice by his father, for instance. His father is very proud of him because he is the first of the family to attend university.

After some sessions it becomes evident that the underlying root of these symptoms is the patient's problem with separating from the parental home. His need for autonomy only surfaces indirectly. When he receives the news that he can participate in a research project in the USA after his exams in the coming year, he is able to eat an entire meal at McDonald's with no problem. Due to this experience, he does not suffer under any symptoms anymore.

Specific (Isolated) Phobias (ICD-10: F 40.2)

In specific phobias the fear is limited to the proximity to certain animals (animal type), heights, flying (situative type), thunder, darkness (forces of nature type), the sight of blood and injuries (blood injection and injury type) or the fear of being exposed to certain diseases, such as AIDS (fear of illness type). The extent of the disorder depends on how easily the patient can avoid the phobic situation or the phobic object.

Case Study: Specific Phobia

A 36-year-old patient, who lives with her partner (36 years) and their 3-year-old son is suffering under a severe fear of developing breast cancer like her grandmother and like an insignificantly older acquaintance. This anxiety increases and in addition also dizziness which are incomprehensible to her. Only when the family doctor refers her to a psychotherapist and after she can overcome her first inhibition, she finds the opportunity to relieve her tension in the conversations, accepting and learning to deal with her fear. It turns out that she has hardly talked to her partner about her fear because she is afraid of his lack of understanding. At the same time, she has withdrawn from him, and the quality of the relationship has deteriorated noticeably for both of them. The newly gained openness is increasingly bringing her back into the partnership as her fear decreases accordingly.

Generalised Anxiety Disorder (ICD-10 F 41.1)

Generalised and persistent fears, which are not, however, limited to certain situations in the environment can be observed. They refer to fears and worries in several areas of life, such as workplace, partnership, family, etc.

Patients with a generalised anxiety disorder usually turn to their family doctor or general practitioner for physical symptoms expressing the increased level of anxiety: restlessness, constant “being on the go”, easy fatigue, concentration disorders or emptiness in the head, irritability, muscle tension and sleep disorders. Other symptoms include tension headache, gastrointestinal problems (nausea, abdominal pain, diarrhoea), frequent urination, hot flushes or chills, shortness of breath and choking, sweating and difficulty swallowing. The generalised anxiety disorders include:

- Anxious personality with chronic anxious tension
- Worries, fears and brooding over situations on the job, in the partnership and in the world
- Psychological and physical accompanying symptoms such as panic disorder
- Frequently accompanying depressive symptoms (see Chap. 8)

Case Study: “Generalised Anxiety Disorder”

A 38-year-old patient reacts to changes on the job, which happen completely unexpectedly to him. After the retirement of his boss, he reacts with severe anxiety attacks and deep feeling of helplessness and despair. He feels incapable of resisting these feelings and feels passively doomed, as if he was falling into a chasm. Only through intensive psychiatric-psychotherapeutic support he very gradually reaches more stability.

After trying—from his perspective in vain—for several months to get along with his new boss, and by for example, reducing his working time, he decides to resign. After an extremely short phase of relief this new situation of unemployment throws him into a new crisis. Again, he does not stabilise for several months, until he has the opportunity to enter an extensive training programme offered by the state employment office.

Through conversations with his doctor, it becomes clear that he is suffering under severe fear of illness, permanent lack of self-confidence and considerable trouble in making decisions ever since being a child with only brief phases of greater stability.

Hypochondriacal Disorder (ICD-10: F 45.2) or Illness Anxiety Disorder (DSM-5)

The patient is constantly concerned with the possibility of having one or more serious and progressing physical diseases. General physical sensations are interpreted as abnormal and stressful and ascribed to a serious disease.

Somatoform Autonomic Dysfunction of the Heart and Cardiovascular System (ICD-10: F 45.3)

While other anxiety disorders focus on anxiety and are accompanied by physical symptoms, cardiac phobia is characterized by a left-thoracic feeling of pressure, palpitations, sweating, shortness of breath and headaches. In this phobia, the feared object is not part of the external world but part of one's own body. The focus is fear of an unrecognised heart disease and the fear of dying a cardiac death. The symptoms often correspond to those of angina pectoris but are demonstratively dwelt upon. Heart phobics do not have an elevated risk of heart attack. But by continually undergoing examination, despite unremarkable findings, the patient's conviction is that he/she is or will be suffering under a serious disease (also see Chap. 12).

Obsessive-Compulsive Disorder (ICD-10: F42)

The core features of this disorder are obsessions (intrusive, unwanted thoughts) and compulsions (performance of highly ritualised behaviours intended to neutralise the negative thoughts and emotions resulting from the obsessions). Practicing the specific highly ritualised behaviours leads to a short-term relief of the tension triggered by the intrusive thoughts. One symptom pattern might be repetitive handwashing beyond the point of skin damage to neutralise the fear of contamination.

Differential Diagnosis

The following important physical differential diagnoses must be taken into consideration:

- Hyperthyroidism
- Coronary heart disease
- Paroxysmal tachycardia
- Pheochromocytoma
- Hypoglycaemia
- Cerebral seizures
- Drug side effects and as a progression anxiety with serious physical illnesses, e.g. cancer
- Drug abuse

Frequency and Course

Anxiety disorders have a lifetime prevalence of 14% in European countries, making them the most common emotional disorders among the general public. The

following lifetime prevalence rates are found for individual anxiety disorders: specific phobia 6.4%, social phobia 2.3%, agoraphobia 2%, panic disorder 1.8% and generalised anxiety disorder 1.7% (young people) to 3.4% (elderly) (Wittchen et al. 2011).

There is a risk of chronicity mainly in secondary abuse of alcohol and/or medication, comorbid depression and an excessive number of visits of medical and psychosocial institutions.

The “fear of fear” (expectation of fear) leads to pronounced avoidance behaviour and social withdrawal. With agoraphobia, social withdrawal can be so pronounced that it is no longer possible for the person to leave the home. Social phobia can also lead to the complete withdrawal of the patient without therapy. Panic disorders usually shows a relapsing course; the generalised anxiety disorder is rather chronic and progressive. There is a risk of chronicity associated with alcohol and drug abuse, development of a depressive disorder and frequent visits to the doctor.

Onset

The following three factors of the biopsychosocial model play a varying role in patients suffering from an anxiety disorder.

Neurobiological Changes

Congenital and acquired elevated neurophysiological excitability accompanied by feelings of anxiety are stored in the amygdala and hippocampus. This emotional memory is long term, can be activated in certain situations, but also inhibited via controlling impulses from the prefrontal cortex by psychotherapeutic and psychopharmacological means. Moreover, there is a dysfunction of serotonin and noradrenalin metabolism in anxiety patients.

Psychosocial Disposition

As a human being passes through the various phases of life, coping with fear is one of the developmental tasks set. If the parent’s childrearing style is not very empathic and offers little protection or on the other hand is overprotecting, this is detrimental to strengthening mechanisms for coping with fear in conflict situations. Anxiety in situations of separation during childhood is a specific risk factor for the occurrence of panic disorder or agoraphobia in young adulthood. Elicitors of anxious states are typical threshold situations like puberty, end of

the school years, leaving the parental home, marriage, when children are leaving the home, separation or divorce, end of professional life or death of someone close. A reliable bond between children and their parents constitutes a good protection against the onset of an anxiety disorder. Other protective factors are genetic resilience and social support.

Stressful Life Events and Illness

These events include changes in habitual circumstances, e.g. moving to another city or a different country, the real or expected loss of someone close and change at the job or at home. Fear of death occurs with the feeling of suffocation in an acute attack of bronchial asthma or heart attack.

Practice

Recognition

When visiting their practitioner's practice or the emergency room of a hospital, many patients primarily do not notice the anxiety symptoms but rather physical complaints, such as tachycardia, hyperventilation, dizziness, etc are observed. If there are no indications of an organic disease or if the existing organic disease does not explain the extent of the physical complaints, the following specific anamnesis should be conducted:

Key questions for anxiety disorders:

Current complaints

- How do your symptoms manifest themselves? (4-level model)
- When, where and how often do your complaints occur? How long do they last?
- What intensifies/alleviates your complaints?

Trigger

- When did your symptoms first appear?
- What do you think triggered your symptoms?
- What was your life situation like when the fears occurred (threshold situation)?
- Were there existentially shocking events?

Resources

- What do you think you're going to do today?
- What do you generally enjoy?

- What helped you to master difficult situations in the past?

Biography

- How did you grow up? Parents' parenting style? Family climate?

Example of an Introduction

“Many people are frightened in a wide variety of situations. Can you tell me if the following situations or things would frighten you or make you want to avoid them?”

Sample of Anamnesis Questions

Panic Syndrome

- “Do you sometimes suffer from sudden and unexpected panic attacks, even though there is no real threat?”

Agoraphobia

- “Are there certain situations or places, like department stores, driving a car, crowds of people, lifts or closed rooms, that frighten you or that you avoid wherever possible?”

Social Phobia

- “Are you frightened by or do you avoid certain situations in which you might be observed or judged by other people, such as speaking or eating in public or at parties etc.?”

Specific Phobia

- “Do certain things or activities frighten you, such as certain animals (e.g. spiders, dogs), heights, flying, the sight of blood or injuries?”

Generalised Anxiety Syndrome

- “Do you often suffer from excessive worries which you cannot control, such as family matters, your job or finances?”

Obsessive-Compulsive Syndrome

- “Are there senseless or unpleasant thoughts that you cannot get rid of or acts which you have to do over and over again, even though you would like to stop them?”

Basic Therapeutic Attitude

Patients with anxiety disorders often are often friendly, adapted and happy to have found a doctor they trust and who will treat them well. At the same time, however, they tend to distancelessly cling to and use the doctor as a person who gives them security, without any consideration of him/her or his/her interests. It is noticeable what high expectations, even demands, the patient associates with the doctor: the doctor should be permanently available, always a friendly authority that unquestionably supports and encourages them. An ideal attitude for treatment is avoiding overprotectiveness without abandoning the patient or overtaxing him/her. The doctor should endure the patient's contact hunger and need for security, should not be upset by the many complaints but should give the impression of both consistency and safety.

This results in the following components for the treatment:

- Detailed exploration of symptoms, triggering and maintaining conditions
- Taking the complaints seriously (=appreciation of the patient)
- Dealing with the subjective understanding of disease
- Consider difficulties in the doctor-patient relationship
- Understanding of helplessness and need for security (=appreciation of the patient)
- Friendly distance, structure, clarity, transparency (conveys security and orientation)

A helpless regressive patient will find structure and is helped by choices given to him/her and the experience of his/her capacity for action and decision. It is possible to list a number of problem areas and to ask the patient to decide on their own order of importance and the sequence in which they should be treated. An example would be, "We now have three topics: topic one, topic two, topic three. What would you like to talk about first? What second, and what third? I'll write down the order".

Risks in the Treatment of Anxiety Disorders and Possible Solutions

- Too strong identification with the patient → Friendly structuring and distancing
- Doctor gets scared himself and is overprotective → Promote autonomy of the patient
- Therapeutic activism and frequent change of treatment strategies → Small steps
- Idealization of the physician by the patient → Promotion of the autonomy and dismantling of the avoidance behaviour

Small Steps

If a patient suffers from **fear of heights** and already gets wet hands at the sight of an observation tower, he should not immediately try to climb one.

He should first visit an observation tower and take his time to look at the building. After a few visits, the sight of the tower should be familiar and should not cause anxiety anymore. Now he can try to climb the first floor. Once there, he should focus on his body and feel the feeling of fear slowly diminish. At this point it can be helpful to name the thoughts and feelings aloud to a companion or to write them down. During the following visits, climbing the first floor should be much easier. Then he can move up to the next floor and so on. After some time the ascent to the top is no longer a problem (**systematic desensitization**).

Basic Interventions**Strengthening Autonomy**

The patient's personal responsibility and self-confidence should be maintained, protected and promoted. In cooperation with the patient, the doctor attempts to find out what the patient feels, what he/she can do despite his/her complaints and limitations and what recommendations and suggestions he/she can put into practice. Changes occur usually only in small steps. Relapses are more frequent if leaps, which are too big, lead to overtaxing. In developing countries where the doctor is viewed as the person who has the power to heal, statements like "Doctor, you are the one who knows what I must do in order to get well" should be counteracted gently to support the patient's autonomy.

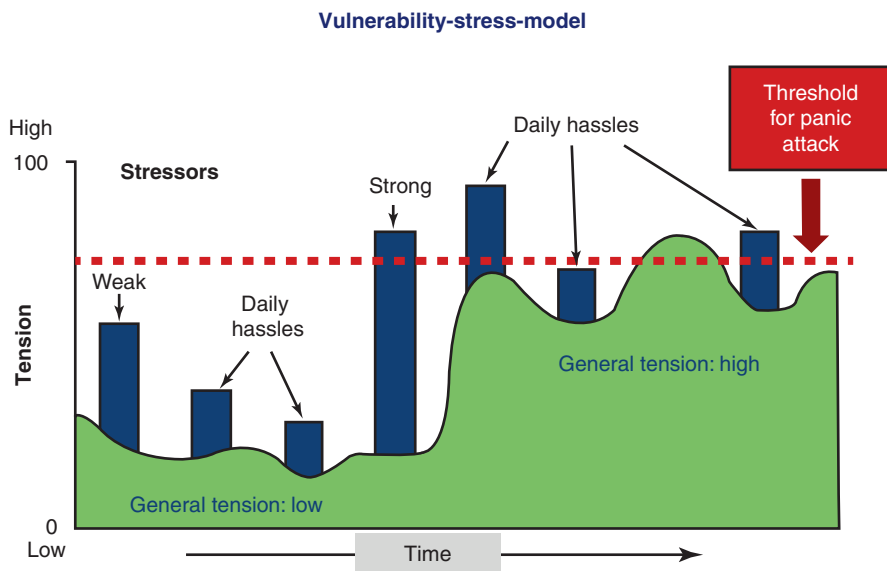


Fig. 9.1 Vulnerability-stress model. (Modified from Margraf and Schneider (2013))

As shown in Fig. 9.1, in patients suffering from anxiety the physical and mental stress level increases dramatically.

Doctor: In periods of low internal tension, it usually takes a long time until the body reacts to external stressors with anxiety symptoms. If the inner tension is already very high, even a little bit of stress can cause the body to react with feelings of anxiety and stress symptoms such as elevated heart rate, shortness of breath and sweaty palms. The threshold for a panic attack is lower in times when the general tension of the body is already very high.

Practical Tip: Examples of Breaking the Vicious Circle: “Exposure” and “Cognitive Restructuring”

The patient experiences shortness of breath and palpitations as a threat and thinks: “Soon I will die”. The physical reaction is coupled with this thought (**conditioning**). As a result, every heartbeat triggers anxiety (**generalization**) and activities that cause heart palpitations are avoided. Thoughts about palpitations also trigger fear, and fear of the fear can arise (**fear of expectation**). To correct the misperception and misinterpretation of his/her physical symptoms, the patient is instructed to develop a new fear-reducing assessment of physical symptoms. In addition, he/she will get used to these complaints by specific confrontation with the anxiety-provoking symptoms and will experience them to be harmless. Suitable for this confrontation are, e.g. squats,

walking in place, jump rope, sauna and gym for the generation of heart palpitations and sweating. The fear sets in, is perceived but does not lead to the feared death. Instead, the patient gets used to the fear (**habituation**). Through frequent and targeted confrontation with the anxiety-triggering symptoms, the patient learns that palpitations are associated with fear of death (**reassessment, cognitive restructuring**).

In patients with anxiety-related functional respiratory disorders, e.g. hyperventilation, the symptoms may be caused directly by a joint exercise. In the office the doctor asks the patient to inhale and exhale in a fast manner until the first physical symptoms such as tightness, mild dizziness or tingling sensation under the skin occur. By doing so, the patient experiences the harmlessness of his/her complaints and that he himself/she herself has control over them. In severe hyperventilation, the CO₂ rebreathing in a plastic bag or cupped hands that surround the nose can be performed.

Relaxation Techniques

A first general measure involves reducing the increased internal tension through a relaxation technique such as progressive muscle relaxation according to Jacobsen. This achieves a significant reduction of anxiety.

The Vicious Circle of Fear

The onset and maintenance of an anxiety disorder can best be explained to the patient as a “vicious circle”. In people who tend to have particularly strong physical vegetative reactions or those who observe their own body especially intensively, fear may lead them to only perceive the physical changes but not the accompanying emotional factors. Situations that trigger anxiety trigger physical reactions, and these bodily processes in turn reinforce anxiety (**conditioning**). These physical reactions can then also trigger fear in other situations that were not originally associated with fear (**generalization**). Such people tend to work themselves into a state of “fear of the fear”, in this case the pressure of expectation and tension itself results in eliciting fear signals. This process can become stronger and stronger in the vicious circle, leaving the patient feeling completely at the mercy of events (Fig. 9.2).

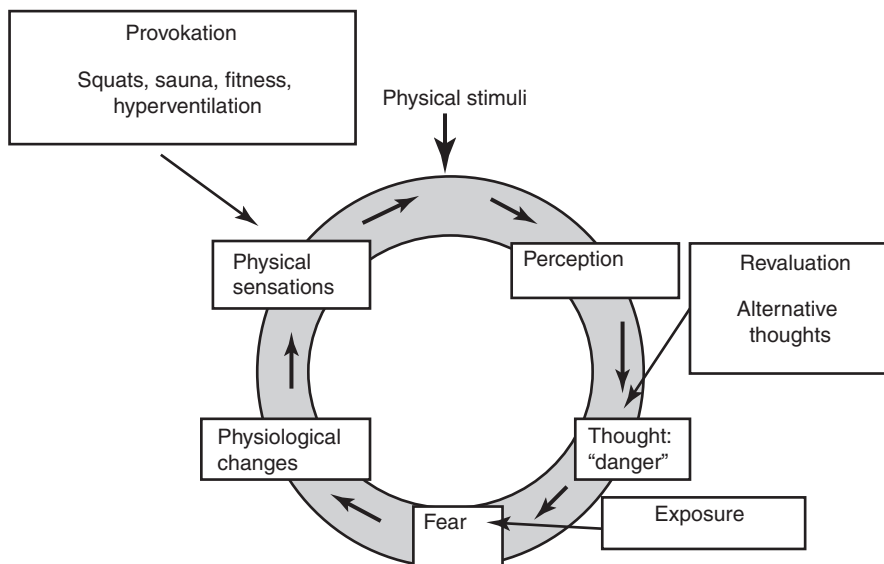


Fig. 9.2 Vicious circle of fear

Symptom Journal

A 35-year-old graduate economist with a recurrent feeling of pressure and pain in the left chest, combined with shortness of breath and fear of a heart attack is introduced. The doctor orders her to fill out a symptom journal every day (see Table 9.3).

Writing down thoughts and feelings during incidences of heart complaints is discussed and re-evaluated with the patient, e.g. "Now the chest pain is coming back and I am afraid of having a heart attack. Even though my father, who died of a heart attack, had similar symptoms, all the examinations I had in recent weeks and months have shown that my heart is completely healthy and that I can put full physical strain on my body". As a result, the patient continues her gardening work and experiences that the complaints subside without having to lay down or call an emergency ambulance.

Drug Treatment

Patients with anxiety disorders are often sceptical about treatment with medications and fear side effects or becoming addicted. For this reason, it is important to discuss the effects and side effects of the medication in detail with the patient and to take

Table 9.3 Symptom journal

Date	Symptoms Divided according to severity ^a Situation	How did you feel? Divided according to severity ^a (anxious, very tense, sad, nervous, angry, happy, restless)	What did you think about? Divided according to severity ^a
01.05.05	Chest pain (8). During gardening	Anxious (6)	I'm having a heart attack (9)
07.05.05	Shortness of breath (4), Tachycardia (6) I was lying in bed	Anxious (9)	Something is wrong with my heart (8)

^a(Severity 0–10; 0 = not at all, 10 = very pronounced)

Table 9.4 Drug treatment in anxiety disorders

Benzodiazepines	Phytotherapeutic substances	Antidepressives
Brief efficacy confirmed in panic attacks (esp. alprazolam, e.g. lorazepam 1 mg, also sublingual or diazepam drops); problems of dependency and tolerance	Used in general anxiety and increased susceptibility to anxiety, evidence is lacking, e.g. hop or valerian combinations, Kava-Kava; cave liver damage	SSRIs, SSNRIs proven for panic disorders and social phobia; in generalised anxiety disorder sometimes effective even in low doses

his/her concerns absolutely seriously. It sometimes occurs that the anxiety symptoms worsen under the impression of side effects such as anxiety and sweating, and panic attacks occur more frequently (fear of loss of control). Therefore, the dosage should be slow and careful.

If a person with anxiety disorder chooses drug treatment, offer a selective serotonin reuptake inhibitor (SSRI). Monitor the person carefully for adverse reactions (Table 9.4).

Taking into account the following factors:

- Tendency to experience withdrawal symptoms (especially with paroxetine and venlafaxine)
- Side effect profile and potential for drug-drug interactions
- The risk of suicide and likelihood of toxicity in case of overdose (especially with venlafaxine)
- The person's prior experience of treatment with particular drugs (particularly adherence, effectiveness, side effects, experience of withdrawal symptoms and the person's preferences)

Do not offer a benzodiazepine except as a short-term measure during crises. Do not offer an antipsychotic for treatment!

Crisis Intervention in Panic Attack

If a person presents with a panic attack, he/she should be asked if they are already receiving treatment for panic disorder. The minimum examination necessary should be undergone to exclude acute physical problems. The patients should be given appropriate written information about panic attacks and sources of support (Table 9.5).

During a panic attack, it is necessary to calm the patient down. Speak in a calm, confident and friendly voice. Try to normalise the physical sensations of the patient. At the same time, strengthen his/her reality testing of irrational beliefs, and make clear that he/she has no reason to be frightened. Positive suggestive measures may be helpful. For example, you could symbolically feel his/her pulse.

Practical Tip

“What you are experiencing right now is a panic attack. Your heart is beating faster; you are breathing very fast. I can understand that this upsets you. You feel as though you are in great danger. I want you to know that there is nothing to be afraid of. Here in my office, you are completely safe and your heart is healthy. Nothing is going to happen to you. I will stay with you until the attack is over. I can already see that your heart rate is slowing down”.

Table 9.5 Written information about panic attacks for patients

Anxious patients have no greater risk of a feared catastrophe occurring than any other person
Unpleasant feelings belong to every person’s emotional range. Do not waste energy on trying to suppress fear. This is not a successful strategy in the long run.
Overcoming fear is most successful if you are willing to admit and accept that you have unpleasant feelings and stay in the situation without giving up until the fear abates.
When you practice facing fear-inducing situations, the following attitudes and sentences can help you:
<i>It is all right to be afraid</i>
<i>I will see this situation through</i>
<i>The physical symptoms certainly will not last forever</i>
<i>I will feel relieved and stronger when it is over</i>
The physical sensations in a fear-inducing situation are very unpleasant, but they are neither damaging nor dangerous. The goal of your exercise is to learn to deal with fear and not to avoid it
Learn where your personal stress limits are and try to stay within those limits, since too much physical-emotional stress is often the basis for anxiety disorders

Practical Tip: “Techniques of Panic Management”

- Breathing techniques
- Focus the patient’s attention on something else, e.g. “Tell me five things that you see right now”
- “Reality check” of irrational beliefs

Especially if the patient is worried about “going mad” or being incurably ill, it may be helpful if you do not stress the pathological but rather the underlying normality of the experience and behaviour, from which the patient has gradually deviated.

Practical Tip

“Actually, it’s quite normal that you are worried. But we should ask ourselves why your worry has become so strong that you became panicked”

“I believe anybody would have been annoyed in such a situation. But your annoyance was stronger than that; you became completely irate”

Pitfalls

- The confident, overly caring doctor tries to provide a fearful patient with maternal security, protection and warmth. For a brief period of time, the doctor and the patient are comfortable in this constellation. In the long-term, however, this doctor may cause harm to the patient in that the overprotective attitude may inhibit his/her chances for an emancipatory development.
- An insecure doctor will try to get rid of a patient suffering from an anxiety disorder. The clinging behavior and the repetitive requests for reassurance or for medical examination are a nuisance and can lead to impatience and anger. The insecure doctor avoids to empathise with the helplessness of the patient. He/she provides little support to the patient and tries to get rid of him/her with advice that seems overwhelming to the patient.

It is important that the doctor keeps the necessary distance. There is a high risk for him/her to over-identify with the patient or even becoming infected by the patient’s fear. In the worst case, it could lead to unnecessary therapeutic activism obscuring the problem rather than clarifying it.

Cooperation and Stepped Care

Good evidence exists of both drug and psychotherapeutical treatments individually being effective in managing anxiety disorders (NICE guidelines 2011). Moderate and severe forms of anxiety disorders require professional psychotherapeutic treatment. If the management of anxiety symptoms is in the foreground, a *cognitive behavioural therapy* is indicated. Treatment programs usually contain components such as providing information about anxiety and panic attacks, talking about the distorted perception and interpretation of anxiety-related physical symptoms, confrontation with anxiety-provoking thoughts and step-by-step exposition of the patient with the feared triggers.

For panic disorder with agoraphobia, confrontation (exposure therapy) has proven to be the most effective method. It consists of information about panic attacks and behavioral experiments (e.g. provoking the symptoms by hyperventilating). As a cognitive intervention, thoughts and images are systematically worked out by collecting alternative explanations for the symptoms. For the panic disorder without agoraphobia, cognitive interventions such as re-evaluation of physical symptoms, thinking through of catastrophic thoughts (exposure in sensu), thought stopping and behavioral medical measures such as distraction strategies in connection with a relaxation procedure are also effective.

For social phobias, specific phobias and generalised anxiety disorder, systematic desensitization, confrontation, cognitive approaches and relaxation techniques have proven effective.

Steps of treatment in anxiety disorders following the stepped care model are:

- GP consultation and education
- The use of relaxation techniques
- Recommendation of a self-help group
- Short-term administration of psychotropic drugs
- Psychotherapy by itself or combination treatment of psychotherapy and psychotropics
- Inpatient treatment

Evidence-Based Medicine

Active therapeutic elements such as anxiety exposure training have proven to be very effective, especially for phobias and panic attacks. In the case of generalised anxiety disorder, the effectiveness of relaxation techniques, psychodynamic therapy and cognitive behavioural therapy are recommended. The effects are stable for up to 2 years. Data on longer catamnese-intervals (≥ 5 years) are not yet available.

Cultural Aspects

The cultural background has a significant effect on the expression of fear. People in different cultures express their emotions in different ways in language, gestures, physical reactions and facial expressions. In most cases, both physical symptoms and psychological symptoms of anxiety are present. Also, many everyday sayings (idioms) show the relationship between mind and body such as “Butterflies in the stomach” or “a pain in the neck”. In Chinese, there are expressions like “lost spleen spirit”—meaning losing one’s temper or “elevated liver fire”, meaning being emotionally aroused (Kirmayer and Young 1998; Tseng 2006; Karasz et al. 2007).

In Asian countries, for example, people tend to inhibit expressing their anxiety and avoid going to a doctor practicing “Western medicine” such as a psychiatrist. Instead patients with anxiety disorders and their families may seek help from doctors practicing traditional medicine and from religious healers in temples rather than from psychiatric services (Ma et al. 2010).

Some examples of culture-specific manifestations of fear are presented below.

Taijin kyofusho (Japan)

Taijin kyofusho means disorder of fear of interpersonal relations or “anthrophobia” in contrast to patients with social phobia, which have a persistent fear of social performance situation in which the person is exposed to unfamiliar people. Patients with *taijin kyofusho* are more concerned with self in other’s view, associated with feelings of embarrassment and many dismorphic concerns. They are eager to socialise with others and have no problems relating with strangers but are concerned with how to properly relate to friends, colleagues or superiors. The same difficulties with a familiar group in semiprivate circumstances are found in Korea, but not in China (Kitanish et al. 1995).

Dhat Syndrome (Asia)

Patients, mostly young men, often present multiple somatic symptoms such as fatigue, weakness, anxiety or feelings of guilt, supposedly caused by loss of semen such as masturbation or prostitution. In India, it is referred to as *Dhat* syndrome; in Sri Lanka, Nepal, Bangladesh and Pakistan as *Pramha*; and in Taiwan as *Shenkui*. The common belief is that the loss of semen can lead to disease.

Koro (China)

This phenomenon was first described in 1934 in Southern China and later in other parts of Asia and Africa. Koro refers to the fear of a sudden disappearance of sex organs (penis but also breast), usually by retracting into the body.

Frigophobia (China)

Frigophobia is a morbid fear of catching a cold. It is said to develop because of an imbalance between yin and yang. Excessive yin caused by cold air or excessive eating of cold food is said to result in weakness and sickness.

Heart Distress (Iran)

“Heart distress” is seen as a manifestation of anxiety and depressive disorders in traditional medicine in Iran (Good and Good 1982). It ranges from mild excitations to fainting and heart attack (also see Chap. 12).

Susto (Latin America)

Susto (“soul loss syndrome”) is widespread in Latin America. It is based on the idea that the body and soul are two separable components of the human being. The soul is said to leave the body when a spirit steals it. Susto is said to mainly occur in children because their soul were weaker. Physical symptoms of susto are loss of appetite, nausea, vomiting and diarrhoea. The affected children are said to be scared, to scream and cry particularly at night. Many symptoms of “susto” are treated with herbs. There are also other forms of magic treatment “calling the soul” through a traditional healer who prays to benign spirits in order to recover the soul.

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Chapter 10

Somatic Symptom Disorder



Kurt Fritzsche

Case Study

Since childhood, Mrs. D. regularly suffered from lower abdominal pain, sometimes associated with frequent bowel movements. She has not seen a doctor because of the complaints for a long time. She has become accustomed to these complaints coming and going. Often the symptoms persist for several weeks, never disappearing completely. The pain has also become much worse, sometimes the pain is so bad that she cannot fall asleep at night. Again and again she wakes up at night and has to go to the toilet urgently. The worst thing is the frequent tenesmus. When she wakes up at night she must immediately go to the toilet because she is afraid of not being able to hold her stool, and the pressure is also very painful. Since she works all day long as an assistant in a clothing store, she is very embarrassed of her frequent visits to the toilet. She always thinks of new excuses to tell her clients and colleagues; however, she thinks those excuses are no longer credible. (to be continued)

Definition

Internationally, the terms “functional somatic symptoms” and the diagnostic categories “somatoform disorders” (ICD-10) and “somatic symptom disorder” (DSM-5) are currently being used. Especially in primary care settings in Western countries, the term “medically unexplained symptoms” (MUS) has gained popularity to describe the bodily complaints of patients when the aetiology of the symptoms is unclear.

The following terms may be distinguished:

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(a) *Medically unexplained symptoms (MUS)*

- General term, very broad

(b) *Functional symptoms*

- Disturbance of normal functioning of bodily processes

(c) *Somatization*

- A psychological problem or emotional disorder is expressed somatically.

(d) *Somatoform disorders*

- Diagnostic category in the psychiatric classification of ICD-10

(e) *Somatic symptom disorder*

- Diagnostic category in the psychiatric classification of DSM-5.

According to ICD-10, a somatoform disorder is characterized by the following features:

- Repeated presentation of somatic symptoms
- Persistent demand for medical examination despite the lack of any organic findings (dysfunctional illness behavior)
- Emotional problems are being denied, although there is a close relationship between the somatic symptoms and psychosocial life events or conflicts (somatic fixation)
- Doctor-patient relationship is characterized by disappointment and frustration

Relevance

About 20% of patients who consult the family doctor have physical complaints with no adequate organic finding. The treatment of patients with symptoms without an sufficient organic explanation is difficult. The patients explain their symptoms through a previously unrecognized physical illness and initially do not accept a psychosomatic explanations. Because of the ensuing, often low motivation for psychotherapy, these patients are more frequently treated in general hospitals and medical practices of different disciplines than by a specialist in outpatient or inpatient psychotherapy. Extended time on sick leave and high costs due to the extensive use of inadequate medical diagnostics in outpatient and inpatient care while symptoms persist demonstrate the importance of psychosomatic treatment approach in health care.

Theory

Symptoms

Somatoform symptoms may affect any organ system. The most frequent manifestations are shown in Table 10.1.

Most of the complaints listed in Table 10.1 are ascribed to certain diagnoses. It is thus suggested that the disease is physical. Accordingly, therapeutic success with medication, operation and other primarily somatic-oriented therapeutic procedures is low.

Table 10.2 presents an overview of the diagnoses found in a wide variety of specialties and in which somatization is usually present.

Table 10.1 Manifestation of somatoform symptoms

Organ system	Frequent symptoms
Heart	Chest pains, paroxysmal tachycardias
Blood pressure	Hypertension and hypotension regulation disorders, syncope
Upper gastrointestinal tract	Nausea, feeling of repletion, meteorism
Lower gastrointestinal tract	Pain, diarrhoea, obstipation
Respiration	Hyperventilation with paresthesias
Motor apparatus	Back pain
Urogenital system	Urination problems, menstruation problems
Nervous system	Dizziness, convulsions, paralysis

Table 10.2 Diagnosis in various specialties

Speciality	Diagnoses
Allergology	Allergy to foods
Cardiology	Noncardiac chest pains, mitral valve prolapse
Dentistry	Complaints with mandibular joint, atypical facial pain
General practice	Tinnitus, dizziness, globus syndrome
Gynaecology	Premenstrual syndrome, chronic lower abdominal pain
Occupational medicine	Multiple chemical sensitivity (MCS), chronic fatigue syndrome (CFS), sick building syndrome ^a
Orthopaedics	Prolapsed disc
Pneumology	Dyspnea Hyperventilation
Rehabilitation medicine	Whiplash
Rheumatology	Fibromyalgia
Military medicine	Gulf war syndrome ^b

^aUnspecific symptoms like headache, nausea and rash on staying in buildings for longer periods

^bMarked fatigue, skin rash, impaired sense of smell, etc. in English and American soldiers who participated in the 1990 Gulf War

Diagnostic Categories

10.3.2.1. Somatoform Disorders (ICD-10: F 45)

The following subclassification has proven helpful in practice:

- **Undifferentiated somatoform disorder** (ICD-10: F 45.1): multiple somatoform symptoms for at least 6 months.
- **Somatoform autonomic dysfunction** of the vegetatively supplied organ systems like the heart and gastrointestinal tract and respiratory and urogenital system (ICD-10: F 45.3) (see Table 10.1).
- Persistent somatoform **pain disorders** (ICD-10: F 45.4).
- **Hypochondriasis** (ICD-10: F 45.2): the patient is excessively occupied over long periods of time with the possibility of suffering from one or more serious, progressing physical diseases. Everyday physical sensations are misinterpreted as threatening and stressful.
- **Body dysmorphic disorder** (ICD-10: F 45.22): the body is interpreted as being deformed. This is usually accompanied by a desire for cosmetic surgery.

10.3.2.2. Dissociative and Conversion Disorders (ICD-10: F 44)

Dissociation means literally “splitting of the consciousness”. Examples are feelings of alienation, like depersonalization and derealization, loss of memory and escapism, semiconsciousness and non-epileptic convulsions.

These phenomena occur frequently in connection with severe emotional traumas, especially after experiences of violence and sexual abuse. No verbal working out of the event is possible. The traumatic experience is split off and finds expression in fear, in states of vegetative tension and in the symptoms described under “posttraumatic stress disorders” (see Chap. 13). Conversion symptoms are dysfunctions of the **arbitrary motor** function and the **sensorium**. The symptoms affect body functions and body regions that are important in communication such as arms and legs, eyes and ears. Examples are paralysis of the musculature with gait disorders, sensory disorders such as numbness of the skin, sudden loss of sight, numbness and fainting. A repressed conflict is symbolically expressed in body language in order to keep the consciousness free of unbearable feelings.

Functional somatic symptoms exist in all clinical specialties. Here is a list of the most common **functional symptoms from other medical specialties**, classified according to **ICD 10**:

- Gastroenterology: irritable bowel syndrome (K 59)
- Nonulcerous dyspepsia (K 30)
- Rheumatology: fibromyalgia (M 79.0)
- Internal medicine/neurology: chronic fatigue syndrome (G 93.3)
- Dentistry: orofacial pain dysfunction syndrome (K 07.6)
- Gynaecology: pelviphathy (N 94)

Other terms that may stand for functional body complaints outside the ICD-10

- Environmental body complaints, such as multiple chemical sensitivity
- “Electrosmog”, or amalgam-related complaints, “Gulf War syndrome”
- “Food intolerance”
- “Whiplash trauma”
- “Chronic Lyme disease”

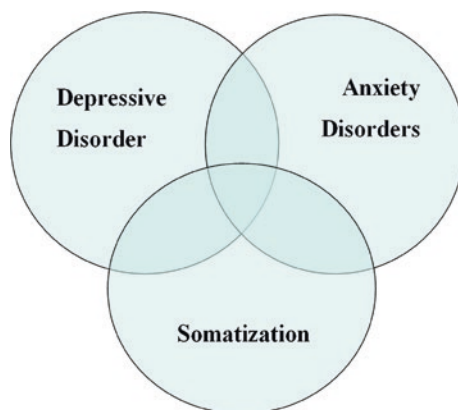
Differential Diagnosis

Somatoform symptoms may also be part of an anxiety disorder or depression. Feelings of anxiety or depressive symptoms are not experienced consciously but are expressed through the body. We also speak here of **affect equivalent**. See Fig. 10.1 for the overlapping of somatization, anxiety and depression.

Changes in DSM-5 and Outlook on ICD-11

The concept of “medically unexplained symptoms” fosters the dualism of the mind and body. The patient’s symptoms are viewed as either organic (“medically explained”) or “medically unexplained” which implies a psychosocial cause. To overcome this issue of dualism, there is a need to describe relevant factors on all three dimensions (biological, psychological and social) contributing to the distress and suffering of patients with multiple somatic symptoms. The new edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) attempts to overcome this dualism. In a new diagnostic category called “Somatic Symptom Disorder” (SSD), physical complaints are diagnosed in dysfunctional disease perception, conspicuous disease behaviour and pronounced health fears predominate. In the ICD-11, the diagnosis “bodily distress disorder” (BDS) was created to attend to the same problem. It requires both the presence of one or more distressing bodily symptoms, which can be either “medically unexplained” or caused by a general medical condition, and also “excessive, disproportionate or maladaptive” responses to the symptoms.

Fig. 10.1 Overlapping of somatization, anxiety and depression



DSM-5: To meet criteria for SSD, criteria A, B and C must be met.

- A. **Somatic symptoms:** one or more somatic symptoms that are distressing and/or result in significant disruption in daily life.
- B. **Excessive thoughts, feelings and behaviours related to these somatic symptoms or associated health concerns:** expressed in at least one of the following characteristics: (1) high level of health-related anxiety, (2) disproportionate and persistent concerns about the medical seriousness of one's symptoms, and (3) excessive time and energy devoted to these symptoms or health concerns.
- C. **Chronicity:** although any one symptom may not be continuously present, the state of being symptomatic is chronic (at least 6 months).

Comment

The stronger emphasis on psychosocial factors marks great progress. However, suggestions for an effective doctor-patient interaction are missing. The implementation of these criteria to severe life-threatening physical diseases is unclear. The practical consequence is a strengthening of the psychotherapeutic aspect in diagnostics (in primary care), e.g. how the patient experiences his complaints, which thoughts, which feelings and which behavior are associated with them. The often difficult decision about whether or not the symptoms are sufficiently medically explained or not is omitted.

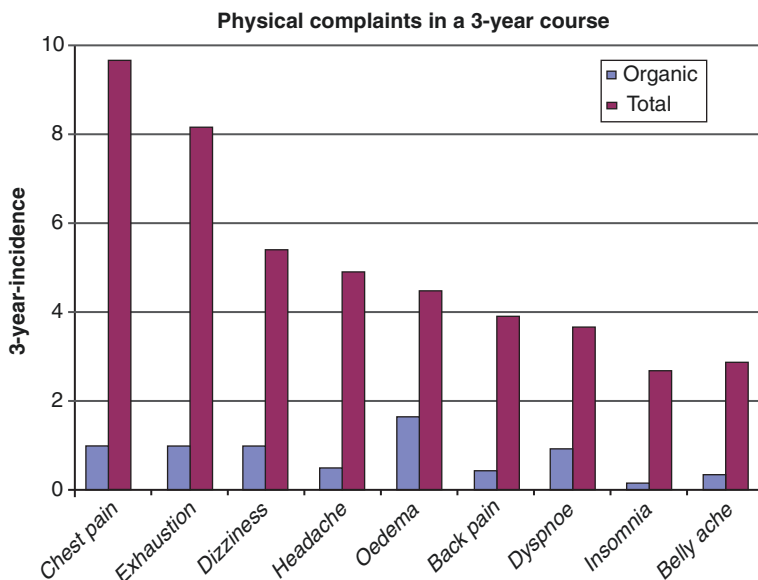
Frequency and Course

The 12-month prevalence of somatic symptom disorders in the European adult population is 6.3% (Wittchen et al. 2011). After anxiety and affective disorders, they are ranked third in terms of frequency of occurrence. Somatic symptom disorders are diagnosed much more frequently in women than in men.

Approximately 30% of patients who consult a family doctor have physical complaints without sufficient organ findings.

A distinction is made between the following forms of progression:

1. Short-term complaints, often lasting a few hours or days, which occur in every person and disappear quickly without further measures. No somatoform disorder is coded here.
2. Complaints that last for weeks to several months are often associated with acute stress, some of which subside spontaneously, but some of which require treatment to avoid chronicity (70–75%).
3. Prolonged somatization over months and years, sometimes with changing symptoms, leading to frequent visits to the doctor, diagnostic and therapeutic interventions, severe suffering, reduced quality of life and inability to work (25–30%).



Aus: Kroenke & Mangelsdorff 1988, Rief 2000

Fig. 10.2 Physical complaints in a 3-year course

- An American study (Kroenke and Mangelsdorff 1989) examined the proportion of physical diseases for the ten most frequent complaints over a 3-year period. An organic cause was identified in only 16% of 1000 patients. Functional somatic symptoms were prevalent in a large number of the remaining patients (see Fig. 10.2).

Onset

Every person reacts to emotional stress with physical symptoms, such as sweating, insomnia, palpitations, diarrhoea. Either patients with medically unexplained symptoms (MUS) do not perceive the emotional stress or there is inhibition of expressing emotions. The attention is focused instead on the accompanying physical symptoms, which undergo negative assessment and potentiation and are no longer associated with the eliciting feelings. Complaining about the physical pain replaces the expression of unpleasant feelings.

In a **vicious circle**, the physical symptoms increase the fear, which in turn results in greater physical symptoms (see Fig. 10.3).

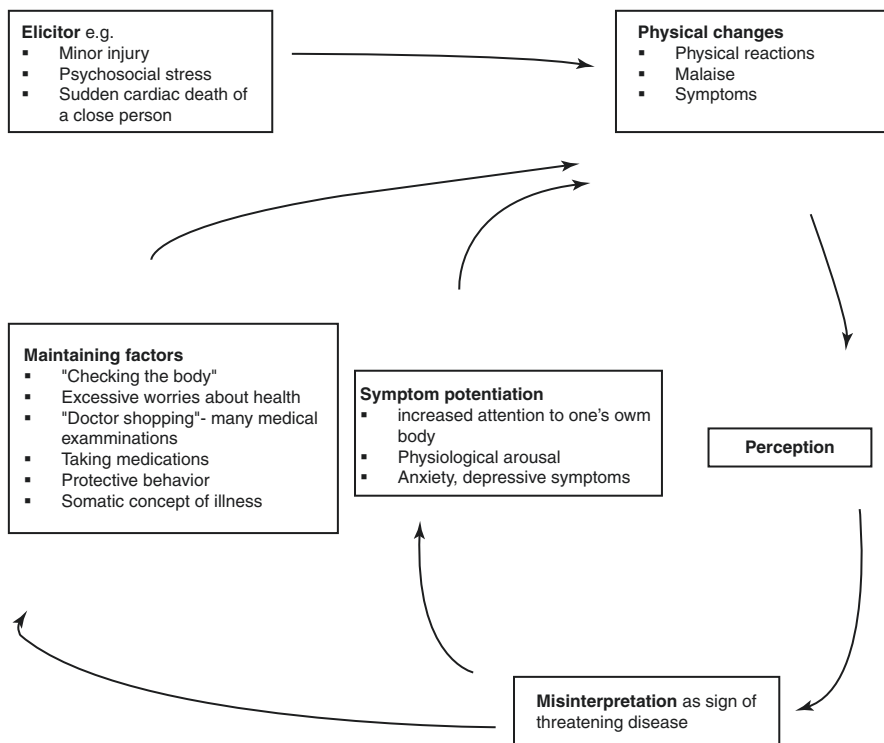


Fig. 10.3 Vicious circle

In a vicious circle (also see Chap. 9, Anxiety Disorders, Vicious Circle of Anxiety), misperception and misinterpretation of physical symptoms as threatening signs of disease increase attention to the body. The associated physiological excitement and emotional distress trigger feelings of anxiety, which in turn intensify the body's reactions.

The following **psychosocial factors** promote the tendency to somatize psychosocial problems:

- Traumatization in childhood
- Negative bonding experience
- Observational learning from parental models, who experience similar complaints
- Tendency to emotional and physical overtaxing
- Low self-esteem, easily insulted and hurt
- Strengthening of the role of illness with increased attention and support of the environment
- Relief from social or family demands and responsibilities as a result of the complaints

Practice

Recognition

Signs of functional symptoms/somatic symptom disorder may be:

- The symptoms do not follow anatomic or physiological patterns
- Large difference between objective findings (clinical examination, laboratory, imaging) and subjective complaints. The report of the symptoms is diffuse.
- Complaints are accepted without emotion on the one hand, described in dramatic images and inadequate effects on the other
- The patient appears lamenting, demanding and clinging
- There are other complaints which cannot be adequately explained organically
- Frequent change of doctor (doctor shopping)
- Current stress at work or in the family

Detection of Severe Progressive Forms

The goal is to detect functional symptoms/somatic symptom disorders early and to prevent their chronification. So-called yellow flags indicate a complicated course (see Table 10.3). On the one hand, these are criteria for the presence of functional symptoms/somatic symptom disorder; on the other hand, they allow a differentiation of severity into lighter and more severe forms of progression (Schäfer et al. 2012).

Practical Tip: “Pain History”

- What relieves the pain?
- What aggravates the pain?
- What does a typical day with pain look like?
- Is there a change in pain level during the day?
- When did the pain first occur?
- What kind of experiences with respect to pain are there in the family and personal history?

Basic Therapeutic Attitude

The objective of treatment in psychosomatic primary care is to establish an empathic and trusting doctor-patient relationship, in which the patient feels that he is being taken seriously in his complaints and his view of the illness. After an organic

Table. 10.3 Characteristics of lighter and more severe forms of somatoform/functional disorders as a guide to important yellow flags (Schäfer et al. 2012)

Criteria/ process	Easier, uncomplicated process	Severe, complicated progression ("Yellow flags")
Frequency Number of complaints	Approx. 50-75% One or few complaints (mono-/ oligosymptomatic course)	Approx. 10-30% Several complaints (polysymptomatic course)
Frequency/ duration of complaints	Rare or short (longer complaint-free intervals)	Frequent or persistent (without or only with rare/ short intervals free of complaints)
Disease perception	Largely adequate	Dysfunctional, like catastrophic thinking, severe disease fears
Disease behaviour	Largely adequate, e.g. appropriate utilization behaviour	Security seeking behaviour (protection and avoidance behaviour, reinsurance, high utilization behaviour)
Functional impairment	Largely normal functionality "Findings" largely corresponds to "Findings."	Significantly reduced functionality; inability to work > approx. 4 weeks, social withdrawal, Physical deconditioning, Possible physical consequential damages
Psychosocial (possibly also biographical) load	Low	High stress in life situation and biography (traumatization)
Psychic comorbidity	No relevant mental comorbidity	Severe mental comorbidity (depression, anxiety, PTSD, addiction, personality disorder)
Doctor- patient- relationship	Largely uncomplicated	(Both) experience as "difficult", frequent treatment discontinuations

disease has been ruled out (as the sole cause of the complaints), other explanatory models can be discussed and, if necessary, the doctor should motivate the patient to accept further psychotherapeutic treatment. Treatment goal **in primary care** is relief of complaints, not cure. Regular appointments, e.g. every 14 days, are recommended.

The following **basic therapeutic attitude is advised**:

- Take the patient's physical complaints seriously
- Understand the patient's helplessness, disappointment and anger
- Identify the unlikeliness of a serious organic disease while carefully keeping track of the somatic causes. Even if the doctor does not believe there is an organic cause of disease, the patient should at least undergo brief physical examination
- Do not jump to hasty conclusions about a connection between reported or presumed emotional stress and the physical complaints
- Avoid or prevent long sick leaves of the patient, unnecessary referrals and interventions. Practice patience, calmness and utilize your knowledge of the limitations of therapeutic possibilities.

Basic Interventions

The Three-Stage Model

For treatment in primary care, the **three-stage model** has proven helpful.

Stage 1: Feeling understood

- Take a full medical history of the symptoms.
- Build an empathetic, trusting doctor-patient relationship.
- Ask about the patient's **subjective** perception of illness: "What do you think caused your illness? How serious do you think your illness is? From which therapy would you benefit the most?"
- Explore emotional problems.
- Explore social and family factors.
- Explore symptom beliefs and similar problems and treatment in the past
- Perform a brief focused physical examination.

Following a detailed description of all physical ailments, the doctor elicits the disease and treatment expectations of the patient.

The dialogues are very simplified here. In real conversations, both partners find subtle strategies to convince the other person of their own view of the symptoms or to question the (hasty) psychosomatic interpretations of the physician/therapist (Burbaum et al. 2012).

Case Study, Continued

Dr. "What do you think is causing your abdominal pain?"

Pat. "I know it sounds silly, but my mother had uterine cancer, and it started with abdominal pain as well. I often think that no one has recognized my cancer yet".

Dr. "Do you worry about it a lot?"

Pat. "Yes, I do." (to be continued)

Short, targeted physical examinations, coupled with empathy for the physical symptoms, convey a serious attitude towards the patient's physical experience.

The diagnosis should be done as a parallel or simultaneous diagnosis of somatic and psychosocial factors. Even during their first visit, patients should be asked about their mental well-being.

Careful physical examination should be repeated at regular intervals, especially with persistent somatoform complaints. In this way, changes in symptoms can be detected in time, it will give the patient a feeling of security and of being taken seriously, and ideally complex instrumental tests can be avoided. In case of emerging symptoms, somatic as well as psychosomatic diagnosis should be adjusted or extended.

Stage 2: Broadening the agenda

Objectives of the second treatment step:

- Acknowledge distress or symptoms
- What does the patient want?
- Explain the results of the examinations

Case Study, Continued

Example for feedback on the results of the examinations and encouraging the patient to talk about straining emotions:

Doctor: "The laboratory tests, ultrasound and computer tomography have not shown any evidence for an organic disease. I would like to examine your abdomen... Your abdomen is sensitive in the middle area, but I can't find anything else remarkable. But I can imagine that you suffer a lot from your complaints"

Stage 3: Making the link

Objective of this third treatment step:

- Reframe the complaints by linking symptoms with stress or lifestyle (see three-level explanation for anxiety, Fig. 10.4).
- Acknowledge bodily distress.
- Treatment of depression and anxiety.
- Self-management strategies.
- Watchful waiting.
- Motivate the patient for psychotherapy.

Develop an *alternative model of disease* by explaining psychophysiological relationships, such as between fear and physical symptoms. The following phrases can be used here:

- “In frightened people, the body excretes more adrenalin. That’s why their hearts beat faster in situations of fear”.
- “If people are worried or depressed the intestines can contract and that causes abdominal pain”.
- Everyday body-related expressions are especially helpful, such as “when the heart skips a beat”, “makes you sick to your stomach” and “gets under one’s skin”.

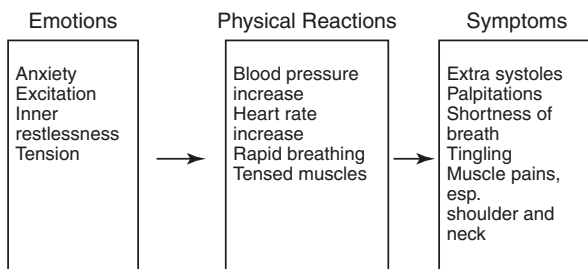


Fig. 10.4 The relationship between anxiety, physiological reaction and somatic symptoms

Symptom Diary

In this phase we also recommend the use of a symptom diary (Table 10.4) in which the perception of complaints and their individual assessment, such as the fear of having a serious illness, are captured. These cognitive and emotional mechanisms of processing can be addressed and discussed during doctor visits, i.e. be placed in new contexts.

Table 10.4 Symptom journal for a better understanding of pain

Day/ time	Symptoms/ extent of the complaints	Situation, other people, activity, demands	Thoughts in that situation	Feelings and moods in that situation
Monday 10 am	Stomach ache (8) ^a Tenesmus (8)	I am giving a sales pitch, another customer wants advice	I must come to an end, otherwise I am losing the other customers	Pressure to perform, fear of failing
Monday 7 pm	Severe abdominal pain (10) Tenesmus (9) Burning pain with bowel movement (9)	My husband just came home, 2 h late, without explanation or apology	Where has he been? At least he could have called while I'm sitting here alone	Anger, tense atmosphere

^aSeverity 0–10: 0 not at all, 10 very strong and pronounced

Practical Tip: Symptom Journal

“There are a lot of different causes for stomach ache. We’ll find the problem together. I would like to get a complete picture of the complaints you have. Please keep a symptom journal until your next appointment”.

The recording of thoughts and feelings when abdominal pain and tenesmus appear is discussed and re-evaluated with the patient.

Symptom diaries should not be used for too long as they lead to an increased perception of the symptoms and can therefore intensify the process of somatization. A duration of 1 to a maximum of 2 weeks is sufficient. The symptom journal identifies situations in which the patient is particularly susceptible to experiencing symptoms. It is not the situation alone that is decisive for understanding the symptoms, but the feelings and thoughts that accompany it. Therefore, it is important that the patient fills in these

fields. This is very difficult for many patients who are not used to reflecting themselves. Close supervision during the time when the diaries are filled out is therefore essential.

The links between the appearance of physical symptoms and stressful life situations are explained, and the patient is motivated for psychotherapeutic treatment.

Take Your Time

Listening to the patient's disappointment about previous treatment attempts and the complaints of the patient about the lack of understanding which he has encountered so far with doctors and caregivers has an immediate relieving function for the patient as well as a therapeutic effectiveness. Since the patients do not have access to the psychological dimension of their suffering, they can initially only express their emotional need through their physical complaints. Acceptance and understanding of these complaints promote self-esteem and strengthen trust towards the doctor.

Case Study, Continued

- Dr. "Last time you mentioned that you were having problems at work?"
Pat. "Yes, I'm really worried. Sometimes I even cry."
Dr. "I see you're tense and sad at the moment. Physical tension can cause muscle cramps and cause such pain as you are now having."
Pat. "You think that's related to my abdominal pain?"
Dr. "I think your worries may be affecting your stomach."
Pat. "You believe that the muscles in my abdomen are cramping and causing my stomach ache? But my being sad – does that cause pain, too?"
Dr. "Yes, of course. Can you relax, for example, when you are in bed?"
Pat. "Oh, no."
Dr. "I think that's a result of the worries you have."
Pat. "Hmh – could be. But what can I do about it?"
Dr. "How do you feel when you talk about it?"
Pat. "It feels good to express how I'm feeling and to know that you'll understand. I try to be strong, but I really have no idea what's going to happen next."
Dr. "I think psychotherapeutic interventions could help you to deal better with your anxieties and worries about your job and help to you relax."
Pat. "What does "psychotherapeutic interventions" mean, exactly?"

The stressful emotions are linked to the physical discomfort. Encouragement to verbalize feelings, to express criticism and to assert of one's own position has a relieving and symptom-reducing effect.

Cognitive Processing

Influencing the **cognitive processing** of the complaints can be done, for example, by the vicious circle model of anxiety (see Chap. 9).

Relaxation Methods and Body Awareness

The control over the physical symptoms is facilitated by relaxation methods and exercises for body perception.

For example:

- “Place one hand on the chest and abdomen. Feel the movement under your hands without changing your breath. Now you will notice your breath flowing in and out. Imagine how exhaling can release tension from the body. Imagine now, how with inhalation new oxygen comes in and with it new energy flows into the body”.

Other Treatment Measures

Physical exercise, e.g. aerobics and activating physical therapy, should be well monitored. The intensity should be gradually increased, alternating with resting periods.

Drugs, e.g. for the regulation of cardiac dysfunction, symptomatic drug therapy for irritable bowel syndrome, and drugs for pain relief should be used only after a critical risk-benefit assessment and only for a limited time.

Psychopharmaceutical Treatment

In more severe, pain-predominant functional symptoms/somatic symptom disorder with and without accompanying depressive symptoms, antidepressants are moderately effective.

For non-pain-predominant complaints, additional temporary antidepressants should be given, only in clinically relevant mental comorbidity of anxiety or depression.

Pitfalls

- The doctor believes he has recognized the psychosomatic relationships and would like to share his/her knowledge with the patient. However, the patient does not accept the interpretation of the doctor. On the contrary, because of the interpretation of the physician, the patient is closing himself/herself up even more and increases talking about his/her physical complaints. For the treatment, it is important to recognize that one's own understanding is not relevant. The decisive factor is the willingness of the patient to be open to alternative explanations.
- The doctor wants to proceed too quickly to motivating the patient for psychotherapy. The treatment of medical complaints without sufficient medical finding is a very gentle process and requires a lot of sensitivity.

Cooperation

The referral to an outpatient or inpatient psychotherapeutic treatment facility is done best as part of a stepped-care model (adapted from Henningsen et al. 2007).

The algorithm shown in Fig. 10.5 can be used to decide which treatment step is appropriate for a patient with unexplained physical symptoms (Kroenke 2003).

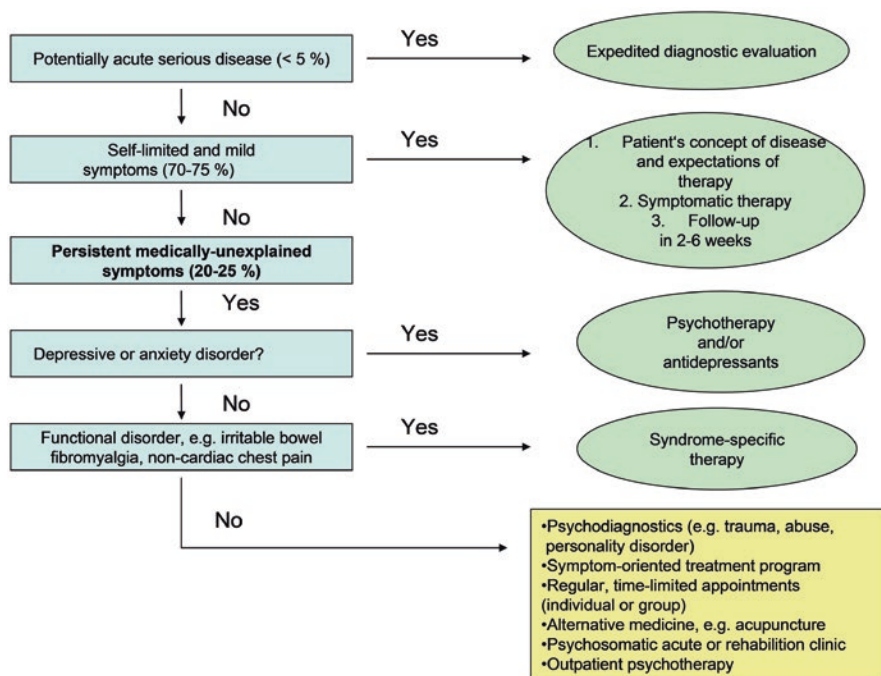


Fig. 10.5 Algorithm of the management of patients with somatic complaints

Referral to outpatient or inpatient psychotherapeutic treatment can be indicated for two reasons:

1. Problems and conflicts arise within the framework of the GP treatment programme, e.g. in patients with personality disorders, which exceed the time frame and the objective of this procedure and can only be treated in an in-depth, long-term psychotherapy.
2. Depression and anxiety disorders often hide behind physical symptoms. If the criteria for a moderate or severe depressive episode or anxiety disorder are met, the physician informs the patient about this clinical picture and motivates him to seek appropriate medication and psychotherapeutic treatment (see Chaps. 11 and 12).

If the patient refuses a referral, there is still the possibility of a joint discussion with the patient, the psychotherapist and the general practitioner in the general practitioner's practice or independent treatment by the general practitioner himself in close cooperation with the specialist.

Cognitive-behavioural treatment methods are effective in terms of improving the physical comfort and the quality of life and in reducing health-care costs. In chronic fatigue syndrome, fibromyalgia and not organically related heart problems, improvements were found on the symptom level.

A **psychodynamic treatment approach** has been shown to be effective in patients with functional upper and lower abdominal complaints (irritable bowel syndrome).

Cultural Aspects

Non-specific, functional and somatoform symptoms occur in all cultures but differ with respect to the complaint type, the explanatory models, the attribution of importance and expression. In addition, there are “culture-specific syndromes”, which exist only within a specific culture.

There are no systematic cross-cultural differences in the overall incidence of somatoform symptoms (Gureje et al. 1997; Kirmayer and Young 1998). The irritable bowel syndrome seems to be more common in Western cultures than in non-Western (Chang et al. 2006), as well as multiple chemical sensitivity or the sensitivity to amalgam (Hausteiner et al. 2005).

Culture-Specific Syndromes

- “Brain fag”, first described in 1960 in Southern Nigeria (Prince 1960): cognitive impairments, visual and other sensory disturbances and various physical complaints, mainly burning pain in the head and neck area. Brain fag is subjectively attributed to mental stress (Tseng 2006).
- “Dhat”, in India, Nepal, Pakistan, Bangladesh and Sri Lanka (first described in young Indians): various body symptoms such as fatigue, weakness, loss of appe-

tite and sexual dysfunction, caused apparently by nocturnal loss of semen in the urine (Tseng 2006; also see Chap. 9).

- “Pibloktoq” (or “Arctic Hysteria”), first described in 1913 in Northwest Greenland: sudden disturbed consciousness up to the loss of consciousness associated with behavioural problems such as tearing clothes off the body, swearing and tossing objects, mostly occurring in women in the Arctic winter, most likely under extreme physical and psychological stress, but was also attributed to hyperglycaemia or hypervitaminosis A (Tseng 2006).
- Hapa na Hapa syndrome in East Africa: “Hapa na Hapa” means pains here and here. A description of somatization symptoms such as headaches, tiredness, constipation or other unspecific symptoms, common with health workers in Kenya, East Africa (Jenkins et al. 2010).

Treatment Aspects

Diagnosis and therapy usually take place within local independent medical systems such as Ayurveda and TCM. Explanatory models, expression of complaints and attributions of importance and therapy differ in the different cultures (Karasz et al. 2007). A typical example is the traditional Chinese concept of neurasthenia (Shen Jing Shuai Ruo) from Lin (1989).

The term *neurasthenia* was introduced in the United States by New York neurologist George M. Beard in 1869. It was very popular at the time and included about 30 symptoms. The diagnostic concept spread around the world, and it was referred to as *shenjing shuairuo* in China and *shinkei suijaku* in Japan. *Shenjing shuairuo* includes somatic, cognitive and emotional symptoms. Patients whose clinical picture included insomnia, dizziness, headaches, concentration problems, being easily exhausted and many other similar symptoms very often received this diagnosis (Lee 1998; Lee and Wong 1995; Yan 1989). Despite its origin in Western psychiatry, *shenjing shuairuo* has become a popular concept in Chinese folk medicine.

Symptoms such as weakness and exhaustion are important in traditional Chinese medicine, and they are related to a lack of “qi” or hypofunctioning of the “kidney”, imbalance between “yin and yang”, hyperfunctioning of the “liver” or imbalance between the function of “kidney” and “heart”. Its origin was regarded as organic, but the treatment consists of psychological and social therapies such as traditional Chinese medicinal herbs, acupuncture, qi gong and shadow boxing. In addition, drug therapy, physical therapy and group psychotherapy were used after a philosophical and medical examination of patients (Yan 1989; Kleinman 1982; Lin 1989; Shixie 1989; Yan 1991). The concept of *shenjing shuairuo* additionally has the advantage of not being stigmatizing.

In 2001, the concept of somatoform disorders was introduced into the Chinese Classification of Mental Disorders (CCMD-III). At the same time, hierarchical rules were established permitting the diagnosis of *shenjing shuairuo* only after exclusion of depressive disorders and anxiety disorders. Neurasthenia received code 43.5 in the CCMD-III and therefore ranked behind other forms of somatoform disorders. As a result, *shenjing shuairuo* is now rarely diagnosed by Chinese psychiatrists. However, in neurological and general hospitals outside the major urban centres, the diagnosis is still used (Lee and Kleinman 2007).

Differences in illness attribution are found for heart problems in the Middle East and in Central America, in contrast to Western countries. Heart problems were not only understood as signs of illness, rather as metaphors for different emotions such as an expression of anxiety and depression (Kirmayer and Young 1998). These culture-specific characteristics indicate that in the doctor-patient dialogue, it is important to know the subjective view of patients on the origin of their symptoms and the appropriate treatment.

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Chapter 11

Psycho-oncology



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Case Study

55-year-old Mr. M. is hospitalized because of an intractable cough. His medical history shows Mr. M. has been smoking an average of 20 cigarettes per day since he was 18 years old and stopped smoking only 5 years ago. He is married, has two adult children, and works as a clerk in a small company.

The chest X-ray and chest CT scan show a mass, and the bronchoscopic biopsy indicates small cell lung cancer. After the examinations he spontaneously says to the doctor: “All these examinations have made me increasingly scared. Four months ago, when I spat blood, I knew: now I have cancer!” (to be continued)

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Definition

Cancer is a disease which in 50% of the cases is fatal. The treatment is highly stressful both physically and mentally. Generally, a cancer diagnosis triggers anxiety and helplessness, as the disease is often associated with death and dying. The diagnosis is an intrusion into the patient's structure of life which may affect the entire family. The field of psycho-oncology is concerned with the influence of psychological and social factors on the development, course, and coping of oncological diseases and investigates the effectiveness of psychotherapeutic treatment methods to improve the emotional well-being and quality of life of oncological patients.

Relevance

If the extent of stress exceeds the coping ability of patients and their families and affects the mental state and interpersonal relationships of the patient, psychosocial support is necessary. This is the case in 20–50% of all patients with a cancer diagnosis, depending on the type of cancer and the treatment stage. These patients exhibit—at least immediately after the diagnosis—clinically significant symptoms of a mental disorder. The patients mostly show anxiety and depressive symptoms such as rumination, insomnia, and/or physical impairments during radiotherapy and chemotherapy such as pain, nausea, and fatigue.

Theory

Not all causes of cancer are completely explained yet. There are many psychosocial factors that play a role in the development of cancer, including unhealthy behavior (smoking, alcohol consumption, unhealthy diet, exposure to carcinogenic substances at the workplace). Overstraining, loss of attachment and, resulting depressive symptoms lead to the activation of the pituitary adrenal cortex axis and the associated increased release of cortisol. Cortisol in its anti-inflammatory function reduces the gene regulation of cytokines (tumor necrosis factor, interleukin 1, 2, and 6) and the cell activity of T lymphocytes and natural killer cells (NK). Thus, the immune system's defensive function in the formation and elimination of tumor cells is limited. Protective and damaging influences in the development of cancer are no longer in balance. Carcinogenic substances, such as those contained in cigarette smoke or chemical substances, a genetic disposition, radiation, or viruses can develop their harmful effects on the body more easily. In order to prove a connection between psychosocial stress and the development of cancer, studies with very large case numbers and a very long data collection time are necessary. However, the studies currently available do not allow a clear conclusion in one or the other direction.

The situation is different regarding investigations into the *course* and *management* of cancer. In the majority of the studies, the following psychosocial stressors have had a negative impact on the quality of life and coping with the cancer diagnosis: depression, anxiety, helplessness and hopelessness, suppression of feelings, and social isolation. Coping styles (see section “**Coping**”), such as an active problem-oriented approach to the disease, had a positive influence on coping compared to resignation and withdrawal.

There is no clear evidence to date that psychosocial factors influence the *development of cancer*. However, there are clear indications that psychosocial well-being and certain dysfunctional coping strategies have an influence on the subsequent *management of the disease*.

Symptoms

The mental problems of cancer patients are not fundamentally different from those of patients with other serious physical diseases. It is important to realize that these patients are not primarily mentally ill; rather their mental problems are emotional reactions to the cancer diagnosis, such as anxiety, depression, resentment, and anger. Depending on the type of cancer, 20–50% of patients show symptoms of a mental disorder. In most cases patients show an acute stress reaction with anxiety and depressive symptoms (ICD-10: F 43.0, ICD-10: F 43.2).

The symptoms accumulate during the first weeks after the diagnosis and become less thereafter. In a small number of patients, the symptoms may last for another year or two.

Table 11.1 shows typical emotional reactions and challenges patients may have to deal with in the course of a cancer diagnosis and treatment.

Subjective Disease Theories

In view of the existential threat posed by a cancer diagnosis, patients develop their own ideas about the cause of the disease, its course, and what they can do to cope with it. These “subjective disease theories” are often not in line with or even contradictory to the current scientific view. In a German survey of breast cancer patients, 80% cited the environment, 70% stress, 68% mental problems, 58% fate, and 54% family burdens as the causes of their cancer. Approximately half of all patients see their cancer as a **challenge**, and a third consider it a valuable experience. Only 3–5% see the disease as a personal failure and a punishment

Cancer and Family

A cancer diagnosis is an attack on the entire system of interpersonal relationships surrounding the patient. In addition to the individual’s psychological burden, the cancer diagnosis often leads to a disturbance in the partnership and the whole family dynamic. Some of the negative psychosocial effects of cancer on the social environment are difficulties in talking about feelings and the fear of the progression of the disease in the future, including possible death. Some positive psychosocial

Table 11.1 Mental reactions occurring in the course of a cancer diagnosis and treatment and the patient's upcoming challenges in coping with the disease

Illness phase	Mental reaction	Tasks to be managed by the patient
Diagnosis	Shock, fear	Accepting the diagnosis, coping with intense emotions
	Disbelief, despair, depression	Making a decision regarding treatment
	Anger	Notifying the social environment
Primary treatment phase	Anxiety, depression, loss of control and autonomy	Accepting illness and treatment
	Loss of physical integrity	Coping with treatment side effects
	Loneliness, loss of intimacy, and sexual contacts	Establishment of viable relationships with the treatment team
		Regaining mental and physical self-esteem
Remission	Relief, gratitude	Return to everyday life, living with uncertainty
	Fear of recurrence and metastases, increased awareness of the body	Development of new perspectives on life, returning to work
Recurrence	Shock, anxiety, depression	Accepting uncertainty of the future
	Denial	Accepting the progression of the disease and the likelihood of death
	Loss of hope and trust	Adaptation of the perspective of life to the new situation
	Increased vulnerability	
	Search for meaning, feelings of guilt	
Terminal stage	Fear of death, depression, demoralization	Dealing with death and dying, mourning the loss
	Denial	Accepting your own death
	Loss of control	Accepting the physical decline and the negative prognosis
	Fear of loneliness	Arrangement of family affairs and legal matters and parting from family and friends
	Increasing dependence on doctors and nursing staff	Looking back at your own life, dealing with spiritual issues
	Retreat	
	Anger and resentment	

effects of cancer on the social environment might be stronger family ties and positive changes in relationships to siblings and children. The desire for sexuality and sexual activity decreases in all forms of cancer. The main problems are difficulties in reaching orgasm, lack of sexual desire, pain, and incontinence.

In the near future, the wide possibilities of predictive diagnostics in the field of oncological disease will additionally challenge the coping resources of affected families. Reliable detection of gene mutation carriers and biomarkers for cancer pre-

disposition will pose questions, such as: “How should these genetic risks and predispositions be communicated within a family?” “Who should talk to children and adolescents who are gene mutation carriers themselves, and when is the right time for that?”.

Children of Parents with Cancer

Having a parent with cancer is an extremely dramatic experience for a child. Depending on their age, children’s reactions can include fear of separation, bed-wetting, thumb-sucking, difficulties in falling asleep, and aggression toward other children but also toward other adult caregivers (in order to relieve the sick parent). Children can also show concentration problems, learning difficulties, rapid decrease in school performance, somatoform symptoms such as headaches or stomach pains, social withdrawal with neglect of friends and hobbies, and physical self-neglect. Younger children often react with behavioral changes, while adolescents might appear cold and uninvolved.

Diagnostic Categories

Of the whole spectrum of mental disorders, the following diagnostic categories are mostly relevant in the context of cancer.

Acute Stress Disorder (ICD-10: F43.0)

An acute stress disorder can develop in response to exceptional physical or mental stress. Acute stress disorder is a transient disorder, which generally subsides within hours or days. The symptoms vary from a feeling of being overwhelmed, narrowing of consciousness, and limited attention to an inability to process stimuli and disorientation. This state may be followed by a further retreat from the social environment, or a state of restlessness and overactivity. Frequently, vegetative signs of panic such as tachycardia, sweating, and blushing occur.

Adjustment Disorder (ICD-10: F43.2)

The symptoms include depressed mood, anxiety, and excessive worrying. In adolescents disturbed socialized conduct may be an additional symptom. Short depressive and anxiety reactions, lasting less than 1 month, are differentiated from longer reactions, lasting up to 2 years.

Fatigue Syndrome

Fatigue is observed as great tiredness, exhaustion, reduced performance, and muscular weakness. It especially affects patients after radiation or chemotherapy. About 30–40% of patients suffer from chronic fatigue even after the cancer treatment has been completed. Fatigue is considered a separate syndrome, even though there is some overlap with depressive symptoms. It probably originates from a complex interaction between the tumor disease, chemo- and radiotherapy, tumor anemia, other secondary diseases, immunological processes, and emotional coping processes.

Frequency

Especially during the first few weeks after being diagnosed with (or learning about the recurrence of) cancer, 30–50% of patients show symptoms of emotional distress. Usually this is an acute stress reaction with anxiety and depressive symptoms (see diagnostic categories). Psychiatric disorders in the strict sense are rare.

Onset and Course

Risk factors for mental decompensation after being diagnosed with cancer include previous and current mental problems (especially depression, alcoholism, earlier suicide attempts), lack of social support, recent experience of separation and/or death, marital or family problems, financial problems, problems at work, previous negative experiences with illness, uncontrollable pain, a poor prognosis, an advanced tumor, and physical and emotional exhaustion.

Coping

Coping is any behavior used by the patient to overcome, alleviate, or accept already existing or expected health-related stressors in an attempt to endure the disease. Patients try to keep feelings of fear, self-esteem impairment, and loss of control within at a tolerable level.

Coping strategies can be found at the cognitive, emotional, and behavioral level:

1. **Cognitive processing** strategies such as finding subjective explanations for the disease, refusing to believe the diagnosis, and blaming oneself or others for the disease.
2. **Emotions** such as irritability, rumination, sarcasm, quarreling and other moods, and emotions and affects.
3. **Processing on the behavioral level** such as actively tackling upcoming problems, distracting oneself, carefully following medical advice, or social withdrawal. The state of mental well-being during cancer treatment depends on the coping mechanisms that are available to each individual patient. The following coping styles have been found to be helpful in dealing with the disease:
 - An active, confrontational approach to the disease (a so-called fighting spirit)
 - Search for meaning and spirituality
 - Good interpersonal relationships and social support
 - Trust in the doctors

Coping styles that are not helpful:

- Passive acceptance and resignation
- Social withdrawal and isolation
- Helplessness and hopelessness

Studies have shown that using a wide range of coping strategies (according to the situation) enable a better adaptation to the situation than the presence of only one coping strategy.

Practice

Recognition

Indication for psychotherapy/psychosocial care for cancer patients is assessed by the biopsychosocial anamnesis.

Indications for Psychosomatic Basic Care

- Anxiety and depressive reactions after receiving the diagnosis or during the course of the treatment
- Suicidality
- Psycho-vegetative reactions such as nausea, weakness and fatigue, insomnia, and concentration problems (fatigue syndrome)
- Mental impairments (e.g. after surgery)
- Avoiding going outside after face or larynx surgery or after breast surgery
- Changing roles in the family and relationship conflicts
- Physically unexplained pain syndromes persisting for a long time despite treatment
- Posttraumatic stress disorder, for example, after a surgery with many complications

Basic Therapeutic Attitude

There is a very important balance to be kept between hope and acceptance. Hope, as positive anticipation, could promote the psycho-neuro-immunologic system. Without acceptance the anticipation could lead to an anxious and aversive attitude. Acceptance of the reality of a disability and the possibility of dying in the near future is an significant point of coping with cancer, but without hope the confrontation with upcoming disabilities and dying can lead to a passive and fatalistic attitude.

The doctor should accept the behavior of the patient, even if the patient denies his/her disease. Fear, despair, gloom, withdrawal, anger, and rage are all considered adequate responses to the diagnosis. The goal of the therapeutic interventions is for

the patient to be able to better cope with the disease; to eventually regain control of thoughts, feelings, and behavior; and for him/her to develop an overall active and solution-oriented attitude toward the disease.

Basic Interventions

Information and Consultation (Psycho-education)

The first stage includes informing the patients and their families about the disease and the recommended treatment measures. This consultation has the aim of reducing feelings of helplessness and uncertainty due to the lack of knowledge. Information on anxiety and depressive reactions as common reactions to the diagnosis and reassurance on the availability of the doctor as a contact person should be included. Patients should be encouraged to ask questions, to express their thoughts about cancer (subjective theory of disease) and the progression of the disease, and to talk about upsetting thoughts and feelings. These first basic informations should be offered to all patients after cancer diagnosis either as an individual consultation or as part of a group counselling program. It requires the physician to have basic knowledge of psycho-oncology and psychosomatic basic care (an in-depth psychotherapeutic competence is not required). Many patients also benefit from self-help groups.

Specific Measures for Pain, Fatigue, Nausea, and Vomiting

There is a wide range of intervention options to treat pain and fatigue: progressive muscle relaxation, autogenic training, hypnosis, meditation, biofeedback, passive muscle relaxation, and guided imaginations or visualizations. Another common problem of chemotherapy is the anticipatory vomiting and nausea. These side effects follow the rules of classical conditioning and can be treated with a desensitization treatment. The main objective of these symptom-oriented methods is the development of positive associations and pleasant body sensations. The techniques also strengthen mental coping skills and increase feelings of self-control. A combination of progressive muscle relaxation and imaginative techniques has been shown to be effective in reducing pain in mucositis, a very common and painful complication of chemotherapeutic treatment (Syrjala et al. 1992).

Psychotherapeutic Interventions

The physician should inform the patient about psychotherapeutic support services. This includes art therapy, music therapy and imagination therapy, as well as cognitive-behavioral and psychodynamic treatment approaches and person-centered psychotherapy, for individuals or in group settings. Depending on the

patient's problem and personality, individual elements or a combination of treatment methods can be used. In practice, different therapeutic approaches are often combined. A psychotherapeutic intervention is most successful if it is adapted to the patient's needs and his/her individual psychological and social resources.

Objectives of Psychotherapeutic Interventions

- Reducing anxiety, despair, and depression in patients and relatives
- Crisis intervention in case of suicidality
- Improving compliance with respect to the medical treatment
- Activating the patient's coping resources
- Teaching behavioral techniques and mental approaches to better manage and accept the disease
- Teaching relaxation techniques to reduce insomnia, pain, nausea, and other physical symptoms
- Breaking the taboo of talking about death and dying

Breaking Bad News

More than 90% of all cancer patients in Western countries want to be informed about the disease and possible treatments. An important component of the conversation is the emotional support in dealing with the information. The doctor should be adequately prepared for this difficult task.

Ineffective strategies like blunt and insensitive (disease-centered) information and kind and sad (emotion-centered) sympathy may make the adjustment process more complex and problematic or even traumatic. In contrast, an empathetic and positive (patient-centered) attitude facilitates adjustment and adherence (Brewin 1991).

The six-step SPIKES protocol by Baile et al. (2000) provides a guideline for delivering bad news to patients with cancer.

1. SETTING UP the Interview

Set the time frame, communicate the objective of the conversation, arrange for some privacy, and ask the patient if he/she would like you to involve a significant other in the interview.

The doctor's checklist:

- Do you have all the test results at hand?
- Do you have a treatment plan? What are the next advised examinations or further diagnostic steps?
- What exactly do I want to tell the patient?
- Where do I want to start?

2. **Assessing the Patient's PERCEPTION**

Before discussing the medical findings, the doctor uses open-ended questions to create an accurate picture of how the patient perceives his medical situation. Based on this information, the doctor can correct misinformation and adjust the bad news to the patient's level of information and understanding.

3. **Obtaining the Patient's INVITATION**

While most patients express a desire for full information about their diagnosis, prognosis, and details of their illness, some patients do not. Some patients would rather focus on the next treatment steps. To find out about the informational wishes of the patient, doctors can ask questions such as: "Do you want as much information as possible, or are you a person who would rather like to not know everything?"

4. **Giving KNOWLEDGE and Information to the Patient**

Examples of phrases that can be used are: "Unfortunately, I've got some bad news to tell you. Based on the examination, we suspect that you may be suffering from cancer."

5. **Addressing the Patient's EMOTIONS with Empathic Responses**

Conversation techniques that reflect displayed or perceived feelings are helpful. ("You are very sad and confused. I have the impression that you are also angry because you have not been told earlier that it could be cancer.")

For the **emotional support** of patients and their significant others, an orientation toward the following five-stage scheme is helpful:

1. Naming emotions: cautiously, questioningly, as an offer, possibly in the subjunctive.
2. Check your own understanding: continue asking questions, listen carefully, and take breaks.
3. Appreciate the patient's situation and his/her attempt to cope with it: you can show this verbally and nonverbally through facial expressions, changing the sitting position, and possibly touching the patient's hand or arm, if appropriate.
4. Offer serious and feasible support.
5. Inquire more deeply, if the patient is ready for this.

Practical Tip

- Adapt your information to the patients' speech.
- Explain complex information in pictures, and make reference to the patient's everyday experience.
- Do not make the word cancer a taboo, but watch the patient's reaction, and adapt your language according to the reaction.
- Refer to the emotional reactions of the patient and the family members; do not switch immediately to "facts" when emotionally difficult situations arise.

- Silence and pauses with concurrent physical and mental presence are more effective than talking excessively.
- Always leave room for hope. Ensure reliable, competent, and best possible treatment, e.g., against pain. Give the patient the feeling that he/she will not be given up on, but do not raise false hope.
- Check repeatedly whether the patient has understood the information. Inform the patient that he/she can contact the nursing staff or the doctor on duty if needed

6. STRATEGY and SUMMARY

- *Summarize* the conversation.
- Offer *Support* for the following hours and on the way home.
- Ask the patient if he/she is ready to discuss the treatment plan, or set a date for a new appointment. (“If you have no further questions, we can stop here. I can imagine that a lot of questions will come to you later. If you want, we can meet again this evening/tomorrow morning and talk some more about it.”)

Case Study (Continued)

55-year-old Mr. M. was diagnosed with small cell lung cancer. The attending doctor asks the patient whether it would be okay for his wife to join the conversation; the patient agrees, and the doctor invites both into his office.

Before the conversation, the doctor thinks about what exactly she wants to tell Mr. M. and how she would like to phrase the findings so that Mr. M. would still have hope, i.e., offering the possibility of radio- and chemotherapy and telling him that the associated symptoms such as pain and shortness of breath can possibly be treated. She also realizes that she must explain the findings and the treatment to the couple in simple terms. She does not want to share a prognosis, because, on the one hand, she knows from her own experience that they rarely come true and, on the other, she would like to prevent Mr. and Mrs. M. from losing hope.

In the conversation, the doctor tries to communicate the findings in a straightforward manner while remaining objective, yet approachable. She tries to dampen the initial shock, by building confidence in the treatment options. She avoids technical terms and explains the treatment options to the couple and how they work as accurately as possible.

It is difficult for Mr. M. to follow the explanations of the doctor. He feels numb. Toward the end of the conversation, he finally dares to ask whether he will be dying soon. At first, the doctor is surprised about the directness of this question. Through empathetic questioning, she learns about the painful death of a co-worker, who suffered from cancer. Gently, she addresses the fears of the patient and assures him that everything will be done to help him and to avoid unnecessary pain and suffering.

Preparing for Death

Doctor-patient communication becomes difficult when the doctor cannot offer any more treatment options. Feelings of powerlessness and helplessness spread in both the patient and the doctor (“empty hands” syndrome).

“Why don’t the doctors understand the importance of just being there? Why can’t they see that the moment in which they can offer nothing more is the moment in which one needs them most?” (Paula in Yalom 1999)

Hope is usually associated with a positive goal and success orientation, e.g., reduced to the formulation “with favorable prognosis.” It appears treatment failure would rule out hope. Giving hope is an important dimension in creating the doctor-patient relationship. Cancer patients, whose legitimate hope for cure and recovery is disappointed, are not necessarily without hope. When the hope of survival fades, other forms of hope, such as a peaceful death, reconciliation with estranged family members, or wishes like seeing the newborn grandchild become more important. Many dying people show a great calmness, wisdom, and humor in this extreme situation, which amazes the outsider. In order to develop these capabilities, respectful, empathetic attendance is necessary. The dying person needs to feel that he/she is not abandoned. It must be clear to the doctor that he/she will experience an intense, emotional bond to the patient who is preparing for death. Past experience with dying friends, siblings, or parents could possibly be triggered. It is important for the doctor to recognize his/her own “weak points” and vulnerabilities. Doctors who have experienced traumas and loss in their own lives are in the best position to empathize with others and to recognize their own limits. They can best understand what it means to prepare for one’s own death.

Case Study (Continued)

Chemotherapy had to be discontinued after 2 months due to severe side effects such as nausea and vomiting, loss of appetite, weight loss, and poor general condition of the patient. During this time, he was frequently visited by his family doctor as part of an outpatient palliative treatment and was emotionally supported by him. The patient died half a year later with his family present.

Pitfalls

- The doctor continues to talk, even if the patient is no longer receptive.
- There is too much information given at once.
- He/she ignores the patient’s emotional reactions.
- The doctor quickly changes to the factual level, because he/she can no longer take the emotionally stressful situation and feels overwhelmed by the task of caring for the patient long term.

- The doctor gives in to the pressure of the patient or the family and prescribes a new chemotherapy cycle, although he/she is not convinced of the indication. In short-term, this calms down the situation but moves all questions related to further tumor growth and the end of life to a time when the course of the disease has worsened and reached a critical state, and there is little time left for the patient to sort out all remaining questions in his/her personal life. It is merely an evasion of answering vital questions by physician, patient, and relatives.

Cooperation

Psychotherapeutic support is appropriate and necessary when the extent of stress exceeds the patient's coping capabilities with detrimental influence on the emotional well-being and social relationships over a longer period. This is the case in about 10–20% of all cancer patients. For these patients, depending on the severity of the psychosocial stress and therapy motivation, there is a need for psychological treatment. Emotionally stressed partners, children, and other persons close to the patient can also be in need of psychotherapeutic help.

Research Evidence

Studies have shown psycho-educative and psychotherapeutic treatment to be efficient in improving the well-being and quality of life of cancer patients. It could also be shown that side effects of chemotherapy, such as pain, nausea, and vomiting, can be influenced by cognitive behavioral therapy and imagination therapy. The influence of psychotherapy on the cancer prognosis has not yet been convincingly demonstrated. In many hospitals, there is a psychiatric and psychosomatic consultation and liaison service which takes over the specialist psychotherapeutic treatment and supports doctors and nurses in learning the basic psychosomatic competences.

Cultural Aspects

Patients of different cultures react differently to the diagnosis of cancer. American patients mostly hold views of adaption and hope. African patients maintain and hold more fatalistic and powerless views. In the Latin American region, breast trauma and certain “bad” behaviors are associated as being risk factors for breast cancer. How cancer and its symptoms are described is subject to the patient's educational level, medical knowledge, and culturally formed beliefs. Chinese describe a depressed mood as “I feel my heart is empty” without any cardiac problem. A

culturally sensitive physician will try to understand the symbolic meaning behind what is said rather than taking the complaint too literal. Furthermore, the patient's relation to the medical team may be different. Japanese patients will try to ask the nurses, whom they feel most comfortable to share their problems with. In Western societies, a person is expected to have an established family physician, but in Asian countries, a patient will shop around for physicians without feeling a commitment to remain with any particular family physician.

Also a wide range of concepts as to whether the physician should inform the patient truthfully about the diagnosis exist. The way to deliver bad news is influenced by cultural aspects (Ong et al. 2002). In many Western countries, oncologists usually inform cancer patients about their cancer diagnosis (Grassi et al. 2000). Studies have shown that 98% of patients would like to know their diagnosis, and 87% of patients would like to receive all available information, both good and bad (Jenkins et al. 2001). The individual wishes of the patient are highly respected. The ethical principle of autonomy supports this approach (Beauchamp and Childress 2001). However, it needs to be pointed out that in the USA and other Western countries, it was not common to practice disclosure of "bad news" about terminal illness prior to the 1960s. Currently, disclosure of medical information to patients is necessary because of the physician's concerns about malpractice lawsuits and the legal requirements to obtain the patient's consent for the treatment. Today cultural views as to whether the physician should truthfully inform the patient about the diagnosis of a life-threatening disease or not still vary from county to country. Patients from different ethnic backgrounds react differently to the disease of cancer. Patients from Western countries mostly hold views of adaption and hope. Patients from Africa and Asia maintain more fatalistic and powerless views.

Asia

For Asian physicians, disclosing diagnosis and prognosis to patients presents a big challenge, because they are confronted with a family-centered model of decision-making (Back and Huak 2005). Accordingly, it is expected that physicians first talk to the family members, who then decide whether the patient should be informed or not. Mostly, it is the task of a senior physician, and it is seen as a sign of competence and respect. If a junior physician or a nurse broke bad news directly to the patients, it would be seen as a breach of trust and might cause dissatisfaction. However, junior physicians and nurses are expected to give more detailed information to patients afterwards, to be in charge of the patient's following treatment and counseling. Most Asian families, however, ask physicians not to reveal the diagnosis and prognosis to patients (Hu et al. 2002). One reason for that might be the fear that the patient might commit suicide out of desperation after finding out about the diagnosis (Tse et al. 2003). This approach places emphasis on keeping patients away from harm and is integrated in the ethical principle of beneficence (Beauchamp and Childress 2001). However, more and more patients in Asia would like to be fully informed, and the right to be informed has been regulated by law. This new development represents a dilemma for oncologists. On the one hand, they must respect the

patients' autonomy, and on the other hand, they need to consider the families' concerns (Wang et al. 2004).

Iran

Cancer is the third leading cause of death in Iran. The increase in cancer incidence is one of the most critical challenges for the Iranian health-care system. Recent epidemiologic data show an age-standardized incidence rate (ASR) of about 142 per 100,000 inhabitants. It is estimated that there will be 100,000–110,000 new cases per year (Global Cancer Observatory 2019).

Several studies conducted in Iran demonstrated that cancer is a taboo subject, and the word cancer, as well as other indicative terms, were rarely used in daily communication. A climate of nondisclosure predominated as patients were the last to know their diagnosis, they were unaware of their prognosis, and family members and physicians employed strategies to conceal this information. The mutual concern of patients, family members, and physicians was the main reason that a cancer diagnosis is not discussed (Zamanzadeh et al. 2011).

Along with improvements in curative care (using advanced methods in diagnosis and treatment) palliative and supportive care including psycho-oncology is also improving in Iran (Rassouli and Sajjadi 2016; World Health Organization 2017; Khanali Mojen 2017). Qualified care for cancer patients, their families, and health-care providers is needed starting on the first days after diagnosis and this need poses a high demand on Iranian health-care providers (Omidvari 2016; Rouhollahi et al. 2014). Many clinical and health psychologists are studying and working in Iran, and most of the oncology hospitals need skilled psychologists to work with oncologists and palliative specialists.

Some of the essential skills in psycho-oncology include disclosing bad news, communication skills, a meaning-centered approach, spiritual care for some, and attending the decision-making process of the patient and family. The attitude toward cancer is very much influenced by culture and needs experience and expertise (Jünger et al. 2010; Jünger and Payne 2011; Scheidt et al. 2017; Ehsani et al. 2016 Ahmadifaraz et al. 2015). Currently, relatively good palliative care and psycho-oncology settings are found in Isfahan City, which includes the University Psycho-oncology Clinic, the University Pain Clinic, and a consultation and liaison service for inpatients. Palliative and psycho-oncological care is also provided by non-government organizations (NGO) in a Cancer Prevention and Control Center (MACSA), in Isfahan and Tehran. MACSA services are provided by the hospital outpatient clinic and ward, home care network, cancer rehabilitation center, hospice, call center, and cancer supportive social network, which has been developed over the past 5 years (MACSA 2019).

Regarding the high number of cancer patients and number of interested psychologists, recently, a culture-based and adaptive psycho-oncology educational program is being established by a joint program between the Department of Psychosomatic Medicine and Psychotherapy of Freiburg University, Germany, and the Psychosomatic Research Center of the Isfahan University of Medical Sciences, Iran.

Latin America

In most Latin American countries, cancer is highly stigmatized and viewed as a “death sentence,” with a culture of silence and fatalism implying that there is no treatment that can change the outcome of death. Given income inequalities and the weak health-care infrastructure, the treatment options are often limited. Perceptions of cancer (cause and treatment) vary with educational and social background and access to early detection and treatment services.

A research group of 98 doctors established in Cuba has shown that in case of serious illness, communication between doctor and patient takes place in an active-passive or a top-down paternalistic approach. In this mode there is a preference for not communicating bad news to the patient and avoiding talking about the facts of the illness. Also, among others, lack of empathy and mutual trust in the communication process was found, as well as lack of exploration on what the patient already knew about the illness and what the patient wanted to know. This study revealed that a great number of doctors surveyed did not have adequate communication skills (Martinez and Trujilo 2009).

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Chapter 12

Psycho-cardiology



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Case Study

Mr. S. is 50 years old, married, and a father of three daughters. He has been suffering from chest pain-related symptoms for 5 years. His risk factors for coronary diseases include high blood pressure, elevated blood lipid levels, obesity, and smoking. His risk factors are poorly managed, and he avoids doctor's visits. Four weeks ago, he suffered an acute posterior wall infarction.

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Psychosocial anamnesis

When the patient was 4 years old, his mother was diagnosed with cancer and, after a long battle with the disease, she passed away when her son was 12 years old. The patient still misses her to this day. The father had no emotional understanding for the boy's needs. He would live by the motto: "High performance and achievements are all that counts." In the aftermath of the myocardial infarction, the patient finds himself to be ignorant and depreciative to others ("lazy bone!").

The patient is a trained auto mechanic. He worked extremely hard up until the moment he fell ill (he feels indispensable at work), with little reward. He perceived work as being menial ("slaving and sweating away").

He regularly felt upset, experienced repeated fits of rage leading to conflicts at work and at home. He tried compensating these states of intense inner tension and irritation with excessive eating and alcohol consumption.

Definition

Coronary heart disease (CHD) denotes a deficient supply of the heart with oxygen due to increasingly narrowing coronary arteries (angina pectoris) up to total occlusion of the vessels eliciting a coronary infarction. The consequences of tissue destruction in infarction are impairment of the cardiac pump function with heart failure and cardiac arrhythmias with sudden cardiac death. Psychosocial problems after myocardial infarction can be destabilization of self-esteem, the fear of cardiac complications, loss of physical integrity, loss of job and decreased social status, feelings of dependence on doctors and caregivers, and impulsive aggressive behavior. Psycho-cardiology studies the psychological factors in the etiology, diagnosis, treatment, and prevention of coronary heart disease.

Relevance

In addition to many widely known risk factors (such as hypertension, increased serum levels of LDL cholesterol and triglycerides, diabetes mellitus, smoking, obesity, lack of exercise, and genetic factors), psychosocial stress also plays a decisive role in the development and course of coronary heart diseases. Changing the individual's lifestyle, for example, by quitting smoking, adjusting to a healthier diet, performing more exercise, and reducing stress can lower the risk of a heart attack by 80%. After myocardial infarction, 20% of patients meet the criteria of a depressive disorder; these patients also have a higher risk of dying.

Theory

Psychological Reactions After Diagnosis (ICD-10: F 43)

About 30% of patients experience anxiety and depressive symptoms during the first days and weeks after an acute heart attack. These psychological reactions are triggered by a destabilization of the patient's self-esteem, fear of cardiac complications, loss of physical integrity, loss of a job, social decline, feelings of dependence on doctors and nursing staff, and aggressive impulses.

Anxiety

Anxiety is the most significant psychological symptom during the acute phase. Anxiety can increase to the point of panic with feelings of mortal danger. Anxiety manifests through some of the following symptoms: a trembling voice, a fearful facial expression, clingy behavior, frequent reassuring questions, and suspicious controlling behavior. Anxiety is caused by the continuing angina pectoris symptoms, menacing phantasies about the cause and consequences of the cardiac infarction, loss of control, dependence on medical devices, fear of permanent damage, and impairments.

Depression

Overall a depressed patient displays a longer reaction time, as well as a lack of interest, and is often reclusive. Helplessness to the point of self-abandonment is hidden behind the apparent silent inconspicuousness. These symptoms often go unnoticed in the hustle and bustle of acute care hospitals.

The American Heart Association (AHA) therefore recommends a screening for depression consisting of two screening questions referring to the previous 4 weeks (Lichtman et al. 2008):

- “During the past month, have you often been bothered by feeling down, depressed, or hopeless?”
- “During the past month, have you often been bothered by little interest or pleasure in doing things?”

Patients who answer positive in both questions have a high probability for a depressive disorder (also see Chap. 8) and are subsequently further tested with another 9-item Patient Health Questionnaire (PHQ-9). In addition to an unspecific reaction to the cardiac disease, the depression symptoms are mainly caused by a sense of helplessness, suppressed aggressive impulses such as rage and grief directed at oneself, prior professional and/or personal resentments, or a depressive personality structure.

Diagnostic Categories

- Acute stress reaction (ICD-10: F43.0)
- Adjustment disorders (ICD-10: F43.2)

Onset and Course

Psychosocial Factors in Coronary Heart Disease

Psychosocial factors such as low social status, acute and chronic stress, depression, and anxiety are associated with an increased risk of cardiovascular disease and a less favorable course of the disease. Other important psychosocial stress factors are listed in Table 12.1.

Gender-Specific Aspects of Coronary Heart Disease

In women the risk of manifestation initially rises moderately after the onset of menopause and subsequently increases exponentially from age 75 onward. The cardiovascular mortality is higher than in men. This is likely due to the double burden of professional and family-related stress. Additional psychosocial stress factors in women include partnership, children, grandchildren, and other family-related problem areas.

Correlation Between Depression and CHD

Depression is a risk factor for the outcome of coronary heart disease. The mortality risk is 3–4 times higher for patients with depression. After a myocardial infarction, 20% of patients meet the criteria of a depressive disorder; these patients have a twofold increased mortality risk.

The correlation between depression and cardiovascular disease is illustrated in Table 12.2.

Table 12.1 Psychosocial stress factors associated with a higher risk of coronary heart disease and heart attack

Emotional stress factors	Occupational stress factors
Negative bonding experience	Excessive willingness to work with underestimation of the external demands and overestimation of one's own strength coupled with a high need for importance and recognition
Problems of self-esteem	
Chronic partnership conflicts	
Hostility	High professional demands with a concurrent low level of control over the work load, order of work tasks and their outcome
Social isolation	
Vital exhaustion	
Depression	
	High personal engagement with low returns in terms of pay, status, job security, and chances for promotion
	Lack of good relationships on the job

Table 12.2 Correlation between depression and cardiovascular diseases

Depression		
HPA axis ^a	Sympathovagal dysregulation	Altered health behavior
Hypercortisolemia	Impaired endothelial function	Noncompliance, e.g., medications
Elevated blood lipids	Arrhythmias	Smoking
Adiposity	Vasoconstriction	Lack of exercise
Insulin resistance	Hypertension	Unhealthy diet
Diabetes mellitus		

Type D personality

^aHPA hypothalamus-pituitary-adrenal axis

Interaction of the Risk Factors

Certain behavioral patterns develop due to an accumulation of stressful events during childhood which may later lead to stress responses in interpersonal relationships. A prolonged imbalance of the stress system increases depressive symptoms and promotes unhealthy behavior such as smoking, an unhealthy diet, and physical inactivity. Depression in turn represents a persistent internal stressor that may lead to the development of coronary heart disease through activation of the immune system and of blood coagulation and changes to the vascular endothelium. Patients often try to relieve psychological tension through nicotine abuse and overeating. *Negative personal relationships* and occupational disappointments are experienced as *re-traumatizing* and trigger depression as well as suppressed *hostility*. The interaction between these somatic and psychosocial risk factors increases the probability of dying a cardiac death at an early age tenfold.

Pronounced acute stress situations (e.g., anxiety, anger, grief) are found to promote plaque ruptures and trigger a heart attack via the acute response of stress hormones, the immune system, and the coagulation system.

Practice

Recognition

In coronary heart disease, 50% of deaths occur during the first 4 hours following the infarct; therefore a quick initial reaction to the symptoms is vital. Right after receiving the life-threatening diagnosis from the doctor, the patient might react with suppression and denial. This coping style can have the function of reducing anxiety and restoring mental functioning (see Chap. 1, section “Coping”), which can have a short-term stabilizing effect.

Although many patients experience a heart attack “out of the blue,” 25% of heart attacks have preceding characteristic warning signals that are usually ignored. These include fatigue, decrease in performance, trouble concentrating, dizziness, insomnia, anxiety, and a general feeling of illness. These symptoms are summarized under the term “vital exhaustion.”

Basic Therapeutic Attitude

The doctor obtains a better understanding of the patient's thoughts and behavior within the scope of the *biopsychosocial anamnesis*. He/she gets to know the patient's disease concept and identifies maladaptive coping strategies. In addition to finding out more about the patient's recent psychosocial stressors, the doctor offers regular appointments and emotional support. This can help the patient experience a sense of security as well as reduce his/her fears and strengthen his/her trust in the doctor.

Basic Interventions

Acute Phase

In the acute phase, the patient is in ambivalence between his wish for independence and (hypochondriacal) fears. The anxious side and the wish for regression are combated by a dominant and expansive manner so as not to lose "control."

Maladaptive coping strategies such as denial of a heart attack are coupled with the following consequences:

- Calling the doctor or ambulance too late.
- Angina pectoris symptoms are not recognized and not taken seriously.
- Prescribed bed rest is not followed.

Practical Tips

The doctor attempts to understand and accept the patient in his emotional ambivalence, by *reflecting both sides* to him:

- "You have always been used to being in control of your own life and making your own decisions. Now, maybe for the first time in your life, you are dependent on doctors, nurses, and machines. You might feel something like fear and helplessness. If you wish, you can tell me more about what you are thinking and feeling."
- "How did you feel when you learned you had had a heart attack? I can imagine, and I have heard from other patients, that it is a shock at first."

The doctor informs the patient about the goals of treatment and the treatment plans, as well as techniques to reduce lack of confidence and anxiety. Depending on the patient's need for information, potential causes of the heart attack may be discussed:

- "A heart attack seldomly comes out of the blue. What happened in your life during the past few months?"

Postinfarction Phase

Many patients experience the need for rest and the absence from work as passivity, which is difficult to bear. Their lives were formerly dictated by self-confirmation based on achievements and not compatible with longer bed rest and being “coddled.” Therefore, these patients soon show a tendency to take up their old life style, for example, with respect to smoking, diet, and working overtime.

Measures for prevention and treatment of coronary heart disease that only address changes in lifestyle (e.g., dietary advice, guidance on physical activity, smoking cessation program) may fall short in many cases. Rather, treating the psychological “scars” of earlier psychosocial stress should also be considered. In this regard, the therapeutic doctor-patient relationship offers an important learning area in which maladaptive relationship patterns that lead to emotional stress become apparent and may also be changed.

Sexuality and Coronary Heart Disease

Many patients and their partners are concerned that the physical strain of sexual intercourse may put the patient at risk. Especially men are often insecure about their sexual potency, when they are taking medication that might interfere with their sexuality (e.g., beta blockers). By actively addressing sexuality, the doctor relieves the patient and shows interest in his/her quality of life. The offer to talk about this topic is usually gladly accepted. The American Heart Association (AHA) has published detailed recommendations regarding sexual activity in cardiovascular diseases (Levine et al. 2012).

Intervention After Myocardial Infarction

Multimodal interventions include drug therapy, educational therapy, physical activity, movement therapy, as well as psychosocial therapy approaches, such as supportive and motivating conversations and stress management. The aim is to cope with the heart attack on the emotional level as well as a comprehensive promotion of lifestyle changes. These interventions are offered as part of cardiological and psychosomatic rehabilitation programs. It has been shown that follow-up rehabilitation after acute myocardial infarction and bypass surgery significantly reduced overall mortality, reinfarction rates, and hospitalization over the course of 1–2 years

Antidepressant Drugs

During the acute or chronic phase of coronary heart disease, patients with moderate or severe depressive episodes benefit from SSRIs (e.g., sertraline) and mirtazapine. However, the contraindications and warnings of the coronary heart medication

should be taken into consideration and appropriate tests (especially ECG) should be arranged. Anticholinergic effects of paroxetine, the long half-life of fluoxetine, as well as the high interaction potential of fluvoxamine and cardiac drugs such as hypericin are unfavorable for cardiac diseases.

Pitfalls

- The doctor is overwhelmed by the stories about past achievements and feels that his/her offer to talk is rejected. However, the “stories” often mask indications of severe anxiety, negative relationship experiences, and relationship desires.
- Some patients negate the threat of their physical health condition. The patient comes across as emotionally unfazed, is rigid, and refuses to cooperate. The doctor should understand that the denial may be a protection effort against the unbearable feelings of threat.

Cooperation

The need for psychotherapeutic support exists in 20% of patients both in the acute hospitalization and in outpatient or in-hospital rehabilitation. The aim of psychotherapeutic interventions is to reduce psychological symptoms, promote disease management, and reduce psychosocial risk factors.

The following treatments have proven beneficial:

- Cognitive-behavioral training programs to reduce stress and promote health-conscious behavior, with the aim of influencing cardiovascular risk factors
- Psychotherapeutic modification of coronary-endangering behavioral or personality characteristics, such as suppressed anger and social withdrawal
- Psychotherapeutic and psychopharmacological treatment of depression

Meta-analyses show that short-term psychotherapeutic interventions reduce psychosocial stress and lead to significant improvements in the psychological well-being and quality of life. The interventions normalized the heart rate, reduced cholesterol levels, and reduced the risk of cardiac events and cardiac mortality (Linden et al. 2007). The combination of established therapy approaches (consultations with the family doctor, psychotherapy and, if necessary, antidepressant medication) and basic cardiological therapy under the guidance of the family doctor (“collaborative care”) have been proven most successful (in studies conducted in the US).

Other Common Heart Diseases and Their Psychosocial Aspects

Heart Failure

The prevalence of depressive disorders in patients with heart failure is 2–4 times higher than in the general population. Depressive symptoms in turn increase the risk

of cardiac mortality. This is due to reduced adherence to necessary lifestyle changes such as fluid and salt restriction, daily weighing, physical activity, tobacco abstinence, limiting alcohol consumption, and medication adherence. Due to reduced cerebral perfusion, up to 50% of all heart failure patients suffer from at least mild cognitive impairments.

Cardiac Arrhythmia and Internal Cardioverter/Defibrillator (ICD)

Psychological factors such as depression and anxiety can significantly increase sensitivity to ventricular tachyarrhythmias (VT) in heart patients. Pronounced acute major stressors, such as a terrorist attack or an earthquake, can, however, also trigger VT independently of an existing heart disease.

The implantation of an internal cardioverter/defibrillator (ICD) places great strains on the mental adaptation of patients with heart disease. Approximately one fifth of patients suffer from anxiety, depression, and symptoms of post-traumatic stress disorder (see Chap. 13), which can be associated with a state of shock. In ICD wearers, PTSD correlates with unfavorable disease progression and increased mortality.

Arterial Hypertension

Arterial hypertension is the most common chronic cardiovascular disease with an increasing prevalence worldwide and is responsible for approximately 50% of cardiovascular mortality and morbidity. Loneliness, insomnia, and chronic stress at the workplace (e.g., frequently working overtime) can contribute to the development of arterial hypertension. High blood pressure also promotes the development of impaired cognitive functioning or dementia.

Takotsubo Cardiomyopathy

Takotsubo (or stress) cardiomyopathy, also known as “Takotsubo syndrome”, is a particularly impressive example of organic heart damage caused by acute psychosocial stress. The symptoms are infarct-like and result from a pronounced disorder of the systolic left ventricular function. Although the pumping function usually recovers within a few days or weeks, many patients still suffer from latent heart insufficiency. Almost half of the patients have current or previous anxiety disorders and depression. The assumed mechanism is an excessive release of catecholamine with resulting damage to the myocardium via cytotoxic effects or microcirculatory disturbances.

Non-cardiac Chest Pain/Somatoform Autonomic Dysfunction of the Heart and Cardiovascular System (ICD-10: F 45.3)

Heart-related complaints such as chest pain, palpitations, and shortness of breath are common symptoms in the general population as seen by general practitioners. If despite of extensive research no organic cause for the complaints can be found, so-called functional heart complaints are diagnosed (also see Chaps. 9 and 10).

The most common symptoms are the following:

- Diffuse, oppressive, or burning pain in the chest with radiations into the left arm
- Chest tightness
- Heart stumbling and palpitations
- Shortness of breath with accelerated breathing up to hyperventilation
- Sweating, trembling, fainting spells, weakness, and tendency to exhaustion

- Feeling of panic
- Sudden rise in blood pressure
- Feeling a lump in the throat

It involves an increased excitability of the vegetative nervous system. The above-mentioned physiological symptoms trigger feelings of anxiety. The anxiety leads to the activation of the stress axis. This leads to an increase in blood pressure and heart rate, which then leads to a vicious circle of anxiety (see Chap. 9). The psychosocial anamnesis often includes recent intense stressors such as experiences of separation, trauma, or death. About 30% of patients are diagnosed with panic disorder or depressive disorder.

After the patient has been informed about the results of the examination, regular visits are held every 2–4 weeks as part of the basic psychosomatic care. The above-mentioned stressors as well as possible treatment approaches are discussed. The first goal is to prevent the chronicity of the complaints. In case of severe chronic illness with frequent emergency hospital admissions, in-patient psychotherapy may be indicated. Relaxation techniques help to decrease anxiety and reduce stress. Physical activity prevents avoidance behavior of the patients, who are afraid of putting any physical strain on their body in fear of a heart attack (see Chap. 10).

Cultural Aspects

Iran

In recent years, psychoeducation and psychotherapy are sometimes applied during cardiac rehabilitation courses for stress reduction and comorbid depressive and anxiety disorders in Iran. Also, a so-called cultural psychotherapy is applied in Iran (Rajaei 2010). Since 2016 an international team has been working on national guidelines for psycho-cardiology in order to standardize psychosocial services for patients with psychological problems and integrate psycho-cardiological treatment into the health-care system (Roohafza and Goli 2018). As cultural components are significant for the understanding of symptom development, the aim is to yield more effectiveness in the doctor-patient communication and psychotherapy.

Regarding the location of the mind in the body, some anthropologic studies mention the culture of Iran to be cardio-centric rather than a cephalon-centric or abdomin-centric culture (Sharifian et al. 2008). In the Persian medical system, the heart is regarded to be the central organ to control the emotions as well as the location of life energy. Because of its high sensitivity, it instantly responds to mental and physical states. Traditionally the heart has been seen as the connection between mind and body, as well as an organizer of the whole body (also see the cultural aspects of Chaps. 9 and 10). Disruption of the heart functions therefore receive special attention. An irregular heartbeat may indicate personal emotional issues or problems in interpersonal relationships. The symptom attributions of patients with respect to cardiac symptoms include a long list of biopsychosocial causes (Good

1977): sadness, anxiety, thoughts of death, debt, poverty, conflicts, family problems and diseases, specific problems in everyday life, pregnancy, childbirth, an unhappy marriage, and many somatic attributions, such as anemia, low blood pressure, and vitamin deficiency.

Taiwan

A study on the personal beliefs about heart disease on patients with coronary artery disease (CAD) showed that Taiwanese patients have more false and maladaptive beliefs, in comparison to their British counterparts (Lin et al. 2008). Relatively lower prevalence rate of CAD in Taiwan, less well-developed health services for CAD patients, and the influence of the Chinese culture may account for the difference. A Canadian study revealed a similar finding: New immigrants from Chinese societies lack awareness of heart disease and stroke (Chow et al. 2008).

Latin America

The Latin American continent is facing an increasingly aging population, as well as a significant rise in urban populations, which has increased poverty, a sedentary way of living, and obesity. This has been causing health deterioration in general, with a significant increase of coronary heart diseases. Research has shown an increase in hypertension, hyperglycemia, and high levels of cholesterol. Coronary heart disease has been causing the highest mortality rates, as high as 34% or more in the overall American countries; the USA, for example, has been making attempts to bring CHD under control since 1960.

Health authorities have been taking some preventative action to face the increase of coronary heart diseases, which has been mostly based on information on developing a healthy lifestyle, as well as some follow-up home visits to some population groups who are the most affected by the disease. Unfortunately, despite efforts and optimism of health authorities, research findings have brought to light that the measures that have been taken so far, show no significant change in the lifestyle of the population undergoing these general educational procedures. Coronary heart disease continues to increase. In regard to prevention and treatment, findings show that it is still precarious, mostly among those who rely on the government free health-care system, while the ones on private health care are better cared for.

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Chapter 13

Acute and Posttraumatic Stress Disorder (PTSD)



**Kurt Fritzsche, Sonia Diaz Monsalve, Catherine Abbo,
and Frank Kuan-Yu Chen**

Case Study

A 45-year-old ENT physician was critically injured by a drunken 52-year-old patient with multiple stabbing wounds in the abdomen. Afterwards a verbal dispute from the patient's perspective followed, due to unsatisfactory treatment outcome. The doctor was treated at the hospital emergency room and then transferred to a normal ward. In the following days he seemed mostly irritable and developed anxiety in enclosed spaces, complaint of insomnia and restlessness. Upon questioning, he reported very frightening dreams that were directly or indirectly related to his experience of violence, waking up drenched in sweat and having trouble to find his bearings. Initially, he avoided to talk about these experiences and his mental condition. Only by careful inquiries by the ward physician it was possible to gather information on the full extent of the acute trauma. (continued)

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Definition

Psychological trauma is defined as the result of a momentary or prolonged stressful event that is beyond normal human experience and that would be stressful for anyone. The defining characteristic is the large discrepancy between external threats and the coping skills available.

A traumatic event meets the following criteria:

- Having been a victim in or witness of an event in which the person's own life or the lives of others were threatened; as a result of a serious injury due to a natural disaster, war, a traffic accident, diagnosis of a terminal illness, stay in intensive care, terrorism, rape or violent crime.
- The reaction of the person concerned involves feelings of intense fear, helplessness and horror.
- Due to the traumatic experience, the confidence in oneself and others is shaken fundamentally.

Another classification is often linked to the duration of the potentially traumatic event. Traumatisation, which was caused by a rather short and single event (e.g. serious accident or sexual abuse in adulthood), is referred to as Type I trauma. A longer-lasting and repeated trauma (repeated physical and sexual abuse in childhood) is referred to as Type II trauma. In Type I trauma, usually there are very clear, vivid memories of the event, and there is a classic picture of posttraumatic stress disorder (PTSD), whereas, in Type II trauma, often there are only diffuse, unclear recollections. Here, various comorbid mental disorders (e.g. anxiety, depression, physical symptoms and eating disorders) may occur (see Table 13.1).

Relevance

It is assumed that traumatic experiences, which have not sufficiently been processed and integrated, are a reason for numerous physical and psychological complaints, which come up in primary care. A traumatisation increases the likelihood of developing other mental illnesses such as depression, anxiety disorders, somatoform

Table 13.1 Types of trauma

Accident-induced trauma		Man-made trauma (interpersonal trauma)
<i>Type I trauma</i> Short	Car accident Work-related (i.e. police, firefighters) Work-related accident Natural disaster (such as a hurricane, stroke of lightning)	Criminal and physical violence (i.e. rape) Experience of civil violence (i.e. bank robbery)
<i>Type II trauma</i> Long-lasting Repetitive	Long-lasting natural catastrophe (i.e. flood, earthquake) Technical catastrophe (i.e. poisonous gas)	Sexual and physical abuse during childhood Being held hostage (wartime experiences) Torture and political imprisonment Mass extermination (concentration camp)

disorders and drug and substance abuse. Identifying trauma in time and providing necessary care will shorten the suffering and prevent the chronication of symptoms.

Theory

Symptoms

One can distinguish three groups of symptoms of PTSD.

Intrusions

Obsessive intrusive images such as nightmares, flashbacks or other sensations such as noise and strong sense of smell that directly emerge from the triggering event (accident, robbery, etc.) are difficult to access through voluntary control of the person concerned (*intrusion symptoms*).

Hyperarousal

Severe irritability, sleep disturbances, lack of concentration and overall significantly reduced physical and mental stamina.

Avoidance

Places and situations that are mentally and emotionally related to the traumatic experience are avoided. Feelings are superficial.

Other consequential symptoms of PTSD include sense of shame and guilt, identification with the aggressor, dissociation, self-harming and violence against others.

The long-term effects of PTSD are:

- Lasting personality changes such as hostility, distrust, withdrawal, chronic emptiness and feelings of alienation (Diagnosis F 62.0)
- Muscle or joint pain due to continuous strain of the deep structure of the muscles as a result of the interrupted, quasi-frozen fight or flight reactions in the acute phase of trauma stored in the body memory
- Lower abdominal pain after sexual intercourse as a result of sexual trauma

Diagnostic Categories

Acute Stress Disorder (ICD-10: F43.0)

This is a temporary disorder of an otherwise mentally stable person following extraordinary physical and/or emotional stress, which subsides within 4 weeks after the trauma. The symptoms include a shock reaction, feeling of absence, numbness

and disorientation as well as hyperactivity and autonomic arousal. They are adequate emotional and physical ways of reacting to heavy stress.

Posttraumatic Stress Disorder: PTSD (ICD-10: F43.1)

The symptoms occur within a few weeks (acute PTSD) or 6 months and later (delayed-onset PTSD) after the traumatic event. The symptoms last for more than a month. The person concerned is affected psychologically and socially.

Adjustment Disorder (ICD-10: F43.2)

The psychological responses, mostly in the form of depressive or anxious symptoms, may last for several months and up to half a year. There are patients who actively deal with the trauma and related psychological and physical symptoms and others who try to numb themselves with alcohol or tranquilizers.

Complex Posttraumatic Stress Disorders in the ICD-11

In addition to the core symptoms of PTSD (intrusion, hyperarousal, avoidance), complex PTSD is characterised by additional symptoms:

- Severe and profound disturbances of affect regulation
- Persistent belief that one has been destroyed, devalued or degraded by the traumatic event, with a profound sense of guilt, shame and failure regarding the traumatic event
- Persistent difficulties in maintaining interpersonal relationships and feeling close to others

Lasting Personality Change After Extreme Stress (ICD-10: F62.0)

The disorder is characterised by a hostile or distrustful attitude towards the world, a feeling of alienation, feelings of emptiness or hopelessness and a chronic feeling of tension. Posttraumatic stress disorder may have preceded this type of personality change.

Frequency

The 12-month prevalence of PTSD in the general population in Western countries is about 2% (Wittchen et al. 2011). The probability of the occurrence of less pronounced disorders is substantially higher. Women are affected twice as often as men. The occurrence of PTSD depends on the kind of trauma: trauma due to violation,

PTSD prevalence of 50%, due to other violent felonies 25%, and due to war victimization 20%. Less frequent PTSD prevalences are due to accidents, e.g. traffic accident (18%), trauma due to serious, life-threatening illness, e.g. cancer, (15%), and trauma due to intensive medical measures, e.g. polytrauma, (5%) (Kessler et al. 1995).

Onset

The *acute phase*, also referred to as shock phase lasts for up to 1 week.

The subsequent weeks are characterised by the attempt to return to a normal life and to process and integrate the trauma as an extreme experience. During this phase, which is referred to as the *impact phase*, a range of mental health symptoms may occur, mainly anxiety and avoidance. With increasing and enduring strain depressive symptoms are possible as well. This phase can last for several months and up to half a year. Then, the memories of the trauma slowly fade, and the symptoms subside (*recovery phase*). In about one-third of all patients, *chronification* must be expected.

Practice

Acute Trauma

Basic Therapeutic Attitude

Early interventions aim for basal *calming, safety and stabilisation*. They should offer patients a *safe space with clear boundaries*. They should be directed *less towards emotions* but primarily to *relaxation* and a *reduction* of the psychophysiological *stress symptoms*. The doctor's speech should be simple, slow, repetitive, objective and transparent.

Basic Interventions

The five essential elements of trauma treatment are *hope*, a sense of *safety, calming*, a sense of *self- and community-efficiency* and *connectedness* (Hobfoll et al. 2007). These principles can already be applied during the first 4 weeks.

A Safe Place

The most important thing in an acute crisis situation is to create a safe place where the arousal of the patient can subside.

Flashback management and dissociation stop. When patients are in a distressing dissociative state, it may be therapeutically necessary to help them to get out of this condition, so that they can reorient again in reality:

- Address the patient sternly, loudly, if necessary, give direction to the actual here and now.
‘Mrs. A, are you still here? Look around: You are safe!’
- Ask the patient to look around the room and to name five objects that he/she can see.
- You can hand the patient an ice cube or a hedgehog ball in order to draw attention to the sensory stimulus, even strong scents with a stimulating effect may be helpful.

Anamnesis and Resources Exploration

Case Study (Continued)

In our case study, the ward physician initially creates an undisturbed atmosphere. Outside the door she hangs a sign reading, ‘do not disturb’. Only when the patient has found a relaxed sitting position, she asks the patient about his present condition and, in terms of a narrative interviewing, she provides room for his experience. Possible topics of conversation can be found under ‘Practical Tip’. (continued)

Practical Tip

Brief resource-oriented anamnesis

- Current symptoms
- Event only in keywords: no invasive questions, no details, do not ask about emotions, keep everything superficial and at a distance
- Earlier traumatisations and coping strategies (trauma profile)
- Respect or support avoidances

Explore resources

- ‘What in your life has been helpful in difficult situations to calm down and to feel safe’? (make the patient tell concrete situations in more detail, if possible)
- ‘What is benefitting you in your life today’? (anything that gives pleasure, is important and is benefitting in more detail)
- ‘In earlier times: what has brought comfort and was helpful’?

Always aim at coupling possible associations with the traumatic event back to positive resources

‘...you did the best you could in the situation...and you survived...’

Psychoeducation

Case Study (Continued)

In another consultation, the ward physician provides the patient with information about the relationship between the acute trauma and current thoughts, feelings, physical sensations and behavioural impulses. She advises what measures have proven to be helpful for emotional stability. Examples can be found under ‘Practical Tip’.

Practical Tip

Providing information about trauma

- Simple models in simple, slow language, oriented at information already obtained from the patient: The current symptoms and state are the normal reaction to an abnormal, traumatic event/extreme stress. Most people would react this way. ‘The nervous system is flooded with stress hormones by such an event and needs time and a quiet environment to deal with the trauma/extreme stress through its own inherent self-healing powers’.

‘You can do something’—mediation of wholeness and self-efficiency

- Keep all stimulation and stressful things and input away from you, watch little TV, do not read newspapers
- Easily manageable diversion
- Emotional and practical support from important and close people
- Permission: talk when, about what, with whom, how long; you may or even must say *no*
- Provide safety and protection

Daily agenda and helpful activities

- Discuss and support structured agenda.
- Pick up helpful habits and daily rituals which were pleasant, relaxing and comforting before and after the trauma.
- Try out what will work and do this more often.
- Reactivate social network in everyday life.

Interventions on an Imaginative Level

Whenever traumatic or terrifying material threatens to flood the patient, ask them to lock these images and ideas in an imaginary vault or safe, where they will be stored until a sufficient stabilisation allows for their processing. In this exercise, defence mechanisms of denial and repression are specifically supported.

Psychopharmaceutical Treatment

In higher degrees of traumatisation, insomnia should be treated with zopiclone 7.5 mg or mirtazapine 15 mg at night. In cases of moderate or severe depression, selective serotonin reuptake inhibitors (SSRI) are necessary.

Cave: Benzodiazepines promote fixation of traumatic memories and should therefore be limited drastically or avoided.

Up to 4 Weeks After Psychotrauma

- Fulfilment of primary needs
- Creation and mediation of physical safety
- Practical and emotional support
- Psychoeducation/ information
- Stabilisation, medications (in higher degrees of traumatisation)
- ‘watchful waiting’ (in milder traumatisation)

Pitfalls

- Especially in temporal proximity to the event, there is the increased risk of *re-traumatisation* through flashback-like reliving of the traumatic situation with the consequence of a renewed mental destabilisation. Therefore, direct or repeated inquiries with respect to the traumatic situation must be avoided in order not to jeopardise the stabilisation that has occurred already.
- On the other hand, there is the risk that the treating physician supports the avoidance behaviour of the patient beyond the period necessary. This prevents the integration of the traumatic experience in the patient’s personality.
- Helpers in a potentially traumatic situation must also protect themselves. The probability of occurrence of secondary traumatisations is relatively high.
- Relaxation exercises, e.g. autogenous training can promote regression and should not be used.

Posttraumatic Stress Disorder (PTSD)

PTSD is diagnosed if the symptoms do not regress, are present over a period of 4 weeks and are persistently burdensome to the patient. The onset of symptoms may be delayed, with a symptom-free period directly after the traumatic event. The aim here is coping with what has been experienced by integration and compensation.

Case Study

Mrs. Hill, 60 years old, presents to the family doctor. She is currently in her second marriage, has been married for 20 years, has 2 children and 2 grandchildren. She lives with her husband in a small town near the doctor's office. She is treated by the family doctor for her high blood pressure and joint pain in the hands, which has become increasingly more painful. Currently, after not having visited the doctor's office for a very long time, the patient has an appointment because of insomnia and inner tension. When asked by the doctor about stressful events in the near and far past, Ms. Hill reports a car accident 2.5 years ago, in which the 4-year-old grandchild died. Her husband had momentarily nodded off, gone off the road, and the car had flipped over. While she herself suffered only a few bruises, the granddaughter eventually passed away from internal bleeding. Since then, the husband had become a mere shadow of his former self. Her first husband also died in a car accident at the beginning of her first marriage. (continued)

Recognition

For patients who seek the doctor's help for not only nonspecific symptoms such as insomnia, tachycardia, sweating, tension, irritability and depressed mood but also alcohol and drug abuse and report interpersonal and professional conflicts, one should always consider the possibility of PTSD. Especially, when the psychological reaction to an acute event, such as a minor accident or death of a distant relative, appears seemingly inadequate, one should always ask cautiously (risk of re-traumatisation) about an accident or other violent events in the patient's history. Based on the report of the patient, the doctor will then determine which phase (acute phase, the impact phase or chronic phase) the patient is in.

Case Study (Continued)

Mrs. Hill reports sleep disturbances and inner tension. Upon sympathetic enquiry of the doctor, she also mentions that she sometimes relives the accident like in a movie, especially when driving on a country road. In this situation she starts sweating, becomes dizzy, and her heart races. She can't think clearly anymore and is unable to stop the 'movie'. She then feels stunned, not knowing what to do with herself. In the evening or at night, she dreams about the accident and often wakes up sweating. She also shows strong reactions when seeing newspaper articles about accidents or when others by chance talk about minor accidents. Overall, she is more restless, more irritable and can no longer focus. In everyday situations, pictures of the accident overcome her uncontrollably. While reporting her experiences to the doctor, the patient appears very tense, speaks hesitantly and does not look at the doctor but rather restlessly back and forth in the room.

Based on the medical history and current symptoms, the doctor can make a diagnosis of PTSD, and thereby, timely initiate an important change in the direction of a targeted psychotherapy.

Cooperation

Trauma therapy has the objective to make the traumatic experiences relievable in order to be able to integrate them into the overall personality. It is subject to the following conditions:

- Adequate stabilisation of the patient, no acute psychopathology in need of psychiatric treatment
- Sufficient trauma-specific skills of the therapist, enough experience with trauma exposure
- No offender contact whatsoever
- No severe dissociative states, from risk of severe mental decompensation to suicidality in the emergence of traumatic memories

Example of Trauma Therapy

Trauma exposition (remembrance)

- As an introduction, reactivating self-calming and positive inner images (safe place, helpers inside).
- Divide trauma processing into individual steps; schedule intervals for stabilisation.
- Techniques: screen technology, eye movement desensitisation and reprocessing (EDMR), a bilateral stimulation of both hemispheres of the brain in the form of auditory or tactile stimulation.

Cultural Aspects

Africa

It is necessary for primary healthcare workers to gain an understanding of religious and spiritual healing and its role in healing patients with trauma; below are detailed aspects of an example of the Acholi people of Northern Uganda.

‘Acholi People in Northern Uganda’

The Acholi people in Northern Uganda have a constructive and dynamic approach to the task of dealing with traumatic experiences of the Lord’s Resistance Army returnees for the purpose of reintegration in the community. The returnees, especially children, experience bad dreams and nightmares. According to the Acholi people, the dreams and the nightmares are bad spirits that disturb the children, and this must be dealt with accordingly. Communities have a number of rituals, which can rid the child of these and restore peace to him or her. These ceremonies are intertwined with:

- The language of forgiveness
- Healing
- Restoration

One specific ritual, referred to locally as ‘the breaking of eggs’, is utilised to acknowledge children’s physical and spiritual absence, return and cleansing and to make them a member of the family. In this ceremony the child walks on a path and is required to step on and break some eggs. Towards the end of the ceremony, the child walks through the door of the house, and then water is poured over his or her head. By the time the child has completed the ritual process, the broken eggs are left behind, and the child emerges as cleansed.

The role of religion and spirituality in healing the emotional and psychological effects of psychotrauma is twofold:

1. To restore spiritual equilibrium shattered by the effects of trauma on the individual, family and community
2. To tap into the positive aspects of religious and spiritual coping to facilitate emotional and psychological healing of the effects of trauma

Primary healthcare workers’ role is to facilitate these two processes in the clients who are spiritually oriented, be it in traditional African religion or any other, and who may be going through an existential crisis of a spiritual nature. There is a need to be sensitive to cues about the client’s spiritual orientation as they talk about their trauma story. It should be remembered that many persons from the African sociocultural contexts have dual religious inclinations, that is inclinations that have elements of both traditional African religious practice and Judeo-Christian and Islamic influences.

How Health Workers May Facilitate Religious/Spiritual Healing

Traumatised patients need/want answers, justice and relief from negative emotions to get on with their lives. Most Africans are religious and have religious identities, something that can be harnessed to help them effectively deal with emotional and psychological effects of trauma. The health worker can facilitate religious and spiritual healing through the following:

- Assessing the religious and spiritual identity and needs of their client. Using a standardised tool to do this (see note above) and refer those who require and will benefit from religious/spiritual healing.
- Need to know the ‘good’ religious/spiritual healing resources in their community. Ideally should have formal contact with these practices where to refer their clients.

Fica Peel: A Tool for Assessing Religious/Spiritual Identity and Needs of Trauma Clients

- How important is *faith* in your daily life?
- How do your beliefs *influence* daily life?
- Are you a member of a religious *community* and how can they help you?
- How would you like your spiritual needs to be *addressed* in your treatment?
- Generally all your clients should have a *psychiatric* evaluation before referring them for religious/spiritual healing.
- Get the client’s and importantly others’ spiritual *explanations* for the trauma, e.g. if is it due to a curse, etc.

- Is the client's *experience* in keeping with those of immediate significant others and with cultural and religious beliefs of that community?
- Mental health workers need to *liaise* and appreciate the role of religious/spiritual healers in trauma management.

Taiwan

Due to the culture of expecting obedience from children, corporeal punishment is well accepted and prevalent in Taiwan and other Chinese societies. A study showed that about one-third of children in Taiwan experienced physical violence in their lives, a rate much higher than that of Western societies. The prevalence of PTSD related to physical abuse is also higher, about 13.6% of the maltreated children (Chou et al. 2011).

Regarding PTSD related to natural disasters in Taiwan, mainly typhoons and earthquakes, many religious groups, such as Tzu Chi Foundation (Buddhist), Chinese Christian Relief Association, Presbyterian Church in Taiwan and so on, provided many relief actions, but there is still no published scientific study to follow the effects of these relief actions.

Latin American

Armed conflict in Colombia has resulted in the displacement of an estimated 7.6 million people, or about 15% of the Colombian population. Hundreds of thousands of Colombians are exposed to violence and forced displacement annually. PTSD occurs frequently but is not detected or treated early. This severe problem has been highlighted in the study by Richards et al. using survey methods to assess levels of PTSD in the city of Medellin in a sample of 109 internally displaced adults. A large proportion of respondents showed clinically significant PTSD (88%). Focus group findings suggested that participants were interested in specialised psychological treatments as well as broader psychosocial interventions to treat the consequences of exposure to violence and forced displacement (Richards et al. 2011).

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Chapter 14

Dependence Syndrome



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Case Study

A 40-year-old man visits the family practitioner because of recurrent nausea and pressure symptoms in the upper abdomen. Based on the initial examinations, the family physician diagnoses gastritis; however, he harbours the suspicion of a possible alcohol dependence of the patient. Upon further

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questioning, the patient talks about consuming three to four bottles of beer daily, sometimes also adding hard liquors. It helps him to relax and to fall asleep faster at night. At his job, he is currently under a lot of pressure, sometimes fearing losing his job. During weekends, the patient consumes up to half a bottle of cognac by himself. He tolerates this amount of alcohol well and is not hung-over the following day—he appears to almost be proud of this.

Introduction

Definition

The World Health Organization (WHO) defines dependence as an insurmountable craving for a particular substance or a particular behaviour that can no longer be controlled and is dominating. The basis of dependence is the desire to experience the psychological effects of the addictive substance. After a certain time also, the aim to avoid unpleasant withdrawal symptoms (such as restlessness, insomnia, headaches, anxiety, sweating) becomes more and more relevant. The addiction leads to an increased tolerance and sometimes to physical withdrawal symptoms. During the course of the disease, the supply and consumption of the respective substances can develop into a life-determining matter. There is a distinction between a *dependence syndrome* and *harmful use*. The dependence syndrome refers to a cluster of physiological, behavioural and cognitive phenomena in which the use of a substance takes on a much higher priority for a given individual than other behaviours that once had greater value. A central descriptive characteristic of the dependence syndrome is the desire (often strong, sometimes overpowering) to take the psychoactive drugs, alcohol or tobacco. It is a weaker variant of the substance abuse behaviour—a consumption having a demonstrably harmful effect (physically or mentally), without the presence of any dependence.

Relevance

A vast majority of alcohol-dependent patients can be found in general hospitals and private practices. Only a minority speaks openly about their problems with a general practitioner. Even physicians have difficulty recognizing an addiction disease, confronting the patient about it and offering treatment options. The open dialogue is made more difficult because many alcohol-dependent patients come to the doctor for functional disorders or symptoms of pain; these complaints stay at the forefront of the patient interview, and an addiction is denied or trivialized.

Theory

Symptoms

The main symptoms of dependence are:

- Loss of control
- Withdrawal syndrome
- Development of tolerance

Clinical evidence for alcohol dependence includes a reduced general state of health and mental disorders such as anxiety, poor concentration, changes in appetite, sleep patterns and sexual functions. Also, hypertension, supraventricular arrhythmias, increased sweating, a slightly enlarged liver and tenderness in the epigastrium are seen. Twenty percent of the patients show signs of polyneuropathy.

Drug-dependent patients suffer from many psychological and physical symptoms such as general depression, rapid fatigability, decreasing performance, sleep disturbances, headache, aching body, muscle pain, tension, anxiety and other somatoform disorders.

Diagnostic Categories

- Acute intoxication (ICD-10: by alcohol F10.0 and other psychoactive substances F11.0–F19.0)
- Harmful use (ICD-10: of alcohol F10.1 and other psychoactive substances F11.1–F19.1)
- Dependence syndrome (ICD-10: chronic alcoholism F10.2 or other psychoactive substances F11.2–F19.2)

In general, a distinction is made between:

- *Substance addiction*: alcohol, medicines, drugs and stimulants such as caffeine and nicotine.
- *Non-substance or behavioral addiction*: e.g. pathological gambling. These disorders are classified in the ICD-10 as ‘habit and impulse disorders (F63)’.

Frequency

Alcohol, opioid and cannabis dependence rank together as the fourth most frequent group of mental disorders. The lifetime prevalence of alcohol dependence in Europe is about 3.4% (Wittchen et al. 2011).

Onset

Regarding the development of dependence, a multicausal model is used, in which there are interactions of genetic predisposition, personality structure, drug and social environment (family, social class, occupation, cultural influences).

According to the biopsychosocial model, various factors influence the development of a dependence syndrome:

- The addictive substance acts directly or indirectly on the dopaminergic neurons and triggers an activation of the reward system with euphoria and well-being. Furthermore, genetic vulnerability through genome variants can influence the reward system and the resulting addictive behaviour.
- The addictive substance can help to solve depressive moods, to fill loneliness, boredom and the search for experience during the feeling of inner emptiness. It may lead to increased performance and pain relief.
- In the social sphere, a 'broken home' situation, negative parental role models and peer pressure play a role.

Hypersexuality

Hypersexuality ('sex addiction') can also be evaluated as a non-substance-related dependency: if psychological strain develops and important parts of life (e.g. social contacts) are restricted significantly by often time-consuming sexual behaviour patterns (Kobs et al. 2011). The causes are depressive disorders but also obsessive-compulsive disorders or impulse control disorders.

Practice

Recognition

According to ICD-10, a dependence syndrome can be diagnosed, if at some point during the past year, three or more of the following criteria were simultaneously present:

- A strong desire or sense of compulsion to take the substance
- Difficulties in controlling substance-taking behaviour in terms of its onset, termination or levels of use
- A physiological withdrawal state when substance use has ceased or has been reduced, as evidenced by developing the characteristic withdrawal syndrome for the substance, or the intake of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms
- Evidence of tolerance, such as intake of increased doses of the psychoactive substance in order to achieve effects originally produced by lower doses (clear examples of this can be found in alcohol- and opiate-dependent individuals who may take daily doses sufficient to incapacitate or kill non-tolerant users)

- Progressive neglect of other pleasures or interests because of psychoactive substance use, increased amount of time necessary to obtain or take the substance or to recover from its effects
- Persisting with substance use despite clear evidence of overtly harmful consequences, such as harm to the liver through excessive drinking, depressive mood states consequent to periods of heavy substance use or drug-related impairment of cognitive functioning. Efforts should be made to determine if the user was actually, or could be expected to be, aware of the nature and extent of the harm.

Practical Tips

AUDIT (alcohol use disorders identification test; Bush et al. 1998)

The AUDIT questionnaire was developed on behalf of the WHO, which also recommends it. It consists of ten questions that are answered on a five-point scale. The points for each question are added to a total score. The minimum score is 0; the maximum is 40. *A score of 8 or higher indicates dangerous and harmful alcohol consumption.* In women and in men over 65 years of age, it is recommended to set the limit at 7 points.

Sample questions:

- How often do you drink alcohol?
- How often have you noticed that you have been drinking more than you actually wanted within the past year?
- How often have you felt guilty or bad about your alcohol consumption within the past year?

The entire test is available online (<https://auditscreen.org/using-audit>) in many different languages.

The diagnosis of drug dependence is complicated because most patients hide the symptoms—out of shame or fear of no longer getting prescriptions for the addictive drugs. Evidence for dependence may be obtained from the following:

- Patient's resistance against attempts to discontinue the drug
- Prescription forgeries and losses
- Obtaining drugs from other doctors
- Unauthorized increase of the dosage
- Improper use in times of psychological stress and in order to relax

Basic Therapeutic Attitude

Indirect evidence of alcohol dependence may be obtained from an increase in the typical laboratory parameters such as gamma-GT, transaminases, mean erythrocyte cell volume (MCV) and increased carbohydrate-deficient transferrin (CDT).

The doctor might be tempted to use these indirect measures to ‘condemn’ patients with so-called objective evidence. The doctor runs the risk of strengthening the defence mechanisms of the patient and to impair the patient’s relationship to the doctor. The best path to timely detection and diagnosis of an addiction problem is a constructive dialogue with the patient. If the patient does not feel condemned immediately as an addict/alcoholic, an open and informative discussion may develop.

As a basic attitude towards addicted patients, it is advised to rely on the techniques of motivational interviewing (Miller and Rollnick 1991), which are summarized below:

1. Show and express empathy

An empathetic approach fosters acceptance and facilitates change. The techniques of active listening are indispensable. Confrontations should be avoided by all means.

Doctor: “Alcohol consumption can lead to organ damage that can be seen in laboratory changes such as those we just found. Have you ever worried about your alcohol consumption?”

Less suitable would be: “Your laboratory results clearly indicate that you are an alcoholic. You can’t go on like this!”.

2. Foster the perception of discrepancies and willingness to change

Developing an awareness of the consequences of the addiction behavior is important. A discrepancy between current behaviour and important future goals promotes the willingness to change. The patient should provide the arguments for change himself/herself.

Doctor: “You are obviously very concerned about the threat of long-term organ damage. Still, you currently have laboratory values that point to the direction on these organ damages”.

3. Avoid gathering evidence

The doctor sometimes seems to become a detective who wants to convict the patient. Such an argumentation is counterproductive. If the patient shows resistance, it is a signal to change the conversational strategy. The patient may try to distract by trivializing, interrupting the doctor and blaming the environment. All of these behaviors are part of the resistance. The doctor should not react directly to these counterarguments but rather look at the emotional side, e.g. hidden fears of stigmatisation.

Doctor: “I understand that you don’t want to be put in the derogatory category of an “alcoholic”. Could it be possible, though, that you have already experienced damage or unpleasant consequences from your alcohol consumption?”

4. Go along with the resistance of the patient

Defensive arguments of the patient can be used positively. New perspectives are proposed, not prescribed. The patient himself is seen as a competent advisor in solving his/her problem with alcohol himself/herself.

5. Build up the patient’s trust in his self-efficacy

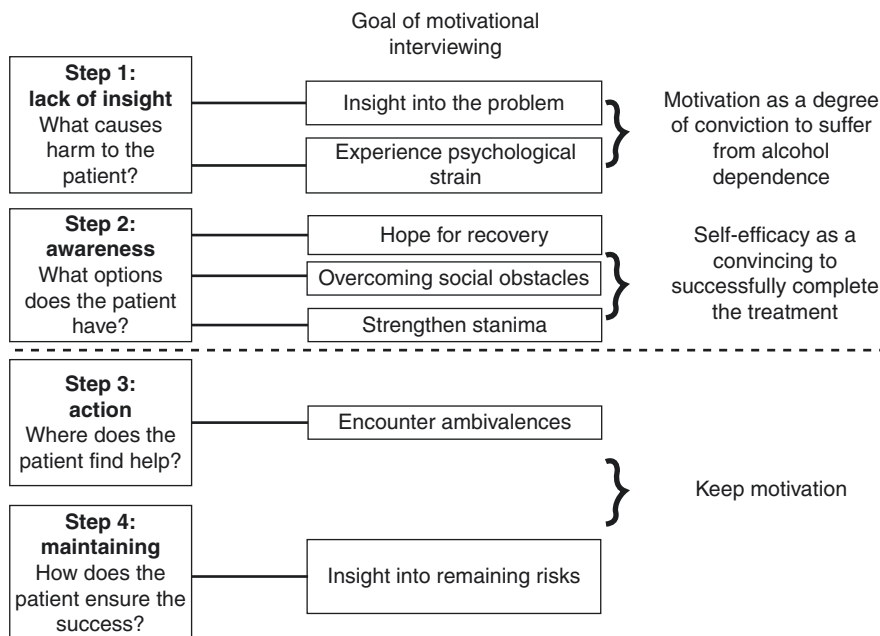


Fig. 14.1 Goals of motivational interviewing

The belief that change is possible, that the patient can do it himself/herself, is an important source of motivation. The patient is responsible for making the decision change and for going through with it (Fig. 14.1).

Doctor: “The fact that you have already managed to live abstinely for a few weeks in the past shows that you will be able to see abstinence through in the future. I would like to give you some information on how you can further improve your chances of success”.

Basic Interventions

The task of physicians in independent practices and hospitals is to provide an insight into the disease and to motivate the patient for the withdrawal treatment and the subsequent detoxification treatment.

Four Stages of Readiness to Change (Prochaska and DiClemente 1986)

Stage 1: From Precontemplation to Contemplation

Case Study

'Asking about consumption behaviour'

Doctor: I've now completed the examination, and I can say that I am presuming gastritis.

Patient: I am sure there is treatment available for it.

Doctor: Yes, there is. I would like to talk to you about possible maintaining factors and about your health behavior. For example, do you consume alcohol and nicotine?

Patient: I quit smoking 7 years ago, from one day to the next. It was not a problem at all.

Doctor: And alcohol?

Patient: Yes, I drink now and then. But that's normal.

Doctor: A lot of people drink regularly, that's true. How much do you consume?

Patient: About three to four beers in the evening. You have to understand! After work, I am exhausted. Currently, we are under a lot of pressure, and I'm a little worried about losing my job.

Doctor: So you drink to be able to relax better.

Patient: Yes, then I sleep wonderfully.

Doctor: What is the highest amount of alcohol that you can drink in one evening?

Patient: Well, on the weekend I had half a bottle of cognac. But I didn't feel much, I wasn't really drunk.

Doctor: And the following day?

Patient: I felt good, no problem. I can tolerate quite a bit.

Doctor: Have you thought about reducing your alcohol consumption?

Patient: Hmm...my wife keeps making comments.

Case Study

'Communicating the diagnosis of addiction' In the following conversation the diagnosis of alcohol dependence is clearly communicated to the patient without condemning him.

Doctor: After all that you've told me, and with the results of the blood test, my diagnosis at this stage would be 'alcohol dependence'.

Patient: Oh, come on! What are you telling me?

Doctor: I can understand your reaction. It sounds like a condemnation. But that's not what it is about. It's about me telling you very clearly what my findings are.

(Pause)

Patient: Yes, what do we do now?

- Doctor: That's the right question. Let's talk about what this diagnosis implies in terms of changes.
- Patient: Less drinking, I can see that, okay.
- Doctor: This is also very important to recognize. Alcohol dependence is a disease and not a character flaw. And I advise you very clearly to avoid alcohol completely in the future.
- Patient: What do you mean, completely? How can I possibly do that?

They agree on a 3–4-week alcohol abstinence. In most cases, the alcohol addict has already tried this temporary abstinence and has managed to handle it to a certain extent. In this respect, he may be willing to repeat this attempt in order to prove to himself and the doctor that he is not an alcoholic. It is agreed that if he is not able to follow this agreement, he will immediately come to the practice to discuss the situation that led him to drink again. In the subsequent visit, the physician goes into the anamnesis again more thoroughly. He diagnoses the above-mentioned symptoms of alcohol addiction clearly gets a picture of the professional as well as the family situation through a psychosocial anamnesis. In most cases, the patient is conspicuous at the workplace by showing reduced performance, frequent late arrival or absence, frequent injuries or sick leave.

Stage 2: From Contemplation Towards Action

Promoting motivation for change includes the identification of discrepancies in behavior and raising awareness in the patient, addressing his/her ambivalence on abstinence.

The patient experiences the dependence in an ambivalent manner: On the one hand, he/she realizes that it has become a problem and that he/she must do something about it. On the other hand, the function of an addiction is to protect oneself from unbearable feelings, to balance out insurmountable tensions and to create pleasure. The patient cannot imagine having to give up this comforting companion. The result is a mixture of contradictory feelings (guilt, fear, stubbornness, resistance, ...). Patients develop avoidance strategies regarding a detoxification treatment. This explains why they seem to listen to the consultation patiently and attentively but have actually zoned out internally. The doctor feels this ambivalence and should bring it up in conversation.

Case Study

'Promotion of readiness for change'

Patient: Never drinking again? I don't think I can do this.

Doctor: I am more hopeful about this than you! If you think about quitting smoking, you were actually able to do that! I think that you could also easily succeed in stopping to drink alcohol.

Patient: You may be right, indeed. But to be honest, I am not sure if I really want to.

Doctor: I have the impression that you still feel torn about this. One part of you clearly recognizes that you are addicted to alcohol and need help. Another part of you does not want to quit drinking and is fearful what might happen during a possible treatment. You are faced with a situation in which there are reasons for and against quitting.

Stage 3: Action Phase

This includes emphasizing the freedom of choice, to encourage abstinence and to create a plan for change with the patient.

Motivation is not seen as something static, rather as a dynamic process which requires a specific approach for each phase.

Stage 4: Maintenance Phase

Relapse is more the norm than an exception; it is a part of the ‘normal’ course of the disease. Outpatient follow-up (self-help groups, counselling, psychotherapy) can prevent or catch incipient relapses effectively. Recidivists avoid self-help groups more often than abstainers, even though the groups are extremely helpful, especially for them.

How Can We Prevent Individual Relapses?

- Early recognition and identification of high risk situations
- Preparing for and practicing possible actions in a high risk situation (development of appropriate abstinence thoughts, planning how to react in this situations)
- Making lifestyle changes (creating positive dependencies, long-term preventive measures)

Case Study

‘Dialogue after relapse’—relapse management

Patient: I don’t know how this could happen. I thought I had everything under control.

Doctor: You feel desperate and angry. But the important thing is that you came here.

Patient: I thought I had it under control.

Doctor: Relapses do occur. This is perfectly normal. The important thing is that we now deal with the relapse jointly and constructively.

Patient: What should I do now?
Doctor: My suggestion is that you go to the hospital immediately for the withdrawal treatment.
Patient: What? To the hospital? Doctor, is this really necessary?
Doctor: Yes. At the moment this is the safest place for you in order to ensure your long-term abstinence.

- Talking about how to deal with the shock of a relapse in case of a slip
- Continuous monitoring

Pitfalls

- If the doctor distances himself/herself too much, it is difficult to maintain the balance between therapeutic distance and empathetic closeness to the patient.
- The behavior towards the addict is formal, and the doctor responds mechanically to rule violations, without differentiated assessment of the current situation. This behavior leads to mistrust and distance between the doctor and the patient.
- The doctor has not maintained enough distance. He/she tends to play down and cover up the patient's apparent misconduct. He/she denies the extent of the addiction, though already several attempts of outpatient treatment have failed and inpatient treatment is urgently needed.
- At the first meeting, the patient makes the doctor believe that he/she is the only one who could help him/her out of this plight. The doctor is over-engaged and takes full responsibility for the patient's problems. Sooner or later, his/her idealistic commitment breaks down. He/she retreats disappointedly and angrily: 'Never again I will take care of an alcoholic. They cannot be helped. I'm bitterly disappointed'.
- Through his/her behavior, the doctor may be counterproductive, disease-prolonging and thus co-dependent if he/she believes that addiction is treatable with medical consultations and medication only, without requiring abstinence from the patient.

Cooperation

Usually, an effective addiction treatment can be carried out only in designated outpatient treatment centres and specialized clinics. The withdrawal phase lasts 2–4 weeks, followed by a longer-term psychological detoxification treatment. This is followed by several month-long outpatient follow-ups in an addiction advice centre and attending a support group.

Effectiveness of Medical Consultations

A family doctor intervention such as giving information and advice during a maximum of 30 minutes alone leads to up to 50% of the patients reducing their alcohol consumption (Moyer et al. 2002). Somewhat more extensive short interventions showed effects up to 4 years after implementation (Fleming et al. 2002).

Drug Treatment

Drugs that reduce the pressure of addiction (so-called anticraving substances) can be prescribed as a support of the motivational conversations with the primary care physician. These include the opiate receptor antagonist naltrexone and the NMDA receptor antagonist acamprosate. Treatment with acamprosate doubles the abstinence rate in motivated patients, and the efficacy is maintained even after 1 year of treatment.

Internet Addiction

The number of Internet users who fail to make adequate use of the Internet is increasing in clinical practice (Young 1998). Current national and international studies estimate that 2–7% of regular Internet users have problems handling their internet use adequately, showing addiction behavior. The prevalence of Internet addiction is generally higher for adolescents than for adults and higher for men than for women. While in the USA the prevalence rate for addiction is 5.7%, this rate is not significantly different from the European figures, a study in Taiwan identified 17.9% of adolescents and young adults as pathological internet users.

Professional help is sought out very late, mostly following an escalation in the family environment. Despite considerable suffering of patients and their relatives, internet addiction is not yet recognized as a disorder. There are neither consistent diagnostic criteria nor empirically based psychotherapeutic treatment approaches.

Symptoms and Diagnostic Classification

Pathological internet use is characterized by excessive use of the internet and loss of control with respect to specific forms of use such as online games and pornographic web content. Sufferers report symptoms showing parallels to substance-related addictions such as an intense craving and continuing use despite negative

consequences such as declining performance at work, health problems, family conflicts, withdrawal symptoms when consumption is reduced and the development of tolerance. Neuroscientific evidence has shown similar cortical processing features as in substance-related addictions.

Treatment Goals for Internet Addiction

The main objectives are to reduce the online time to a normal level and relearning of alternative behaviors. Psychoeducation and positive stress-coping strategies should be part of the treatment. A form of social competence training and the resumption of social contacts is important.

Cultural Aspects

Asia

A review in 2008 demonstrated that economic and sociocultural factors influenced alcohol consumption greatly in Asia (Chen and Yin 2008). For example, countries influenced more by Buddhism, such as Thailand and Japan, seem to have higher alcohol consumption than those countries mostly influenced by Judaism or Islam. In Taiwan, prevalence rate of alcoholism varied greatly among populations of different ethnic backgrounds.

In Vietnam, alcohol is considered as an essential component in social communication. Its consumption has become a Vietnamese cultural trait for weddings, festivals, parties, etc. Alcohol is seen as being healthy, especially when containing special traditional medications. Alcohol was homemade by farmers without any control over quality or consumption.

Internet addiction also constitutes a far-reaching problem. Among Chinese adolescents, the number of those who show a problematic use of the internet is rising. A nationwide survey (Hui et al. 2011) was conducted in eight Chinese cities involving 17,599 students. Approximately 8% of all participants reported problematic use of the internet. Compared to adolescents who use this medium to a normal extent, they often lack physical energy, have physiological problems and have a weakened immune system, suffer from emotional disorders and have difficulty adapting to their social environment. Overall, they are also significantly less satisfied with their lives.

Africa

Alcohol consumption in Uganda, like in many other cultures, is a widely accepted social activity. It is embedded in the local culture and tradition and an integral part of the whole village culture and a catalyst in social interactions. Cultural functions

such as weddings, births, funerals and circumcision ceremonies normally do not take place without alcohol.

Latin America

According to the WHO, in Latin America 8–15% of the burden of disease is due to alcohol consumption, as compared to 4% worldwide (WHO 2002). Brazil, the largest country in South America, provides data indicating that the population's alcohol consumption has been growing substantially in the last decade, particularly in young people. The extreme tolerance of the Brazilian society towards alcohol consumption is considered as intrinsically cultural to Brazil. Examples of this include alcohol behavior by young males, often considered positively as 'macho behaviour'; the lack of regulations; and the generalized presence of alcoholic beverages in the majority of gatherings and festivals such as carnival, soccer games, parties, funerals and many other events.

In Brazil, the Ministry of Health has recently adopted a multi-professional approach by means of creating specific institutions, which are at the moment mostly located in the bigger cities, named CAPSad—Centro de Atenção Psicossocial Alcool e Drogas (Center for Psychological Care for Alcohol and other Drug Addiction). The operational philosophy of these intervention centres is to keep the patient within the family context, and the family also receives psychosocial support. The CAPSad looks after kids, adolescents and adults within a group and individual assistance which comprises of social assistance, psychological support, physical exercise, occupational therapies and educational activities. Studies evaluation the CAPSad outcomes are still scarce. Nonetheless, some research findings have indicated that this model is managing to produce positive outcomes.

There are a variety of support programmes in progress to help families of drug addicts, with the main aims being to reduce anxiety and depression, as well as to improve interpersonal relations. These projects mainly help those family members who face difficulties in coping with having a drug addict in their homes. The PROAD program (Programa de Orientação e Atendimento a Dependentes—Departamento de Psiquiatria—UNIFESP), as well as other similar projects, is generally free of charge and mostly run on a volunteer or semi-volunteer basis. Studies developed on the outcomes of such interventions have shown significant reduction of depression and anxiety in couples (where one is suffering from addiction), but not in single patients. Moreover, this kind of intervention has also been important for a successful outcome.

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Chapter 15

Eating Disorders



Kurt Fritzsche

Introduction

Eating and drinking behavior are influenced by physiological and psychological processes but are also the result of educational and environmental factors. The prevalence rates for eating disorders seem to be stable in Western countries, while they increase in developing countries due to the influence of Western media and changes in eating habits.

A normal weight can be classified by the Quetelet Index (QI), which is also known as the “Body mass index” (*BMI*).

$$\text{Body mass index (BMI)} = \frac{\text{body weight (kg)}}{\text{body size (m)}^2}$$

Example

$$\text{BMI} = \frac{75(\text{kg})}{1,79(\text{m})^2} = 24$$

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The Consequences of a Disturbed Eating Behavior Are Shown in the List Below

Psychological Consequences

- Emotional changes (depression, emotional instability, anxiety), feelings of guilt and shame
- Cognitive deficits

Physical Consequences

Because of the Constant State of Hunger

- Feeling of weakness
- Bradycardia
- Hypotension
- Muscular atrophy
- Hair loss
- Reduced bone density (→ osteoporosis)
- Brain atrophy
- Endocrine disturbance (altered levels of serotonin, estradiol, LH, cortisol, growth hormone, thyroid hormones, etc.) → amenorrhea

Because of Self-Induced Vomiting and Laxative Abuse

- Electrolyte imbalance (especially hypokalemia)
- Dehydration
- Disorders of the acid-base balance (alkalosis or acidosis)
- Cardiac insufficiency
- Esophagitis
- Reflux
- Enamel defects, periodontitis
- Sialadenosis (swelling of the parotid gland)
- Long-term kidney damage

Social Consequences

- Restricted leisure activities
- Social withdrawal
- Possible debt (in consequence of binge eating)
- Difficulties in education and profession because of time consuming eating habits

Anorexia Nervosa (DSM 5: 307.1; ICD-10: F 50.0)

Symptoms

According to the *DSM 5*, the criteria for anorexia nervosa include:

- A. *Restriction of energy intake* relative to requirements leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significantly low weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.
- B. *Intense fear of gaining weight or becoming fat* or persistent behavior that interferes with weight gain, even though at a significantly low weight.
- C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent *lack of recognition of the seriousness* of the current low body weight.

The weight criterion for adults according to the first criterion (A) is a BMI below 18.5 kg/m². In the upcoming version of the ICD (ICD 11), the criteria for anorexia nervosa will be changed and defined in a similar way.

Distinguish between

- *Restrictive type/restrictive anorexia* (ICD-10: F 50.00)
- *Binge eating/purging type or active anorexia* (ICD-10: F 50.01)

Differential diagnoses

- *Anorexic reaction* (ICD-10: F 50.8) as a temporary eating disorder within the framework of stressful situations
- Weight loss due to an episode of depression
- *Purging in other mental disorders* (ICD-10: F 50.5, see, e.g., Chap. 10 Somatic Symptom Disorder)
- Tumor cachexia
- Inflammatory bowel disease
- Endocrine disorders like hyperthyroidism

Frequency and Course of Disease

The illness usually begins during adolescence. American studies show that 0.3–1% of women between the ages of 15 and 18 are affected (van Hoeken et al. 2003). The majority of the patients are female. 40% of all patients suffering from anorexia nervosa are girls between the ages of 14 and 19 years (Hoek et al. 1995). Anorexia nervosa can be found in all Western countries, less often in developing countries.

Comorbidity with other diseases is common, especially depression, anxiety disorders, and obsessive-compulsive disorder. The disease usually lasts for several

years. About half of the cases are cured after 4–6 years of treatment; in 20% of the patients, there is improvement with some residual symptoms remaining; in about 15% of cases, the disease takes a chronic course. The risk of death of about 9% of the cases is very high.

Psychosomatic Basic Care

The task of the *general practitioner* or primary care physician is:

- Recognizing and naming the disease as well as informing the patient (and his/her family) about physical and psychological consequences of anorexia
- Early involvement of the family
- Information about the basics of psychotherapeutic diagnostics and therapy
- Explaining the threat to life and the danger of chronification
- Obtaining a treatment contract from the patient and the family
- Promoting the patient's motivation for psychotherapeutic treatment while taking into account the often extreme ambivalence of the patients

Recognition

Patients with eating disorders often have little contact to doctors with knowledge about mental disorders. General practitioners, dentists, or gynecologists therefore play an important role in the early detection of eating disorders.

For example, the following risk groups should be considered for a possible anorexia or bulimia (AWMF online Guidelines 2018):

- Young women with low body weight
- Underweight or normal-weight patients with weight worries
- Women with cycle disorders or amenorrhea
- Patients with indications of malnutrition
- Patients with gastrointestinal symptoms
- Patients with repeated vomiting
- Children with a growth disorder

If you suspect an eating disorder, the following questions may be helpful for a first screening:

- “How satisfied are you with your eating habits?”
- “Is there anything you want to change about what and how much you want to eat?”
- “Does your weight affect your self-esteem?”

- “Are you worried about your figure?”
- “Do you eat secretly?”
- “Does it happen that you vomit when you feel uncomfortably full?”
- “Are you worried because sometimes you can’t stop eating?”

Patients with anorexia nervosa are often torn between the desire to get help on the one hand and their feelings of shame and fear of change on the other. The symptoms can be understood as an *attempt to solve inner conflicts*. Therefore, the patient often does not communicate directly but will “test” whether the doctor will believe the rather vague description of the symptoms.

Signs for *anorexia nervosa*:

- Dealing with weight in the form of a pronounced interest in diets, often dramatically low subjective desired weight, pathological fear of becoming fat
- At times, distinctly pronounced weight fluctuations
- Menstrual cycle disorders
- In cases with self-induced vomiting: hypokalemia, (brady-)arrhythmia, swollen salivary glands, scabby back of the hand and fingers, depending on the purging technique
- BMI below 18.5
- Disproportion between body weight and activity level
- Only vague indicated psychological complaints

In the general medical examination, the following elements should be included:

- Height and weight (BMI for adults or percentile curves for children and adolescents)
- Blood pressure and pulse

For the assessment of the vital endangerment due to underweight and the consequences of purging, the following elements can be used:

- Body temperature, inspection of body periphery (blood circulation, edema)
- Auscultation of the heart, orthostasis test
- Blood count
- Blood sedimentation
- Urea
- Electrolytes
- Creatinine
- Liver function test
- Blood glucose
- Urine status
- Electrocardiogram
- Bone density measurement

Psychotherapy

If a patient has a BMI of 15 or lower, treatment should always take place in an inpatient specialized facility. After achieving a minimum weight or base weight during the hospital stay (BMI of 18.5–19), subsequent long-term outpatient psychotherapy is absolutely necessary. Repeated inpatient admissions are common.

Treatment Concept

The treatment concept should contain *symptom-managing and conflict-managing* elements. After an initial focus on symptom reduction (normalizing eating habits, weight gain), the underlying conflicts are increasingly addressed in the course of the treatment (Herpertz, de Zwaan & Zipfel 2015):

1. *Behavioral therapeutic approaches* aimed at normalizing eating behavior in the sense of increased self-control:
 - Contract with determination of a regular weight gain until the basic weight is reached
 - Keeping an eating diary
 - Information about normal food quantities and eating structure
2. After symptom reduction, increasingly individual and group therapy to deal with the underlying *conflicts* with the aim of:
 - Strengthening self-esteem
 - Development of problem-solving strategies
 - Self-confidence training
 - Improving the perception of affects and conflicts
 - Improving affect regulation

Bulimia Nervosa (DSM 5: 307.51; ICD-10: F 50.2)

Symptoms

According to the DSM 5, the criteria for bulimia nervosa include:

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by *both* of the following:
 1. Eating, within any 2-hour period, an amount of food that is definitively larger than what most individuals would eat in a similar period of time under similar circumstances.

2. A feeling that one cannot stop eating or control what or how much one is eating.
- B. Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as *self-induced vomiting*; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.
- C. The binge eating and inappropriate compensatory behaviors both occur, on average, *at least once a week for 3 months*.
- D. *Self-evaluation* is unjustifiably influenced by body shape and weight.
- E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

The following symptoms may occur additionally:

- Electrolyte disorders, mainly *hypokalemia*, which can lead to cardiac arrhythmia and sudden cardiac arrest as well as chronic irreversible kidney damage with dialysis consequences
- *Tooth damage* caused by gastric acid
- Chronic inflammation and swelling of the parotid gland, the so-called hamster face
- Irritation of the esophagus mucosa, heartburn, ulcerations, and cardiac insufficiency
- Feelings of guilt and shame

Frequency

The prevalence rate among 20–40-year-old women is about 3%. About one third of these patients had an anorectic phase. Many years lie between the onset of the disease and the diagnosis, as the patients conceal their symptoms due to strong feelings of shame and guilt.

The following factors play a role in the development of bulimia nervosa:

Low self-esteem and feelings of emptiness and senselessness are hidden behind a strong independent facade.

High performance standards.

After disappointment, e.g., in a partnership, the symptoms of eating serve to neutralize strong internal tensions with aggressive impulses.

In some patients, self-harming behavior (e.g. cuts in the forearms and thighs) occur as an expression of the loss of impulse control.

Comorbidity with personality disorders.

Psychosomatic Primary Care

Recognition

Patients with bulimia nervosa are usually under high psychological pressure but tend to conceal the disease. A cautious but open response of the doctor to the suspected illness often leads to relief.

Warning signals for bulimia:

- Hypokalemia
- Tooth decay
- Calluses on the fingers due to frequent self-induced vomiting
- Otherwise similar to anorexia, but no cachexia

In diagnostics, data should be collected from the following areas of life:

- Family history of eating disorders
- Food-related behavior in the family
- Biographical prehistory of emotional neglect, physical neglect
- Or sexual violence experience
- Self-esteem development
- Problems with impulse control
- Dietary behavior
- Excessive preoccupation with one's own body

Information and Advice

As with anorexia nervosa, the main objective is to identify and name the disorder and to provide information about the clinical picture, the treatment and the motivation for specialist psychotherapy. Special consideration needs to be given to the problem of puberty in bulimia and the strongly fluctuating treatment motivation.

Psychotherapy

In many cases, outpatient, disorder-specific short-term therapy is sufficient. For patients with drug abuse, suicidal behavior, or underlying personality disorders, inpatient psychotherapeutic treatment and subsequent outpatient treatment might be indicated.

Similar to anorexia nervosa, the treatment concept should include *cognitive-behavioral elements*:

- For the modification of eating behavior in the sense of increased self-control
- Strengthening self-esteem,

- Development of problem-solving strategies
- Self-confidence training
- Working on the meal structure
- Working with an eating diary
- Reintegration of “forbidden” foods
- Working on affect tolerance and regulation

Patients learn to endure feelings of emptiness and to express sadness and anger verbally in conflicts without binge purging behavior. In the further process, the treatment of underlying conflicts moves into the foreground.

Medication

Only in addition to psychotherapy, psychopharmacological treatment with selective serotonin reuptake inhibitors (SSRIs), e.g., fluoxetine, is considered effective, especially in cases of pronounced depressive symptoms and loss of impulse control.

Binge Eating Disorder (BED) (DSM 5: 307.51; ICD-10: F 50.8)

Symptoms and Diagnostic Classification

According to the DSM 5, the criteria for *binge eating disorder* are:

- A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
 1. Eating, in a discrete period of time (e.g., within any 2-hour period), an *amount of food* that is definitely larger than what most people would eat in a similar period of time under similar circumstances.
 2. A sense of *lack of control* over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
- B. The binge eating episodes are associated with three (or more) of the following:
 1. *Eating much more rapidly* than normal.
 2. Eating until feeling *uncomfortably full*.
 3. Eating large amounts of food when *not feeling physically hungry*.
 4. *Eating alone* because of feeling embarrassed by how much one is eating.
 5. Feeling *disgusted with oneself*, depressed, or very guilty afterward.
- C. Marked *distress* regarding binge eating is present.
- D. The binge eating occurs, on average, at least once a week *for 3 months*.

- E. The binge eating is not associated with the recurrent use of inappropriate compensatory behavior as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Consequences of obesity are:

- Endocrine metabolic disorders: arteriosclerosis, lipid metabolic disorders, diabetes mellitus type 2, arterial hypertension (metabolic syndrome), and hormonal disorders such as hirsutism, fertility disorders
- Heart failure, sleep apnea syndrome
- Additional mechanical stress: arthrosis and degenerative diseases of the spine
- Decreased performance and mortality 12 times higher than normal weight. Life expectancy shortened by approx. 6 years.

Psychosocial Consequences of Obesity

Depending on its severity, obesity is associated with a significant reduction in individual quality of life, comparable to that of chronic physical diseases. Patients are socially discriminated against in their search for a job and receive lower wages. Incapacity to work and early retirement are often the result. They have difficulties in finding a partner, and there are negative interactions with other people and with the doctors treating them. Psychological problems can take the form of self-esteem crises, feelings of guilt and shame, social withdrawal, depression, anxiety disorders, and functional body complaints. Conversely, depression increases the risk of obesity.

Conditions Under Which BED Develop

If a child has not learned to differentiate negative affects, e.g., to distinguish hunger from fear or grief, negative affects can be alleviated by carbohydrate-rich food. Neurobiologically, the serotonin metabolism and the leptin metabolism are involved. The innate regulation through the feeling of “saturation” is lost. The familial accumulation speaks on the one hand for a genetic component. However, the rapid epidemic-like worldwide increase in obesity cannot be explained by genetic factors alone. Here, sociocultural factors seem to be decisive.

Binge eating disorder is characterized by significant comorbidity, in particular affective disorders and personality disorders. The binges often serve the attempt to neutralize dysphoric moods at least for the moment. In patients who have experienced sexual assault in their childhood, obesity can serve to ward off female attractiveness in order to protect oneself from male assaults.

Psychosomatic Basic Care

Recognizing BED and Metabolic Syndrome

In order to present abdominal obesity as a risk factor, the abdominal girth is needed.

The risk of metabolic syndrome increases with abdominal girth:

Women > 80 cm

Men > 94 cm

Other parameters to be measured for diagnosis of metabolic syndrome: triglycerides, HDL cholesterol, blood pressure, and fasting blood sugar

Basic Therapeutic Attitude

The physician should build a working relationship with the patient and accompany him on a long-term basis. A long-time perspective and small achievable goals are needed. The treatment is most likely to succeed if the doctor has a disease model that does not blame the patient for his behavior but includes biographical, sociocultural and emotional as well as genetic causes. It is always helpful to link eating behavior and weight reduction with general life goals and lifestyles.

Doctor-Patient Relationship

In order to create a viable, helpful *doctor-patient relationship*, the physician should be the one who provides support:

Take the BED patient seriously and do not regard the patient's self-perception ("I don't understand why I'm gaining weight, I'm not eating anything") as a conscious deception.

The doctor should control his (*counter-transference*) feelings of anger, rejection, and contempt, because the patient will notice these feelings and will be further weakened in his self-esteem.

Treatment Goals for BED Therapy

- Treatment of the symptoms (binges, excess weight/obesity, psychopathology specific to eating disorders)
- Treatment of other psychological complaints (e.g., self-esteem and feelings of shame, emotional regulation)
- Treatment of comorbid mental disorders (e.g., depression, social anxiety), relapse prevention through learning of meta-knowledge (Herpertz et al. 2011)

Psychotherapy

Binge eating disorder is often an expression of a typical affect regulation disorder or a lack of impulse control. Therefore, approaches of cognitive-behavioral therapy, which start with the promotion of impulse control, prove to be helpful. Furthermore cognitive-behavioral structured self-help (in group settings as well as autodidactic self-help based on a manual) was found to be very effective in reducing the number of binges, but not effective in reducing the patient's weight (Herpertz et al. 2011).

Important treatment elements of a multimodal treatment concept are:

- Behavioral therapy group sessions with psychoeducation in the form of motivation to change the behavior of diet and exercise, social competence training, problem-solving training, and stress management training
- Nutritional advice on fiber-rich, mixed diet with low energy density
- Possibly initial formula-based diet (protein-rich, low-carbohydrate diet)
- Sport therapy, exercise groups
- Cooking group if applicable
- Long-term support through self-help groups

Drug Therapy

Lisdexamfetamine, antidepressants, and antikonvulsiva are indicated, if psychotherapeutic treatment has not shown any effects or the patients refuse psychotherapeutic treatment.

Surgical Obesity Treatment

Obesity surgery (tube stomach, gastric band, gastric bypass) is indicated for BMI $>40 \text{ kg/m}^2$ or BMI $35\text{--}40 \text{ kg/m}^2$ with additional risk factors. These so-called bariatric surgeries can lead to weight reductions of 20–40 kg in 1–2 years and a remission of type 2 diabetes mellitus. Psychosocial problems such as depression and anxiety disorders, self-esteem problems, and quality of life also improve. In long-term observational studies over 10 years, a higher risk for the occurrence of alcohol abuse, suicide, and nutrition deficits was found.

As there is uncertainty about the benefits and harms in the long-term course, every decision for surgical obesity treatment should be preceded by a shared decision-making process between doctor and patient. At the same time, bariatric surgery should always be supported by pre- and postoperative therapy of a conservative or psychological nature (integrated therapy approach) in order to ensure the long-term effectiveness of the therapeutic success. Lifelong interdisciplinary after-care is required.

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Chapter 16

Personality Disorders



Kurt Fritzsche

Characteristics

Personality disorders are associated with impairments in certain abilities that are essential to mastering the basic challenges of human life, such as building sustainable interpersonal relationships. One characteristic of personality disorder is that these patients do not usually have access to their particular ways of reacting. They consider the behavior of other people toward them to be inappropriate and do not see their own part in it. In fact, the reactions of others are sometimes brusque, negative, or exploitative. As a result, patients with personality disorders very often experience relationship problems. The switch between encapsulating themselves and clinging to others, between idealization and devaluation and the manipulative interaction with other people make the personality disorder a torture not only for the person affected but also for his environment.

However, the patient with personality disorder does not question what triggered such behavior. The disorder is called “egosyntonic disorder” because the patients themselves do not notice their distinctive relationship behavior. The disclosure of problematic relationship behavior is therefore rejected by such patients.

The reason for accepting therapeutic support is therefore not to be found in the insight into one’s own relationship problems but rather the psychological crisis caused by the rejection and humiliation by others. Thus, a depressive disorder with suicidal tendencies can develop as a result of repeated insults.

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Symptoms

Rigidity of Thought

Preconceived and immovable opinions dominate the mind. The persons affected are not open to reasonable arguments. Characteristic are splittings, such as pronounced black-and-white thinking, either/or, good or evil, and all or nothing. They fluctuate between the tendency to strongly idealize other people and life possibilities or to devalue them in the strongest possible way. There is an inability to ambivalence, to dichotomy. Gray tones are not permitted.

Disturbed Emotional Regulation

The patients struggle with strong feelings of anger, despair, and disappointment but also feelings of fear, shame, and guilt, which they can hardly master or adequately express. These feelings are often triggered for no reason at all. A frown or a harmless remark of the dialogue partner, a missed train, or waiting in line can trigger emotions that seem inadequate to the occasion.

Problematic Interpersonal Relationships

Contact with other people is severely impaired. This applies both to the immediate family and partners as well as friends, colleagues, and people met by chance. The lack of empathy, permanence, and reliability is often the result of attachment disorders in the first years of life.

Diagnostic Classification

Paranoid Personality Disorder (ICD-10 F 60.0)

Characteristics are excessive sensitivity to rejection and distrust; friendly actions of others are misinterpreted as hostile.

Schizoid Personality Disorder (ICD-10 F 60.1)

Characteristics are retreat from affective and social contacts, solitary behavior, self-contained restraint, and limited ability to express feelings and experience joy.

Emotionally Unstable Personality Disorder (ICD-10 F 60.3)

Characteristic are impulses that are acted out without consideration of the consequences; impulsive type and borderline type (see below).

Histrionic Personality Disorder (ICD-10 F 60.4)

Characteristics are superficial and unstable affectivity, dramatization, theatrical and exaggerated expression of feelings, egocentrism, lack of consideration, and a tendency to be easily offended.

Anacastic (Compulsive) Personality Disorder (ICD-10 F 60.5)

Characteristics are feelings of doubt, perfectionism, exaggerated conscientiousness, constant controls, and rigidity.

Anxious (Avoiding) Personality Disorder (ICD-10 F 60.6)

Characteristics are feelings of tension, anxiety, insecurity and inferiority, persistent longing for affection and acceptance, hypersensitivity to rejection and criticism, and a tendency to overemphasize potential dangers or risks of everyday situations.

Addictive (Asthenic) Personality Disorder (ICD-10 F 60.7)

Characteristics are passive reliance on others, great fear of separation, feelings of helplessness and incompetence, tendency to submit to the desires of older and other people, and failure to meet the demands of daily life.

Other Specific Personality Disorders (ICD-10 F 60.8)

These include eccentric, narcissistic, and passive-aggressive personality disorders.

In *DSM-5*, personality disorders are grouped into so-called clusters.

Cluster A comprises the PD close to schizophrenia. Persons with these personality disorders are suspicious, odd, and eccentric and act in an emotionally blunted to cold manner. With supposed insults and threats, their mood can quickly turn into

anger. They live in isolation and have hardly any interpersonal contacts (paranoid and schizoid PD).

Cluster B personality disorders are characterized by dramatic, overly emotional, or unpredictable thinking or behavior. They include antisocial personality disorder, borderline personality disorder, histrionic personality disorder, and narcissistic personality disorder.

People with *Cluster C* personality disorder can be described as anxious and fearful. Besides tension and anxiety, central feelings in these people are feelings of helplessness and dependence. They are vulnerable to criticism or rejection and suffer from massive separation anxieties. With excessive conscientiousness, they are less flexible and tend to be passive aggressive (borderline, histrionic, and narcissistic PD).

For everyday use, especially in psychosomatic basic care, frequently occurring personality disorders are presented.

Borderline Disorder (ICD-10: F 60.31)

Patients with borderline personality disorder are emotionally unstable. Emotional situations, such as insults, frustrations, anger, and disappointment, are very difficult to deal with. Patients react impulsively to such feelings, usually with aggression against themselves and others in the form of outbursts of anger, insults, or the threat of breaking off a relationship. The consequences are unstable, less constant, and crisis-like relationships with other people, which at the same time are often very intense – both positively and negatively. Borderline patients often have a pronounced fear of being abandoned. Central is the desire for a safe, reliable, and intimate relationship. They often, however, lack the tolerance for difficult phases in a relationship – usually due to bad experiences and traumatization. The feeling of unpredictability immediately activates the fear of separation and leads to a derailment of emotions. Their relationships are therefore characterized by fluctuations, which are very intimate in positive situations and very aggressive in negative situations. The fluctuations in the relationship confirm the assumption that they can never be sure of the partner.

Case Study

In 25-year-old Elisabeth, the family doctor notices both fresh and partially scarred cuts on both forearms and thighs. She reacts embarrassed and dismissive to his inquiries.

Yes, she would cut herself. She has been doing that for a long time. That helps her to reduce stress.

How do things look like otherwise in her life?

Nothing special. Although she can't cope with studying sociology and philosophy, she doesn't know what else to do. She does not have a partner. She is still fed up with the last one. Sometimes she goes out with someone, or takes someone home with her, and then she feels bad.

What about at home?

What's that supposed to be? Her father left when she wasn't even 3 months old. He probably had somebody else; that's all she knows. The mother was constantly overwhelmed by the situation, severely depressed, in and out of clinics all the time, and full of gloomy prophecies. As a child, she felt responsible for keeping her mother alive, which oftentimes overwhelmed her. Sometimes a cold anger and despair grab her, and then she doesn't want to live any more. She's already tried twice to take her own life with tablets. The next time she is certain she would succeed.

Fearful, Avoiding (ICD-10: F 60.6), and Dependent (ICD-10: F 60.7) Personality Disorder

Characteristics are hypersensitivity and a constant anxiety of not being able to satisfy their own expectations and demands or those of others. Self-esteem is greatly reduced. All kinds of efforts, challenges, and relationships with other people are fearfully avoided. Sometimes, there is a fixation on one or a few people who are strongly idealized.

Case Study

A mother speaks to her family doctor:

Something is wrong with her daughter Monika.

She is now 19, hardly leaves the house; she's dropped out of school. Various attempts to start an apprenticeship have also been unsuccessful. She sleeps a lot, listens to music; sometimes she brings herself to do a bit of needlework. What sort of life is that?

When you talk to her, or you don't do what she wants, she gets impudent, quick-tempered. Her father recently tried to set a deadline: if she didn't get a job, she would be kicked out. Then all hell broke loose, but that was no solution either. What should be done?

Quiet and withdrawn, she had always been shy, even in kindergarten. Her older brother and younger sister are completely different. The mother worries. If she and her father were no longer there for Monika, she would certainly not be able to cope with life anymore.

Narcissistic Personality Disorder (ICD-10: F 60.80)

Characteristic is *narcissistic overconfidence*. Admiration, success, and applause are addictive. Such people seem demanding, exploitative, envious, and arrogant. If we add a high level of intelligence and eloquence, we find these personality-disordered people in highly successful positions in politics, science, and business.

Case Study

The doctor's assistant comes into the consulting room: "Mr. Walter doesn't want to wait anymore; what should I do?" "Tell him in 5 minutes."

Pale with rage, tense, and narrow-lipped, it breaks out of Mr. Walter: "I've been waiting over half an hour." "I'm sorry, an unforeseen incident, didn't the assistant tell you that?" "That doesn't interest me. If I let my shop slide like that, what do you think would happen there?"

"What brings you to me?" "How nice that I can finally present my request," he says sarcastically. "So, stress at all levels, the company wants to get rid of me; I get bullied. Supposedly, my health isn't up to all the demands any more. You have to certify that I am in top shape. I won't let anyone fool me. My lawyer will call you and tell you what the certificate should say. Is that alright?"

"I'll have to examine you first, and I'll need some information from you." "I said I'm in top shape; isn't that enough? Don't you believe me? Is this going to happen again?" "Please calm down. After all, I'm supposed to help you, but you'll have to go along with that." "Well, I won't do that anymore; I won't do that to myself; I knew right away how this was gonna go here."

He speaks and leaves the practice slamming all the doors.

The primary difference between personality disorders and *psychosis* is the intact relationship to reality. There is a smooth transition to peculiar people with certain personality styles, who stand out as misfits, eccentrics, creative, or highly gifted. Personality disorders are the extreme manifestation of personality styles.

Outlook

The validity of the above characterizations has long been questioned by researchers and clinics. Future classification systems for personality disorders will probably consist of two-dimensional modules to determine the severity and nature of the personality problem.

Frequency and Conditions of Development

Some 5–10% of the population suffer from a personality disorder.

The development of personality disorders is linked to the interplay of the following risk factors, which are associated with the violation or denial of basic emotional needs.

- Overburdened parents or other caregivers
- Questionable educational methods (pampering, rejecting, authoritarian, or ambivalent educational style)
- All forms of child welfare endangerment (neglect, physical and/or psychological abuse, experience of violence, addiction of the parents)

- Separation/divorce of parents
- Parents with one or more problematic personality styles
- Parentification (charging the child early on with tasks that should actually be assumed by the caregivers)
- Other traumas

Attitude in the Doctor-Patient Relationship

Patients with personality disorders are usually referred to by doctors as “difficult patients” and trigger violent emotional reactions and impulses to act. When understood as a relationship disorder, specific, so-called *maladaptive relationship circles* can be described for each type of disorder. They are like a vicious circle and contain the wishes and expectations of the patients, the patient’s own behavior, and the reaction of others (see Fig. 16.1). Due to early, bad experiences – mostly in childhood – the patients have developed *beliefs* that wishes and expectations can only be fulfilled

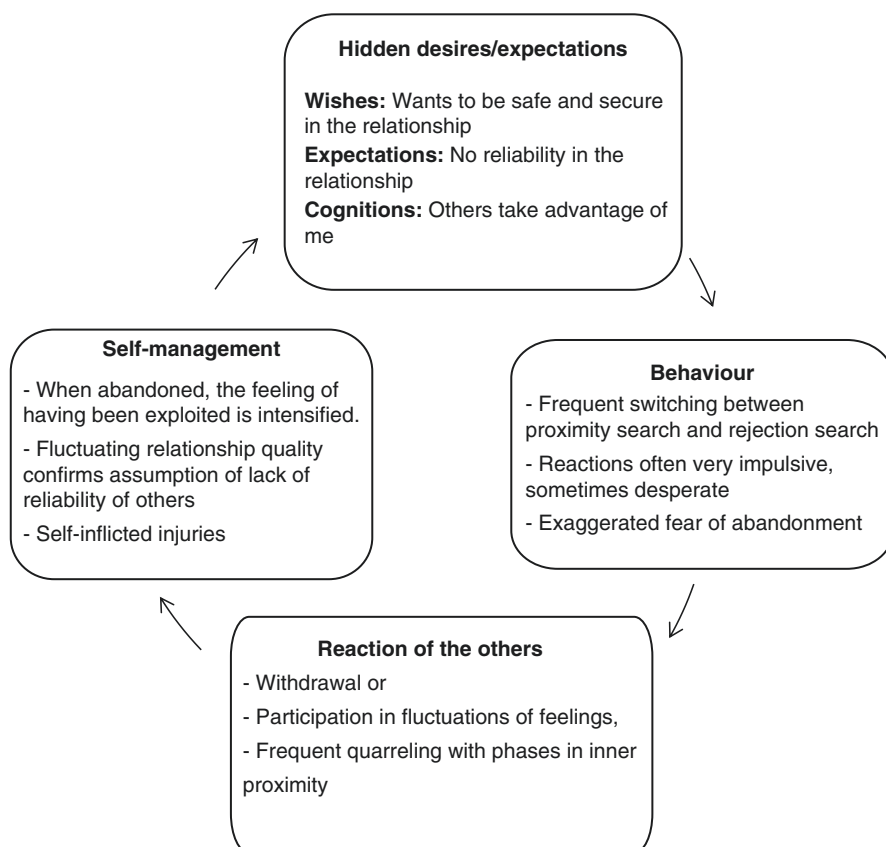


Fig. 16.1 Maladaptive relationship circle for patients with borderline personality disorder

under special conditions. In the sense of a self-fulfilling prophecy, these expectations lead to an unusual, disturbed relationship behavior. A patient whose doctrine suggests that he can only develop freely if he asserts himself against others displays a behavior ranging from highly competitive to strongly aggressive, in order to secure his own autonomy at the expense of others. The reactions of others will be dismissive or even hostile. However, these negative reactions do not lead to a correction of the behavior but – on the contrary – to more of the same. In the example above, the patient will find his belief confirmed by the negative reactions of others.

As central as the belief is for the underlying disorder, it is extremely difficult to change. Such a change requires psychotherapeutic treatment and takes many months. For the doctor it is nevertheless helpful to understand the doctrine as an ultimately insufficient attempt at a solution against the background of the child's denied basic needs. This makes it easier for him to adjust his own behavior to the patient. The mostly unconscious *wishes and expectations* contained in the relationship circle, on the other hand, can be used directly. The physician tries to take the patients' wishes seriously by adjusting his relationship behavior. If the doctor grants the patient autonomy without the patient having to fight for it, a stable and helpful relationship can develop in the medium term that remains comparatively free of relationship disorders and breakups.

The tasks in basic psychosomatic care are:

- Control of one's own emotional impulses such as anger, rage, and indignation towards the patient
- To perceive and respect feelings of helplessness, hopelessness, and compassion in oneself instead of concealing them
- Careful handling of closeness and distance in the regulation of the relationship
- Understanding the patient against the background of their life story
- To also focus on the creative, healthy areas and to strengthen resources
- Clear agreements and reliability but also tolerance with regard to cancellations of appointments and relationship breakups on the part of the patient

Treatment

The limitations of this theoretical concept are clearly identifiable. Of the three case studies mentioned above, the first two at best offer the possibility of further contact, whereas the third example of the patient with narcissistic personality disorder fails from the outset due to the breakup in relationship that is characteristic of this disorder.

In contrast to other patients with personality disorders, borderline patients often have an insight into their problems. Therefore the doctor may try to address the possibility of psychotherapy early on, which is indicated in any case. Due to the fear of separation, the doctor should be clear that the psychotherapeutic treatment will not influence further accompaniment by the doctor. All in all, the treatment of these

patients should be particularly characterized by respect, goodwill, and acceptance, which should still be evident when the patient reacts emotionally.

Case Study: Borderline Disorder

The 23-year-old Mrs. B. is a patient in the practice of Dr. K. She moved to Heidelberg years ago to study. One year ago, he noticed cuts on both her arms for the first time. Asked about this, Ms. B. was initially embarrassed but openly reported that she had been repeatedly cutting herself since the 12th grade whenever she was feeling bad. She also spoke of frequent alcohol excesses. Shortly before graduating from high school, she had attempted suicide with sleeping pills, which was discovered in time. The psychotherapy that followed stopped after half a year.

Since the issue of cutting was taken up by the doctor, Ms. B. comes once or twice a quarter because of minor illnesses and takes the opportunity to talk to Dr. K. about her relationship problems. This time when she comes to talk, she makes no effort whatsoever to conceal the cuts on her forearms.

D: I see you've cut yourself again, how did that happen?

P: My boyfriend moved out because he couldn't stand being with me under the same roof. And also you let me down pretty badly on it, the last time I was here.

D: You are disappointed in me.

P: Yes, the last time I told you about my problems, you listened to it all with understanding, but in the end it's probably purely professional as long as I'm here.

D: Aha, talking to me about personal things does you good, but it's not enough.

P: Exactly, but I know that you can't provide it.

D: I'm always happy to be there for you, even if there may not be a clear medical reason. But what you want is someone who really understands you and is there for you, and what I can offer you is not enough. I offer to continue working together with you in the current form, but I think it would make sense for you to visit a psychotherapeutic colleague at the same time. He can spend much more time on you and can be there for you in a way that is possible for me.

Comment

The first thing to do here is not to be disturbed by the devaluation and attacks. Despite the accusations of guilt, the doctor takes a look behind the scenes and clearly names the desire for a relationship. He makes an offer that does not promise too much, however, and clearly shows his limits. At the same time, he remains very concerned about the patient and tries to find a solution. The possibility of psychotherapy could be such a solution. The doctor emphasizes the additionality of such an offer in order to prevent the patient from feeling abandoned.

Psychotherapy

The treatment of personality disorders is complex and lengthy. It is reserved for the experienced and requires the consideration of various components (multimodal treatment). Outpatient and (partially) inpatient measures are often combined (*interval treatment*).

Inclusion of the Environment

This is accomplished either through direct involvement of partners and family members or, if these are not available, as part of family reconstruction work.

Psychotropic Drugs

Atypical neuroleptics and selective serotonin reuptake inhibitors (SSRIs) are used to treat anxiety symptoms, depressive symptoms, and impaired stress regulation in crisis situations.

Prognosis

We find personality disorders in all places of society. In marginal groups, as failed, multiply burdened niche existences, through to the highest positions of power in politics, economy, culture, and science. Approximately one third of those affected manage to master their lives in an admirable way through their own efforts and therapeutic help – despite severe psychological impairments. This includes the knowledge of their own vulnerability as well as the experience that a balance can be created through compensatory constructive mechanisms. Discussing this with the patient and his relatives is more honest and effective than promising him complete “healing,” which inevitably leads to disappointment and ultimately resignation.

Evidence-Based Medicine

The efficacy of psychotherapy is particularly ensured in borderline disorders and in anxious-avoiding personality disorders. Dialectical behavioral therapy (DBT) has best been studied for borderline disorders, although modified psychodynamic treatment approaches have also proven successful.

Chapter 17

Sexual Disorders



Melanie Büttner

Aspects and Dimensions of Sexuality

Sexuality is a central aspect of being human, throughout the entire life span. It is experienced and expressed not only in thoughts, fantasies, and desires and in beliefs, attitudes, and values but also in behaviors, practices, roles, and relationships. A complex interplay of biological, psychological, social, economic, political, cultural, legal, and historical – and often religious and spiritual – factors influences the sexuality of every human being (World Association of Sexual Health 2014). If a problem occurs in one or more of these areas, it can have a disruptive effect on sexuality (see Fig. 17.1).

Sexuality is characterized by various dimensions and functions that interact closely (Beier et al., 2005):

- *Pleasure dimension*: Sexual experience can give pleasure in different ways.
- *Relationship dimension*: Sexuality is one way of fulfilling basic psychosocial needs for acceptance, closeness, security, and reassurance.
- *Reproductive dimension*: Sexuality can lead to procreation.

Sexuality can be experienced and expressed through a broad spectrum of mental and physical activities. Masters, Johnson, and Kolodny (1988) – three pioneers of sexual medicine – long ago described that sexuality refers to “all aspects of sexual being,” whereby it is about far more than “just an erotic reaction.” A variety of things are possible, but nothing is a must – even if the norms and ideals of Western societies convey the message that it is important to meet certain requirements during sex. Modern media like the world wide web, spread numerous stereotypes (e.g., “dictate of pleasure and orgasm” or “intercourse or nothing approach”). This can

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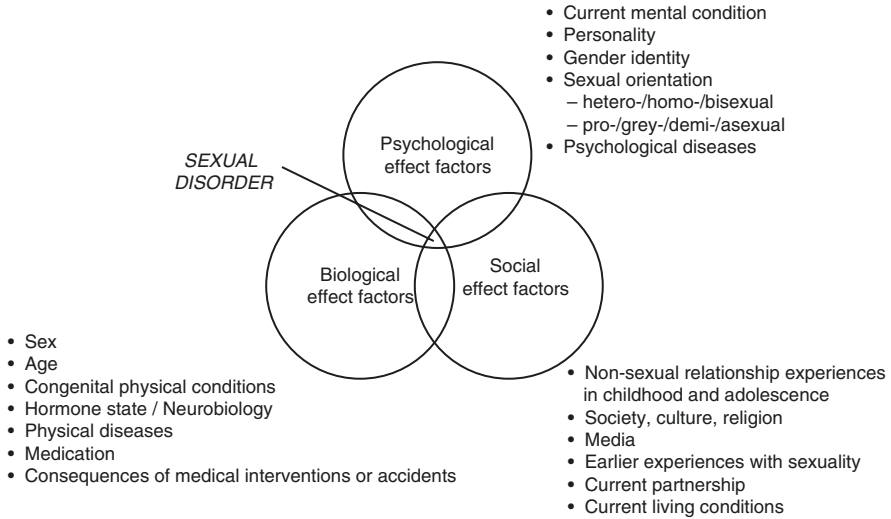


Fig. 17.1 Biopsychosocial etiology of sexual disorders

create a pressure to adapt to sexual conformities. In contrast to this, today's sexual medicine understands sexuality as a very personal issue, which can be shaped according to the needs, wishes, and preferences of the individual.

Types of Sexual Disorders

Sexual disorders are serious health problems that can lead to psychological stress and physical illness. Fear of failure, embarrassment, self-esteem problems, and concerns about the partnership are typical side effects. Many patients feel guilty and afraid to disappoint their partners or be abandoned by them. In fact, relationship problems, infidelities, and split-ups are common in couples with sexual disorders. On the other hand, those who do not have a partner often think that nobody will be interested in them because they have “nothing to offer.” For people who consider sexuality very important, it can mean a serious loss in quality of life. If a sexual disorder is characterized by behavior that is self-damaging or harmful to others, there is also the threat of serious psychological and physical consequences for the patients and their sexual partners.

The sexual disorder should be included in psychosomatic treatment if it:

- Triggers, contributes to, or maintains a mental illness or crisis
- Is a symptom of a mental disorder
- Causes a significant level of distress
- Leads to self-damage
- Leads to harm of others

The following sexual disorders are particularly common.

Sexual Dysfunction

Problems which occur during any phase of the sexual response cycle of desire, arousal, and orgasm that are perceived as stressful and thereby impede a satisfying sexuality. Sometimes, several dysfunctions exist at the same time (e.g., arousal and orgasm dysfunction) or one dysfunction causes another (e.g., erectile dysfunction leading to a decreased sexual desire).

General Causes

In many cases, sexual dysfunction is triggered or influenced by one or more of the following psychosocial factors:

- A strong focus on norms and ideals of sexuality or the partner's wishes makes it difficult to recognize and express one's own sexual needs. When sexuality is practiced mainly to meet the demands of others, it cannot be perceived as pleasurable, so that desire and arousal are absent or it is not possible to reach orgasm.
- Performance demands, self-esteem problems, and fears of being abandoned create pressure to be "normal" and "good in bed". Instead of being relaxed and pleasurable, sex is then experienced as strenuous, which can reduce desire and promote arousal or orgasm problems. A cycle of symptoms can be triggered (see Fig. 17.2), which gradually consolidates the sexual disorder.
- Many people find it embarrassing to talk to their partners about their sexual needs and what they want, what feels good, and what does not feel good. Not talking about it and putting one's own wishes aside can eventually lead to a lack of desire and make it difficult to get aroused or experience an orgasm.

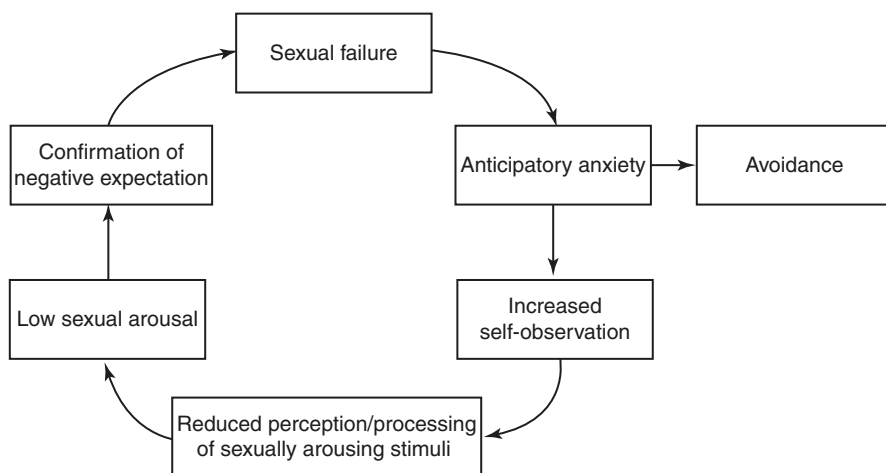


Fig. 17.2 Self-reinforcing symptom cycle

- Recurring conflicts in a partnership can affect the way the partners deal with sexuality and lead to one or both partners withdrawing from it.
- Everyday stress can affect sexual desire and make it difficult to focus on what happens during sex, for example, when it is not possible to get rid of disturbing thoughts about everyday worries. This can lead to problems with arousal and orgasm.
- Adverse experiences with sexuality in the past (e.g., unempathetic partners, pressure, pushing, sexual violence) can result in it being perceived as something so unpleasant and stressful that there is no desire for it. Arousal and orgasm problems are also possible, as well as disturbing feelings like disgust and self-blaming.
- Mental illness (see section “Sexual disorders and mental illness” in this chapter).
- Psychiatric drugs (see sexual disorders and psychiatric drugs).
- Physical illness and disability.
- While alcohol and drugs in small doses can have a stimulating effect on libido, arousal, and orgasm, this effect is reversed with excessive or constant substance consumption, with dysfunctions occurring more frequently.

In addition to these general factors, special causes may also be important in the development of the various sexual dysfunctions (see sections “[Lack of \(or Low\) Sexual Desire](#)”, “[Sexual Arousal Disorders](#)”, “[Orgasm and Ejaculation Disorders](#)”, and “[Male Orgasm and Ejaculation Disorders](#)”).

Types of Sexual Dysfunction

Lack of (or Low) Sexual Desire

25%–45% of all women and 15–25% of all men report a reduced interest in sexuality (Hartmann, 2018). However, the lack of desire is not always associated with clinically significant distress, which is why it is not always possible to speak of a sexual disorder. Often, the low desire only becomes a problem when there is a partner who has a much stronger need for sex. This can lead to difficulties in the relationship.

Special causes:

- Sexuality is perceived as not so important for one’s own well-being.
- In many long-lasting relationships, the sexual desire of one or both partners decreases over time. In addition to an altered hormonal situation in long-lasting relationships, sexual routine, everyday demands, and difficulties in dealing with different sexual needs all contribute to a vanishing desire for sex.
- If you watch porn frequently, you may be influenced by the stimuli presented there, which are always new and often unrealistic. This can lead to real sexuality being perceived as boring and unattractive, so that there is no desire for it.
- In women, contraceptives, pregnancy, or menopause can lead to changes in hormone levels that affect sexual desire. In men, a low testosterone level can be responsible for this.

Sexual Arousal Disorders

Female Sexual Arousal Disorder

Despite sexual stimulation, there is not enough emotional and/or physical excitement, a lack of lubrication and missing pleasurable sensations in the genital area or elsewhere on the body.

Special causes:

- Unfavorable stimulation techniques
 - Due to a lack of experience with masturbation, the patient does not know which techniques are stimulating.
 - The patient has become accustomed to a certain type of masturbatory technique, so that stimulation during couple sex is not exciting enough.
- Physical factors are of little importance. Occasionally you will find
 - Cardiovascular diseases
 - Nerve injuries

Male Erectile Dysfunction

Erections are not possible, not firm enough, or cannot be maintained long enough to perform certain sexual activities (such as penetrating sex). Erectile dysfunction is more common in old age, which is probably due to the fact that physical illness is more present during this period of life. Up to the age of 50, about 5–10% of all men are affected; from the age of 70, about 40–50% (Hartmann, 2018).

Special causes:

- Patients who watch porn frequently can get used to the specific and intense sexual stimuli presented there, so real sexuality is not exciting enough to lead to sexual arousal.
- Physical factors
 - Cardiovascular diseases
 - Nerve injuries

Important!

The appearance of an erectile dysfunction can be the first sign of a serious cardiovascular disease and an early precursor of dangerous complications such as a heart attack or a stroke (“The penis is the antenna of the heart”).

Orgasm and Ejaculation Disorders

Orgasm Disorders in Women

It is not possible, or only with great effort, to reach orgasm.

Special causes:

- Unfavorable stimulation techniques
 - Due to a lack of experience with masturbation, the patient does not know which techniques are stimulating.
 - The patient has become accustomed to a certain type of masturbatory technique, so that stimulation during couple sex is not exciting enough.
- Physical factors are of little importance. Occasionally you will find
 - Cardiovascular diseases
 - Nerve injuries

Male Orgasm and Ejaculation Disorders

Premature Ejaculation

There is little or no control over the arousal cycle, so that ejaculation occurs before or shortly after the onset of sexual activity (such as penetrative sex).

Special causes:

- Low perception of the arousal cycle
- Unfavorable stimulation techniques
 - Due to a lack of experience with masturbation, the patient cannot control his arousal well enough.
 - The patient has become accustomed to a certain masturbatory technique that leads to orgasm very quickly.
- Physical factors
 - Lifelong type: changes in the serotonin system
 - Acquired type: hyperthyroidism, prostatitis, drug withdrawal, and erectile dysfunction

Delayed and Absent Orgasm or Delayed and Absent Ejaculation

Orgasm or ejaculation is not possible or occurs only with great effort.

Special causes:

- Patients who watch porn frequently can get used to the specific and intense sexual stimuli presented there, so real sexuality is not exciting enough to trigger an orgasm.

- Physical factors
 - Age-related degeneration of sensitive nerve structures in the penis
 - Prostate enlargement
 - Urethritis
 - Thyroid disorders
 - Nerve injuries

Sexual Pain Disorders

If there is pain in the genital area during sex, it can be a sign of a protective response to prevent excessive mental and physical stress or injury. Sometimes the patients have ambivalent motivations toward sex, although they are not always aware of it. Often, demands on one's own sexual performance collide with mental or physical needs and limits. It is not unusual for patients to want to be able to have vaginal-penetrative sex at any price, even though there is no real desire for it, no arousal is felt, or they do not like what is happening.

Most of the factors listed in section “[General causes](#)”, also play a major role in the development of sexual pain disorders. In addition, there may be unconscious or unspoken reservations about the partner or his or her desire to have children.

Types of Sexual Pain Disorders

Vaginism

Involuntary tightening or tautness of the pelvic floor muscles leads to difficulties with vaginal penetration. Pain may also occur. Since the extreme muscle tension often affects other areas of the body, many patients also report stress-dependent jaw clenching and teeth grinding (bruxism) or pain in the area of the head, neck, shoulders, back, or lower abdomen.

Special causes

- Distorted notions of the size of the vagina and penis (“The vagina is tiny; the penis is huge”), leading to fear of injury and pain.
- Sex is considered as something forbidden, immoral, or unclean.
- Experiences of genital manipulation or penetration in the past that were unpleasant or painful (e.g., during sex or vaginal examinations, births, or sexual violence).

Dyspareunia

Vaginal penetration causes pain in the area of the vulva, vagina, penis or somewhere else in the pelvic area. Every fifth to tenth woman suffers from such pain over a longer period of her life (Hartmann, 2018). Especially young women, who are at the beginning of their sexual lives, are affected.

Special causes

- Insufficient lubrication
- Impetuous movements during penetration
- Physical factors
 - Infection, allergies, atopic eczema, and autoimmune diseases of the vulva or vagina
 - Inflammation of the bladder or urethra
 - Vaginal atrophy due to low estrogen (e.g., during menopause)
 - Endometriosis
 - Myomas
 - Cysts, inflammations, or tumors of the uterus or ovaries
 - After surgery, injury, or radiation therapy
 - Congenital vaginal shortening

Compulsive sexual behaviour disorder

Loss of control over sexual impulses and behavior. An excessive urge to watch pornography, to masturbate, or to have sex leads to problems in relationships or at work, social withdrawal, and debt.

Causes

- Sexuality is used to distract oneself from unpleasant moods and feelings such as emptiness, depression, boredom, anger, or grief.
- Frequent porn consumption in childhood and adolescence.
- Sexualized atmosphere in the parental home.
- Traumatic experiences in the past (especially sexual, emotional or physical violence, neglect).
- Psychiatric drugs (see section “Sexual disorders and psychiatric drugs” in this chapter).

High-Risk Sexual Behavior

Patients harm themselves by getting involved in risky sexual practices or unprotected casual sex. Others expose themselves to situations with a high risk of sexual victimization. Alcohol or drugs are often involved.

Sexual Disorders and Mental Illness

50% to 90% of all people with psychological disorders have problems with sexuality (Laumann et al. 1999; Zemishlany and Weizman 2008). The sexual disorder can be a (1) trigger (e.g., depression as a result of vaginism), (2) symptom (e.g., re-experiencing of the trauma during sex after incidences of sexual violence), or (3) consequence (e.g., erectile dysfunction in alcohol addiction) of mental illness.

The relationship between sexual disorders and mental illness is bidirectional. For example, sexual addiction can be a consequence of depression and vice versa.

Sexual Disorders and Psychiatric Drugs

Some psychiatric drugs have a detrimental effect on sexuality. If a sexual disorder accompanies a mental illness, it can be further aggravated by psychiatric drugs.

Sexual dysfunction is a typical side effect of:

- Antidepressants
- Antipsychotics
- Mood stabilizers
- Anxiolytics

Compulsive sexual behaviour can occur when taking:

- Antipsychotics
- Mood stabilizers

If it seems appropriate, the medication can be tapered, decreased, or changed to reduce sexual side effects. If this is not an option, sex therapy or psychotherapy can help to find a better way of dealing with the symptoms.

How to Talk About Sex with a Patient

For many people sexuality is still a taboo, even in the doctor-patient contact. Patients are either not sure whether they can talk to their doctor about their sexuality or they do not know how to bring up the subject. Others are ashamed or feel afraid of leaving a bad impression. Many doctors also have their insecurities: Do I get too close to the patient when I ask him about his sexuality? How should I talk to him or her? The following strategies can help:

- *Lower the threshold:* Most patients find it easier to open up when they see that they are welcome to talk about their sexual lives. By asking questions about sexuality in the psychosomatic anamnesis, you can indicate that you are open to talk about the topic and that you will support the patient with sexual problems. A neutral and clear language which neither avoids the hot spots nor trivializes, makes fun, of or even sexualizes the topic is helpful.
- *Respect what the patient feels comfortable with:* During the entire conversation, patients should be able to decide for themselves what they want to talk about and what not. Sometimes it can be good to:
 - Ask for permission: “Is it okay if I ask you some questions about your sexuality?”
 - Hold if the patient seems irritated and clarify: “I can imagine you didn’t expect this question. We don’t have to talk about it if it doesn’t feel right to you. I just want you to know that if you have a problem regarding your sexuality, you’re welcome to share it with me.” Some patients will need some time to “warm up” but get back to you some other time in the process.
- *Avoid to be judgmental:* an open-minded and friendly atmosphere has a depathologizing effect and encourages discussions about sexuality.
- *Normalize:* “Many patients feel that way...” is a very relieving statement, e.g., if you explain that a certain sexual problem is quite frequent and many people experience distress in sexuality.

Sexual Anamnesis

- Introductory question, e.g.:
 - “How do you feel about your sexuality?”
 - “Do you experience problems with sexuality?”

Give room for what the patient has to say and listen actively.

- Detailed symptom assessment, e.g.:
 - “Is your penis only a little flaccid during sex, or don’t you get an erection at all?”
 - “How long can you maintain an erection?”
 - “Can you insert the penis into your partner’s vagina?”
- Since when does the problem exist?
 - Primary (always)
 - Secondary (since a certain point in time). Can you observe any influential factors in the temporal context of the problem’s onset?

- How often and in which context does the problem occur?
 - Generalized
 - Depending on the situation. The problem exists, e.g.:
 - With certain sexual practices, but not with others
 - During sex with a partner, but not
 - During masturbation
 - When indulging in certain fantasies or watching porn
 - During sleep or shortly afterwards (e.g., spontaneous nocturnal or morning erections)
 - With the current partner, but not with other partners
 - When life is stressful, but not on holiday
 - When sober, but not after drinking some alcohol
- Importance of sexuality and psychological distress
 - How important is sexuality to you?
 - Why do you have sex?
 - Does the sexual problem cause a lot of distress?
 - What exactly is the cause of your distress?
 - If there is a partner:
 - Is your partner stressed too?
 - Who among the two of you suffers more?
- Does the sexual problem affect your relationship?
- For single patients: Does the sexual problem prevent the patient from seeking a relationship?
- What factors might play a role in the development of the disorder (see “[Types of sexual disorders](#)”)?

Treatment

Psychotherapy, but also basic psychosomatic care with the family doctor, gynecologist, urologist or other specialists, offers a good framework to begin with a clarification of the sexual problems and to initiate the first steps to solving it. You can:

- Develop a deeper understanding of the problem together with the patient.
- Initiate gynecological, urological, or other examinations, if necessary.
- Give information about sexual health.
- Involve the patient’s partner whenever it seems appropriate.
- Develop first approaches to a possible solution of the problem.

In some cases, this can lead to a significant relief and reduction of symptoms.

If the symptoms are more pronounced, it is advisable to refer the patient to a specialist practitioner, e.g.:

- Sexual physician
- Sex therapist
- Psychotherapist with special expertise in the field of sexual disorders

Patients with complex sexual problems usually benefit from an interdisciplinary approach with different professions (psychotherapists, sexual physicians/therapists, gynecologists, urologists, psychiatrists, physiotherapists, or body therapists) working together in a coordinated manner.

With the right treatment, a significant improvement can often be achieved after just a few sessions, especially in the case of mild and moderate sexual problems.

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Chapter 18

The Terminally Ill and Dying Patient



Kurt Fritzsche

Emotional Ambivalence and Illusionary Misjudgment of Reality

“Basically nobody believes in his own death or – which is the same thing ... in the unconscious, every one of us is convinced of his immortality,” Sigmund Freud speculates in 1915 in his scripture: Contemporary information about war and death (Freud 1963).

This quotation is perhaps alienating, irritating, and also annoying. We are, of course, willing to outwardly represent that death is the necessary outcome of all life, that one must prepare oneself for it, and that death is natural, undeniable, and inevitable. In addition, however, we all know the tendency to push death aside, to deny it, not to eliminate it as part of life. This attitude is described by psychoanalysis as “emotional ambivalence.”

This means that there are contradictory feelings, of which only one is allowed to pass through the inner censorship to consciousness; the other remains latent or subconscious.

In conversations with the terminally ill, it is always noticeable how much these patients hold on to images, wishes, and future perspectives that embody something unreal, utopian, and illusionary for outsiders. It seems like an illusionary misjudgment of reality. This adherence to apparent illusions has a high significance for patients, and an external assessment, from the point of view of an alleged reality and so-called common sense, does not do justice to this phenomenon.

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Palliative Medicine

The psychosocial support of the terminally ill and dying is part of the field of palliative medicine. Palliative care means “the active and comprehensive care of patients whose illness does not respond to curative treatment” (WHO and European Association for Palliative Care). In addition to symptom control, which includes pain therapy, the treatment of internal medical symptoms, and the treatment of neuropsychiatric symptoms, psychosocial and spiritual support is equally important. The aim is to enable patients to live a humane life at the place of their choice until the end.

In adults, about 10% of tumor patients and about 5% of those suffering from incurable non-oncological diseases, the terminally ill and the dying, require specialized palliative care (SPC). However, the majority of the so-called general palliative care (GPC) is provided by general practitioners and doctors in other disciplines. Accompanying terminally ill and dying patients and their families is best handled by an outpatient or inpatient care *team*, social workers, psychologists, pastors, and volunteer hospice attendants.

The early integration of palliative medical measures does not only improve the patients’ quality of life but possibly also significantly extend their lifetime (Temel et al. 2010; Bakitas et al. 2009; Zimmermann et al. 2014).

Pain

In the final phase of a disease, about 60% of patients suffer from chronic pain and require symptomatic drug therapy (Singer et al. 2015). Emotional factors such as anxiety, depression, and loneliness can increase the feeling of pain. Conversely, prolonged pain can increase anxiety and depressive despair. Physical pain, however, can also be an expression of mental pain or grievance. At this point increased emotional care is required. In palliative medicine there is the concept of dealing with “total pain” with “total care.” (Saunders and Sykes 1993).

Basic Spiritual Needs

The loss of a meaning of life in the face of death points to unfulfilled basic needs in the spiritual realm. The fulfillment of these needs leads to an improvement in the meaning of life for a large number of the patients. In the literature this kind of patient care is described as “spiritual care,” which does not necessarily mean religious support, rather the promotion of mostly already existing, sometimes lost spiritual bonds and rites that help to better cope with the terminal situation.

Involvement of the Family

Early involvement of the family, as is done in always the case with children, is also advisable in the case of adults. In their final phase of life patients need a great deal of support from their family, but partners and other family members are often considerably burdened by the situation themselves and the whole family needs emotional support.

Doctor-Patient Discussion About Palliative Treatment

Despite the emotional ambivalence toward dying and death, over 90% of all patients wish to be informed about the prognosis and their treatment options (Fallowfield et al. 2002). However, it is not only the information that is crucial but also the emotional support in processing the information. Discussions about the transition to palliative treatment are experienced as being difficult and stressful for the doctors as well.

Doctors often withhold prognostic information and tend to avoid answering questions from the patient (Fallowfield and Jenkins 2004). The prognostic information is particularly important for the patient. This helps the patient to make use of the remaining time. Information about the prognosis usually does not lead to increased anxiety. On the contrary, dishonest communication increases the emotional burden on the patient and leads to uncertainty. Patients perceive incongruence between verbal and nonverbal communication very precisely.

The delivery of the diagnosis of a life-threatening disease is discussed in detail in Chap. 11 (Psycho-oncology). In the case of an incurable disease and the associated palliative treatment, there is an additional difficulty: the “syndrome of empty hands.” The procedure is the same as for the very first diagnosis. The physician should be guided by the patient’s previous knowledge and the informational need of the patient and convey the information needed by the patient in order to participate cooperatively in the further treatment process. This also means to adequately assess the patient’s coping skills and to accept the need for denial. Nevertheless, it is empirically proven that open communication eases up the situation for both doctor and patient, improves cooperation, enhances the quality of life, and does not lead to an increased risk of suicide.

Fundamental Conversational Skills

- You should have time, be open, and be available.
- Hold yourself back in the conversation, especially at the beginning, to display calmness, and give space to the patient.
- The conversation should relieve the patient; therefore no past or present conflicts should be focussed.

- Don't get stuck in hopelessness nor in unrealistic rescue fantasies which inevitably lead to disappointment.
- Help the patient express his/her feelings of fear, despair, anger, and resentment.
- Build on the patient's previous successful coping strategies.

Information on the Prognosis

It is important to maintain the balance between giving a realistic assessment of the prognosis and nurturing hope. The communication of information should be adapted to the patient's and caregiver's speech. Clear and generally understandable words should be used. A large part of the population does not understand words such as "metastases" or the expression "palliative," or does not understand them correctly.

In order to mitigate the shock of the message, it is helpful to use an expression or introductory phrase that points to the message of bad news.

Examples

"Unfortunately, the results of the examination are not as good as we had hoped."

"Unfortunately, I have to inform you that the treatment was not able to reduce the size of the tumor."

It is also helpful to link the findings to the current state of health in the conversation and thereby build a bridge for the delivery of the bad news:

"You said earlier that you have difficulty breathing. The reason for this is that...."

Even if the current state of health is positive, this strategy can be applied:

"You said earlier that you currently have few complaints and feel fit. That's wonderful, and I'm very happy about it. I hope that we can maintain this condition for as long as possible. Unfortunately, an unfavorable finding is revealed in the CT that does not match your condition..."

Empathetic Response to the Emotional Reactions

When patients learn that their lives are threatened, both they and their relatives often react with strong emotions. For the emotional support of patients and caregivers, an orientation toward the following five-step scheme is helpful (Back et al. 2007):

1. Naming emotions: cautiously, questioningly, formulated as an offer, possibly in the subjunctive.
2. Check your own understanding: continue asking questions, listen actively, and take breaks.
3. Appreciation for the situation and the attempt to cope with it: verbally and/or nonverbally through facial expressions, changing the sitting position, and possibly touching the patient (if appropriate).

4. Offer sincere and feasible support.
5. If appropriate, inquire more deeply.

A doctor who shows both empathy and medical competence conveys security and trust to the patient and the caregiver.

Examples

“I can imagine that you are very confused by this finding.”

“I can imagine that you are very disappointed now.”

“This is probably very difficult to bear now.”

“I can imagine that what I just told you is scary.” (Pause, wait for a positive signal.) “That’s very understandable, and I’m certain that almost everybody would feel like that.”

“I certainly can’t even imagine what that’s like for you right now.”

It is important for the doctor to remain calm and accept the emotions that arise. He/she should serve as an example for the patient, because this way the patient internalizes the emotional events and will be more open to discussing the possible palliative treatment steps.

Developing a Palliative Treatment Plan, Discussing Reanimation

Together with the patient and his/her relatives, the doctor tries to find out what a fulfilling life could look like under the current conditions. It is important to know the current life situation, values, wishes, and fears of the patient and caregivers.

Examples

“The previous cancer treatment was not so successful, and it is also quite certain that the planned chemotherapy will not cure her illness. I would therefore like to talk to you about how you can best shape your life now. I would therefore need to know a little more about your ideas and wishes.”

“I would now like to discuss the treatment plan for the near future with you. As I said, we now no longer believe that we can cure the cancer. However, we will do everything in our power to ensure that you live as well as possible for as long as possible. Let’s consider what is particularly important to you.”

Useful phrases (where applicable)

“Your disease is no longer responding to the... (e.g., chemotherapy) treatment. To continue this treatment would cause you more harm than good (or will give you lots of side effects but is unlikely to affect the cancer). It is likely that you will have a better quality of life without further... (type of treatment, e.g., chemotherapy).”

“I wish that more chemotherapy would help this cancer; but unfortunately at this stage it will only make you sicker. Yet there are many other things we can do to help you deal with your condition.”

“Our goal of treatment needs to change from trying to control the cancer to minimizing the symptoms you might get.”

Furthermore, the doctor provides information on palliative treatment options, which also include psychosocial and spiritual support options. The special approach of a palliative ward and a hospice should also be discussed. When anticipating the course of the disease, it is important to note that patients often only want to know roughly what symptoms they can expect in the dying phase and what possibilities of pain treatment there are. Relatives who function as caretakers usually want to be informed very precisely about all possible scenarios in the dying phase in order to be able to adjust better to the situation. Relatives often have concerns about how they can respond to the patient's desire to die at home. Here, the medical treatment team can offer help and relief. Another issue that is mainly relevant for relatives is the question of how to proceed after the death of the patient. It can therefore make sense to invite the caregivers to a separate discussion.

Examples

“We know from experience with other patients that there are some things that preoccupy people most during this phase of treatment. These are:

- Being free from pain and other distressing symptoms
- The relationship to close relatives and other important caregivers – telling them something you have always wanted to tell them, resolving differences of opinion, and saying goodbye
- Reducing the burden on the family
- Maintaining control over the treatment as long as possible
- Avoiding an unnecessarily prolonged dying process and not wanting to die on a machine”

The clarification of the wish for *reanimation* should also be discussed with the patient at an early stage. This can prevent the situation that the patient becomes so ill that he can no longer make any decisions and that this decision must then be made by the family members who do not always know the exact wishes of the patient with regard to this subject and who are additionally emotionally burdened by this decision.

Example

“We would like your wishes to be implemented, therefore I recommend that we include a note in the file stating whether or not you wish to be reanimation if you find yourself in an acute life-threatening situation. If you decide not to be reanimated, I will order that everything will be done to make you feel as good as possible in this situation.”

The Psychosocial Support

Dealing with Denial

There are patients who, although openly informed about their condition and prognosis, deny the life-threatening nature of their situation. It is a back and forth movement between knowledge and ignorance. It is important to allow this process of

denial to take place, as it may also provide meaningful protection. After all, no one can live in full awareness of a deadly threat. Also in everyday life we need our illusions, our little escapes – Hollywood movies, theater, alcohol, etc. – in order to be able to endure reality and our own smallness and nothingness in view of the existing political, economic, and also personal problems.

This lack of objectivity toward oneself and the environment and the fantasy of being inviolable, infinite, and immortal are seen as necessities of life. In order to cope the sick person creates the illusion of immortality, the illusion of a world without the threat of death. If the doctor recognizes denial as a protective illusion, he will avoid a forced confrontation with reality.

The acceptance of death rarely happens in full agreement. The acceptance occurs much more frequently in the course of a silent, more or less resigned moment of giving in and a process of inner adaptation.

The Physician as a Transitional Object

What attitude should the doctor adopt in this situation in order to enable the patient to die in peace? Ideally, the dying patient should be given a feeling that corresponds to an early stage of development in which protection, safety, and security prevailed, usually with his mother. The need for closeness then increases; as an example, the book *The Death of Ivan Ilyich* aptly describes: “He wanted people to be tender to him, kiss him and weep over him, as children are caressed and comforted” (Tolstoy 2016).

It is important to grant these needs to the terminally ill. The patient is in a state similar to that of a child which is loved unconditionally, and the received affection puts the dying person in a state of great security. Trust in the medical treatment gives him/her a feeling of comfort. It protects against the fear of being abandoned and prevents depression.

According to the psychoanalytical perspective the doctor becomes the object of contact. At the age of 1, children usually have one or more soft objects, a teddy bear, a rag doll, a cuddle cloth, or a certain melody. They are initially a substitute for the breast while over time also representing transitions to the world of the father and mother. A transitional object is an intermediate object between the self and the outside world. In the typical case, we see a child falling asleep, holding such an object firmly in his hand while sucking his thumb at the same time. Each child has a personal pattern of behavior, and this pattern, which is activated at the time of falling asleep or when the child feels lonely or sad or is afraid, can remain until late childhood or even adulthood. All this is part of a normal emotional development. They enable the child to face frustrations and disadvantages and confront new situations.

Holding Function and Containing

Everybody needs a kind of intermediate area of illusion as a place to rest, to recharge their batteries before dealing with the next upcoming tasks – and even more so the patient in the dying process. The doctor provides the patient with the space he needs to experience his thoughts and feelings – be they tender or aggressive – without allowing himself to be carried away or even destroyed by them. The doctor must therefore neutralize his own emotional ambivalence.

It is helpful for the patient to feel the willingness of doctors and nursing staff to help the patient maintain his relationship with them despite the unfavorable course of the illness, the imminent death, and their own therapeutic impotence. What matters is not what is said but the attitude, in which it is said. It should be sincere and come from the heart. This is the only way for the patient to feel it emotionally.

The mere presence of the doctor takes the horror out of death. It is an example of the abovementioned description of the transitional object that gives support and protection and mediates between an “oceanic” feeling (Freud 1930) of unlimited power and the reality of impending death. And it is not only the patient who seems to benefit from it – the doctor too comes to an important realization: a person can die in peace if he is supported by an empathic relationship which makes him feel accepted unconditionally in the process of dying and endure his deep pain, his fears, and his sorrow and lets him hold on to the illusion of the immortality of his experience and thus of himself/herself.

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Part IV
Developing Psychosomatic Medicine in
International Settings

Chapter 19

Systems Development of Behavioral Health in Primary Care



Julie M. Schirmer and Jeffrey F. Markuns

Introduction into Systems Development of Behavioral Health

Case Study

In 1998, two visiting medical school deans and a health-care researcher from Vietnam tour five family medicine training programs in the Philippines and the USA to explore if family medicine training is right for their country. On the last day of this tour, a behavioral health provider and trainer spends the morning with them, giving them a behavioral health overview. Two months later, she makes the first of what turns out to be annual or biannual trips to Asia over a 15-year period to assist with training and systems development. Over this time period, this provider and team have worked with schools of medicine, social work, and different levels of the health care and government to strategize how to best integrate behavioral health first into family medicine training and clinical care and second into social work training and service. This team's work in Vietnam, Laos, and Cambodia continues to involve (1) training medical providers and the rest of the primary health-care team, (2) advocacy to policy makers and administrators, (3) establishing primary care clinics affiliated with the training programs, and (4) encouraging campaigns to reduce stigma.

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Definition

Behavioral health is a term that has been in the literature since the late 1970s. It is defined as “the reciprocal relationship between human behavior and the well-being of the body, mind, and spirit, whether considered individually or as an integrated whole” (Patient-Centered Primary Care Collaborative 2019). It includes assessing and managing mental health disorders and substance use disorders, motivating and promoting healthy habits, and attending to family and other psychosocial issues. Behavioral health has a broad focus that includes prevention, diagnosis, treatment, and rehabilitation. It encompasses the terms *behavioral medicine*, which is the interdisciplinary field of behavioral health (Society of Teachers of Family Medicine 2019) and behavioral science, which provides the evidence to support behavioral health practices. These terms have been used interchangeably over the years. We will use the term behavioral health throughout this chapter, considering it the more inclusive term. Behavioral health providers can include primary care physicians, assistant physicians, psychiatrists, nurse practitioners, nurses, social workers, psychologists, counselors, midwives, and community health workers. Each discipline plays a different role and has different levels of training and responsibility for addressing the behavioral health needs of an office practice or a community. The core principles of behavioral medicine health educators in primary care are listed below.

The Core Principles of Behavioral Medicine Health Educators in Primary Care

Those who apply these principles:

1. Use biopsychosocial- and relationship-centered approaches to care
2. Promote patient self-efficacy and behavior change as primary factors in health promotion, disease prevention, and chronic disease management
3. Integrate mental health and substance use care into primary care services
4. Integrate psychological and behavioral knowledge into the care of physical symptoms and diseases
5. Promote the integration of sociocultural factors within the organization and delivery of health-care services
6. Demonstrate the importance to health of familial, social, cultural, spiritual, and environmental contexts in patient care to improve health outcomes
7. Practice a developmental and life-cycle perspective with learners and clients
8. Encourage and support provider self-awareness, empathy, and well-being (Schirmer 2019)

Training resources include a Behavioral Science Basics Wiki, which provides free, up-to-date resources for persons who train primary medical providers in behavioral health care (Society of Teachers of Family Medicine Digital Resource Library

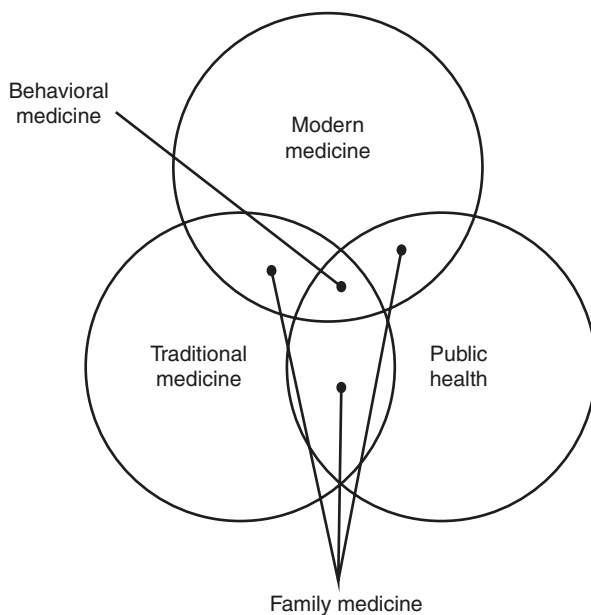
2019). The University of Massachusetts and others provide a 6-month, 6-day online training course for behavioral health providers in primary care (Certificate Program for Primary Behavioral Health 2019).

Theory

Biopsychosocial-Spiritual Theory (See Also Chap. 1)

The biopsychosocial-spiritual model provides the conceptual framework for the practice of behavioral health. Many add the spiritual component to George Engle's biopsychosocial model, emphasizing the importance of spirituality in one's perception of health, illness, and death. The biopsychosocial-spiritual model is at the intersection of modern medicine, traditional medicine, and public health (Fig. 19.1). Modern medicine involves the biomedical causes, treatment, rehabilitation, and management of disease, including mental illness and substance use disorders. Traditional medicine honors the familial, cultural, and spiritual perspectives of the patient, includes the impact of a community or group on the patient, and acknowledges and interprets the impact of stress on the body. Public health involves the study of social, economic, and environmental factors that impact the health of a community. The public health world includes the social determinants of health, such as access to food, transportation, and medical care, which both the individual patient and health-care provider predominantly have very little control over during routine office visits.

Fig. 19.1 The three components of the biopsychosocial-spiritual model



Medical Anthropology Theory

Medical anthropology and medical sociology are fields of study looking at cultural issues and how they relate to health and health care (Scrimshaw 2001). This approach involves:

- Learning about common beliefs and practices.
- Understanding how the local culture's family structures, values, and everyday activities shape systems of care or how different health or mental health interventions might work in the local context.
- Being aware of other professionals', lay practitioners', and, most importantly, patients' perceptions of health care and healing.

Organization Theory

The Three World View of Systems Change recommends that every action designed to produce a change in an organization or system must satisfy the demands of the clinical, operational, and financial worlds (Peek 2008). In health care, including behavioral health care, *the clinical world* involves how patients are assessed, diagnosed, and treated. *The operational world* involves how patients move through the health care and behavioral health-care systems and the processes these systems use to function in a productive way. *The financial world* involves how the care is financed, the costs of providing the service, and the net gains and losses. The practice section below suggests ways to address these worlds when developing behavioral health-care training and care in low-to-moderate income countries.

Practice

The Example: Vietnam

After the team's initial 5-year consultation, the Vietnam Ministry of Health acknowledged the need for family medicine and declared that all medical schools were required to develop training programs in family medicine. Although training programs in the medical schools and a national family medicine curriculum were approved, the government had not approved full funding of these training programs. With the help of several international health-care funders, the Ministries of Health and Education, five medical schools, and select provincial and district health systems worked with the US consultants to develop family medicine training and systems over the following decade.

Support for behavioral health would come from psychiatrists at the medical schools and the traditional medical physicians. There were three psychiatry training programs in the major cities of Hanoi, Hue, and Ho Chi Minh City and no professional counseling training programs (Schirmer et al. 2004).

The Example: Laos

Although they are neighbors, the Laos medical and behavioral systems looked and operated very differently. Starting in 2002, US consultants began visiting Laos to meet with government and medical school leaders to explore family medicine

training and resource development. The medical and psychosocial needs as defined by the government looked very different between Laos and Vietnam. Compared with Vietnam, Laos was extremely low resourced, especially in the area of human resources for health. Laos had two psychiatrists, one masters level social work school and one medical school, all of which were in Vientiane, the capital of Laos. Social work training focused on women and children.

Laos and Vietnam share a border, but their economies were very different. The per capita income in Vietnam was more than US\$ 200/year higher than in Laos, allowing more total money to be dedicated to health and mental health-care education and training.

Tensions

A country's economic, political, and health-care structures tremendously influence the country's readiness to focus efforts on behavioral and mental health care. The national health-care infrastructure and national priorities—including both the political and economic—dictate the degree of development of the primary care and behavioral health-care systems.

When working in countries different from one's own, it is important to know who else is doing behavioral health development work in the country. The in-country behavioral health champions may not necessarily inform you of the work of other consultants. It is important to ask in-country champions directly about these matters and seek out these other consultants in order to enhance each other's efforts and not work at cross-purposes. Developing countries typically are operating with both limited financial and human resources. Well-intentioned but duplicative, competing, or uncoordinated programs can quickly overtax a nation's available committed resources for the task. Key tensions which influence the development of mental and behavioral health systems are summarized below.

Key Tensions Which Influence the Development of Mental and Behavioral Health Systems

- Tension between horizontally integrating behavioral health into the primary care system versus developing vertical-based specialty behavioral health systems. Where resources are few, behavioral health specialists may work more effectively as consultants, supervisors, and trainers to primary care providers.
- Tension of training professionals (psychiatrists, family physicians, professional nurses, midwives, or social workers) versus training nonspecialist behavioral health providers (communal health workers, spiritual advisors, clergy, or community leaders). The evidence has illustrated that trained nonspecialists can provide effective mental health with sustainable results (Patel 2003; Bolton et al. 2003).
- Tensions between the different ministries within a country.
- Tension between different cultural perspectives about the cause and treatment of mental health.
- Tension between the medical model of behavioral health that involves diagnosis and treatment versus the “personal fault” model given to persons with these disorders.
- Tension between consultants focused on specific health-care clinic development (i.e., those who go to create and set up health, mental health, and social

service clinics in low-resourced areas) versus consultants focused on training and larger system development (i.e., those who primarily develop system-based infrastructure to advance a nation's overall education and health-care system).

Opportunities

The WHO and the UK have developed key strategies for mental health development (Garrison et al. 2012). These strategies, along with the authors' recommendations, are incorporated into the lists below, which are organized according to the financial, clinical, and operational domains of the Three World View of Systems Change.

A consensus statement of national and international US experts delineating the principles for successful behavioral health integration into primary care has been created by a leading panel of national and international US experts. These principles affirm the strategies outlined above and are listed below.

Financial Strategies for Country-Wide Mental Health Development

- Financial and human resources are needed (WHO/Wonca 2008).
- Policy and plans need to incorporate primary care for mental health (WHO/Wonca 2008), eventually on a national scale. This involves legislating and funding curricula, training centers, job codes for new specialties, and system changes.
- National policy must allow for flexibility, based on community need (NICE Guidelines 2011).
- Relationship development is needed with persons in pertinent government and nongovernment agencies affiliated with health, education, finance, labor, and social services.

Clinical Strategies for Country-Wide Mental Health Development

- Epidemiological studies must identify the prevalence and needs in the country so that politicians and leaders can see the significance and not discount mental health and behavioral health problems.
- Adequate training of teachers and practitioners is essential (WHO/Wonca 2008) and must include multiple providers such as psychiatrists, family physicians, social workers, and nurses.
- Primary care tasks on behavioral and mental health must be focused, limited, and doable (WHO/Wonca 2008).
- Primary care providers must have access to psychiatric and behavioral specialty supervision and support for sustainability purposes (WHO/Wonca 2008).
- Patients must have access to essential psychotropic medications (WHO/Wonca 2008).
- Quality improvement studies are needed to identify what is feasible and effective and to improve care and policy.

Operational Strategies for Country-Wide Mental Health Development

- A behavioral health service coordinator is needed (WHO/Wonca 2008); linking specialty mental health professionals and primary care providers must be developed.

- Referral pathways are needed for patients with severe and chronic mental illness (NICE Guidelines 2011).
- Patients and caregivers must be involved in the process of developing and maintaining mental health and behavioral health-care services (Garrison et al. 2012).
- Integration must be seen as an on-going process, not an event (WHO/Wonca 2008).
- Partnering with community agencies, nongovernment agencies, village health workers, and volunteers is required (WHO/Wonca 2008).
- Advocacy and social marketing will educate communities, reduce stigma, and increase access to treatment (Garrison et al. 2012).

Principles for Successful Behavioral Health Integration into Primary Care

- Agreement on clear and consistent language across disciplines, particularly on the terms behavioral health, mental health, and behavioral change.
- Understanding of the central role of the patient and family in articulating needs and developing a plan of care.
- Defining the different roles and skill sets required for physicians, behavioral health clinicians, and other members of the health-care team to provide whole-person care.
- Interdisciplinary training offered to practicing clinicians and other team members, faculty fellows, residents, and students for the roles that behavioral health clinicians, primary care clinicians, and other team members will assume when integrated into a primary care system.
- Research to better define the optimal provision of behavioral health integration, with attention to patient, practice, training, and financing issues.
- Recognition of local adaptations of integrated, whole-person care so as to include all persons and to take advantage of the differing requirements and resources of different communities across a region or country.
- Assurance that behavioral health services are appropriately financed.

Cultural Aspects

The Three World View described in this chapter must take into account the cultural differences and similarities between consultants and advisees. Strategies to address culture are listed below:

- Recruit the insider and outsider perspective. The US consultants strategically recruited Vietnamese consulting teachers who were physicians and insiders to the medical culture and others who were well-respected “outsiders” to the Vietnamese medical system.
- Recognize and address stigma at all levels. There are many successful strategies that spell out best practice in this area that can positively affect patients and improve primary care providers’ knowledge, skills, and confidence in addressing these issues (Garrison et al. 2012).

Conclusion

Behavioral health systems are best developed alongside primary care systems development in low- and moderate-income countries. Many lessons are to be learned from countries where this has not been the case and the care is fragmented. Using Vietnam and Laos' examples, key theories, principles, and strategies are outlined to assist in integrating behavioral health into a nation's health-care system.

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Chapter 20

The Development of Psychosomatic Medicine in China, Vietnam and Laos - The ASIA- LINK Program



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Background

China, Vietnam, and Laos have undergone major social, economic, and cultural changes. Traditional values are being questioned or are disappearing, and new social values and structures have not yet been established. Despite significant increases in the wealth of the population, particularly in the cities, there have been simultaneous increases in uncertainty and in stressful living situations for a large majority of the population. As a result of these social upheavals, psychological and psychosomatic

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disorders and problems are on the rise (World Health Organization (WHO). The World Health report 2001; Patel and Kleinman 2003; Lopez et al. 2006; Prince et al. 2007; Saxena et al. 2007).

In Southeast Asia, 11% of disability-adjusted years of life and 27% of years lived with disabilities are the results of neuropsychiatric disease (Lopez et al. 2006). Depression is the largest contributor to this disease burden (World Health Report 2001). The majority of the patients, who suffer from common mental disorders (CMDs), such as depressive and anxiety disorders, seek help in primary care. The point prevalence of CMDs in South Asian primary care practices varies between 20% and 45%. A review of eight epidemiological studies of CMDs in South Asia showed that their point prevalence in primary care was 26.3% (95% CI, 25.3–27.4%). Less than one-third of clinically significant CMDs are recognized by a physician (Ustun and Von Korff 1995; Xiao et al. 1997; Patel 1999; Yu et al. 2004). The resulting chronicity causes severe burdens on the affected patients, their families and the health system.

In contrast, East Asia, particularly China, has a health system that is based on high-tech Western medicine. But there are only about 20,000 registered psychiatrists in China. Moreover, most of them used to focus on diagnosis and treatment of psychosis.

Basic care is lacking for common mental and psychosomatic disorders and problems, and this care is not adequately addressed by traditional medicine. In the current medical education systems in China and Vietnam, psychosomatic or psychological content is only marginally taught (Tao 1994; Schirmer and Ninh 2002; Montegut et al. 2004; Liu 2005; Schirmer et al. 2005). More psychiatric education is available; however, it is taught mostly, if not always, in a biological manner, and there is a strong emphasis on psychotropic drugs and custodial care. Psychiatric resources are also lacking, which often allows the treatment of only severe cases (such as psychosis). In Vietnam, there is one psychiatrist for every 300,000 inhabitants. Only half of the eight medical schools have first-degree specialty training programs in psychiatry. Psychologists do not work in hospitals but rather administer psychological testing and sometimes perform consultations, primarily in schools and industry (Schirmer and Ninh 2002; Montegut et al. 2004; Schirmer et al. 2005). Furthermore, education on consultation-liaison psychiatry and psychosomatics in daily clinical practice is nonexistent (Zhao et al. 1998; Yu et al. 2004). The situation in Laos is even worse: for the entire country, there are only two trained psychiatrists in the capital city, Vientiane.

It is apparent that the current systems of medical education in China, Vietnam, and Laos need support in different ways to develop efficient educational institutions and care structures.

From 2005 to 2008, a European-Asian cooperative project funded by the European Union was coordinated by Freiburg University, Germany (Department of Psychosomatic Medicine and Psychotherapy). The objective of the project was to support the development of psychosomatic medicine in China (Tongji University), Vietnam (Universities of Ho Chi Minh City and Hue), and Laos (University of

Vientiane). In this project, a basic psychosomatic care curriculum for postgraduate medical doctors was applied.

The Project

During the first year, a team of prospective teachers was recruited for each center. The didactic elements of the new curriculum were taught to the future teachers. This was a process that involved the German team teaching the future teachers and adapting, modifying, and redesigning the lessons to the cultural context of the partners. Teaching the teachers served as an experimental curriculum while supporting the future independence of the partners. The experimental lessons followed the contents of the intended curriculum. Teaching the teachers, therefore, focused on three target areas:

- Teaching both the content of the biopsychosocial approach in medicine and the topics included in the planned curriculum.
- Teaching didactic methods, strategies, and skills for managing and teaching the lessons.
- Adapting the teaching methods to specific contexts.

At the end of this activity, the future teachers were able to manage the pilot curriculum with the assistance of their European partners during the second year.

During the third year, the Asian partners were encouraged to organize and implement the new curriculum on their own. The results of the evaluations and the partners' accumulated competence helped to fit the curriculum elements to the needs of the partners. The European staff provided supervision but limited their participation in teaching the curriculum (except for roles as guest lecturers on special topics). Supervisors supported the teachers' needs in managing the courses and becoming competent trainers of biopsychosocial skills.

More information and an overview of the 3-year program, including the experimental and supervision phases, can be found in a previously published report (Fritzsche et al. 2008).

Results

Regional training centers were formed in China (Shanghai), Vietnam (Ho Chi Minh City and Hue), and Laos (Vientiane). A total of 200 physicians completed the training, and 30 physicians acquired the status of future teacher. The acceptance of the training was high, and feelings of competence increased over the course of the training. The interactive training methods were greatly appreciated, with the skills training and self-experience ranked as the most important topics. Adaptations to the

cultural background of the participants were necessary for the topics of “breaking bad news,” the handling of negative emotions, discontinuities in participation, the hierarchical doctor-patient relationship, culture-specific syndromes, and language barriers. In addition to practical skills for daily clinical practice, the participants wanted to learn more about didactic teaching methods. Half a year after the completion of the training program, the participants stated that the program had a great impact on their daily medical practice.

Misunderstandings and Cultural Adaptions

The results in this section are extracted from interviews with the future teachers and from debriefings of the course trainers.

Handling of Negative Emotions

Chinese culture emphasizes the inhibition of strong emotional expression (Li 1985; Ots 1990; Lee 1997). Young children are sometimes scolded by their mothers for aggressive behavior (Bond and Hwang 1986). In our communication skills training, we introduced elements of “active listening” (Rogers 1942, 1997), which include “mirroring emotions,” naming perceived feelings, and showing these emotions through nonverbal displays of anger or sadness, for example. Because of their cultural background, this communication behavior was met with resistance by the participants. The essentially empathic nature of the *Rogers approach* was not questioned, nor was the usefulness of empathic support during difficult emotional situations, e.g., during discussions of a life-threatening disease or critical life events. However, the expression of personal concerns or feelings in difficult doctor-patient relationships was rejected, e.g., if the patient was upset and angry because he/she experienced a prolonged wait. In this case, a statement such as “I can understand that you are very angry” or “If I were you, I would be upset, too” would be considered an admission of guilt by the doctor. Such an admission would be associated with a loss of authority over the patient and could cause the patient to change doctors.

Balint Groups, Sculpture Work, and Reflecting Teams

(See Also Chap. 8 Balint Group)

It is foreign to some Asian cultures to discuss negative feelings outside of the family unit (Lee 1997). During the first Balint group sessions, these traditions were repeatedly confirmed by the future teachers. Our experience with classical Balint work appeared to confirm that the participants felt overwhelmed by the instruction to express their thoughts, feelings, and fantasies freely. Subsequently, we modified the classical Balint work by introducing sculpture. This modification completely changed the results: the participants became absorbed in their roles; they spoke of their fears, their anger, and their sadness; and they identified with the people they represented. In this way, sculpture facilitated vivacity and improved doctor-patient

dynamics. The doctor-patient relationship was part of the system and could be influenced by a change in the position of the doctor.

Family Norms and “Breaking Bad News” (See Also Chap. 11)

For the physicians in the three countries involved in the program, disclosing diagnoses and prognoses to patients is extremely challenging. Most Asian families ask doctors not to reveal the diagnoses and prognoses of a family member to the patient himself/herself (Hu et al. 2002). One reason for this request might be the families’ fear that a loved one suffering from cancer will become hopeless upon learning of their diagnoses and will end up in despair (Tse et al. 2003). The methods of delivering bad news in oncology are influenced by cultural differences (Ong et al. 2002). In Western countries, oncologists usually inform cancer patients of their diagnoses (Grassi et al. 2000).

When patients follow the principle of autonomy and families follow the principle of beneficence in disclosing information about cancer, physicians find themselves in a dilemma (Wang et al. 2004). Doctors need support in solving this dilemma and determining what to tell cancer patients. In our communication skills training, we addressed this dilemma and tried to find solutions for it in specific cases. We must find a balance between disclosing information about cancer and the needs of patients and families. We took physicians’ concerns about disclosing information about cancer diagnoses seriously, and we carefully sought ways to solve the conflict between the patient’s right to be informed and the traditional norms of the Asian family without harming the patient. In Asian cultures, the principles of family decision-making and family involvement in decision-making are paramount and constitute an integral part of the self-concept of the individual (Fan 1997). This cultural characteristic should be appropriately recognized and acknowledged.

Future training sessions will continue to address this issue, in an attempt to find a family-centered approach (Back and Huak 2005) of breaking bad news to the patient and his/her family.

Doctor-Patient Relationship

The doctor-patient relationship in all three Asian countries can be described as patriarchal and is characterized by a doctor-centered mode of communication. Patients expect the doctor to be the expert and to tell them what to do. Patient-centered interviewing is not common in Asia.

The patients in the live patient interviews and the participating physicians appreciated the empathic, respectful, patient-centered interview style. However, the German teachers were also considered “famous professors from abroad,” from whom cures for their ailments were expected. Due to the traditional norms, a cooperative doctor-patient relationship with a patient-centered interview style might not be immediately implemented in everyday life. Elements of patient-centered communication skills such as short breaks, summarizing, and questions regarding subjective health have proven to be highly teachable and easy to learn as a first entry into different attitudes and a better design of the doctor-patient relationship.

Focus on High Performance and the Resulting Pressure

In most general outpatient clinics and in outpatient psychiatric and psychosomatic clinics, 30–60 patients are seen by one doctor in a single morning; in large hospitals in China, a total of up to 10,000 patients per day are seen. Usually, the doctor has only 2–3 min for each patient. In specialty outpatient clinics, which are usually operated by experienced specialists and are rather expensive, the doctors might have 10–15 min. This high pressure raises doubts about whether the diagnostic and therapeutic skills learned in the training sessions can be applied in everyday practice. We recommended that the participants initially gather psychosocial background information from selected patients and provide supportive care only when there is a sufficient time frame of 10–15 min.

Impacts on the Health-Care System

Primary care is part of community hospital health center-based services (Schirmer et al. 2005). In outpatient clinics, there is little room for individual, personal doctor-patient relationships, which frequently form the basis of successful treatment. Somatizing patients in China often complain about a lack of understanding of their complaints by their doctors and about a lack of treatment success (Meng et al. 1999). Conversely, a WHO study of mental disorders in primary care showed that patients with continuous doctor-patient relationships expressed somatic symptoms as frequently as those who did not experience such relationships (Ustun and Von Korff 1995; Simon et al. 1999). Continuous doctor-patient contact and good doctor-patient relationships should be implemented, comparable to the role of the general practitioner in primary care services in Europe and other American countries.

In future courses, a more detailed medical history of subjective illness conceptions and expectations would certainly expand our range of knowledge. Future training programs should also include rural areas. In the future, these cultural blind spots can be better addressed through our new insight about these potential misunderstandings and close corporation with our partners (Like 1996; Haq et al. 2000; Galanti 2008; Ring et al. 2008, Schirmer and Montegut 2009; Mostow et al. 2010).

Past Projects in China and Vietnam

In China and Vietnam, advanced training in psychosomatic medicine and psychotherapy have taken place. Tongji University in Shanghai, together with the medical faculty of Freiburg, Germany, launched a Master's degree in psychosomatic medicine and psychotherapy in September 2011. In Vietnam, a 4-year program was conducted in 2011 to 2015 with the following three objectives: (1) the introduction and implementation of a three level, modular curriculum on psychosomatic medicine and psychotherapy for medical students and doctors; (2) the establishment of this curriculum as a regular part of the national curriculum of medical education on psychosomatic medicine and psychotherapy; and (3) the development of international European-Asian networks and the enhancement of intercultural communication.

The ASIA-LINK curriculum has also promoted the development of joint research projects and the exchange of doctors and medical students between Germany and China. Through contact with the Cancer Hospital in Beijing, a training program for Chinese oncologists, “Breaking Bad News,” has been developed and scientifically evaluated (Wünsch et al. 2013). The German Robert Bosch Foundation, the German Research Council, and the Sino-German Center for Research Promotion in Beijing have supported research projects on illness perception, illness behavior, doctor-patient relationships, and the treatment outcomes of patients with medically unexplained physical symptoms (somatoform disorders) in China.

The Chinese government has decided to set up psychosomatic medicine departments or psychological departments in the tertiary hospitals which represent high service quality hospitals in China. Consequently, this means more well-trained psychosomatic medicine doctors are urgently needed. On October 26, 2012, the National People’s Congress adopted the first national mental health law of the People’s Republic of China. It contains important implications for the integration of mental health in primary care (Mental Health Law of the People’s Republic of China 2012).

Under the administration of Professor Zhang Lan, a work team of psychiatrists and nurses has been formed in Chengdu pursuing two aims:

1. The scientific explorations of prevalence of psychosocial and psychosomatic problems and disorders in the general hospital and the need of patients and doctors to treat them.
2. Implementation of training programs in Psychosomatic Basic Care for medical doctors and nurses in the general hospitals in Chengdu.

Nurses and medical doctors are counseling and supporting patients with psychosocial problems. If it concerns serious mental disorders, they turn to the psychiatric consultation-liaison service.

Finally, the experiences with Balint groups in our program led to the establishment of a Chinese Balint society. The first conference, which included international participation, occurred in May 2011. The participants expressed a desire to establish Balint groups at their own hospitals, which has led to a plan to offer a Balint group leader seminar at the international conference.

Conclusions

This project had a significant impact on all of the participants. The course evaluation demonstrated that the medical doctors enrolled in the courses received high quality and effective training and demonstrated the participants’ progress in both professional competence and self-development. These physicians are now connected by international collaboration and intercultural cooperation. The establishment of national and international networks has been facilitated. The future teachers learned practical clinical skills, didactic, and management skills in applying the

training curriculum. They have taken over key responsibilities in continuing and consolidating the future training and education of medical doctors in their countries. The partner university hospitals, as institutional stakeholders, have shown interest in the project and have granted support for further development in this field. The European partners gained valuable experience and competence in international projects and in the successful conduct of intercultural communication. As a result of the exchanges of ideas and practical experience between the Western and Asian medical doctors and patients, new elements can be added to Western treatment theories in Germany, China, Vietnam, and Laos that will help to create promising new research fields. Finally, patients will benefit from an improved mental health-care system.

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Chapter 21

Development of Psychosomatic Medicine in China



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The Need for Psychosomatic Medicine and Psychotherapy

There is a great need for further development of the health care in the field of psychosomatic medicine and psychotherapy in China. According to different large scale reports, up to 241 million Chinese people are currently living with a mental disorder. The prevalence rate for mental disorders in China lies between 7.0% and 17.5% (see Table 21.1). Only few get proper medical treatment for their mental illness. About 222 million (92%) of these patients with mental illnesses have never been treated (Phillips 2009).

With a distribution key of 1.5 psychiatrists per 100,000 habitants and a strong urban-rural gap, one of the reasons for this high number of patients who have never

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Table 21.1 Mental disorders

Diagnose	Peking and Shanghai (2001–2002) ^a	4 provinces (2001–2005) (95% CI) ^b	31 provinces (2013–2015) (95% CI) ^c
Mood disorders	2.2	6.1 (5.7–6.6)	4.1 (3.4–4.7)
Anxiety disorders	2.7	5.6 (5.0–6.3)	5.0 (4.2–5.8)
Substance use disorders	1.6	5.9 (5.3–6.5)	1.9(1.6–2.3)
Psychotic disorder	—	1.0 (0.8–1.1)	0.6 (0.2–1.1)
Organic mental disorders	—	0.3	—
Other mental disorders	—	0.3	1.2 (0.9–1.5)
Any mental disorders	7.0	17.5(16.6–18.5)	9.3 (5.4–3.3)

^ac12-month prevalence; ^b1-month prevalence

received medical help for their mental illness could be the lack of qualified medical personnel especially in the rural regions of the country (Cyranoski 2010). If patients with mental disorders are not treated, there is a high risk for chronification of the mental disorder. Chronification is highly cost intensive for the whole society, as these patients can become unable to work and remain in the health-care system for a long period of time.

There are also high comorbidities between mental disorders, such as depressive disorder or anxiety disorder and physical diseases, such as cancer, coronary heart diseases, stroke, and diabetes. The interaction between physical and mental disorders is mostly overlooked in the Chinese health-care system. However, qualified psychosomatic care makes it possible to efficiently improve central outcomes such as mortality, quality of life, and degree of impairment of somatic diseases. Thus, psychosomatic medicine raises “somatic medicine” not only to a higher level through qualified “psychosomatics” with psycho-oncology, psychocardiology, and psychosocial support in the context of complex/complicated disease processes (transplantation, intensive care) but has also become an important pillar of modern high-end medicine and is indispensable in order to remain “competitive.”

Mental Health-Care Developments in China

It is imperative to improve the training of non-psychiatrist, nurses, psychiatrists, and psychologists. One decisive step in the right direction was the Mental Health Law, which became effective on May 1, 2013 (Phillips et al. 2013). It specifically demands the establishment of a psychiatric and psychosomatic consultation and liaison service in the general hospital. In 2015, the General Office of China’s State Council published the 2015–2020 National Mental Health Work Plan which focuses on the recognition and treatment of “severe mental illnesses” such as schizophrenia, bipolar disorder, and mental retardation. However, psychosomatic medicine and the interactions between common physical diseases and common mental disorders, such

as depression, are not mentioned in the 2015–2020 National Mental Health Work Plan, while it refers to psychotherapy only on the side (Xiong and Phillips 2016).

What Kinds of Trainings Have Been Implemented So Far?

Psychotherapy

In the past few decades, the need for qualified personnel has been answered with the help of international cooperations in the field of clinical education and research. The German-Chinese Academy of Psychotherapy has been established over 20 years ago. It organizes regular training programs in psychodynamic psychotherapy, cognitive behavioral therapy, and systemic and family therapy. By now it can look back at several thousands of participants, who successfully completed the training in China. Over the past years, education programs from Norway, the USA, and France have been added.

But nevertheless psychotherapy in China is still in the process of formal regulation. The new mental health law promotes the role of psychiatry in assessment of mental disorders and subsequently engaging psychiatrists and clinical psychologists in their treatment. Mental health institutions are requested to regularly improve mental health services and research. Yet unclear and not specified by the law, though, is the type of treatment and especially the formal training that is considered necessary for psychotherapy in China (Phillips et al. 2013).

Psychosomatic Medicine

The Sino-German cooperation in the field of psychosomatic medicine was initiated in 2002: the ASIA-LINK program was funded by the European Union and trained medical doctors in psychosomatic medicine (Fritzsche et al. 2012). Over the past years, the Balint group method, offered within the framework of psychosomatic basic care, has spread across China (Wei et al. 2016). Training courses on the topic of “breaking bad news” have been offered by foreign experts in psycho-oncology, and courses in psychocardiology have been implemented since 2016 (Wuensch et al. 2012; Pang et al. 2015).

In 2015 the Sino-German Institute of Psychosomatics and Psychotherapy at the Beijing Union Hospital was founded. The aim is collaboration in training and research in the field of psychosomatic medicine. In 2016 the 4-year training program in advanced psychosomatic medicine and psychotherapy started at the Beijing Union Hospital. This project is funded by the German Academic Exchange Service (DAAD).

In the Sino-German research network in psychosomatic medicine and psychotherapy, Chinese and German scientists work together in clinical studies about

somatic symptoms disorder, Balint group, psycho-oncology, psychocardiology, and transcultural issues. Results of the past projects have culminated in more than 25 publications in international peer-reviewed journals and 2 books, translated in to Chinese (Wei et al. 2016).

In 2017 the 3-year program “Sino-German Alumni Network in Psychosomatic Medicine and Psychotherapy” has started to bring together psychosomatic specialists from German universities and three Chinese partner universities (Peking Union Medical College Hospital, Tongji University Shanghai, West China University Chengdu). This project is funded by the German Ministry for Education and Research (BMBF).

In 2012, the West China Hospital of Sichuan University initiated a psychosomatic service plan called “the Sunshine Hospital” project. The aims of this project are to strengthen the medical staff’s ability to provide the psycho-social care and making the psychosomatic medical service available to all patients in the general hospital (Huang et al. 2019).

To increase recognition rates of psychological and psychiatric problems of patients, a new fast screening tool was developed by a Chinese project team after 2 years of research (Wang et al. 2017). They also modified the medical process and utilized the new technology to make the brief psychological assessment as “the sixth vital sign” of every inpatient in the hospital. They provided the psychosomatic medical trainings for the medical staff at all levels. A group called “the Sunshine Angels” was built up. The group members were from all the clinical departments in the hospital and trained to be able to give patients basic psychosomatic care in the wards. A collaborative psychosomatic medical care system, called The Sunshine Angels, was gradually set up by the medical staff in charge (the psychiatrists).

In 2016, China Sunshine Hospital alliance was established. It aims to provide the nationwide psychosomatic medical service in general hospitals in China. More than 30 general hospitals met the requirements and became members of this alliance.

Psychosomatic Medicine in Research

The state of research in the field of psychosomatic medicine should be demonstrated based on the example of somatoform disorders/functional syndromes: there are just as many patients with medically unexplained physical symptoms/somatoform disorders in China as in Western countries. Similar to Western countries, psychological and behavioral variables such as dysfunctional illness perception and illness behavior were associated with high somatic symptom severity and low quality of life (Schaefer et al. 2013; Zhang et al. 2014). Treatment satisfaction and the quality of the doctor-patient relationship in patients with MUS and high somatic symptom severity were the highest in TCM (Wu et al. 2015).

There is a currently finished validation study to explore the frequency of DSM-5 somatic symptom disorder (SSD) and the planned ICD-11 bodily distressed disorder (BDD) in a multicenter study in biomedicine, TCM, and psychosomatic

medicine. For young doctors, there is a Sino-German doctorate program for being awarded with the academic title Dr. med.

The following four steps are necessary to develop psychosomatic medicine in the future in China:

1. Integration of training in psychosomatic medicine in the undergraduate student teaching.
2. Basic and advanced training in psychosomatic medicine and psychotherapy for physicians, psychologists, and nurses.
3. Assistance in setting up psychosomatic wards at the general hospital.
4. Supporting basic and clinical research in the field of somatic symptoms disorder (SSD), pain disorders, psychosomatic interaction between mental disorders and physical illness, especially in psycho-oncology, and psychocardiology and to study transcultural issues.

To summarize, the demand for psychosomatic medicine and psychotherapy in China is high. The continuity of training and research in psychosomatic medicine is only at the beginning. A graduate training program and a biopsychosocial health-care model is needed.

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Chapter 22

Psychosomatic Basic Care in the Context of International Migration



Anne-Maria Müller

Introduction

The term *migration* or migrant is frequently used, but often with differing understanding. The *official definition* by the International Office Organization for Migration describes a migrant as “...any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person’s legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is” (IOM 2018). Thus, the term is very encompassing, as reasons for leaving one’s place of origin are diverse and varying in motivation and experiences during the migration process are different. The United Nations High Commissioner for Refugees (UNHCR) uses the term “refugees and migrants” in order to acknowledge all migration experiences and forms. This framework focuses on the exertion of migrants’ and refugees’ human rights, and to address refugees’ and asylum seekers’ specific needs and vulnerabilities that need to be protected by the particular legal frameworks.

In 2017, a total of 68.5 *million people* worldwide were displaced from their homes due to persecution, violence, war and human rights violations (United Nations High Commissioner for Refugees 2018). Since World War II this has been the highest number of displacements. The provision of health care and mental health care for this population is a challenge worldwide.

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Stressors Pertaining to Migration Phases

Migrants and refugees are exposed to specific stressors and vulnerabilities during different phases of migration. The migration trajectory can be divided into three phases: pre-migration, peri-migration and post-migration settlement. All phases of migration are linked to specific losses, hazards, vulnerabilities, stressors and challenges (Shultz et al. 2016). A selection of typical stressors can be extracted from Table 22.1.

Hazards, losses and changes of *pre-migratory* phases include threats to one's life or that of one's family, physical harm, violence, combat, kidnappings, sexual violence, extortion, loss of land, possessions and/or livelihood, separation from family members, loss of social and community networks, and dealing with loss and grief.

Further hazards, losses and changes accumulate in the *peri-migratory* phase, including assault and robbery, threats and violence by human traffickers, homelessness, lack of food and water, lack of sanitation, lack of medical care, lack of privacy and security, dependence on public institutions and goodwill and insecurities concerning legal frameworks of seeking asylum.

Lastly, in *post-migratory* phases, refugees and migrants face precarious living circumstances and unstable socio-economic situations, uncertainty on the right to stay in the host country, restricted access to medical care at the beginning of the asylum process, poor housing, lack of family, friends and social networks, loss of independence, loss of self-esteem, work in the informal sector, exploitation, language barriers, precarious legal status, adjustment to a new culture and sociopolitical system, and experiences with societal exclusion, discrimination and racism (see Table 22.1). This is by no means a comprehensive listing of all stressors and vulnerabilities faced by refugees and migrants and intended only as an attempt to

Table 22.1 Stressors and hazards in pre-migratory, peri-migratory and post-migratory phases

Pre-migration	Peri-migration	Post-migration
Threats	Human trafficking	Precarious living situation
Loss of family members	Assault	Unstable socio-economic situation
Physical harm	Robbery	Precarious legal status
Violence	Homelessness	Restricted access to medical services
Sexual violence	Lack of food and water	Lack of family ties, networks
Loss of land and possessions	Lack of sanitation	Loss of independence
Loss of social and community networks	Lack of medical services	Loss of self-esteem
Injuries	Lack of privacy	Work in informal sector (exploitation)
Extortion	Lack of security	Language barriers
	Dependency of public and private organizations	Acculturation
		Discrimination and racism

illustrate their possible poly-victimization on grounds of restricted resources and coping strategies.

Mental Health

Health and migration are intricately interconnected with each other. Migrant and refugee patients commonly experience elevated rates of symptoms caused by mental health problems and chronic pain (Crosby 2013). Nevertheless, data on mental health problems in migrants and refugees are heterogeneous with wide ranges of prevalence rates. Mental health problems are associated with the migration trajectory and experiences before during and after migration experiences and the policies and regulations in the host countries. Migrants and refugees display rates of *post-traumatic stress disorder of up to ten times higher than non-migrants and refugees, and higher rates of depression, anxiety, chronic pain and somatic complaints* (Mishori et al. 2017; Kirmayer et al. 2011; Steel et al. 2009). Higher rates of psychotic disorders have also been reported (Coid et al. 2008). Nevertheless, studies indicate that only half of the cases of mental health problems are recognized by the primary health-care provider (van Melle et al. 2014).

Barriers to Mental Health Care of Immigrants in the Primary Care Setting

Addressing and treating psychosocial needs and mental disorders of migrants and refugees in the primary care setting comes along with specific challenges and barriers both for the health-care provider and the patient (see Table 22.2).

Primary care providers report challenges due to high rates of mental diseases amongst migrants and refugee patients, especially in patients with experiences of trauma, which they report makes it especially difficult for them to establish a trusting and positive therapeutic relationship (Crosby 2013). Difficulties in communication due to *language barriers* and cultural differences aggravate the doctor-patient relationship (Teunissen et al. 2015; Rousseau and Frounfelker 2018). In addition, health-care providers mention in-house constraints, specifically mentioning heavy workloads and lack of human resources in order to adequately address the need (Suphanchaimat et al. 2015). Further challenges for health-care providers are states' legal regulations, limiting the right to health services for illegal migrants, and the spectrum of health care accessible for migrants in the first stages of their asylum proceedings, which oftentimes are in conflict with personal and professional norms (Lange et al. 2018; Suphanchaimat et al. 2015). These *legal restrictions* can result in a delay of adequate treatment and enhance the likelihood of a chronic course of disease (Hyde 2016). Further challenges for detection of mental health problems and their treatment are indicated as infrequent consultation rates by the patients,

Table 22.2 Barriers to mental health care from the perspectives of the health-care professional and the refugee/migrant patient

	Health-care professional	Refugee/migrant patient
Barriers to mental health care	Language barriers	Language barriers
	Legal restrictions to range of services/treatment	Cultural context
	Perceived lack of trust	Fear of not being understood
	Translation by family members	Socio-economic factors
	Translation by professionals without training on mental health context	Precarious legal status in host country
	Lack of trained human resources	Lack of knowledge of health-care system
	Inconsistent consultation rates by patients	Stigmatization of mental health problems
	Predominantly presentation of somatic symptoms	Help-seeking behaviour is oriented more towards community
	Medical statements in asylum seeking process	
	Feelings of insecurity and helplessness	

rather somatic presentations of mental health problems, high amount of other, usually more socio-economic problems, and a perceived *lack of trust* towards health-care providers (Teunissen et al. 2015). Especially the presentation of physical complaints as an expression of mental health issues leads to an under-recognition of mental disorders (Kirmayer 2001).

Mutual understanding between the health-care provider and the patient presupposes above all a common language. The more in-depth one wants to talk about his/her life situation, the higher the requirement on the level of language skills. Frustration rises on both sides if important concerns cannot be expressed and understood sufficiently. The use of *interpreters or translators* is necessary. In many cases, translation in the primary care setting is delivered ad hoc by family members or friends. This can be difficult for many reasons, especially as it creates role change in the family (Rousseau and Frounfelker 2018). *Children* often have to translate for their parents and are therefore brought into taking on the role of the speaker and caretaker of the family. Preferable is the use of professional translators. Studies also provide evidence that the use of professional translators in comparison to family members improve the communication process and help along the disclosure of mental health problems (Kirmayer et al. 2011). This is especially plausible considering the oftentimes difficult emotional content of mental health problems and which may make patients hesitant to disclose such topics in the presence of family members. Official translators on the other hand need to be trained in working in mental health contexts. Studies show that in the process of translation, leaving out of information, adding information, incorrect translation and role change are not uncommon and

can disturb the understanding of mental health issues during a medical consultation (Sleptsova et al. 2015). Even if trained translators are available, the problem remains that many countries have restrictive regulations concerning their financing.

Treating refugees often also involves legal considerations pertaining to the procedures for granting the right for asylum, especially when mental health problems due to traumatic experiences are presented. Medical reports can have a profound influence on the right to stay in a host country. In these instances, medical treatment is interwoven with legal procedures and a safe space where purely medical care is provided is hypothetical (Lange et al. 2018). Involvement in legal procedures, restrictions in health-care provision, ethical considerations and communication barriers with conceivably severely traumatized patients can lead to profound insecurities and feelings of helplessness in the health-care provider, especially in situations of perceived excessive demands. In these cases, primary health-care providers may even tend to avoid and blend out psychosocial issues during the consultations. This has a profound influence on the recognition and diagnosis rates of mental health problems (see Table 22.2).

From the *perspective of migrants and refugees*, barriers to access to primary care include cultural factors, language and socio-economic factors (Mishori et al. 2017; Suphanchaimat et al. 2015). In comparison to the citizens born in the host country, migrants and refugees make considerably less use of mental health services (Kirmayer et al. 2011). A lack of knowledge on how the health-care system works in the receiving country poses a strong challenge towards effective care and is widely reported (Suphanchaimat et al. 2015). Furthermore, mental health problems are strongly stigmatized and tabooed; therefore they are not readily presented when visiting the doctor's office. Refugees and migrants also may fear not being understood by the health service provider in their problems due to language and cultural differences. Oftentimes, the living conditions of refugees and migrants are precarious; the right to stay and the economic stability are under constant threat. These socio-economic problems are interpreted as the cause of the mental uneasiness by the migrants and refugees. The solution to the mental health issues is considered a social intervention rather than a psychotherapeutic one and consequently the symptoms may not be reported to the primary health-care provider. Support is sought in community networks, amongst family and friends or in religion (Teunissen et al. 2015).

Perspectives on Mental Health Interventions for Refugees and Immigrants

Only few mental health interventions for migrants and refugees have been evaluated in a controlled study design, but in recent years the number is rising. Improved health care has shown to be achieved through *case management*, with individual needs assessment and coordination of care for refugees and migrants (Joshi et al. 2013). Few places have this system in place, though. *Psychosocial interventions* have shown to have a positive effect on migrants and refugees mental health (Turrini

et al. 2019). In general, recommendations point out a more active role of the primary health-care provider in addressing mental health problems (Teunissen et al. 2015). To this purpose, an underlying understanding of the patient's possible exposure to traumatic experiences before and during the migration and an understanding of secondary stressors whilst resettling in the host country are very important. Furthermore, *contextual understanding* of factors that influence communication, the patient's illness and help-seeking behaviour and the patient's legal and socio-economic life situation are necessary. The primary health-care provider should be aware of these issues and be able to communicate with the patient on these matters. The patient's tendency to present physical complaints in the consultation can be used as an entrance into the communication process, adopting a biopsychosocial perspective (see Chap. 10 Somatic Symptom Disorder). Talking about the impact of physical complaints on daily life and the work situation and asking about sources of support in family and social networks can help to integrate mental health problems and stressors into the consultation. The exploration of the patient's interpretation of his mental symptoms, use of *traditional treatment* methods, and use of other sources for treatment enhances the success of the mental health treatment.

The *family system* plays a crucial role in the treatment process. It may be that a young migrant or refugee is separated from his family and thus lacks familial support in the host country. Or it may be that family members migrated together to the new country of residence. In either situation, traditional family systems are strongly present and at the same time changing in the new sociocultural environment. The family is an important source of support and stability and simultaneously undergoing adaptation processes that can be stressful. Understanding and accepting this context and trying to include the family where desired and possible will help the health-care provider build a trustful relationship to the patient.

Not only the family but also the cultural *community network* of a patient with migration background is an important source of support. Knowledge of community resources and building a network with a mutual referral system and support will be helpful to the primary health-care provider and beneficial for the patients.

A *two-phase approach* to mental health care for migrants and refugees in the primary care setting is proposed (Rousseau and Frounfelker 2018). During the first phase non-specific interventions, building a trustful doctor-patient relationship and emotional support are recommended. This should include enhancing patients' understanding of health and disease (health education and empowerment), practical support, integration of family where possible and necessary, provision of interpreters, integrating community networks and individual needs assessment. In a second phase, after a settlement and stabilization process, more specific psychotherapeutic interventions should be considered if symptoms persist.

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Chapter 23

Development of Psychosomatic Medicine in the Latin American Region



Sonia Diaz-Monsalve and Andrés Cubillos-Novella

Introduction

The *psychosomatic concept* in the Latin American region is immersed in the mental health concept. This is part of the generic notion of public health and therefore involves the pragmatic application of knowledge in various fields: clinical, epidemiological, neurobiological, sociocultural, and basic research, as the most important ones. The objective is the normal development of individuals and the maintenance of integrally emotional functions at individual and collective level (Ustun and Sartorius 1995).

Mental health in the region has its origin in the establishment of specific programs within the regional office of WHO, the Pan American Health Organization (PAHO) in Washington, D.C., PAHO convened in 1962, the first mental health seminar in the Latin American region in Mexico City (Roses 2009).

The Declaration of Caracas in 1990 (González and Levav 1990) reiterated that conventional psychiatric attention was not compatible with a necessary assistance based on the principles of *community intervention*, decentralization, participation, integration, and preventive measures in addition to treatment and rehabilitation. Specific suggestions were made in relation to the development of national mental health programs in Latin countries, community campaigns, control of affective disorders, epilepsy and psychosis, promoting mental health and

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psychosocial development of children, increase of vocational training centers, and improved legislation and regulations for the protection of human rights (Brody 1985).

Mental Health Framework in the Latin American Region

In 2004, the World Health Organization (WHO) presented the Mental Health Promotion Report, which recognizes mental health as the *well-being and effective functioning of an individual and the community* (Organización Mundial de la salud 2016).

The nature of the concept and mental health approaches are important determinants in the international, national, political, and normative context, becoming a reference of rights and living conditions: education, housing, work, social, economic, and environmental. These have been the fundamental frameworks that have affected the evolution of mental health at both the legislative and political levels, concerning the mental health of different population, populations differing in life cycles, ethnicity and gender, conditions and situations of poverty, disability (rehabilitation) displacement, migration, and armed conflict, which have been present in the region (Ardón Centeno and Cubillos Novella 2012).

Between 1980 and 2000, the mental health model in the region has shifted from mental healthcare (period from 1960 to 1993) to the mental health model based as part of *primary healthcare*. This shift was due to the change in the national health systems with the reform carried out, having a global character, establishing profound changes in health programs at the national level.

Later, in 2005, the promotional focus on *quality of life* and allowed to establish the perspective of rights with a cross-sectoral orientation, aimed at satisfying social needs from the universality, comprehensiveness, and equity in health action. In this sense, interventions and procedures for health promotion, disease prevention, public health surveillance, and control of risk factors were developed. Collected health risks were addressed by programs and then by lines of intervention that responded to major public health problems, achieving interrelated actions to respect values such as equity, democracy, environmental sustainability, and the recognition of ethnic and cultural diversity for the construction of new social representations around mental health (Secretaría Distrital de Salud de Bogotá D. C. 2016).

In 2008, PAHO approved the 2008–2012 *Strategic Plan* to prevent and reduce the burden of disease, disability, and premature death related to noncommunicable diseases, mental disorders, violence, and injuries. On the other hand, the Health Agenda for the Americas 2008 proposed seven priority areas: strengthening the authority of national health agencies, examining the socioeconomic determinants of health, enhancing social protection and access to services, decreasing the inequalities in healthcare within countries and between countries in the region, reducing the risks and burden of diseases, developing the workforce in the health sector, and taking into account the knowledge of science and technology, all within a high bio-ethical context (Roses 2009).

Mental Health Problems and Mental Health Services

Mari et al. (2009) stated that there are two phases in the research process on psychiatric epidemiology in Latin America. The first phase includes the study of the “Psychosomatic maladjustment syndrome” described in Andean migrants living in marginal areas of Lima, Peru (Seguín 1951). The second phase started with the development of standardized instruments, screening interviews, and questionnaires properly validated, following American US models. The database “Latin American and Caribbean Health Sciences” (LILACS) between 1999 and 2008 with a focus on domestic violence, depression, alcohol and substance abuse, tobacco, and drugs, “showed a substantial increase in those mental health problems” *the prevalence of mental illness* varied between 18 and 36%. The specific rates for depression were 9–27%, for alcohol abuse 7–57%, and for drug abuse 9–19%.

Regarding mental health interventions, the “delayed treatment” is a phenomenon experience by all Latin American countries. The burden of mental disease is high considering its economic costs and the disability associated with both the individual and the family.

Regarding policy and mental health services, at present, 65% of the countries in the region have a *specific mental health policy*, 82% have mental health action plans, and 70% have a specific legislation in this area. Approaches to mental health interventions have minor variations from country to country. Key principles are related to decentralization of services, intersectorial collaboration, multidisciplinary participation, and community support in treatment and rehabilitation. The slow translation of policy into service delivery in the region is shown in the following statistics: There are on average 5.4 psychiatric beds per 10,000 population, of which 4.6 (82.8%) are in psychiatric hospitals and only 0.4 per 10,000 population in general hospitals (Alarcón 2002).

Regarding the work force in mental health services, the WHO Atlas on Mental Health (2005) shows for the Latin American and the Caribbean region a *shortage of mental health professionals* and a heterogeneous distribution within and among countries. The number of psychiatrists, for example, showed an average of 4.3 per 100,000 inhabitants; the extremes were 24 and 22.9 in Venezuela and Uruguay, respectively, to 0.2 and 0.5 per 100,000 population in Guyana and El Salvador, respectively. Argentina had 106 psychologists per 100,000 inhabitants, while Belize had none and Suriname and Trinidad Tobago only 0.2 and 0.3, respectively, with a regional average of 10.3 per 100,000 population. The average does not reflect the large differences within and among countries.

Mental Health Interventions

It can be concluded that although there are still disparities, concrete actions have been implemented in the region to remove inequities. Some good examples are the *training for mental primary healthcare* workers in Cali, Colombia; *community*

psychiatry for marginalized urban areas in Tegucigalpa, Honduras, and Porto Alegre, Brazil; community-university-state government collaboration in Mérida, Venezuela; extension of mental services in Santos, Brazil, support networks and social services in Medellín, Colombia; policy implementation in Black River, Argentina, and care of victims of domestic violence in Monterrey, Mexico; community stress prevention clinics in Havana, Cuba; priority attention for patients with depression in Chile; and prevention of addictions in La Paz, Bolivia (Alarcón 2002).

The challenge ahead for policy makers in many countries of the region is to pay more attention to mental health by policy makers. The strategy of incorporating mental care in the field of primary care can be effective to a point but there is always the risk of placing mental health as subordinate of physical health, when in reality research has clearly shown the opposite (Ustun and Sartorius 1995).

The Way Forward

In its 2016 report, the *United Nations Development Program (UNDP)* recommends that the region incorporate into the mental health policies the guarantee, promotion of mental health and protection, to have a positive impact on peoples' health. These guidelines provide recommendations for the adequate incorporation of mental health and to establish the costs of addressing priority mental health events. The target population identified by this document was made up of people with mental disorders, people with psychosocial problems, and the population in general. It is considered necessary to develop mental health policies in the region that seek the inclusion of vulnerable populations, stimulate support networks, and avoid discrimination, involving the adequate provision of social services, in order to reduce the burden of mental disease and disorders.

The countries of Latin America, whose policies pay most attention to mental health issues, are Paraguay, Colombia, and Peru. *Colombia* is one of the Latin American countries that has established both short- and long-term goals. One of the goals is that 100% of the members of the social security system have access to mental healthcare and that 10% of the total health budget is allocated to this area (Henao et al. 2016). Despite this, suicide rates have increased over the years (particularly among the young population), as have suicide attempts, not to mention that depression is the second cause of illness in the country (Ministerio de Salud y Protección Social 2018a, b). Moreover, on November 7, 2018, the Ministry of Health and Social Protection adopted the national mental health policy (resolution number 4886 of 2018). This policy is an advance for the country in the field of mental health, giving the essential orientations to guide programs of promotion, prevention, and rehabilitation based on community actions and social inclusion. These aspects are fundamental to achieve a positive impact on human well-being in "terms of integral development from the perspective of human rights and capabilities" (Ministerio de Salud y Protección Social 2018a, b).

In 2018 in *Peru*, the National Plan for Strengthening Community Mental Health Services was approved. This Plan projects the implementation of 281 Community Mental Health Centers, seeking the universality of care and the expansion of this type of services to all regions of the country (Perú Informa 2018).

Capacity Building to the Colombian Peace Process After the Civil War

This project is implemented in Bogota and the Atlantic coast of Colombia (Guajira and Valledupar). The project aims to improve the *mental health of internally displaced populations (IDPs)*. Main objectives are to enhance capacities of (1) district clinical primary care practitioners in assessing and treating mental disorders of IDPs in Colombia (primary mental care component) and of (2) local public health service managers in planning, implementing, and evaluating public mental health services for IDPs (public mental care component). The project started in 2017 and is managed by the Public Health Institute of Javeriana University in Bogotá and the Department of Psychosomatic Medicine and Psychotherapy together with the Center for Medicine and Society (ZMG) at Freiburg University, Germany (DAAD PAGEL 2017).

National Mental Health Policies

Finally, it is important to note that in Latin America the regulations in the health sector have recognized in the year 2018 the need for having National Mental Health Policies. It is recommended that these policies make efforts for appropriate monitoring and control of its application, to protect and improve the quality of mental health services. In addition, from the perspective of the professionals providing mental health services themselves, although progress has been made in the mental health of the populations, it is important to strengthen the ethics, quality, and better provision of mental health services.

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Chapter 24

Development of Psychosomatic Medicine in Iran



Farzad Goli and Hamid Afshar Zanjani

Psychosomatic Health Profile of Iran

Because of diversity in definitions and criteria of psychosomatic disorders and etiological heterogeneity, there exists a paucity of large epidemiologic studies in this field. Furthermore, unreliable instruments and indicators for sampling create pitfalls in the interpretation of data. Although the pooled rates for prevalence of different psychiatric and psychosomatic disorders are comparable to the rates in many other countries, the most important finding of these studies is the diversity of the *prevalence rates* among different communities in Iran. This diversity does not seem to be attributed solely to the different time frames and geographical locations of the studies. It might also have resulted from differences in methodologies (e.g., using different research tools to collect the data), study procedures, and study quality. There have only been a few studies about psychosomatic disorders in Iran in the last four decades.

In his article “Epidemiology of Psychosomatic Disorders in Iran,” Bash (1984) reported the results of a psychiatric epidemiological survey from 1963 to 1976 with WHO guides. Samples were taken from all three principal components (rural, urban, and tribal) of the population older than or equal to 6 years. They were based partly on census studies and partly on random samples. Prevalences per 1000 for all psychiatric cases were rural 149, urban 166, and tribal 21; for all psycho-reactive cases (included in the foregoing) 87 were rural, 98 urban, and 12 tribal; for all psychosomatic cases

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(included in the psycho-reactive) 17 were rural, 23 urban, and 9 tribal. All tribal rates were significantly lower. Reactive cases thus accounted for 59% of the total psychiatric morbidity and psychosomatic cases for 14%.

In this study, headaches (including migraine, pulmonary, cardiovascular, gastrointestinal, and heterogeneous and polymorph disturbances) were considered as psychosomatic disorders. This is due to a lack of other classifications and diagnostic tools for other psychosomatic illnesses.

In another epidemiologic mental health survey, Mohammadi et al. (2005) showed that the mental health pattern in Iran is similar to the Western countries, but it seems that the prevalence of psychiatric disorders in Iran may be lower than in these countries. In this study, the prevalence of somatization disorder and dissociative disorders is reported in 0.77% in the studied population.

Although somatoform disorders are considered as a prototype of psychosomatic disorders in the majority of mental health studies, many other disorders and illnesses related to psychosomatic medicine are neglected. Accordingly, no more information about psychosomatic illnesses can be inferred from this study.

In the "Mental health survey of Iranian adult population in 2015," different aspects of mental health were assessed by Noorbala et al. (2017). The GHQ-28 was used as screening tool and the results were gathered by the traditional scoring method. A total of 23.44% of samples were suspected of having mental disorders. The prevalence of anxiety and *somatization symptoms* was higher than the prevalence of social dysfunction and depression symptoms. Comparison of the outcomes from the study with research conducted in 1999 demonstrated an increasing prevalence rate of suspicion for mental disorders. Interestingly, the frequency of somatization symptoms had risen from 17% to 23.76% in the period from 1999 to 2015.

A significant increase in somatization symptoms in epidemiologic studies was congruent with clinical observations in different clinical settings in large cities. Overall during the last decade, psychosomatic illnesses and disorders have been considered as a prominent health problem by most physicians in Iranian population. Somatic symptom disorder, somatoform disorders, functional disorders, bodily distress syndrome, as well as other unspecified psychosomatic symptoms attracted the attention of healthcare providers to these health problems as important causes of referrals to clinical settings.

As a result, several epidemiologic studies regarding the psychosomatic problems in different settings have been conducted by Iranian researchers. For instance, the study on the epidemiology of psychological, alimentary health and nutrition (SEPAHAN) was carried out by Adibi et al. (2012) from among a large sample of Iranian adults living in Isfahan province. In this cross-sectional study, the relationship between several dietary, psychosocial, and lifestyle-related factors on the prevalence of common functional gastrointestinal disorders were evaluated. The prevalence of irritable bowel syndrome (IBS) (21.4%), anxiety (15.2%), depression (30%), and psychological distress (23.1%) was considerably high in this population. It should also be noted that the prevalence of these conditions was found to be significantly higher in women than in men and were related to perceived social support and coping styles.

The establishment and development of psychosomatic care centers in major cities of Iran was the result of reflecting on this unmet need for holistic medical care. In addition, it has been possible to see a significant growth for training and learning in this field recently.

History of Psychosomatic Medicine in Iran

Many Western and Iranian historians are convinced that the field of psychosomatic medicine originated in Iran. Abu Zayd al-Balkhi (849–934), Zakariyya al-Razi (854–925 AD), Ali ibn al-Abbas al-Majusi (930?–994 AD), and Avicenna (980–1037) are known as prominent pioneers of psychosomatic medicine. In his *Spiritual Medicine* (al Tibb al-Ruhani), Razi declares that “temper of body is morality of the self.” Together with the use of storytelling and other diverse psychological treatments (Hunke 2007), he further emphasizes that “physician of body has to be physician of the self” and as such, if we – as the physicians – cannot guide emotions appropriately, not only will behaviors of the body be disturbed but also its functions (Rāzī 2001). A follower of Razi and developer of his works, *Ali ibn al-Abbas al-Majusi* (Hali Abbas), was a prominent ninth-century surgeon, physician, and psychologist who made notable achievements in medical ethics and the doctor-patient relationship (Leach et al. 2012). In his *Kāmil al-ṣinā‘ah* (al-Majusi 2009), he provided a detailed explanation for many mental illnesses, such as depression, sleep disorders, obsessive love, amnesia, and hypochondriasis, and emphasized on the role of nutrition and bodily exercises in treatment of such diseases (al-Majusi 2009). *Avicenna*, in *The Canon of Medicine* (his book about medicine) and in *al-Shifa* (his work on theology and healing with a significant part devoted to psychology – the science of the self), deals with the mind-body connection. He explains how the mind influences behavior and body functions at voluntary and emotional levels (Avicenna 1994). He introduces the roots of many physical disorders in severe negative or long-term emotions in *The Canon of Medicine*. On the other hand, though, he implemented psychological treatments to treat intense and chronic physical diseases (Nasr 2005).

He also made use of hypnosis for the diagnosis and treatment of affective disorders. He describes hypnosis – *al-wahm al-amil*, in his words – as an altered state of perception, in which the patient takes the words of physicians to be real and act in the manner of how they intended (Avicenna 1994). He often led and guided the musician or musicians while he was holding the pulse of the patient in his hand until the patient’s pulse temporarily balanced (Avicenna 1994; Jones 2016).

The Isfahan School of Medicine, founded by Avicenna, was the first and one of the greatest centers where the theoretical and clinical education of medicine was taught alongside psychology and philosophy (the science of the self). However, even before all of these movements, Razi’s teacher, *Abu Zayd al-Balkhi*, is recognized as the father of psychosomatic medicine. He is the author of *Masalih al-Abdan wa al-Anfus* (Sustenance for Body and Soul). Contrary to his teachers –

Hippocrates and Galenius – al-Balkhi did not believe that mere regulation and modulation of the body tempers and medication would remedy mental disorders, such as melancholy and obsession; instead, he believed that the use of words plays a vital and necessary role in emotional regulation (al-Balkhi 2015). He states that emotions are affective conditions, whose intensity and endurance lead to physical diseases (al-Balkhi 2015). To change the behaviors, he used techniques, such as belief altering, regular musing, rehearsals of experiences, and imagination. Moreover, he recommended stoic practices to his patients for increasing their acceptance of losses and their resilience, so that – in his words – the self can return to “its best state” after a trauma (al-Balkhi 2015). He maintained that mental disorders originated from sorrows due to losses, which can give rise to fear, anger, and anxiety (al-Balkhi 2015).

On the other hand, he indicated how various emotional disorders disturb the balance of pulse, breath, and internal organs and cause somatic pains (al-Balkhi 2015). The analysis which Abu Zayd al-Balkhi provides from the role of body and psyche in health and illness conditions is very close to the modern psychosomatic medicine viewpoint; unfortunately, many methods started by him were not continued and developed by his disciples.

After the eleventh century, Iranian physicians did not achieve any novel advances in medicine or related fields. In the Safavid era (1571–1629), Shāh Abbās the Great (Shāh Abbās I) sent a number of physicians to India, where the official language at that time was Persian. This not only led to the adoption of *Ayurveda medicine* by Iranian physicians and its introduction to Iran but also triggered the first contacts of Iranian medicine of the time with Western medicine, which was still under influence of Galenius and Avicenna (Ebrahimnejad 2004).

The arrival of Western physicians to Iran, the establishment of the Darolfonoon school, and the translation of some original texts specifically from French and then from English witnessed the onset of a period, in which physicians used a blend of traditional and modern medicine (Ebrahimnejad 2004).

Modern Psychosomatic Medicine in Iran

As far as we know, the first public hospital where psychiatric patients were treated together with other patients was marizkhaneh-ye dowlati (state hospital) in the mid-nineteenth century; however, the exact time it began to offer psychiatric services is unknown (Ebrahimnejad 2004).

Finally, *the first psychosomatic department* was established headed by Dr. Hossein Rezayi in 1939. This movement was followed by Dr. Mirsepasi. The services of the department involved the education of medical students in psychosomatic and psychiatric diseases. This marks the starting point of applied modern psychiatry in Iran. Then, the Educational and Clinical Department of Psychiatry was established in the Pahlavi hospital (now known as the Imam Khomeini Hospital) in 1950, which was transferred to the Roozbeh hospital in 1951. Although the title of the Psychosomatic Department was changed to the Mental Diseases Department,

symposiums and seminars on the psychosomatic subjects were held in this hospital for many years (Nourbala 2005). Temporarily, psychosomatic medicine was almost marginalized and forgotten by the development of the biological approach to psychiatry.

The first and second generations of psychiatrists of Iran were mostly influenced by the *biological approach*. However, the third generation adopted an *analytical approach*. This analytical approach began under the management of Dr. Iraj Syasi and the establishment of the Tehran Psychiatric Institute. This movement was stopped after the Islamic revolution in Iran and the wave of anti-Westernism until 1985, when Dr. Mohammad San'ti started the education and practice of psychotherapy at the Iran University of Medical Sciences and the Tehran Psychiatric Institute. This movement led to the establishment of a psychotherapy fellowship for psychiatrists in 2016 (Goli 2015).

From the late 1980s, particularly at the end of the Iran-Iraq war, *New Age* movements increasingly and extensively found their way into Iran's society, and a large number of scattered workshops on meditation, self-hypnosis, yoga, NLP, and healing traditions such as Reiki and Pranic were held. Different techniques of mind-body medicine were mostly presented by nonspecialist people without an academic education in psychology or medicine. One exception to this disorder existed, and that was *hypnosis*. Although it was established in 1990, the Iranian Scientific Society of Clinical Hypnosis was approved as a scientific institution under the supervision of the Ministry of Health and Medical Education and officially started to teach hypnosis to physicians and subsequently psychologists. Other noteworthy movements naturally included the formation of the Iranian Association of *Music Therapy* in 1998 and the Music Application in Mental and Physical Health Association, which has organized congresses, educational programs, and researches in this field.

On the other hand, the first committee for complementary medicine organization and parapsychology was organized by the Isfahan Provincial Government and the first *integrative medicine* program developed by the Danesh-e Tandorosti Institute (DTI) following the relevant experiences of the World Health Organization (WHO) and National Institutes of Health (NIH). After being approved by the Health and Treatment Committee of the Provincial Government, the Health and Treatment Committee of the Islamic Parliament of Iran was established (Goli 2002). The bulk of this integrative medicine draft consisted of mind-body coordination including methods such as hypnosis, meditation, yoga, music therapy, and art therapy capable of being integrated into biomedicine. Although it led to the establishment of an office for traditional, complementary, and alternative medicine (in the Ministry of Health and Medical Education), it unfortunately yielded nothing more than the formation of traditional medicine groups in medical universities.

If psychosomatic medicine is regarded as the extension from medicine to psychology, then health psychology, behavioral medicine, and medical psychology are extensions of psychology to medicine.

In 2001, the first *Health Psychology* study course was established in Tehran University. Since then, many universities have accepted students in this major. In 2011, the first Iranian Health Psychology Association was established. The curriculum

for health psychology is mostly planned based on the biobehavioral approach. As yet, though, none of the courses include internship or practical training in psychotherapy.

In 2008, the *First International Congress on Psychosomatic Medicine* was held in the Isfahan University of Medical Sciences (IUMS) in cooperation with the Razi Association in the presence of Iranian and German professors from Freiburg, Ulm, Marburg, and Hamburg. This congress led to the formation of a memorandum of understanding for cooperation between IUMS and Freiburg University. Subsequently, the Psychosomatic Research Center (PSRC) started its activities in the IUMS in 2009.

In 2009, the *Clinical Department of Psychosomatic Medicine* was established in the Psychiatry Department at the Iran University of Medical Sciences; this department returned to its origin. In the same year, the syllabus for the Psychosomatic Medicine Fellowship for psychiatrists was approved. This fellowship was established first in the Tehran University of Medical Sciences, and subsequently in the Beheshti, Mazandaran and Iran medical universities. The activity of this group led to the establishment of the Psychosomatic Medicine Association in 2016.

The first psychotherapy and psychosomatic medicine workshop was held in Isfahan in the presence of Prof. Dr. Michael Wirsching and Prof. Dr. Carl Eduard Scheidt from Freiburg University in cooperation with the DTI. The same year saw the implementation of the project “Globalization and Health – an Interdisciplinary Project of Cooperation between Germany and Iran” with the cooperation of the Psychosomatic Department of Psychotherapy and Psychosomatic Medicine of Freiburg University, the Psychosomatic Research Center on IUMS, and DTI with the financial support of the German Academic Exchange Service (DAAD). This program was followed by “Improvement of the psychosocial care in primary medicine – a German-Iranian cooperation project” in 2010 and “The Fourth International Congress on Psychosomatic Medicine.” This cooperation has also led to the publication of the interdisciplinary *International Journal of Body, Mind, and Culture*, starting in 2014. Continual educational and research programs undertaken in these years in Isfahan, Mashhad, and Freiburg led to the training of specialists and trainers in this major. Educational and research postdoctorate courses in psychotherapy and psychosomatic medicine for MDs and PhDs in clinical and health psychology were held in the IUMS (from 2014) and the Mashhad University of Medical Sciences (from 2018) under the supervision of the Freiburg University psychotherapy and psychosomatic group.

Psychosomatic Discourses in Iran

Currently, there are two psychosomatic movements working and developing in Iran: biobehavioral and systemic movements. The hub of the *biobehavioral* approach is the Tehran University of Medical Sciences. This approach is the descendant of the organic-descriptive tradition of Rouzbeh hospital. It is based on American

psychosomatic medicine traditions and focuses on consultation-liaison psychiatry (CLP) and behavioral medicine.

The *systemic approach*, whose hub is the Isfahan University of Medical Sciences and the Danesh-e Tanderosti Institute, is based on the German school of psychosomatic medicine and psychotherapy and systemic approach to health. Although it makes use of behavioral and biomedicine approaches, it is rooted in internal medicine, phenomenology, and psychoanalytical traditions.

The biobehavioral movement places psychosomatic medicine as a subdiscipline to psychiatry, focused on the role of psychiatry in other settings of medicine. The systemic movement is primarily focused on psychological disorders in psychotherapy and psychosomatic settings. While it deals with the specialist training of physicians and psychologists in this field, it works as an approach to the integrity of health and medical care rather than a specialty or subspecialty. The systemic approach invites all health providers to care for all aspects of health and illness in an integrative system. From this viewpoint, psychosomatic medicine is a whole-person medicine. By promoting sensitivity, understanding, and competencies of clinicians in different specialties of medicine and psychologists, this approach has created diverse settings as psycho-oncology, psycho-cardiology, psycho-gastroenterology, psycho-dermatology, etc. In such a *biopsychosocial model*, CLP is in fact an important part of the process of integrating medical specialties.

The family physician at the core of the health delivery system is an appropriate focal point for embedding and formation of the process of integration of this concept (Goli et al. 2017). The rising development of these two movements promises the fusion of the two movements, so that they have the ability to make the education, research, and treatment in Iran's health system more effective.

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Chapter 25

Psychosomatics in the Context of the Development of Integrative Medicine: The Russian Perspective



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Somatopsychiatry and Psychosomatic Medicine

An integrative approach in medicine assumes an interaction between two clinical categories: somatopsychiatry and psychosomatic medicine. It seems reasonable to make yet another attempt to define their boundaries.

Somatopsychiatry is a clinical discipline dealing with predominantly severe mental disorders requiring immediate intervention, which develop in patients with severe somatic disorders or decompensated chronic somatic conditions. This subject area includes various types of *somatogenic psychosis* (substance intoxication delirium, transient hallucinosis, pseudodelirium with perplexity, clouding of consciousness with changes in the level of wakefulness), as well as *nonpsychotic somatogenic disorders*: affective disorders (depression with episodes of dysphoria, severe asthenia, tearfulness; euphoric atypical hypomania with low productivity) and neurosis-like manifestations, specifically developing as a reaction to the presence of disease and the associated limitations.

Psychosomatic medicine can be defined as a systemic concept, represented by a wide range of research (clinical, biological, psychological) at the intersection of medical sciences studying normal and pathological interactions between psychological and somatic processes. For several decades, psychosomatic medicine was dominated by the psychodynamic tradition (Alexander 1951; Dunbar 1954), which focused on a limited group of so-called psychosomatic disorders. Now we universally accept the biopsychosocial model of the disease as proposed by Engel (1982), which implies involvement of psychological and psychosocial factors at early stages of many forms of somatic and mental pathology (see Chap. 1).

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Mental Disorders and Physical Disease

Mental disorders, especially affective disorders, almost invariably accompany the occurrence and exacerbation of somatic disease just like certain somatic disorders accompany mental disorders, aggravate their evolution, create difficulties in treatment selection, and in many cases significantly reduce the *life expectancy* of patients. The results of studies in this regard show that the life expectancy of patients with affective disorders and schizophrenia is 15–20 years less than in the general population (Sharma and Markar 1994; Saha et al. 2007; Saxena and Maj 2017). A reduced life expectancy is observed even in such a “neurotic”-level pathology as panic disorder (Hole et al. 1972; Coryell et al. 1986). Moreover, the essential negatively contributing factor in all these cases is not just suicide but rather cardiovascular and cerebrovascular disease. A special “*vulnerability*” of psychiatric patients to various stress factors can be assumed. This alarming data calls for an active scientific and practical collaboration between psychiatrists and other medical specialists. Such *collaboration* will contribute to a better understanding of both mental disorders and physical diseases and to finding optimal ways to help these patients.

In modern Russian psychiatry, the studies conducted under the supervision of A. B. Smulevich can be considered as truly *interdisciplinary* and at the same time as large-scale research in the area of psychosomatic medicine carried out in recent decades (Smulevich 2011, 2014). This school is developing the traditions of the Russian clinical medicine, which by the beginning of the twentieth century was already taking the form of *integrative medicine*.

Unfortunately, by the middle of the twentieth century, the integrative nature of the scientific and practical principles was lost for a long period. Specifically, the loss of the integrative nature had led to the isolation of psychiatry from general medicine. Only now, both in Russia and worldwide, the pertinence of restoring the integrative approaches becomes apparent, in view of recent clinical and biological data and the experience of providing various forms of medical care. The most intensive search for interactions and mutual understanding takes place in the area of *psychocardiology* (see Chap. 12). The volume of research conducted in this area is so extensive that it deserves a special review. Particular attention should be paid to the generally accepted connection between cardiovascular pathology and affective disorders (bipolar disorders, recurrent depression, various affective spectrum disorders, including anxiety and somatoform disorders).

The results of joint efforts of specialists from the Moscow Institute of Psychiatry and the Pulmonology Center are an example of a multidisciplinary long-term comprehensive research into the dynamics of somatic and mental changes at different stages of *asthma* (Krasnov et al. 2010). The results are schematically presented in Table 25.1.

Psycho-rheumatology can also be considered as an example of collaboration between specialists from two disciplines (Zeltyn et al. 2009; Lisitsina et al. 2014). The joint research carried out by psychiatrists and rheumatologists was supported by the modern psychiatric genetics. The results of genome-wide association studies

Table 25.1 *Psychosomatic and somatopsychiatric interactions*, based on the example of the clinical dynamics of asthma (Krasnov et al. 2010)

Clinical stages	Main pathogenetic factors	Psychopathological manifestations
“Asthma-like bronchitis” stage	A combination of an exogenous (dust, toxic, and allergic) “trigger” and non-specific distress, negative response to stress, vegetative, immunological, and endocrine dysfunctions	Non-specific asthenia and hyperesthesia (emotional and vegetative lability, sleep disturbance, fatigability) Hypothymic disorders, predominantly of the anxiety type
Formation of a typical clinical presentation of asthma	Toxicoallergic inflammatory process + anxiety-mediated vegetative (psycho-vegetative) elements are added to the clinical presentation	Episodes of fear occurring with the first asthma-like attacks. A persistent subdepressive [dysthymic] mood change
Asthma progression	Intensified bronchoconstrictive processes, manifestations of hypoxia; immunological endocrine dysfunctions	Asthenia exacerbation. The dramatic awareness of the disease—a severe somatic disease with the limitation it entails. The occurrence of anguish elements along with anxiety, with a sensation of unpromising treatment perspective and “dependence on therapy”
Evolution to chronic obstructive pulmonary disease	Hypoxemia, electrolyte imbalance, hemodynamic disturbances. Predominantly somatogenic mechanisms of mental disorders	Complex affective disorders with elements of apathy, episodes of dysphoria. Identification of problems with memory, attention, and intellectual productivity

published by the Cross-Disorder Group of the Psychiatric Genomics Consortium (2013) suggest cross-genetic linkage both between major psychiatric disorders, specifically schizophrenia, affective disorders, autism spectrum disorders, and a number of somatic and neurologic disorders, such as rheumatoid arthritis, systemic lupus erythematosus, psoriasis, Crohn’s disease, type 1 diabetes, and multiple sclerosis.

Psychosomatic pathology can be viewed as a “transition zone.” It investigates such clinical groups as psycho-vegetative impairments (including both changes in vegetative regulation, available objective verification, and subjectively experienced “somatoform” phenomena), psychosomatic disorders, and the equally named diseases (truly somatic). At the same time, they involve an obvious or suspected mostly affective, psychopathological stage.

Psychosomatic disorders that have both a functional and an organic basis can be compensated but cannot be fully reversed (e.g., the early stages of hypertension, coronary heart disease, cerebrovascular disease, repetitive allergic reactions, etc.).

(Psycho-)somatic diseases are predominantly severe forms of actual somatic pathology with impairments of one or more physiological systems, which are mostly irreversible or amenable only to symptomatic therapy; in this context, the primary triggers become irrelevant.

Somatoform disorders occupy a significant place in the continuum of psychosomatic disease. They occupy an intermediate position between general medicine and psychiatry. From the psychopathology perspective, they are characterized as somatized mental disorders of the constitutional, neurotic, and affective spectra with “no physical basis.” In a new American diagnostic manual DSM 5 (American Psychiatric Association 2013), somatoform disorders have been replaced by “somatic symptom disorders” (SSD), without specific interpretation (see Chap. 10).

According to our observations, the structure of somatoform disorders includes the following components:

1. Emotional (mostly blunt hypothymic)
2. Sensory (mostly hyperesthesia)
3. Vegetative (psycho-vegetative)
4. Motor (uneven muscle tone, smooth muscle motor disorders)
5. Motivation (reduction or disharmony of activity motivation; possibly impaired vital urges)
6. Cognitive: hypochondrial fixations and psychologically clear interpretations, unexpressed phobias, and overvalued body image (including dysmorphophobia); executive functions are usually preserved, but certain neuropsychological techniques reveal their “vulnerability.” Thus, the structure of somatoform disorders is generally consistent with the structure of affective spectrum disorders (Krasnov 2011).

Neuropsychiatry

The term “*neuropsychiatry*,” which has recently found increasing use (Taylor 1999; Arciniegas and Beresford 2001; Schiffer et al. 2003) and allows us to outline the area of interaction and intersection of the professional domain of neurologists and psychiatrists, does not yet possess a generally accepted unambiguous definition. Mental disorders, and especially affective and cognitive disorders, are identified in many neurological conditions. On the other hand, certain neurological stigmas or symptoms are observed in the clinical presentation of a number of mental illnesses, particularly neurodegenerative in nature, predisposing to dementia. At all its stages, the intermediate dynamic category of “psycho-organic syndrome” clinically presents a complex relationship of mental (cognitive, affective) and somatic (mostly somato-vegetative but also often metabolic and endocrine) disorders together with neurological changes visible on imaging assessment tests (Krasnov 2011).

Thus, there is a basis for a systematic understanding of a significant number of various forms of pathology from the perspective of their multifactorial nature, i.e., the presence of psychopathological and somatic or somato-neurological components at their origin and in their clinical manifestation.

Summary

The arguments presented above show that a number of diagnostic and therapeutic problems can no longer be successfully solved by a team of same-discipline specialists without the joint efforts of specialists from multiple disciplines. Consequently, the *interdisciplinary collaboration* is a promising direction of development for most medical disciplines both in research and in clinical practice.

Significant impediments are appearing (especially in Russia) on the path to the successful completion of the tasks set forth in the field of psychosomatic pathology in relation to the organization of medical care of this numerous group of patients. The organization of medical care in the field of general physical diseases based on the principles of *integrative medicine* is insufficiently developed due to the persistent lack of collaboration between psychiatry and general medicine disciplines.

The application of integrative principles as a basic approach for studying psychosomatic disorders is a promising and progressive avenue to understanding this pathology and the development of effective therapies for its treatment.

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Chapter 26

Psychosomatic Medicine in Africa



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Historical Background

The coining of the term “psychosomatic” is credited to Heinroth in 1818; however, modern psychosomatic medicine was born much later in the 1930s (Fava and Sonino 2000). The defining concepts of psychosomatics in its early years were basically two: psychogenesis and holism. Each of these concepts defined a specific époque of the development of psychosomatics with psychogenesis taking the earlier three decades, from 1930 to 1960 (Fava and Sonino 2000). It basically suggested that physical illnesses were caused in part by psychological factors. Holism on its part arose after 1960, and it rallied medical practitioners to take their patients in their totality. It is from this that Engel in the 1960s developed the multifactorial model of illness that we now popularly refer to as the “biopsychosocial model” (Engel 1977). Later on, Lipowski took up the biopsychosocial model of Engel and operationalized it to form the backbone of psychosomatic medicine, by defining it as a scientific discipline that embodied holistic approach to the medical practice and encompassed consultation-liaison psychiatry (Fava and Sonino 2000).

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What Is Psychosomatic Medicine?

Psychosomatic medicine can be seen as a comprehensive framework for a holistic consideration of patient care that encompasses the interaction between psychosocial factors and biological factors in the predisposition, precipitation, perpetuation, and the patient's coping with disease or health state (Wittkower 1964; Baasher 1965; Brautigam and Osei 1979; Fava and Sonino 2000). In this multifactorial frame of reference, the roles of stressful life events, allostatic load, and health-damaging behavior have provided an opportunity for prevention efforts. In the past 60 years, psychosomatic medicine has addressed some fundamental questions about health and disease (Fava and Sonino 2000); however, many of these questions were addressed in different areas of the world, well ahead of the current prevailing medical orientation. One of these places is Africa.

Psychosomatics in Africa

According to T.A. Baasher, the first time that the word “psychosomatics” appeared in African literature was just after World War II in the *East African Journal of Medicine* of 1949 (Baasher 1965). He narrates the editor's concern with the alien word that suggested psychological methods of managing previously neglected medical problems. This, however, may not be an accurate depiction of the evolution of psychosomatic medicine in Africa, especially, since the African medicine man has always been holistic – viewing his clients in their totality.

The advent of western medicine in Africa in the nineteenth century came with what was perceived as modern methods of making a diagnosis and new technologies to support it (Baasher 1965). This reduced the focus from holistic to illness-oriented medical practice among the western trained health practitioners in Africa (McEvoy and McEvoy 1976). The art and craft of modern medicine then seemed to be one that sought to avoid disease and death and not necessarily equipping the patient with skills to cope and to live their fullest life. Furthermore, cultural differences begun to raise considerable problems for evaluating the history and eliciting the examination findings since local patterns of the expression of illnesses were shrouded in local superstitions, taboos, and religious beliefs (McEvoy and McEvoy 1976; Ndeti and Muhangi 1979; Reiff et al. 1999; Othieno et al. 2001; de Jong and Reis 2010; Hegeman 2013). Consequently, western medicine providers observed several over-demanding patient visits to their practice, with somatic complaints (McEvoy and McEvoy 1976). These types of neurotic presentations became common place, perhaps, a clear indication that the African patient sought an opportunity for his problem to be understood but in vain.

The frustrating state of affairs led to development of a culture of duo health seeking that has persisted to date. Many patients present to both the hospital and to the African medicine man without feeling any contradiction. An obvious clash of per-

spectives resulted which has led to conversations that pit one approach against another, with name-calling and mutual suspicion among the practitioners.

Early authors in the field of psychosomatics in Africa blamed the early western trained African physician for abandoning the psychological, spiritual, and cultural aspects of the patients in favor of the western medical practices (Baasher 1965; McEvoy and McEvoy 1976; Brautigam and Osei 1979; Ndetei and Muhangi 1979; Reiff et al. 1999). It is possible that the medical training of the day required the shedding off of the African perspectives layer and be reborn in western medicine perspective.

Psychosomatics, therefore, seems to have been deeply entrenched in most African cultures and patient care practices. The associations between emotional states and physical states are plentiful in ordinary African vocabulary with descriptions such as “thick skin” denoting the antisocial-like personalities and “soft gut” denoting the neurotic personality (Baasher 1965).

Even though it is now widely accepted that psychic conflicts can and do result in somatic symptoms, in Africa, the mechanisms by which this occurs is highly linked to the African’s externalizing view of the world. In Africa, the tendency is to seek explanations from outside of the self, for example, the mind and the body can be affected by the evil eye of a neighbor, a curse from an elder, unhappy ancestral spirits, and so on (Baasher 1965; Ndetei and Muhangi 1979). Nevertheless, with recent social changes in Africa and the advent of globalization, new ways of living have been adopted as well as new ways of expressing disease. Some of the changes seen in Africa today include changes in family size, family structure, intermarriages, and economy. It is very important to observe the effects of these changes on the patterns of psychosomatic syndromes. One of the early effects that can be observed across the continent is the increasing recognition of previously shunned diseases such as depression. With improvement in knowledge and technology, training of health workers in fields such as psychology and psychiatry, there is a real chance that medical discussions across Africa will gravitate towards psychosomatics, if not already in low tones.

However, for this to be realized, we must refocus our attention to the time-tested principle that healing practices are based on contemporary beliefs concerning the cause of a patient’s symptoms. In addition, factors such as healer-patient relationship are equally crucial and deserve due attention in order to realize optimum treatment outcomes.

A major challenge for African physicians today lies in dealing with patient’s beliefs, customs, values, and explanatory models of disease causation. Interestingly, in this challenge, therein lies the justification as to why African doctors need to embrace psychosomatic medicine. The approach to a patient who believes that the cause of his hallucinations and agitation is the “ancestral spirits” from his lineage needs to differ from that of a biologically plausible illness-cause match such as malaria and mosquito bites. Since, traditionally, African healing practices used a combination of psychotherapy, hypnotherapy, phytotherapy, and group support psychotherapy to effect treatment, the orientation towards psychosomatics need not be such a challenge (Baasher 1965; Ndetei and Muhangi 1979; Othieno et al. 2001).

Moreover, social therapies and religious therapies are still broadly practiced by the traditional and complementary medicine practitioners on the continent. These are avenues of entry into treatment practices for psychosomatics. Psychosomatic medicine is the best meeting point for any two or more medical models from different regions that wish to coexist.

There are variations in literature and experiences in different aspects of psychosomatic medicine. Cultural differences may explain these differences. One of the differences lies in individualistic and collectivistic cultures.

From the earlier definition of psychosomatic medicine as a branch of medicine that deals with the interaction between physical, emotional, and social processes in the occurrence, course, and patients coping with disease and states of suffering, we look at the influences of cultural differences by carrying out a SWOT (strengths, weaknesses, opportunities, and threats) analysis as presented in Table 26.1.

Table 26.1 SWOT analysis of cultural differences

Description	Allocentric (collectivistic)	Idiocentric (individualistic)
What motivates them	Collectivistic cultures encourage strong links among members of a social group, who subordinate personal needs for the good of the group or choose goals which do not threaten group harmony	Members of individualistic cultures see themselves as autonomous agents motivated by their own preferences and goals
What they value	Tradition, sociability, and interdependence	Competition, hedonism, and self-reliance. Valued a comfortable life, competition, pleasure, and social recognition
<i>Strengths</i>		
Occurrence of psychopathology	Values in social harmony behaviors that increase group cohesion and interdependency, expectations of support buffers risks, and environment that may serve as triggers for depression	A more positive evaluation of high well-being in individualistic cultures may confer greater health benefits in these cultures via the association between positive affect and both improved physiological functioning (Steptoe and Wardle 2005) and healthier lifestyle choices (Grant et al. 2009)
Coping with stress	Being able to depend on personal alliances, and to give and return cooperation from others, is advantageous in small groups. Use context more when making attributions Modest more sensitive to social rejection, lower in uniqueness and higher in affiliation	Pay principal attention to their own internal belief. Self-enhancing display social loafing

Table 26.1 (continued)

Description	Allocentric (collectivistic)	Idiocentric (individualistic)
Prevention of ill health and promotion of mental health		
Development	A negative consequence is that the energies of group members may be absorbed in social relationships, decreasing productivity	Individualism may be most advantageous, because then one can focus on one's own goals. They work better alone than with group members and work best when they have a choice in what activities they will undertake. High self-efficacy Self-actualization at risk of social isolation
<i>Weaknesses</i>	There is little opportunity to explore emotional aspects of relationships, emotions then may remain unexplored or undifferentiated, emotional distress then is presented as somatic symptoms or conversion symptoms with which doctors are known to deal Use of external coping mechanisms in situations where the collective community is thin	A negative consequence is stress, and, after failure of competition, depression An emphasis on personal well-being in individualistic cultures may cause individuals with low well-being to feel distressed (Leu et al. 2011), which may impact negatively these individuals' health. A more negative appraisal of low well-being in individualist cultures may also result in harmful coping practices, including smoking or excessive alcohol consumption (Verger et al. 2009)
<i>Opportunities</i>	Upbringing of children who learn both external (e.g., relying on relatives) and internal (e.g., cognitive) coping mechanisms	Societies with vertical individualism emphasize inequality and competition, which may lead to high levels of creativity and greater effort
<i>Threats</i>	The risk of authoritarian regimes and ethnic violence, as may occur when group leaders activate in-group–outgroup animosities	Social isolation, because individuals may end up pursuing their own goals in the absence of major social support for their endeavors

Clinical Implication

The practice of psychosomatic medicine may not in itself tell us the level of how individualistic or collectivistic a person is, particularly because no single society will conform to a one stereotype and that in reality, a continuum exists between the two. However, holding this in mind while interacting with patients helps in understanding oneself and others in social relationships, personality traits, and coping strategies. Within a given culture, individualistic persons may have traits that value competition, hedonism, and self-reliance, and those with collectivistic traits may value tradition, sociability, and interdependence. Like extremes of anything in life may not be good for health, extremes of any of either individualistic or collectivistic traits may be risk factors for poor mental health.

Moreover, some researchers have suggested the “concept of person-environment fit” (Triandis 2000) stating that having a personality which matches the values of the overarching culture should increase subjective well-being, while a mismatch will decrease it. In other words, individuals whose characteristics fit well within a given culture context will tend to show better adaptation to this context than individuals with characteristics that run counter to the demands of their culture (Ward and Chang 1997).

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Chapter 27

Maternal Mental Health in South Africa and the Opportunity for Integration



Simone Honikman and Sally Field

Maternal Morbidity and Mortality

Common perinatal mental disorders (CPMD), including depressive and anxiety disorders, are more prevalent in low- and middle-income countries (LMIC) than in high-income settings (Fisher et al. 2012). In South Africa, the prevalence of CPMD has been shown to be very high with 47% of diagnosed antenatal depression demonstrated in a rural setting (Rochat et al. 2013). In urban settings, rates from studies using diagnostic measures have been reported at 22% for antenatal depression (Van Heyningen et al. 2016), 37% for postnatal depression (Cooper et al. 1999) and 23% for antenatal anxiety (Van Heyningen et al. 2017). Risk factors for CPMD are well documented (Sawyer et al. 2010; Fisher et al. 2012) and in the South African setting include poverty, lack of emotional and practical support, domestic violence, HIV status and food insecurity (Rochat et al. 2006; Van Heyningen et al. 2016, 2017; Abrahams et al. 2018; Field et al. 2018).

South African health policy provides the framework for treatment and prevention of mental disorders at primary care level (Robertson et al. 2018). While there is good evidence that non-specialist primary health-care practitioners can be supported to implement mental health interventions effectively (Singla et al. 2017), these staff in South Africa have not yet been adequately trained to provide this support (Robertson et al. 2018). Maternal mental health services in most settings within South Africa (and other LMICs) are lacking, with few strategies in place to detect and manage CPMDs at primary health facilities (Baron et al. 2016).

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Despite high rates of maternal morbidity and mortality, South Africa has invested substantially in maternity care and seen a reduction in maternal deaths since 2009 (Moodley et al. 2018). The proportion of pregnant women receiving some antenatal care is 77.4%, with 66.6% of them booking for care before 20 weeks gestation. Of all births, 75.8% occur within a health facility, and 70.1% of these mothers receive a postnatal assessment within 6 days of delivery (Day et al. 2018). This provides an opportunity for the integration of mental health into maternal care.

The Perinatal Mental Health Project (PMHP), of the University of Cape Town, has supported the integration of mental health services into maternity care services in several locations within South Africa. Most communities served by these services face the complex intersecting adversities of poverty, food insecurity, gang violence, unemployment, alcohol and substance abuse, domestic violence and child abuse and neglect (Van Heyningen et al. 2016; Field et al. 2018).

The PMHP has developed an adaptable stepped-care, collaborative model for delivering mental health screening, counselling and case management (Honikman et al. 2012; Field et al. 2014). The services are free of charge and are usually delivered on-site, within the maternity care environment (clinic, hospital, non-governmental organisation).

The core components of the service model are described below, including the rationale behind certain design choices. We refer, in particular, to the experience of the site currently in operation at Hanover Park Midwife Obstetric Unit (MOU), Cape Town.

Preparing the Environment

Prior to initiating a mental health service within the maternity care environment, we established a small multidisciplinary team of staff, with experience working in public sector health and social services. We held several meetings with stakeholders at different levels of the maternity care system, from junior nursing staff, health promotion officers, administrative clerks, managers, senior clinicians and mothers themselves. Some meetings were conducted individually, and some took place in the form of group workshops. We aimed to ascertain existing mental health literacy among these staff, the staff motivation levels in general and their willingness to support the development of an integrated mental and physical service. We aimed to understand more deeply the common phenomenon of disrespectful maternity care in our setting (Jewkes et al. 1998; Kruger and Schoombie 2010) – its root causes and possible ways to address the problem.

A respectful and enquiring approach enabled us to learn early some key factors about the context in which we planned to launch our services. These included a concern by staff about taking on additional work in an already overburdened environment, the belief that mental health care should be placed in the realm of specialist providers only, a lack of confidence in primary care providers being able to detect and manage cases and the belief that mental health problems were rare and difficult to manage.

These findings enabled us to develop our approach in subsequent engagements with stakeholders. We were able to acknowledge concerns specifically and thereafter impart targeted evidence-based information about maternal mental health. We normalised for staff that mental health care and physical health care occur in parallel and gave rationale for how addressing mental health will have significant benefits for physical health on mothers and their infants. We dismantled the perceived complexity of providing integrated care, giving examples of how others in low resource settings have managed to do this. We suggested that this work may create greater professional fulfilment for staff than solely providing physical health care. Thus, we were able to generate excitement in the novelty and potential of the proposed service. With these stakeholders, we were able to codevelop service design ideas and to anticipate together the opportunities and challenges. We are able to identify those that would be able to champion and lead the service development together with the PMHP, going forward.

Capacity Building of Maternity Care Staff

The lessons we learned in preparing the environment enabled us to identify existing training platforms in which to embed our training and to develop the content of the training accordingly. In addition to simple knowledge transfer regarding maternal mental health, we discovered that staff of all cadres (nurses, midwives, medical officers and managers) needed to see demonstrated empathic engagement skills and, themselves, to spend adequate time practising these and critiquing their own skills. This critique would follow more easily if an informal style of training was adopted with frequent use of humour and the incorporation of ‘ice-breakers’ or games that involved a physical activity or creative processes. Further, we learned that staff needed to reflect in a safe and contained way on their own mental well-being and develop approaches for self-care: some activities together with their colleagues, and some on their own. We were able to integrate these elements into our trainings.

Over time, we were able to develop resources such as short films, text books, learning briefs and train-the-trainer modules for others involved in capacity building for providers working with mothers. These were extended to include social workers, undergraduate medical and nursing students, workers in the non-governmental organisation sector and others.

Detection Matters

The timing of the mental screening was a critical design consideration. In order to maximise screening coverage, screening procedures were integrated in to the routine medical history-taking procedures of the MOU staff, at the initial antenatal visit. Care was taken not to conduct the screening after the women learned of their

HIV testing result. Stationery and record keeping processes were refined to work seamlessly with existing maternity care process.

We learned that standardised screening instruments, even if locally validated within research settings, are not necessarily appropriate for busy, clinical settings. Unless tools have undergone cognitive testing, they may be culturally incongruent. Likert-type scoring systems and too many items reduce the technical feasibility and acceptability of the tools.

Through our research programme, we developed and validated an ultra-brief, binary (yes/no) symptom questionnaire for depression and anxiety symptoms as well as suicidality. We chose to combine this with a list of psychosocial risk factors for CPMDs. This coheres with the international recommendations on combining symptom screening with risk screening, e.g. experience of domestic violence, lack of partner or social support and prior mental health problem history (Meltzer-Brody et al. 2018). Referring for support based on risk factors enables the detection of women who may screen negative on the symptom tool and who may go on to develop symptoms of maternal distress in the future, thus enabling preventive work to be done. Risk screening allows for a more focussed and rationalised approach to referrals.

Referral Is a Thing

The *quality* of the referral to care is strongly related to whether women will take up this care. Women face several socio-economic and emotional barriers to accepting mental health care or formalised social support (Baron et al. 2015), and the methods used in making a referral need to take these into account, explicitly. Without due care taken in this process, treatment coverage will be low, and scarce resources may be wasted. Those staff making referrals are given training in the gentle and enquiring way referrals should be made. Staff explain in simple terms the rationale for the referral. Where possible, they provide options for referral sources and timing, and they discuss potential barriers and enablers of uptake. The maternity stationery includes a field where a record can be made of the referral being offered. At subsequent maternity visits, staff are thereby reminded to engage with the mothers about the referral – whether this was taken up, if it helped with the problem and whether another referral should be made. Importantly, signage and terminology pertaining the term “mental” is avoided. Rather, language used by staff and noted in the stationery draws on terms such ‘distress’, ‘support’ and ‘care’.

Scheduling and Tracking of Counselling Appointments

Where possible, appointments with the PMHP counsellor are scheduled for the same day as the women’s follow-up antenatal appointments. This maximises uptake of care and minimises inconvenience and costs for women facing several

socio-economic burdens. When women do not attend counselling appointments, a tracking system is instituted whereby the counsellor attempts to make contact through a maximum of two phone calls and then sends a letter to encourage the women to attend. This tracking system is monitored.

Brief Mental Health Counselling and Activating Social Support

The PMHP counsellor at Hanover Park MOU is professionally registered with a 4-year Bachelor of Psychology degree. Counsellors at other sites have a range of different qualifications, depending on the organisation. The counsellor conducts a detailed assessment and tailors the intervention according to the needs of the client. Where the counsellor has the expertise, this may include an eclectic mix of couple or family therapy, motivational interviewing, problem-solving therapy, psycho-education and interpersonal and cognitive behavioural therapies. In settings where the counsellor does not have the expertise, supportive counselling is provided.

Even though counselling is available till one year after the birth, most women experience several logistical barriers to using the service postnatally. Thus, most of the PMHP intervention work occurs during pregnancy with a 6–10-week postnatal telephone assessment and follow-up counselling session provided for those women who received counselling antenatally. Counselling women attend for a mean number of three 50-minute sessions (see Fig. 27.1).

The flow diagram depicts service utilisation at the PMHP service site at Hanover Park MOU, since inception.

In addition to these sessions, the counsellor frequently spends significant time, activating social support, such as safe housing, police protection orders and liaising with social workers or non-governmental organisations, as required. We thus advocate for ‘mental health counselling’ to broaden its traditional scope to include social work and case management activities, in order to optimise impact for women with multiple needs and who face difficulties in accessing care.

A small minority of women with severe symptoms are eligible for and accept referral to psychiatric services.

Caring for the Counsellor

The emotional burden experienced by the counsellor in providing this work is substantial. In order to manage this and to ensure retention of loyal, skilled staff, we ensure weekly supervision processes – where possible alternating between group-based (with peers) and individually based sessions with a clinical psychologist. The supervisor and the counsellor together identify ongoing professional development opportunities, and counsellors are encouraged and supported by management to

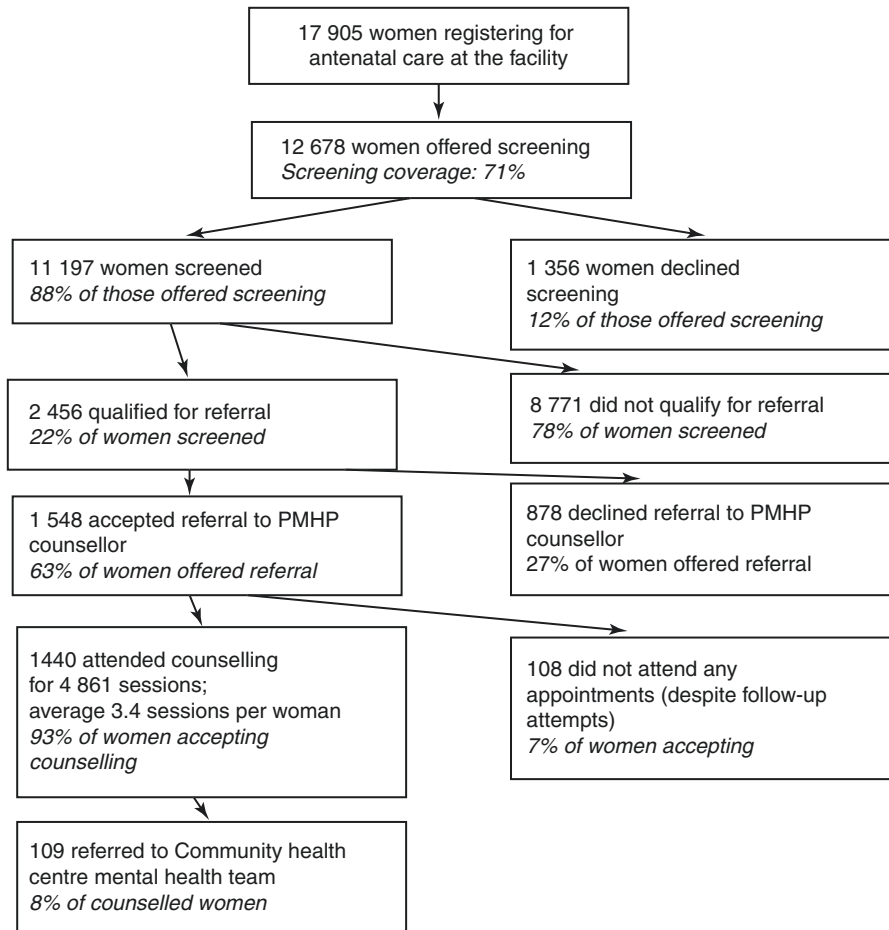


Fig. 27.1 Service utilisation September 2012–December 2018

attend a minimum number of these per year. Staff are offered regular mental health days where they can enjoy leisure activities in natural environments together.

Responsive and Regular Monitoring and Evaluation

Monitoring and evaluation systems are simple and routine. Several staff contribute to data collection, analysis and interpretation and to developing improvements based on the analysis. Key indicators include screening coverage, number of women receiving counselling, number of referred women lost to follow-up, number of sessions per woman and number of referrals made to external agencies. The data collected from the postnatal follow-up assessments enables an analysis of before-after

symptom score changes as well as determining the degree of resolution of presenting problems. Several researchers have conducted in-depth interviews with clients and staff to establish their attitudes and preferences with respect to the service. These data are regularly fed back to stakeholders, using different mechanisms, e.g. email, meetings, website and social media.

Linking the Service to Research, Resource Development and Advocacy Work

As mentioned previously, the PMHP experience of running integrated mental health services in maternity care environments generated the need for answers to scientific questions (e.g. can we develop a brief, psychometrically valid screening tool that has cultural and construct validity for use in our clinical settings?). The PMHP research project continues to work in an iterative way with the service site. The evidence generated is translated for a wide range of audiences and disseminated using traditional and social media platforms and through ongoing relationship building and collaborations with several sub-directorates of the Department of Health and Department of Social Development. Furthermore, the service has generated the need for the development of evidence-based resources like psychoeducational materials for clients as well as multimedia training materials, which are available as open access materials.

By drawing on nearly two decades of service delivery experience, we have thus been fortunate to be able to inform policy, guidelines and practice beyond the immediate reach of our clinical service sites.

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Chapter 28

Mental Health in India: Perspectives for Psychosomatic Medicine



Gayatri Salunkhe and Matthias Braeunig

The Treatment Gap

India has seen tremendous advancements in the field of mental health over the past decades. Yet, India, the world's second most populated country, continues to contribute disproportionately to the global burden of disease compared to the other middle-income and neighbouring countries (Patel et al. 2015). According to the National Survey of Mental Health Resources, a striking deficit of 77% psychiatrists, 97% clinical psychologists and 90% social workers was reported against a standard reference of 1 psychiatrist, 1.5 clinical psychologists and 2 social workers per 100,000 persons (Lok Sabha Secretariat 2013). The high demand for mental health services and the overcrowding of medical facilities in India increase the possibility that the mental health element contributing to somatization may go untreated by medical practitioners.

Cultural Impact on Perception, Diagnosis and Treatment

Mental illness may be experienced and interpreted differently in India given its heterogeneous cultural and philosophical background which has also seen some western influence (Wig 1999). Among persons with serious mental disorders and

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not seeking care in the past 12 months, 99% Indians did not perceive a need for mental health care – a significantly higher ratio than the mean of 48% for other countries (Andrade et al. 2014). The WHO's goal to promote the integration of mental health into primary care in order to make the provision of care more accessible to people even in remote and rural areas (WHO and Wonca 2008) relies on a better understanding of mental health and illness in the local context.

A study by Kermodé et al. (2010) surveyed mental health literacy (MHL) among 240 community members and 60 village health workers (VHWs) in rural areas of Maharashtra in India. In this sample, it was found that the most widely acknowledged causes of mental health problems included various socioeconomic factors such as conflict with family members, neighbours or at work, an addicted family member, not being married, crisis, bereavement, childhood problems and poverty or financial hardships. By contrast, biological and supernatural causes were not commonly endorsed. Thus, the understanding of mental distress was rather related to outwardly relationships rather than an internal factor; strikingly divergent from the concept accepted in western countries. Over 25% of the sample, including VHWs, viewed the lack of marriage as a factor related to a psychosis vignette. By contrast, those unable to get married were regarded to have a lower risk of mental disorders – possibly as marriages were viewed to be stressful and cause socioeconomic strains, particularly so by women. Interestingly, an addicted family member, but not the addiction itself, was commonly viewed as a cause for poor mental health. The risk perception towards mental health problems was higher for women, the unemployed and the poor. However, contrary to the community's perception, it was not women but rather the elderly that had elevated mental health risks. This finding was linked with rapid economic changes and urbanization that may leave the aged vulnerable despite this population generally being treated with care and respect by its community. The authors of this study concluded that better knowledge of the local conceptualizations of mental health and illness can aid develop approaches enhance MHL in VHWs and community members.

In a large sample of psychiatric patients in India, Chaturvedi and Michael (1988) studied the prevalence of psychosomatic disorders such as hypertension, peptic ulcer, bronchial asthma, rheumatoid arthritis, ischemic disease and chronic pain. The incidence of psychosomatic disorders was high in neurotic patients and low in psychotic patients and that the symptoms of chronic pain (14.4%) and hypertension (9.9%) were overall most common. It is also noteworthy that psychosomatic patients were largely older in age, female, married and from an urban background. It can be speculated that these findings are related to higher psychological stress due to modernisation and urban life, especially for the married females.

Somatic symptoms are reported as the most common form of presentation in primary health-care (PHC) attenders with a common mental disorder (CMD) in Goa, India (Patel et al. 1998). This finding highlights the importance of sensitizing Indian PHC practitioners – the first-degree contact persons – to better identify, treat or refer on patients with psychiatric or psychosomatic symptoms. One country-related challenge may be that these medical professionals typically have very limited time with their patient due to the high demand for care. Thus, future capacity-building projects in India must incorporate techniques that ensure time efficiency.

With regard to the patient's perceptions of psychosomatic aspects of mental disorders, Patel et al. (1998) found that 51% of those with biomedically definable CMDs, mostly women and those suffering chronic illness, provided psychological attributions highlighting their awareness to the emotional context of their illness. The provision of psychological attributions led to a higher likelihood of the illness being recognized by Indian PHC physicians, in line with findings from developed countries. In this sample, the General Health Questionnaire (GHQ-12; Goldberg and Williams 1988) performed better than the Primary Care Psychiatric Questionnaire (PPQ; Srinivasan and Suresh 1990) in detecting psychiatric cases, suggesting that psychological and cognitive symptoms were superior to somatic symptoms in discriminating CMDs.

The Diagnostic Criteria for Psychosomatic Research (DCPR; Fava et al. 1995) were developed to explore a variety of possible psychological conditions and emotional responses to medical illness. Preliminary work on the feasibility of the DCPR in the Indian context was conducted by Chaturvedi and Goswami (2012) at the psychiatry outpatient department in Bangalore, India, for a sample of 20 nonpsychotic patients, each having at least 1 medically unexplained physical symptom as a chief complaint. While the DCPR interviews were generally useful in tapping upon psychosomatic symptoms, patients found the “yes/no” options of the instrument difficult to respond to due to perceived inadequacy of information provided to them regarding their illness. With some adaptations and the possibility to ask patients for the underlying reasons for their responses, the DCPR was regarded useful for the Indian setting.

Attitudinal barriers restrict access to mental health care in India. For example, as dementia is viewed as a natural part of ageing by most Indian communities, biomedical services are rarely sought (Patel and Prince 2001). If people do wish to seek biomedical care, it is often hindered by demand-side barriers and high out-of-pocket costs for mental health services; frequently resulting in a preference towards self-help or traditional care (Patel et al. 2016). Research shows that these attitudinal and demand-sided challenges can be addressed by, firstly, avoiding the use of complex diagnostic label for CMDs in primary care in India and, secondly, by building stronger links between psychiatry and community care (Patel et al. 1997). Regarding the treatment of CMDs in the primary care setting, Patel et al. (2003) found that in a randomized controlled trial in Goa, India, psychological intervention was no better than placebo – potentially due to the culturally unacceptable nature of a purely “talking” intervention by a professional therapist. Contrastingly, anti-depressants were superior to placebo in improving psychiatric outcomes at early stages. These effects however faded off in the later stages – possibly due to the lack of adherence to treatment over time.

Traditional Psychosomatic Medical Systems and the Ministry of AYUSH

India's diverse and multi-faceted cultural history has brought about a number of traditional, holistic medical systems that are actively present and contribute substantially to the public health-care sector (see Bode 2013, for an overview).

These systems combine the best influences of medical knowledge that India has received over the centuries. They correspond to the diverse cultural, ethnic, religious and economic backgrounds of a population of more than 1.3 billion people. As such, not surprisingly, India is seeking ways to integrate the traditional medical knowledge with the changing demands of modern life style (Ruhil 2015).

In order to better understand traditional psychosomatic medicine in India, one first has to acknowledge medical pluralism in dealing with the very diverse demands on this multi-faceted subcontinent (Sujatha and Abraham 2012). This understanding benefits from a careful consideration of its philosophical background. In the common view that mind is primary, although elusive, physical and mental well-being is a matter of balance that is reflected in one's behaviour, ethics and held beliefs. Mental health is thus seen as both precondition and result of balance. The primary goal of medicine is, therefore, helping to maintain this balance under changing environmental conditions (e.g. seasons) in the human life cycle. Over centuries a vast number of practices have appeared, of which some are precisely codified and condensed, while others are more situated non-codified regimes of knowledge that perform as idiosyncratic systems. The ritualistic systems, often non-codified healing practices, are a fascinating category of study that is better left un-institutionalized to preserve their therapeutic value (Sax 2014). However, all the codified systems are more or less amenable to scientific investigation, as an evidence-based psychosomatic medicine, that makes them perhaps better suited for integration within standard health care (Samal 2015a).

India has gathered the major systems under the Department of Indian Systems of Medicine and Homeopathy (ISM&H) in 1995 which has then been renamed the Ministry of AYUSH in 2003 as a separate government body. AYUSH is an acronym for Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homeopathy. In 2011, the system of Sowa-Rigpa (Tibetan medicine) has been added, so that altogether seven complementary medical systems are officially recognized and supported by the Government of India. Ayurveda, Yoga and Naturopathy and Siddha are indigenous medical systems derived from the vast knowledge collection of the Vedas (ancient religious texts). Other systems have been integrated from extraneous influences such as Unani (from Greece), Homeopathy (from German origins) and Sowa-Rigpa from a confluence of Chinese medicine with Ayurveda (mainly in the Himalayan regions). Their holistic approach is generally non-invasive and focuses primarily on prevention and management of chronic and systemic diseases (Ministry of AYUSH, GOI 2019a).

An impressive number of 3639 hospitals with 56,250 beds, 26,405 dispensaries and 771,468 doctors, 8667 drug manufacturing units and 550 educational institutions with 36,595 students contribute to this end. Infrastructural facilities are co-located with 497 district hospitals, 2649 community health-care centres and 8124 PHC centres (Ministry of AYUSH, GOI 2019a).

It has been a major policy objective of the Ministry of AYUSH not only to preserve the traditional knowledge but to infuse and validate the systems with the methodologies of modern science. There are great efforts undertaken to present them in a scientific idiom so they can co-exist with mainstream health-care delivery.

The systems are represented in 11 national institutes and 5 independent research councils that oversee teaching, research and clinical practice. The quality of research and dissemination of scientific publications has thus increased in recent years and made publicly searchable through the research portal of the Ministry of AYUSH (Ministry of AYUSH, GOI 2019b).

AYUSH services were developed as part of the 5-year plan in which the health-care sector was an integral part of the planning process since the beginning in 1951. From the ninth plan (1998–2002) onward came an important strengthening of services through improving quality control, investment in human resources development and encouragement of research and development in therapeutics. With the 11th planning period (2007–2012) the concept of “Mainstreaming of AYUSH and Revitalization of Local Health Traditions” was introduced to strengthen public health services. Despite local problems with the alignment of AYUSH with standard health-care delivery, the improvement of education and training and the increase of quality of research have led to a wider acceptance of AYUSH services in the public sector. Meanwhile medical tourism has become a successful economic factor that promotes Indian systems of medicine world-wide through popular therapies such as Yoga and Ayurveda application (Samal 2015b). Although the former planning commission was dissolved in 2014, it has been replaced by the NITI Aayog (2019), the National Institution for Transforming India, substituting the 5-year planning scheme with a 3-year NITI India Action Agenda. Time will show if the programme of mainstreaming AYUSH as equal partner in India’s health-care system can be pursued as envisioned by the last 12th plan (Shankar and Patwardhan 2017).

About 7% of patients receive AYUSH treatment, irrespective of living in rural or urban areas. However, there is a slight difference in relative economic status (as measured by monthly per capita consumer expenditure, or MPCE): AYUSH was observed less in middle MPCE quintile households and higher on either extremes of the MPCE distribution. Assuming correlation with higher education, then upper class patients tend to use more AYUSH than average (Rudra et al. 2017).

AYUSH systems provide affordable and efficacious health services for the masses and so contribute to the public health care if properly implemented and administered by properly trained practitioners. The necessity to mainstream its services has been recognized by government authorities in order to preserve their knowledge and to make their potential widely available to the public. This is important not only for remote rural areas where health care is not easily accessible but in urban centres with a high population density and increasing socioeconomic inequality as well. The holistic nature and culturally embedded history of AYUSH systems is well-suited as a mental health-care regime that can fill the treatment gap currently observed in modern India.

In conclusion, India as the second most populous country in the world with its great diversity of languages, cultures, religions and socioeconomic statuses highlights the importance of and demand for medical pluralism. A careful consideration of the targeted population is essential for future medical practice and research and for psychosomatic medicine in particular.

Considerations for and Developments Towards Improving Mental Health-Care Coverage

Among the various strategies to raise mental health awareness and reduce stigma, the inclusion of participation of family members is particularly critical as, in India, the care of a mentally ill person is mainly the responsibility of the family. The family's perception to mental illness plays a pivotal role, as family members often make important decisions like opting for treatment and treatment type (Khandelwal et al. 2004). The acute shortage of affordable professionals, rehabilitation services and residential facilities from the private or public sector underlines the importance of the family care model in India (Murthy 2011). Since the start of the twenty-first century, families have been playing a more active role – with the formation of self-help groups and the willingness of professionals to work in partnerships with families (Srinivasan 2008) although more support of professionals and planners is desired to integrate these aspects into routine psychiatric care in India (Shankar and Rao 2005).

Given India's shortage of specialists like psychiatrists and psychologists, the training of non-specialists in identifying, diagnosing and treating people with mental health problems or task sharing is a key strategy to address the challenge of workforce shortage. Trained lay counsellor-led collaborative care has been found to improve recovery from CMDs among patients attending public PHC facilities in Goa, India (Patel et al. 2010). Another promising approach is inter-sectoral collaboration. The success of a WHO Indian epilepsy study that included various care providers, even faith healers, highlights the importance of such collaborations in increasing community awareness and encouraging attitudes of seeking help (Nizamie et al. 2009).

Technology may be crucial in addressing the issue of poor access to care in remote or rural areas of India. A recent study by Deb et al. (2018) investigated the scope, considerations for design and limitations of implementing smartphone mental health apps for patients with severe mental illnesses and caregivers in low-income settings of North India. As only a third of patients and caregivers had access to smartphones and the Internet, alternatives such as Short Message Service (SMS) or Interactive Voice Response System (IVRS) are recommended. Cost, non-familiarity and language were significant barriers to app use. The apprehensions of the already burdened caregivers may be alleviated by hand-holding and encouragement from treating doctors. Conclusively, the promise of technology for mental health care in India can be achieved with a bottom-up collaborative approach to app development and careful consideration of the country's economic, cultural and educational diversity.

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Chapter 29

Development of Psychosomatic Medicine in Myanmar



Myint Oo

Background

In Myanmar, the term “psychosomatic” has been accepted as medical jargon specifically related to health-care professionals. “Liaison psychiatry” is a small curriculum included in the undergraduate and Master of Medical Science (M.Med.Sc) (Mental Health) programs at medical universities. While psychosomatic is strictly confined to medicine, the words “mind and body” (Nan-Yoke) or “*nāmarūpa*” in Sanskrit have been familiar to almost all Buddhist people in Myanmar, where 96% of population believe in Buddhism. The “*Nāma*” is typically considered to refer to psychological elements of the human person, while *rūpa* refers to the physical. The Buddhist *nāma* and *rūpa* are mutually dependent and not separable; so *nāmarūpa* designates an individual being. *Nāmarūpa* is also referred to as “the psychophysical organism,” “mind and matter,” and “mentality and materiality” according to Buddhist Phenomenology

Buddhist Concept of Mind and Body

The Buddha (480–400 B.C), founder of Buddhism, described the mind and the body as depending on each other in a way that two sheaves of reeds would stand leaning against one another and taught that the world consists of mind and matter which work together interdependently. Buddhist teachings describe the mind as manifesting from moment to moment, one thought moment at a time as a fast flowing stream. The

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components that make up the mind are known as the five aggregates (i.e., material form, feelings, perception, volition, and sensory consciousness), which arise and pass away continuously. The arising and passing of these aggregates in the present moment is described as being influenced by five causal laws: biological laws, psychological laws, physical laws, volitional laws, and universal laws. The Buddhist practice of mindfulness involves attending to this constantly changing mind-stream.

Ultimately, the Buddha's philosophy is that both mind and forms are conditionally arising qualities of an ever-changing universe in which, when "nirvāna" is attained, all phenomenal experience ceases to exist. According to the "anattā" doctrine of the Buddha, the conceptual self is a mere mental construct of an individual entity and is basically an impermanent illusion, sustained by form, sensation, perception, thought, and consciousness. The Buddha argued that mentally clinging to any views will result in delusion and stress, since, according to the Buddha, a real self (conceptual self, being the basis of standpoints and views) cannot be found when the mind has clarity (mind-body problem).

Mental Health Care in Myanmar

The 2015 Global Burden of Disease study reports that in Myanmar, both depressive and anxiety disorders are among the top 10 contributors to years lived with disability and both have increased over the past decade (Institute for Health Metrics and Evaluation 2017).

Mental health services are provided primarily through 2 psychiatric hospitals, 22 psychiatric wards of general hospitals, and 35 outpatient mental health facilities (WHO 2015). Primary care physicians can prescribe psychiatric medications and have access to mental health treatment manuals, but the majority has not received training on mental health within the past 5 years (WHO 2011). For every 100,000 people, only 0.6 trained mental health workers (e.g., psychiatrists, psychiatric nurses) are available, and only 16% of them work in outpatient settings. For comparison, there are 125.2 per 100,000 in the USA and 318.9 per 100,000 in the UK (WHO 2015).

The World Health Organization (WHO) advocates for the integration of mental health services into primary care and other community-based delivery platforms to improve access and lower cost (Funk and Ivbijaro Ivbijaro 2007; Patel et al. 2013). Taken together, data from the WHO resources (WHO and Ministry of Health 2006; WHO 2011) indicate a lack of human resources for community-based therapeutic interventions within the formal health-care system. The historical role of the psychiatric hospitals in Myanmar, paired with the likelihood of prolonged hospitalization if committed, may reduce help-seeking behaviors (Kent 1996; Way 1996; Zaw 1997). The use of informal service networks for mental health care is not well documented, although anecdotal reports suggest that people in distress may receive counseling support in monastic settings and meditation centers (Way 1996). Most of the documented psychosocial and psychotherapeutic interventions have been provided by various non-governmental and community-based organizations, often by lay providers or community health workers (Risso-Gill et al. 2014).

Psychology Versus Psychiatry

At conventional patient care settings even in the hospitals, there is still a lack of collaboration between psychologists and psychiatrists. Psychology is separately taught at the University of Yangon. In recent years, a 1-year “Diploma in Applied Psychology” course attracted some private general practitioners (GPs). There are only two clinical psychologists working at the mental health hospitals in Myanmar. A psychiatrist of Myanmar origin has linked the strong Buddhist tradition in Myanmar to the appropriateness of psychotherapy, explaining that Buddhist teaching identifies the mind as the source of happiness and misery (Way 1996). The influence of Buddhist practice is reflected in the interest of graduate students in Myanmar on the potential mental health benefits of meditation (Kyaing 2002; Aye 2007; Kasai et al. 2017). Few evaluations of psychotherapeutic or psychosocial programs for people from Myanmar have been published in the black or gray literature. Incorporating rigorous evaluations into existing and future programs is imperative for expanding the evidence base for psychotherapeutic and psychosocial programs in this context. Some traditional witchcraft healers use paranormal or “Payawga” medicine in treating some chronic mental illnesses in rural areas.

GPs and Mental Health

Myanmar’s undergraduate medical curriculum only consists of 2-week didactic training in the whole 6-year course. An estimated 18,000 GPs work in the private sector without having received additional formal continued training. The GP Society provides continuing medical education and professional development programs to private GPs, but it can only reach those practicing in big cities. Beginning from 2014, the UK Royal College of Psychiatrists (RCPsych), in cooperation with Myanmar General Practitioners’ Society and Mind to Mind Myanmar (a non-profit charity organization in the UK), conducted a series of yearly workshops on WHO’s mhGAP (mental health Gap Action Program) module to private general practitioners. Nearly 200 GPs have been trained in the mhGAP Intervention Guide. The mhGAP did not describe culture-bound syndromes such as “Latah”, Koro-type “tounar” genital retraction, possession syndrome, and ghost sickness which are somewhat prevalent in rural areas in Myanmar.

The Need for Psychosomatic Basic Care Training

Psychological and psychosomatic disorders and problems are insufficiently recognized and treated, and there is a need for bio-psychosocially orientated medical care. Little is known about the transferability of Western-oriented psychosomatic training programs in the Southeast Asian cultural context. The transferability of

Western concepts should be tested locally and adaptations undertaken where necessary (Fritzsche et al. 2012).

Demonstration by the Freiburg Team in Myanmar

From 7 to 13 June 2016, a Freiburg team led by Prof. Michael Wirsching and Prof. Kurt Fritzsche arrived at Myanmar Medical Association (MMA) and met with officials from the GP Society, Mental Health Society, Rector of University of Medicine (1), Yangon, and officials from the Myanmar Nurses Association. The team also visited the Ywar Thar Gyi Mental Health Hospital in Yangon and conducted a 2-day training workshop at MMA where 34 GPs and 32 junior psychiatrists participated in the Psychosomatic Basic Care Training workshop. Myanmar doctors witnessed for the first time the “Family Sculptor,” “Balint Group,” “psychosocial anamnesis,” and the “live interviews” with patient and family members in the context of psychosomatic medicine.

The Poster at the Fourth SEARME Conference in Yangon

In relation to the demonstration training, a poster paper on “An effective strategy for promoting active learning for mental health care in Myanmar” was presented at the fourth South East Asian Regional Association for Medical Education (SEARME) Conference in Yangon.

First Psychosomatic Basic Care Training

The GP Society and Freiburg University drafted a joint proposal and submitted it to the German Government for funding, but it was not successful. They revised the proposal and submitted it to the German Academic Exchange Services (DAAD) and won a 4-year grant. An initial Letter of Agreement (LoA) and the Memorandum of Understanding (MoU) between Freiburg University and University of Medicine (1), Yangon, were signed in 2018. The first intake of 40 Myanmar participants (15 GPs, 15 psychiatrists, and 10 senior nurses) was recruited, and the first Psychosomatic Basic Care Training was conducted in April 2018.

Myanmar Context of Psychosomatic Basic Care

After 80 hours of training, Freiburg University will confer the Certificate in Psychosomatic Basic Care acknowledged by the German Chamber of Physicians. The training includes theoretical didactics, practical exercise and self-experience,

An Effective Strategy to Promote Active Learning for Mental Health Care in Myanmar

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4th SEARAME Conference Theme 4: Paradigm Shifts in Strategies for Continuing Professional Development

Background: The German Freiburg University, the Myanmar General Practitioners' Society and the Mental Health Society collaboratively organized a training on Psychosomatic Basic Care at Myanmar Medical Association on June 9 and 10, 2016. 40 GPs and 40 junior psychiatrists attended. A GP representative visited Freiburg University in August to plan for further trainings for GPs and nurses in Myanmar.

Objectives:

- To introduce psychosomatic basic and advanced care trainings for Myanmar health care professionals
- To integrate interactive communication skills into existing curricula of postgraduate mental health nursing science and family medicine in Myanmar

Method: The modern strategies on patient-therapist relationship and communication skills described below were taught and discussed during the two-day training programme. How the skills could be applied within a Myanmar-specific context and feedback on their usefulness were sought.

Psychosomatic basic care training for Primary Care providers



HIT: highly interactive Teaching Model



Family sculpture

Family Sculpture work is a method in couple and family therapy. A sculpture of a system (family, hospital team) enables access to tensions, conflicts, and previously unseen positive and negative relationships with the system. Symptoms are personified, and positioned in the class room as a sculpture.

Balint groups

Balint Groups are case studies with particular emphasis on patient-therapist relationship. A therapist presents a patient who is on his/her mind for various reasons. The group (therapists) reflects on the therapist-patient relationship from various angles, which allows the therapist to obtain the views of others and perceive interfering unconscious influences as well as his/her own contributions to the problem, and provides the impetus as a healing force.

Metta, Mudita, Karuna, Upekkha

The Brahmaviharas (sublime attitudes, lit. "abodes of Brahma") are a series of four Buddhist virtues that can be practised in everyday life, that means also in the contact with the patient.

Results: Interactive teaching elements will be integrated into the existing mental health curriculum. This can be achieved through a Highly Interactive Teaching (HIT) model for post graduate education in family medicine and nursing science.

Conclusion: The training in psychosomatic medicine for GPs and young psychiatrist resulted in a positive response. The transferability of western concepts should be tested locally, and adaptations should be undertaken where necessary.

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case work and supervision, the Balint Group, and an 8-day study at Freiburg Summer School. Currently, 15 GPs, 15 psychiatrists, and 10 senior nurses are participating in the first intake (2018), having already completed a summer school training in Freiburg. The program will continue for 4 successive years until the end of 2021. In January 2019, Freiburg University, in cooperation with University of Medicine 1, Myanmar GP Society, and Myanmar Mental Health Society, is applying to the Else Kröner-Fresenius Foundation (EKFS) for a larger grant to further improve collaboration with Myanmar medical universities and promote psychosomatic medicine and psychotherapy in Myanmar.

The first intake of training participants are planning to add psychosomatic medicine to the undergraduate and postgraduate curriculum at medical universities and are seeking support and political commitment from the Myanmar Ministry of Health in order to improve mental health care in Myanmar.

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