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Psychosomatic Medicine in Iran and Germany

Michael Wirsching[1]

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Editorial

Citation: Wirsching M. **Psychosomatic Medicine in Iran and Germany.** Int J Body Mind Culture 2017; 4(2): 65-6.

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This is an outstanding volume showing the results of a yearlong collaboration between the universities of Isfahan and Freiburg. Psychosocial problems and disorders have become the most prominent global burden of disease. Depression, anxiety, and somatoform disorders are accountable for the highest number of disability-adjusted life years (DALYs) and early retirements worldwide.

Thus, mental health is not only a challenge for individuals and families but for all our societies being part of the centennial process of globalization.

As most psychosocial problems show firstly in a primary care context and not in mental health facilities, Family Medicine becomes the cornerstone of a timely and efficient health system.

Sollmann and his colleagues provide a lively and inspiring case study on cultural aspects, body, and gender and how body-centered psychotherapy can change symptoms and emotions, and heal the behavior and doctor-patient relationships positively.

They reveal the importance of nonverbal, body-centered communication in Psychosomatic Medicine specifically in the treatment of somatoform disorders.

Goli, Afshar, Zamani, and Ferdosi analyze the opportunities of the current Iranian Health Transfer Plan (HTP), emphasizing the need for further training by redesigning the field of modern Family Medicine. They address how psychosomatic basic care can provide a ground work for the vertical (between all preventive levels) and horizontal (bio-physical-social-spiritual interventions) integration.

As Fritzsche and I show in this issue, Iranian development is rooted deeply in the German approach, following the implementation of a bio-psycho-social systems model in the German health system over the past 70 years, starting from internal medicine and psychoanalysis, immediately after World War II. The result of this process is the definition of quality requirements and financial regulations on all levels of care. Unique for Germany is the creation of a medical specialist for Psychosomatic Medicine and Psychotherapy, complementary to Psychiatry and Clinical Psychology.

In Scheidt's paper, you can find a live picture of Psychosomatic Medicine in history and how the psychosomatic basic care curricula have been established, and improved management of psychosomatic problems.

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Finally, the impressing findings of Monajemi and Goli in their empirical study is how clinical reasoning is changing from the more biomedical in junior physicians to the more psychosomatic in their senior practitioners. It shows that psychosomatic sensitivity naturally is the part of being expert and professional in medical practice.

Interesting are results from China where a process similar to Iran's current efforts started 10 years earlier, also following the German experience in collaboration with Freiburg University.

A fascinating transcribed expert discussion centers around breaking bad news. Here we are experiencing the importance of Psychosomatics for all fields of modern medicine especially for chronic and life-threatening disorders like cancer.

Discussing around the cross-cultural differences in this clinical field and the transcultural principles of doctor-patient relationship provides some inspiring and critical notes for the both novices and experts.

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About 4th Psychosomatic Congress

Masoud Ferdosi[1]

[1] Associate Professor, Department of Healthcare Management, School of Management and Medical Information Sciences AND Health Management and Economics Research Center, Isfahan University of Medical Sciences, Isfahan, Iran

Letter to Editor

Citation: Ferdosi M. **About 4th Psychosomatic Congress.** Int J Body Mind Culture 2017; 4(2): 67-8.

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Mental disorders are increasing throughout the world. In Iran also these disorders and their consequences include higher percentages of mortality and morbidity among others.

On the other hand, people are now more sensible about their mental health than ever; the point that sometimes is neglected or underestimated. It means that they are expecting higher amount of joy, comfort, and happiness. But, modern life stresses make it more difficult to have and to understand these feelings.

All of these changes in mental health need and demand mean that health system managers should run more sophisticated mental services (preventive, curative, and rehabilitative services) for the people.

Meanwhile, national, regional, and international collaboration for sharing knowledge and experiences are necessary. Some of these collaborations are long-term. Others are cross-sectional. Psychosomatic Research Centre (PSRC) of Isfahan University of Medical Sciences, Iran, has started some common projects with some German Partners in the psychosomatic issues by the German Academic Exchange Service (DAAD) support. These projects have led to some exchanges among scholars and students between the two countries, and some scientific proposals which are in progress.

The main goal of this project is to focus efforts toward psychosomatic disorders with a biopsychosocial approach in the Iran basic healthcare services such as family physicians, and other first contact caregivers. This goal is following in coordination with health system authorities.

As a short-term but fruitful action, PSRC is going to hold the 4th International Congress of Psychosomatic Medicine in Isfahan from November 15th to 17th. In this congress, some of the scholars and researchers from Germany, Lebanon, and Afghanistan would share their new findings and viewpoints beyond Iranian ones.

Some of the attendees hope to get more information about international projects of PSRC like Post Docs and other courses during the Congress. Mental health authorities of the Iranian Ministry of Health and Medical Education would present their lectures and would have some panel discussions, too. Besides, there is some good news for those who are engaged in

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psychosomatic fields such as:

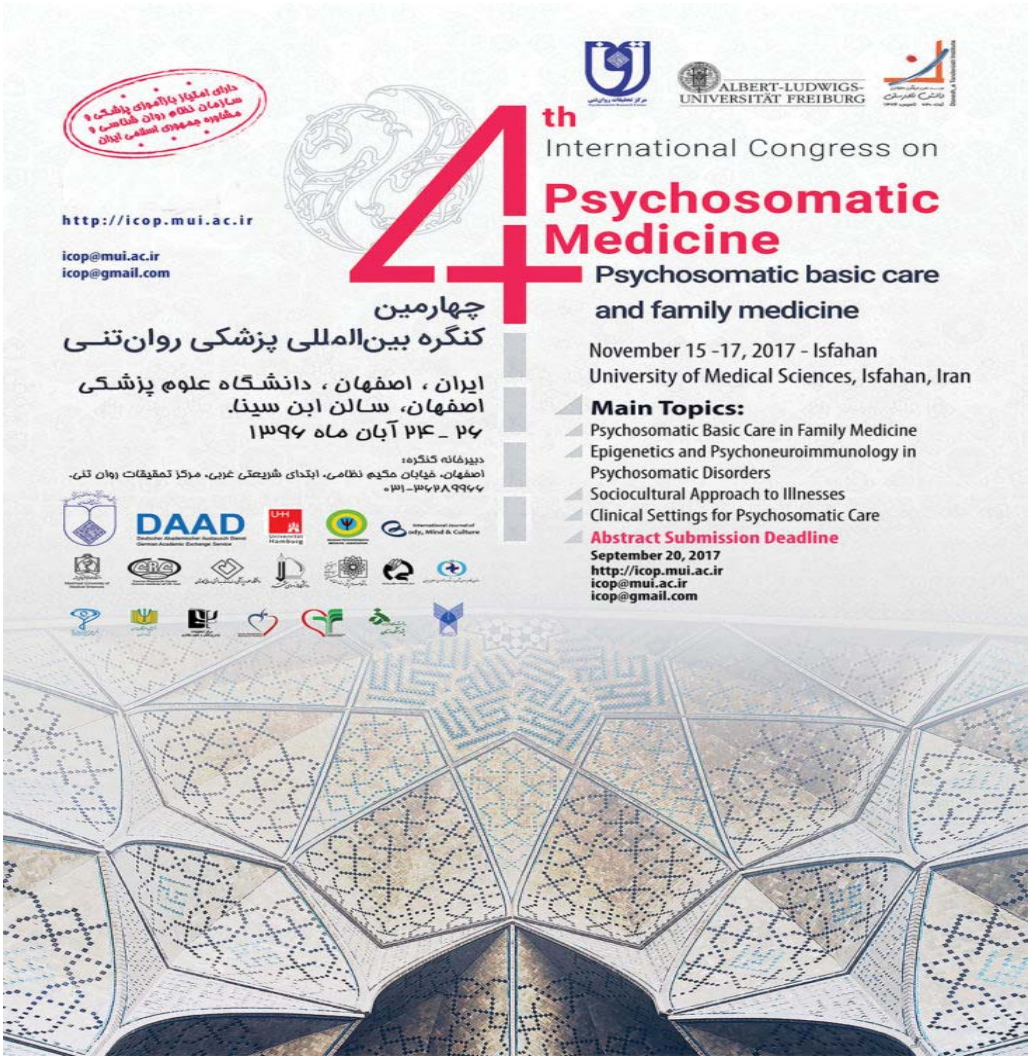
1-Publishing abstracts and full papers of accepted articles in International Journal of Body, Mind, and Culture (IJBMC).

2- Starting "Isfahan Branch of Psychosomatic Association" in concordance with the main branch.

3- Inserting psychosomatic content in the formal curriculum of family medicine specialist after two years of a successful pilot in Isfahan with the hand of social medicine school.

4- Developing national basic psychosomatic care plan for different groups of providers like the family physicians, the nurses, and other caregivers via health system authorities.

5- The last, but not the least, is the opportunity to get more familiar with the amazing historical attractions of Isfahan City, which makes a long lasting memory of the congress.



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The Development of Psychosomatic Reasoning in General Practitioners: An Empirical Study

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Empirical Study

Abstract

Background: Monajemi, Goli, and Scheidt (2014) proposed a theory of development of psychosomatic (PSM) reasoning. They hypothesized that the integration of psychosocial knowledge with biomedical (BM) knowledge may have started at the level of GPs. An experimental study was conducted to explore and compare junior and senior practitioners regarding their shift from BM to PSM in terms of their decision-making.

Methods: Two cases were presented to GPs in a sequential manner based on the reports of different settings (inpatient vs. outpatient). Each participant read each part of the case carefully in order to provide the management plan (Mx), determine which parts of the scenario were the most important, and write down, first, an explanatory model, and then, the management plan for the patient. The accuracy of item selection, explanatory models, and management plans were analysed.

Results: GPs have already acquired some PSM knowledge, and thus, they will be able to differentiate between the two focuses (i.e., BM and PSM), but are not yet proficient enough to deal with a case in a PSM focus efficiently. This results in ineffective judgment. In other words, GPs discern the importance that should be given to psychosocial factors when examining their patients; however, they do not take into consideration such factors in the management plan.

Conclusion: The results were largely in line with our assumptions based on the theory of the development of PSM reasoning; however, there is a definite need for more experimental studies here to support this argument.

Keywords: Psychosomatic reasoning, General practitioner, Hypothesis

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Introduction

Although the biopsychosocial (BPS) model is generally accepted, the focus of medical education and patient care is still on the biomedical (BM) model. Monajemi Goli, and Scheidt, (2014) proposed a theory of development of psychosomatic (PSM) reasoning. During their training, students acquire knowledge largely from textbooks and lectures with limited real patient encounter. There is a strong emphasis on the BM approach, which is often not accompanied by the same emphasis on developing a PSM approach. Medical students confronted with a clinical task will most likely act with a BM focus. This is the only mode of processing of a case they have some experience with when they graduate

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from medical school and start practicing as GPs. PSM becomes more concrete for GPs when they gain some clinical experience in an outpatient setting. The primary care practice that is largely based on the ambulatory setting serves as a good basis for PSM or BPS. It can be concluded that the integration of psycho-social knowledge with BM knowledge may have started at the level of GPs which is corroborated by the fact that GPs emphasize more on psychosocial issues and allocate more time to such subjects.

Because of the important role PSM plays in primary care settings, an experimental study was conducted to explore and compare junior and senior practitioners regarding their shift from BM to PSM in terms of their decision-making and processes of care when they encounter the same patient in their clinical work.

Methods

Participants: The study participants consisted of 30 GPs with an MD degree. They were divided into 2 groups based on their years of work experience; 15 GPs were placed in the less than 10 years' experience group (junior) and 15 GPs were in the group with more than 10 years' experience (senior).

Material: The materials consisted of a booklet containing an instruction about the procedure, 2 written descriptions of clinical cases, and 2 blank response sheets following the text of each case for writing the clinical management plan. The order in which the cases were presented to all participants was the same.

Procedure: In this study, 2 cases were presented to GPs in a sequential manner based on the reports of different settings (inpatient vs. outpatient). Each participant read each part of the case carefully in order to provide the management plan (Mx) for the patient (whatever each participant thinks is necessary for the patient and not only the treatment). After each section, the data within the case was presented again and participates were asked to determine which parts of the scenario were the most important by simply putting a checkmark in front of each item. After completing the first and the last part, they were asked to write down, first, an explanatory model, and then, the management plan for the patient. There was no time limitation for these tasks.

Analysis: The accuracy of item selection, explanatory models, and management plans were independently assessed by 2 PSM experts on a 2-point scale ranging from 0 (completely inaccurate) to 1 (completely accurate). The kappa value was 0.8 which shows a good agreement between the two experts.

Disagreements between experts were resolved through discussion. To analyze Mx plans, the protocols were segmented into propositions by adapting a technique used by Patel and Groen (1986). Propositional analysis involves segmenting a protocol into individual propositions each which corresponds to discrete units of the idea in the test. Based on clinical case studies which were conducted previously, the scores were used by using 3 measures. The measures were based on the classifications of propositions into biological, psychological, familial, and social propositions.

As the classification principle is based on the object of a proposition, often propositions from adjacent protocol fragments must be taken into account. The items were classified by 2 raters, and an inter-rater agreement of 0.95 was obtained. When raters disagreed, inconsistencies were resolved through discussion. All data were analyzed using analysis of variance (ANOVA) and effects were considered significant if $P < 0.05$.

Results

Item selection: Among the 88 items of cases, a significant difference was observed between the two groups in only 17 items. Table 1 depicts the mean and standard deviations in the two groups. The junior group was superior only in 1 item (I11), while in the other 16 items, the senior group performed better.

Table 1. The mean and standard deviations of item selection in the two groups

Number	Item	Senior	Junior
I3	The pain started two hours ago.	0.70	0.26
I11	After he was moved to the CCU, where he repeatedly asked the health personnel not to do anything because there was no problem.	0.11	0.41
I15	The patient visited a cardiologist two weeks after being discharged from the hospital.	0.71	0.21
I29	The cardiologist suggested that he also get an angiography in order to evaluate the function of his coronary arteries.	0.90	0.46
I30	He used to play sports when he was young.	0.55	0.20
I33	Negative history of cigarette or alcohol use	0.88	0.46
I39	He thinks that his stressful family and job are the main causes of his problems.	0.88	0.53
I43	Since his hospitalization, his family has supported him more.	0.88	0.53
I44	He is content with this support.	1.00	0.6
I46	Refer him to a clinical psychologist.	1.00	0.70
I61	Whenever he goes back home, his wife starts complaining about unimportant issues.	0.88	0.40
I65	He cannot stand to imagine the limitations and handicaps of his illness.	0.88	0.53
I68	He is concerned with losing his job.	1.00	0.33
I72	He has experienced panic attacks in some periods of his lifetime.	1.00	0.73
I74	He has a pessimistic attitude towards human communication.	1.00	0.66
I83	During the recent 2 years, his sexual potency has gradually weakened.	1.00	0.44
I87	After 3 sessions, he gained more insight about his psychosocial conflicts as well as their impact on his health and quality of life.	0.88	0.46

Among the above 17 items, 4, 10, 3, and 1, respectively, belong to the BM, psychological, familial, and social categories. It seems that the senior GPs had superiority over junior GPs because of the psychological components of the cases. The only item that had more weight among junior GPs was item 11 that is counter-intuitive; however, the percentage of both groups was lower than 50% that shows this item had low impact on their reasoning.

Accuracy of item selection: Among the 17 items that showed a significant difference between the senior and junior groups, only 6 items were the same with the key. Table 2 depicts the accuracy of item selection in the two groups.

Table 2. The accuracy of item selection (in percentage)

Accuracy of item selection	Junior	Senior
Inpatient	7.66 (2.6)	8.1 (1.1)
Outpatient	12.12 (6.1)	15.22 (4.5)

No significant difference was observed in accuracy of item selection between senior and junior doctors.

No significant difference was indicated in the inpatient setting. However, a borderline difference was shown in the outpatient setting (P = 0.1).

Explanatory sensitivity: Table 3 depicts the accuracy of explanatory models in the two groups.

Table 3. The accuracy of explanatory models (in percentage)

Accuracy of explanatory models	Junior	Senior
Inpatient	0.55 (0.31)	0.57 (0.20)
Outpatient	0.59 (0.27)	0.72 (0.14)

The analysis showed no significant difference in the 1st part, but a borderline difference in the 4th part (P = 0.1).

Mx Sensitivity: Table 4 depicts the Mx sensitivity in the two groups.

Table 4. The sensitivity of the management plan (in percentage)

	Junior	Senior
Inpatient	25.0000 (25.94373)	55.5556 (39.08680)
Outpatient	32.1429 (37.24732)	40.0000 (40.62019)

The analysis showed that the difference between sensitivity in the inpatient setting was significant, while in the outpatient setting, there was no significant difference. It was reasonable as the last part took place in a psychologist's office so the context sensitize the juniors.

Discussion

According to the theory of medical expertise (Monajemi, Goli, & Scheidt, 2014), it seems that the development of psychosomatic reasoning follows the process explained below. Experts in PSM construct their clinical case representations similarly. On the other hand, as GPs have already acquired some PSM knowledge, they will be able to differentiate between the two focuses (i.e., BM vs. PSM), but are not yet proficient enough to deal with a case in a PSM focus efficiently, leading to ineffective judgment. Hence, at the level of GPs, there is sensitivity towards psychosocial issues that they do not reflect in their judgment and decision-making. In other words, GPs discern the importance that should be given to psychosocial factors when examining their patients; however, they do not take into consideration such factors in the management plan.

The results were largely in line with our assumptions, in that an inaccurate and very general idea about managing psychological problems was the main characteristic of GP Mx plans. In addition, they managed some psychological problems, but they did not know when to refer for psychological problem. Their protocols were inaccurate and almost exclusively focused on management without any need to provide a plausible explanatory model. This fact is corroborated by the absence of any link between explanatory models and Mx plans. Although inaccuracy of Mx plans produced by the junior GPs can obviously be linked to their insufficient experience in outpatient settings as well as lack of PSM knowledge. It is important to note that incomplete or absence of linkage between BM and PSM knowledge can affect the overall accuracy of Mx plans in senior GPs.

The comparison of senior and junior doctors showed other aspects of the development of PSM reasoning. In terms of items accuracy and explanatory model sensitivity, senior GPs were significantly more accurate than junior GPs, which showed that the integration of PSM knowledge starts at the level of senior GPs. On the other hand, junior GPs could not simultaneously consider both somatic and psychological problems. However, there was also a non-significant difference in Mx accuracy between senior and junior doctors in the outpatient setting. This non-significant difference in accuracy between them supported the idea that the higher sensitivity of senior GPs in both item selection and building an explanatory model does not result in a more accurate Mx plans. There would still be no difference between senior and junior doctors in terms of the Mx plan, which highlights the fact that long experience in outpatient settings without systematic training in PSM does not guarantee a highly accurate practice. This transitory nature of intermediates is one of the developmental characteristics of PSM knowledge that should be explored in future studies.

The developmental pattern of Mx knowledge acquisition was reflected in 2 findings. First, we found that providing accurate Mx plans was a characteristic of expert doctors. The low accuracy of the two groups of GPs has different origins. In the junior doctors, this low accuracy stems from their inability to take both BM and PSM into consideration when providing Mx plans. However, in senior doctors, it is more due to their inconsistencies in keeping a line of reasoning.

The second finding that corroborates the developmental nature of PSM reasoning was that there was no difference between senior GPs and junior GPs in terms of their accuracy. The observed difference was in the format and size of their protocols, which again shows the transitory nature of GPs' knowledge.

Among all participants, only 6 of them (20%) were in pure PSM pattern that means that they recommended cardiac treatment, psychotherapy, and lifestyle modifications. Of the participants, 13 (50%) only recommended psychiatric therapy. It is very interesting to note that this group focused only on patients'

cardiac problems in the first scene. Therefore, in this group, a switch from BM to PSM thinking was observed. Moreover, 30% of participants suggested both psychotherapy and lifestyle modification.

Shackelton-Piccolo, McKinlay, Marceau, Goroll, and Link (2011) suggest that internists and family practitioners may develop different "disease" perspectives. This is probably due to the fact that, during their medical training, they may use different explanatory models, that is, respectively, pathophysiological and biopsychosocial. Their article aimed at exploring the differences between internists and family practitioners in their suggested diagnoses, level of diagnostic certainty, test, and prescription ordering when they encounter the same "patient" who suffered from coronary heart disease (CHD). Their findings indicated that internists were more certain of a CHD diagnosis, while family practitioners tended more to act on this diagnosis. The latter group tended more to diagnose (and were more certain of) a mental health condition.

Although psychiatric problem ignorance is dangerous, overlooking cardiac problems in light of psychiatric problems is also very hazardous. The integration of these two types of knowledge has not yet occurred. It could be concluded that when the integration of these two types of knowledge is not complete, PSM education may lead to more error-prone practice as the practitioner places more emphasis on psychological knowledge but fails to notice the somatic knowledge.

Especially for GPs or intermediates in PSM, there is a possible distinction between a BM and PS (psycho-social) condition when processing clinical case information; their more recently acquired PS knowledge is not yet fully developed and integrated with their BM knowledge. In most medical schools, PS knowledge does not seem to play an important role during the medical school years, and the integration of BM and PS knowledge, therefore, mainly starts during the primary care practice. As a result, the development of PS knowledge will lag behind the GPs' BM competence and will only become fully integrated with BM knowledge after many years of clinical experience.

What are the implications of this paper for research, and medical education and practice? First, there is a definite need for more experimental studies here to support this argument. Second, concerning medical education, it seems that the translation of such experimental studies and their application in medical education is not so trivial, but opens a new avenue both in training undergraduates and postgraduates. In addition, a more general discourse on the relevance of this theme is necessary for an improvement of medical treatment, something that future research may shed further light on.

Conflict of Interests

Authors have no conflict of interests.

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Psychotherapy in General Practice as an Independent Field of Healthcare

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Review Article

Abstract

Mental and psychosomatic problems and disorders are increasing and have become an enormous cost factor due to their chronification (increase in the periods of incapacity to work and a third of early retirement is due to mental disorders). A timely detection and targeted short-term interventions in primary care can, however, prevent their chronification. Patients desire the consideration of their psychosocial problems and emotional needs by their GP within the framework of professionally competent guided dialogues. Doctors with qualifications in psychosomatic basic care and an additional designation in psychotherapy are further trained for this and are able to intervene promptly and effectively.

Keywords: Psychotherapy, Training, General practitioners

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Introduction

General practice care plays a central role in the identification and treatment of patients with mental illness (de Cruppe, Muler, Herzog, & Eich, 2006; Linden, Maier, & Achberger, 1996; Fritzsche, Burghard, Schweickhardt, & Wirsching, 2006). Despite a well-established and differentiated professional psychotherapeutic care system, a large proportion of patients is primarily diagnosed by general practitioners (GPs), and advised and if necessary transferred (Tress, Kruse, Heckrath, Schmitz, & Alberti, 1997, Jacobi, Klose, & Wittchen, 2004). In the study conducted by Harfst and Marstedt (2009), the GP was the first contact for most patients (87%) who visited a doctor or psychotherapist within one year due to mental complaints. Nearly two thirds of patients consulted only with their GP (66%), while a fifth of patients (21%) were advised both by their GP and others (psychiatrist, psychotherapist, or outpatient department) (Harfst & Marstedt, 2009). In 2006, the German Medical Assembly (Deutsche Ärztetag) explicitly requested to strengthen and promote psychotherapeutic-psychosomatic competence in medical action, because a unilateral somatic oriented medicine involves the risk of not recognizing the mental disorders lying behind the somatic symptoms (Bühren, 2006; Neitscher,

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Loew, & Bodenstein, 2006).

Thus, high importance can be assigned to "psychosomatic basic care" and the "area of psychotherapy" (additional designation psychotherapy) (Ruger & Bell, 2004). The effectiveness of psychosomatic basic care has been proven in several studies (Fritzsche et al., 2006).

Moreover, the networking of primary care with outpatient and inpatient professional psychotherapeutic care is insufficient. In most regions, the number of medical specialists and psychotherapists is no longer adequate to the sharply increasing required numbers. A further problematic aspect is the organization of cooperation between the fields. The factors missing are designed patient- as well as needs-oriented step-by-step offers.

Tasks of Psychotherapy in General Practice

The abovementioned shortcomings are relate in principle to all professional psychotherapeutic areas. These shortcomings are specified in the following section for the field of work of general practice psychosomatic-psychotherapeutic care:

- The particularly frequent somatoform disorders in general practice (e.g., back pain, heart problems, gastrointestinal disorders, and dizziness, respectively, without organic findings) and adjustment disorders (e.g., response to serious illness, loss, separation, and job problems) require a cooperative, interdisciplinary and integrative treatment, which currently cannot be guaranteed for the reasons mentioned above.
- The inadequate treatment of the abovementioned psychosomatic patients results not only in the suffering of the individual and consequential damages for the party concerned and their relatives (e.g., chronification), but also in significant costs in the health care system, which can be attributed to unnecessary and ineffective diagnostic and therapeutic measures.

Especially with interacting comorbidities in the form of severe physical disorders with secondary mental disorders, diagnosis and adequate therapy have an important influence on the long-term course of the somatic disease (Bühren et al. 2008; Linden, Bühren, Kentenich, Loew, Springer, & Schwantes, 2008).

Examples of brief interventions

A 36-year-old female patient had complaints of recurrent progressive panic attacks at work in a tense, professionally demanding managerial position.

She received behavioral interventions with explanations of the vicious circle of anxiety, stress model, anxiety triggering and maintaining conditions, and cognitive techniques training for overcoming one's fears for the duration of 5 sessions.

A 28-year-old female patient with chronic recurrent sinusitis was advised by the ENT physician to straighten the septum and fenestration.

A brief intervention on the formulation of "being peeved" as a colloquial term led to the awareness of conflicts with the husband. After just 1 week, a significant relief could be noted. The involvement of the husband led to an improvement in the relationship and sinusitis after 2 couple consultations.

A 54-year-old male patient had fluctuating intestinal disorders (meteorism and chronic diarrhea) and a cancer phobia.

A 30-minute intervention took place twice to determine the subjective understanding of disease and the motivation for psychotherapy. This was followed by a medical referral for a gastroenterological evaluation including a colonoscopy. Because of normal findings, a referral to an outpatient psychotherapy center with specifically psychosomatic trained psychotherapists followed. After a successful psychotherapeutic treatment, a further treatment with the GP continued with a frequency of twice a year for 30 minutes in the form of an aftercare appointment.

A 42-year-old female borderline patient had been pretreated for 11 years with analytical psychotherapy and drug treatment with anxiolytics and tranquillizers.

A stationary cognitive-behavioral treatment was initiated. Vocational training and employment as a gardener followed. The aftercare took place with the GP once per quarter for 30 minutes. The objectives were everyday life structuring and offsetting of stress-related occurrences in everyday life.

Example for longer interventions

A 70-year-old female patient had presented with progressive chronic nausea after a sigmoidectomy due to subileus.

After an extensive internistic evaluation initiated by the GP, the diagnosis of a somatoform disorder was made. The patient and her insistent husband were offered a corresponding disease model in a couple's consultation, which was well received. The patient could then differentiate the symptoms of an acutely occurring gastroenteritis and an acute bilious attack with a following cholecystectomy from other permanent complaints. After a consultation with the GP, the patient refused a renewed internistic evaluation, which was initiated by the University Hospital postoperatively. This was also encouraged by the disease model offered. As a result, the female patient could again engage in more relaxing activities like walking and reading. Overall, the patient was accompanied by the family doctor for 1 and 1/4 years at intervals of 2 to 3 weeks with consultations lasting about 30 minutes. She rejected psychotherapy with a psychologist.

Proposal for a future cross-sectoral psychotherapeutic primary care

The treatment service offered includes the following elements:

1. Treatment in the context of psychosomatic primary care and the additional designation of psychotherapy consists of specific diagnostic and therapeutic services for the treatment of patients with psychosocial crises, and chronic and acute psychosomatic and mental illnesses. These treatments are only personally provided by the participating panel doctor.

2. The *diagnostic* services include informing consultations, anamneses, indication, motivation, and referral to an outpatient psychotherapist or (part-) specialized inpatient treatment:

- informational consultations on psychoeducation and behavior modification (e.g., diet, addictive behavior, and physical activity) with 1 to 2 appointments per quarter with written patient information
- 3 to 5 consultations with the GP, in which the disease concept and the patient's treatment expectations are specifically discussed and the treatment approach is decided upon (e.g., outpatient or inpatient psychotherapy)
- a joint consultation with the GP, psychotherapist, and patient in the practice of the family doctor.

3. the *therapeutic* services include specific clarification and supportive consultations of varying length and intensity:

- crisis interventions with one to two appointments per quarter
- brief interventions of 3 to 10 appointments including sessions open to partners and families
- implementation of symptom-oriented groups of patients (10 sessions)
- monitoring of chronic patients over an extended period of time
- continuous telephonic monitoring, treatment coordination, and motivation by a case manager (staff of a psychosomatic center), psychosomatic center, or the GP.

Model project

In three representative regions, general and family/internistic practices with an additional designation in psychotherapy in connection with regional psychosomatic centers shall enable a high-quality, patient-centered care with services in psychosomatic primary care and psychotherapy. For the financing, the applicable rules of performance of the benefit processing should be replaced by a lump sum fee for a sufficient time. To keep the cost of treatment as unbureaucratic and economic as possible for everyone involved

(payers and physicians), transparent, flat-rate payments are agreed upon which are divided between the parties involved depending on the proportion of services provided. For quality assurance and evaluation, the services are documented. The treatment outcome is determined in pre-comparison, post-comparison, and catamnesis comparisons and measured with the aid of the outcome criteria [patient satisfaction, quality of life (QOL), symptom relief, and health care costs]. It is expected that the patients' satisfaction and QOL increase with the pilot project, the symptom severity improve significantly, and clinically relevant and health care costs significantly decrease.

Conflict of Interests

Authors have no conflict of interests.

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Psychosomatic Medicine in Germany

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Review Article

Abstract

Psychosomatic medicine developed in Germany after the Second World War as a multifaceted system of inpatient, day-patient, and outpatient treatment. The conceptual roots of post war psychosomatic medicine in Germany were in internal medicine (Victor von Weizäcker and Thure von Uexkuell) and in the psychodynamic and psychoanalytic tradition of G. Engels, Franz Alexander, and others. The implementation of psychosomatic medicine as a speciality of medicine in addition to psychiatry supported an integration of psychotherapeutic methods and interventions in medicine. Consultation-liaison (CL) services have contributed to the dissemination of psychosocial skills and interventions in the medical setting. Psychosomatic basic care curricula have improved the Diagnosis and treatment of psychosomatic problems and disorders in primary care.

Keywords: Psychosomatic medicine, Psychosomatic disorders, Treatment

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History

The institutionalization of psychosomatic medicine in Germany dates back to the late sixties when it became apparent that post-war psychiatry in Germany had developed a rather biological orientation, whereas psychiatry in the Anglo-Saxon world was opening up for an understanding of social factors influencing the development and course of psychiatric illnesses. The German government therefore decided to support the implementation of psychosomatic departments in university medical centers with the aim to promote the use and integration of psychotherapy in the medical context. Between the late sixties and the end of the seventies, around 21 departments of psychosomatic medicine were founded (Ameloh et al., 2013). The psychotherapeutic orientation of most of these departments was psychodynamic, which is in agreement with current trends in the USA. Parallel to the implementation of psychosomatic departments in university medical centers, in the late sixties, outpatient psychotherapy was acknowledged as a form of medical treatment funded by the legal health insurance system under the control of peer-reviewed quality assurance. Originally psychosomatic medicine was rooted strongly in the psychodynamic tradition associated with the work of Franz Alexander, Engel, and others. On the other hand, the influence of the continental tradition of internal medicine associated with the work of Victor von Weizäcker and Thure von Uexkuell extended

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the biomedical perspective of medicine and included a broader perspective on the theory of medicine and clinical practice focusing on the patient as an individual and the importance of communication in the medical setting (Deter, 2004; Ameloh et al., 2013).

The implementation of psychosomatic medicine at the university level had a strong impact on the system of service delivery. During the subsequent decades, the psychosomatic approach was introduced into the primary care system. Large general hospitals founded departments of psychosomatic medicine offering consultation-liaison services (CL services) to the other medical specialities. In rehabilitation, a large range of inpatient facilities emerged treating patients with chronic psychosomatic conditions at risk of resulting in long-term sickness leave and disability. The rationale for the rise of psychosomatic medicine was the fact that a large group of patients suffering from functional somatic symptoms, anxiety or depression, or even somatopsychic problems were not sufficiently cared for in the traditional psychiatric hospitals of the late sixties. This initiated the search for a system of service delivery which would meet the needs of patients more appropriately.

The system of service delivery

Hospital inpatient and day-patient treatment:

Psychosomatic inpatient treatment evolved in many hospitals from psychiatric units, which had run open wards with a psychotherapeutic treatment approach. Other hospitals had inpatient units of general medicine or internal medicine which were integrating psychotherapeutic treatment approaches (Cruppe et al., 2005). Over the last decades, psychosomatic inpatient and day-patient treatment has become a treatment setting of its own characterized by the following features:

a. The treatment is organized by a multidisciplinary team including medical doctors, psychologists, nurses, social workers, and creative therapists (e.g., music therapy, art therapy, or KBT).

b. The main goal of the multidisciplinary team is to structure, monitor, and contain the therapeutic process of the individual patient and the patient group.

c. The number of patients in the treatment group ranges between 15 and 24.

d. Patients admitted to the psychosomatic hospital or ward are usually able to care for themselves. They do not need a sheltered surrounding. This determines treatment selection of patients in psychosomatic medicine.

e. The treatment approach in the psychosomatic ward is mainly psychotherapeutic. This does not preclude however the possibility of patients needing psychopharmaceutical treatment.

f. Patients admitted to the psychosomatic hospital often have an intrinsic treatment motivation. However, some patients may only have limited insight into their problems at the beginning of treatment or may have been sent by their treating doctor, e.g., in cases of anorexia nervosa.

g. The treatment is usually structured according to a treatment plan, which describes the goals of treatment agreed upon with the patient and communicated to the team. Part of the treatment plan is the definition of the timeframe. Inpatient treatment in its nature is short-term and time limited. Therefore, it must focus primarily on those issues which prevent the patient from independently living outside of the hospital.

h. Inpatient treatment is suitable only if outpatient treatment for some reasons is not possible, e.g., because the illness is associated with severe and disabling psychological or physical symptoms interfering with daily functioning. This may apply to severe somatoform pain syndromes, eating disorders (e.g., severe bulimia or anorexia nervosa), personality disorders associated with self-mutilation, developmental crisis in young adulthood associated with depression and social withdrawal, or drug abuse.

i. The average duration of hospitalization

varies depending on the diagnostic groups and treatment approach and ranges between 1 and 4 months.

j. The treatment program consists of individual psychotherapy, group psychotherapy, medical treatment creative therapy (KBT, music therapy, art therapy), physiotherapy and physical exercise, and psychoeducation. The treatment plan is tailored individually depending on the condition of the patient and is continuously monitored and adapted over the course of the treatment.

Psychosomatic departments or wards are often integrated in general hospitals or university hospitals (Cruppe, Herzog & Eich, 2005). There are also psychosomatic hospitals which have no additional medical facilities. The integration of psychosomatic medicine into the general hospital setting was motivated by two goals. First, patients admitted felt less stigmatized as compared to admission in a psychiatric hospital. Secondly, the psychosomatic ward in the general hospital setting is usually complemented by a CL service, which allows the admission of patients from other medical wards if a more specific psychosomatic treatment approach is required.

Patients are often referred to psychosomatic inpatient treatment by primary care doctors, psychiatrists, or physicians of a different specialty (Bühring, 2012). Prior to admission, a diagnostic assessment and treatment selection is performed in the psychosomatic outpatient department.

Psychosomatic day care has developed only more recently. Day care settings were often added to an already existing inpatient unit. The day care setting had a twofold rationale. First, it was expected that inpatient treatment could be shortened if patients were discharged via a day care setting (economic rationale). Secondly, day care treatments were expected to support an earlier reintegration into the social surrounding so that the unwanted effects of hospitalization would be avoided (clinical rationale). Studies evaluating the outcome of day care facilities demonstrated that psychosomatic day care is similarly effective as inpatient treatment (with the exception of some conditions like anorexia nervosa). Therefore, day care is the treatment of choice not in addition to a preceding inpatient treatment, but as an alternative more frequently as initially expected. Patients often prefer the day care setting and want to stay in their own social environment. The limited availability and access of day care facilities, however, may make an inpatient treatment inevitable. Treatment programs between the two settings do not differ substantially which explains the different outcomes.

Inpatient and day care treatment in the psychosomatic hospital in Germany is funded by health insurances. Insurances require a detailed treatment plan substantiating the necessity of inpatient treatment and the length of stay.

Rehabilitation: Twenty years ago, the most prevalent reasons for long-term working disability in Germany were musculoskeletal disorders (MSDs) and cardiovascular diseases (CVDs). This has since changed with psychiatric and psychosomatic disorders leading in prevalence among long-term working disabilities. Many psychosomatic disorders take a chronic course, hamper participation in social life, and are associated with working disability. Therefore, psychosomatic medicine became an important branch in rehabilitation (Schulz & Koch, 2002).

Currently, the treatment capacity in psychosomatic rehabilitation comprises 20,000 inpatient places. The duration of treatment ranges between 4 and 6 weeks. The treatment focuses on those aspects which interfere with the working capacity. Hospitals for psychosomatic rehabilitation often are not affiliated with primary care hospitals, but are independent. This limits their medical equipment and capacity for diagnosis and intervention. The main target of rehabilitation is not the curative treatment of illness, but the improvement of illness-

associated impairments of social functioning. The targets of this treatment are thus different from those of curative hospital treatment. Interventions in rehabilitation include psychoeducation, physical training, psychotherapy, and the training of skills particularly with regard to working ability.

Psychosomatic rehabilitation is funded not by health insurances, but by the ministry of work.

Consultation and Liaison services: The prevalence of psychological comorbidity in the medical hospital population is estimated to amount to 30-35%. Cooperation with psychosomatic medicine was expected to improve treatment and to shorten the duration of stay in the medical ward. During the nineties, the development of CL services was initiated on a large scale. The European Association for Consultation Liaison Psychiatry and Psychosomatics launched a large study funded by the European community which reported on the state of CL psychiatry and psychosomatics in Europe. Two types of service delivery in the CL setting were delineated; the consultation model and the liaison model. Liaison services were often introduced in wards with psychosocial distress for the staff like in oncology wards and also in other wards requiring intense support.

The close cooperation in liaison work contributes to a dissemination of psychosomatic skills and knowledge in the medical setting so that the need for psychological intervention and support is recognized more easily (Diefenbacher, 2005).

Some hospitals focus exclusively on CL services and do not establish additional inpatient and day patient care. Patients in these hospitals cannot be referred to a psychosomatic ward. Today, there is a consensus that a comprehensive psychosomatic department in a general hospital setting should include both a CL service and an inpatient and/or day patient treatment facility (Fritzsche, Spahn, Nubling & Wirsching,. 2007).

Psychosomatic basic care: Primary care physicians have a central role as "gate keeper" for the management and care of patients suffering from functional physical symptoms or from comorbid psychiatric and psychosomatic disorders. Patients considering their complaints as signs of a physical illness usually present these to their primary care physician first (Bühring, 2012). Depending on his or her knowledge and experience, the nature of the problem is recognized and psychosocial targets are integrated into the treatment plan. Empirical evidence has substantiated that, in primary care, it takes up to 7 years to establish an accurate diagnosis of a somatoform disorder. This clearly leads to a high risk of chronification which supports the rationale of training primary care physicians in basic skills of psychosocial assessment and psychosomatic medicine.

In the past 3 decades, a great number of primary care physicians were taught the curriculum of basic psychosomatic care and integrated their skills and knowledge into their daily practice (Geigges & Fritzsche, 2016). Empirical studies substantiated that target indicators, such as drug prescription, could be reduced due to the enhanced psychological and communicative skills trained in the curriculum. In a randomized controlled trial, Larisch Schweickhardt, Wirsching & Fritzsche (2004) evaluated a specific intervention, the reattribution model, in the primary care treatment of somatoform disorders. The study demonstrated the positive effects of the intervention suggesting that, after a 3-month follow-up period, patients who had been treated with the reattribution approach had less physical complaints (Larisch, et al. 2004). Randomized controlled trials on the efficiency of psychosomatic interventions in the primary care setting are possible, but are still relatively rare. This is largely due to the difficulties of implementing such studies in the private practice sector.

Primary care physicians who have undergone a training course in psychosomatic

basic care in Germany gain access to the funding of specific forms of intervention by the health insurance. This allows more time for verbal communication with the patient. The additional funding was a strong incentive for primary care physicians to enroll in the curriculum of psychosomatic basic care (Salize, Rossler & Becker, 2007).

There is a considerable divergence in the ways in which basic psychosomatic care in primary medicine can be integrated into daily practice. The outcome of implementing the approach can be evaluated according to the following criteria:

(a) Patient satisfaction
(b) Amount of drug prescription
(c) Compliance with the treatment regime
(d) Therapeutic outcome
(e) Professional satisfaction

Outpatient psychotherapy, psychosomatic medicine, and psychiatry: Outpatient treatment for psychosomatic and psychiatric disorders in Germany is offered by psychologists and medical doctors. The number of psychologists in private practice in Germany amounts approximately to 14,000 (Beutel, Kruse, Michal & Herzog, 2013; Bühring, 2012). Medical doctors offering outpatient treatment in the private practice setting are either trained in psychiatry, psychosomatic medicine and psychotherapy, or in child and adolescent psychiatry. Psychiatrists in private practices and specialists in psychosomatic medicine amount to roughly 3,000 individuals (Bühring, 2012).

Outpatient treatment facilities in psychosomatic medicine in Germany are organized in two different institutional contexts:

(1) Private practices: A great number of psychologists, medical doctors specialized in psychosomatic medicine or psychiatry, and general practitioners with additional training in psychosomatic medicine (see paragraph below) offer outpatient treatment in private practices (Kruse et al., 2013). Considering the high prevalence of psychosomatic symptoms in the general population, it is clear that outpatient treatment covers the main burden of care for this patient group. Around 90% of patients who are admitted to a psychosomatic ward have received some kind of outpatient treatment before admission and around the same percentage is referred into some kind of outpatient care after being discharged from the psychosomatic hospital or ward.

(2) Hospital-based services: The psychosomatic departments of university hospitals and general hospitals offer a limited spectrum of outpatient services mainly for assessment and treatment selection for specific groups of patients which are not well-cared for like patients with severe multi-morbid, disabling conditions or conditions requiring specific expertise.

Outpatient psychotherapy in Germany is funded by health insurances. A detailed treatment plan explaining the diagnostic assessment and the treatment plan is required. The timeframe of outpatient psychotherapy ranges from 25 to 240 sessions (in analytic psychotherapy). The majority of interventions, however, last between 25 and 80 sessions (6 months to 2 years). The basic psychotherapeutic orientation in outpatient psychotherapy is either psychodynamic or CBT (Fritzsche, Fer, Wirsching & Leonhart, 2012).

Postgraduate training

Psychosomatic basic care: The curriculum for psychosomatic basic care addresses not only primary care physicians and general practitioners, but also those with other medical specialities like gynecologists, pediatricians, and neurologists.
The curriculum encompasses 80 hours usually structured into 5 2-day courses.
addiction. It also focuses on skills of psychosomatic assessment and communication. The teaching formats include life interviews, paper cases, role-play, Balint groups, supervision, and theoretical lectures. All courses are systematically evaluated. During the past decades, a great number of primary

care physicians have participated in this curriculum. Empirical studies have provided evidence that GPs trained in this curriculum prescribe significantly less drugs to their patients and reach a higher level of satisfaction with their professional work. Dealing with patients, particularly those suffering from functional somatic symptoms, is less distressing and leads to less dropouts from treatment among these GPs compared to those who were not trained.

Psychotherapy in the medical setting: The curriculum for psychotherapy in the medical setting aims to improve the prevention, recognition, and treatment of psychosomatic conditions in various medical specialities.

The curriculum consists of 120 hours of theoretical education in psychodynamic theory, developmental psychology, psychopharmacology, and etc. Additionally, the curriculum requires 240 sessions of outpatient psychotherapy under continuous supervision and 100 sessions of training analysis in either in-group psychotherapy or individual psychotherapy. The curriculum can be completed within 2 years. The rationale is to offer psychotherapeutic training to MD's who want to augment their communicative and interactional skills and who wish to focus on psychotherapy in their respective medical field, often gynecology, pediatrics, or neurology.

Psychosomatic medicine and psychotherapy: Psychosomatic medicine as a medical speciality was introduced in Germany in the early 90s, extending the existing qualifications of psychiatry and child and adolescent psychiatry. The curriculum content of the psychosomatic medicine postgraduate training was designed as a 5-year course including 1 year in psychiatry, 1 year in internal medicine, and 3 years in inpatient psychotherapy in institutions authorized for training in this speciality. The curriculum includes 240 hours of theoretical input in psychopathology, psychodynamic theory, learning theory of psychodiagnostic and assessment, couples and family therapy, psychological disorders in primary care settings, and rehabilitation. In addition, 1,500 treatment sessions with supervision after every fourth session, 150 sessions of training analysis or group psychotherapy, and 100 hours of documented and supervised assessments are required. Training in psychosomatic medicine is a full-time training lasting on average 5 years.

Physicians currently specializing in psychosomatic medicine often have already been trained in other medical specialities before entering into psychosomatics. The most frequently observed qualifications are in pediatrics, neurology, general medicine, or psychiatry.

Psychotherapeutic training of psychologists: Since 1999, psychologists in Germany have been entitled to work in psychotherapy funded by health insurances after having qualified with a diploma accredited by the official authorities (Nübling, 2009). In Germany, 170 private and public institutes offer a curriculum to achieve this qualification (approbation) which permits psychologists to work as psychotherapists. Applicants can choose between a basic orientation in psychodynamic and behavioral psychotherapy. The training lasts between 5 and 7 years and requires extensive clinical work and theoretical education. As part of their clinical training, 600 hours in psychosomatic medicine and 1,200 hours in psychiatry are required. In addition, the curriculum includes 1,200 sessions of practice in psychotherapy with supervision after every fourth session.

Psychologists usually enter into psychotherapeutic training immediately after the end of their studies. Currently, the closer integration of postgraduate and undergraduate training into the curriculum is being considered. Upon finishing their training, psychologists can work independently in private practice psychotherapy. Presently, about 15,000 psychologists are working in private practices in Germany, accounting for a major part of outpatient service delivery (Table 1).

Table 1. Physicians and qualifications in the field of psychosocial medicine

Psychosomatic basic care	Psychotherapy in the medical setting	Medical speciality Psychiatry and psychotherapy	Medical speciality Psychosomatic medicine and psychotherapy

Psychosomatic medicine and psychiatry

Overlap and differences: The definition of psychosomatic medicine as a medical speciality has theoretically focused on two lines of thought. The first refers to the delineation of clinical categories and diagnoses, in which the interaction between biological and psychological processes plays an important role. As Alexander (1950) pointed out, psychosomatic medicine primarily deals with a specific group of diseases in which psychological factors play an important role such as ulcerative colitis (UC), Crohn's disease, or asthma. In the modern nomenclature such paradigmatic diseases defining the clinical field of psychosomatic medicine are the somatoform disorders, eating disorders, or psychological disorders due to physical illness. In terms of such diagnostic categories, the boundaries between psychiatry and psychosomatic medicine are rather clear. Psychoses, addiction, severe affective disorders, bipolar disorders, neuropsychiatric diseases, and conditions associated with self-harm or harm to others have to be treated in psychiatry. In contrast, somatoform disorders, eating disorders, anxiety disorders, and depression, particularly when occurring with functional bodily symptoms, are cared for in psychosomatic medicine where institutions offer a more psychotherapeutic climate.

The second approach to the definition of psychosomatic medicine focuses on the basic approach to medicine and psychosocial and communicative skills, which are required across the whole spectrum of clinical medicine. Psychosomatic medicine from this perspective is less a medical speciality, but rather a cross-sectional topic and approach, which should be integrated into all clinical medical specialities. This perspective is the rationale for psychosomatic basic care. Thus, the overlap with psychiatry is not a big issue, as psychiatry has not been conceptualized as a cross-sectional discipline, but rather as its own medical field, with its own institutions and spectrum of interventions and treatment approaches.

The increase in psychotherapeutic competence in psychiatry, however, has blurred the boundaries between psychosomatic medicine and psychiatry. The future may bring a gradual integration of the 3 medical disciplines of adult psychiatry, child and adolescent psychiatry, and psychosomatic medicine. Historically, the contribution of psychosomatic medicine has led to a significant improvement of psychotherapeutic care in the medical setting. Patients with diagnoses such as somatoform disorder, anxiety disorder, or major depressive disorder can find adequate treatment in general hospitals offering a high psychotherapeutic standard. The same applies to outpatient psychotherapy.

In recent researches, an increasing convergence of interests between psychiatry and psychosomatic medicine was observed in recent years. Overlapping research areas included the neurobiological correlates of psychiatric and psychosomatic diseases and their variation due to treatment, the psychosocial and psychobiological sequelae of early adverse childhood experiences and their vulnerability concerning psychological and psychosomatic disorders in later life, and the epigenetic mediation of environmental factors. All of these issues are of central interest in both psychiatry and psychosomatic medicine. There is also a convergence of interests in evidence-based treatment approaches and in approved guidelines for the treatment of specific disorders such as depression or anxiety disorder.

Psychosomatic medicine for children and adolescents

Children and adolescents presenting with severe psychological disorders are usually

admitted to inpatient settings for child and adolescent psychiatry. Some children's hospitals, mostly in university centers, offer a special psychosomatic service to their young patients and their families. The reasons for developing these services were the same as those leading to the emergence of psychosomatic medicine in adults. Child and adolescent psychiatry is more concerned with developmental and psychiatric disorders, rather than with physical illnesses and their associated psychological problems.

Units for psychosomatic medicine in children's hospitals usually work in a multiprofessional team of psychologists and medical doctors qualified in child psychiatry. Interventions are preferably psychotherapeutic including family interventions. Psychosomatic units in children's hospitals mainly offer CL services. However, some departments also have inpatient facilities. There is no separate qualification for psychosomatic medicine in children and adolescents.

Current trends in research

Areas of research in psychosomatic medicine can be clustered into the following 4 groups.

(1) Psychotherapeutic intervention and outcome research

(2) Research on clinical characteristics, course, and etiology (biological and psychological processes) in psychosomatic disorders

(3) Neurobiological correlates and epigenetic determinants of psychological health and disease

(4) Qualitative studies

Psychotherapeutic outcome research is a core issue of psychosomatic research. In recent years, a number of large scale multicenter studies evaluating different treatment strategies have been performed on anorexia nervosa (ANTOP), social phobia (Sophonet), somatoform disorder (PISO), and Internet addiction (STICA) (Herzog, 2012). Other studies have focused on psychosomatic aspects of physical disorders like diabetes (DAD-Study, Mind-DIA-Study, DIAMANT and HeiDi), adiposity (EBOTS, MAIN), and coronary heart disease (SPIRR-CAD). Based on these large-scale outcome studies, psychosomatic medicine is increasing the empirical evidence of its effectiveness.

The description and validation of the biological and psychological aspects of psychosomatic disorders is an important focus of clinical psychosomatic research. Studies in this area aim to validate diagnostic categories, illuminate aspects of psychosomatic syndromes relevant to the course and/or the etiology of the condition, and Determine specific targets for intervention. Often these studies are observational and have a cross-sectional design.

Epigenetic and neurobiological research is a focus of both psychosomatic medicine and psychiatry. In psychosomatic medicine, neurobiological research focuses on bereavement response, pain, and anorexia nervosa (Herzog, 2012). The clinical impact of brain research has been quite limited. Its main contribution was to substantiate models of underlying psychological processes by identifying the neural correlates of these processes.

Qualitative research is still a rather neglected field of psychosomatic research. However, multi-method research designs are becoming increasingly popular. Patients' narratives for example are considered more systematically as windows into their subjective experiences.

In conclusion, the biopsychosocial model which had served as a paradigm of psychosomatic medicine and research for more than 50 years has dissolved into a variety of research fields and methods, which are increasingly difficult to integrate into a meaningful picture of mind-body interaction. This puzzle, however, is still the core question of psychosomatic medicine.

Outlook

Currently, there is no indication of a groundbreaking change in psychosomatic medicine. It is based in various fields of medicine ranging from primary care to large university hospitals. The concept of a distinct

medical speciality of psychosomatic medicine in addition to psychiatry has considerably strengthened the integration of psychology and psychotherapy into medicine.

Countries aiming to particularly improve the psychosomatic approach to medicine have to decide on which level to start. In our experience, the improvement of primary care should have priority. To train primary care physicians in psychosomatic basic care, however, requires experts who offer qualified training. The second step is the implementation of a more advanced psychotherapeutic training.

Conflict of Interests

Authors have no conflict of interests.

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Body-to-Body-Communication and Somatoform Disorder in China: A Case Study Regarding Culture and Gender

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Qualitative Study

Abstract

Somatoform disorder and somatic symptom disorder (SSD) are resistant to traditional medical support. Patients experience a vicious cycle of focused awareness/attention towards distressing bodily sensations. A negative interpretation of these phenomena leads to "worrying, cognitive styles" concerning the body (body-image, which enhances further self-awareness/self-observation) towards unpleasant bodily sensations and hyper-arousal. Body-psychotherapy may be one approach appropriate in dealing with these disorders and syndromes. This article addresses the concept of creative body-work, defines its basic guidelines and aims, and demonstrates a practical approach to support patient familiarization with body-self-experience and how to establish a basic contact (relationship) and control the vicious negative cycle. A positive working definition of somatoform disorder would include the following: illness perception and illness attribution; illness behaviour; health-related anxiety; emotional distress; disability; quality of life; doctor-patient-interaction and health care utilisation. This article relates to specific cultural aspects working with patients in China within a one-day professional workshop including clinical observations and analysis. It also refers to the gender perspective. Psychotherapy and psychosomatics more and more also have to consider these perspectives.

Keywords: Body psychotherapy, Somatoform disorder, Body experience, Somatic symptom disorder, Medically unexplained symptoms, Cognitive behavioural therapy, Psychodynamic psychotherapy, Gender perspective

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Body psychotherapy in China

Interest is growing in China related to body psychotherapy and psychology. Colleagues want to understand the person in terms of the body and learn how to work with the body in psychotherapy. They want to adapt various concepts, strategies and interventions that were developed in the field of body psychotherapy for several reasons:

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Chinese cultural perspective

1) Other kinds of psychotherapy, such as psychoanalysis, are based on complex theories but lack systematic practical training in China. It is difficult for the therapist to combine theories and techniques. Furthermore, our colleagues are not often familiar in self-experience. Compared to other forms of psychotherapy, body psychotherapy is relatively easier to study and to learn. The techniques of body psychotherapy seem to be simpler to use. Therefore, therapists in China are attracted by body therapy.

2) Chinese are often not good at expressing feelings due to Chinese culture. If a person, especially a woman, could bear the tough situation silently, she is considered virtuous. Therefore, repression is a common self-defence and somatoform disorders become a common illness. It is difficult for such women to express their feelings and thoughts to other persons. Body psychotherapy can help them access their inner world and explore their emotional level by focusing on bodily feelings. Thus, body psychotherapy could be suitable for Chinese.

For example, the relationship between mother-in-law and daughter-in-law is easily strained in China. The feud between the two female family members is always hard to avoid. And Chinese people treasure 'filial piety' and 'etiquette'. Therefore, if an argument arises between a mother and her daughter-in-law, no matter who was right, the daughter-in-law would be considered as unfilial and ungracious. The son has the same moral anxiety. So, many daughters-in-law choose to suppress their emotion to adapt to the main cultural trend. They hold back their emotions because they fear that the bad emotions cannot be reasonably expressed. This often produces bodily symptoms. Everyone in the family can better handle this unconscious relational conflict because the bad emotions are held back and suppressed whereas the bodily symptoms can be accepted as merely body symptoms. If body psychotherapy could make patients realize the connection between body and emotion, it would help them.

The academic psychology is convinced that China is well developed-economically and socially. And yet, there is a large discrepancy in the field of psychological and emotional development of people. Ordinary people are deeply interested in psychology, in psychological literature, and psychological issues. Media already defines this movement as psychological hype. Psychological issues and questions are communicated like a storm in the social media. More and more, Chinese people are joining psychological workshops to experience themselves in a new way, to explore their personality, and to develop with more joy, curiosity and happiness.

In 2015 a new internet video platform went online offering videos of psychological lectures, conferences and statements processed for an academic audience as well as for ordinary people (www.iepsy.com). Meanwhile, universities and clinics are trying to establish structures for psychosomatic and psychotherapeutic treatment imported from western countries. Colleagues are trained in various psychotherapy methods, with recent political demand for new psychosomatic departments in many hospitals nationwide.

Body psychotherapy (BPT) is a fairly new approach in China. It is convincing insofar as BPT allows therapists to holistically understand the person as a unit. Insofar that BPT understands the person as a functional unit, it understands the person in his/her functional identity—always connected with the body.

This article offers insight into how BPT functions practically, into the understanding of BPT, and into a special increasing field of problems working with somatoform disorder syndrome (SSD). We offer a specific case study for illustration in connection with specific comments/analysis with reference to relevant concepts and guiding ideas of BPT.

Medically unexplained symptoms (MUS) SSD/MUS

A thirty-two-year old woman involved in a special training-program for physicians complained about regularly occurring, heavy headaches. She has suffered from these headaches for many years. Her headaches were diagnosed as a medically unexplained symptom (MUS). She tried various medications, sports and relaxation exercises. Via her own study and personal experience as a physician, she knew that it would be difficult for her to find proper treatment, nor could she reach a state of deep relaxation and well-being in her life. Nothing helped nor stopped the chronification of her pain.

Chinese cultural perspective

It may be challenging for patients to accept that there may also be a psychological background for their physical symptoms. The development of psychosomatic medicine in China is immature. Many Chinese, including the doctors in the general hospitals, are not familiar with the concept of "psychosomatic medicine" or of "somatoform disorder". It is easy for patients to accept a diagnosis of organic changes, but if told that there could be a mental or psychological health problem, they feel embarrassed. Stigma is very common among such patients.

China suffers from a serious lack of qualified psychiatrists and psychotherapists. Many patients with somatisation symptoms only go to the hospital for testing and diagnosis; they cannot believe that their body has no serious physical problems. They will never choose to see psychiatrists or to get psychotherapy; on the other hand, doctors in general hospitals rarely refer such patients to psychiatrists or psychotherapists.

Therefore, it is important for the therapist to take the physical symptoms of the patients seriously to establish a relationship with the patient. Then the emotion and the physical expression can be treated.

Overall, unexplained medical symptoms are common in primary care settings; there is a high prevalence in primary care (approx. 30%) and in secondary care (approx. 20 %) (Fritzsche, 2015).

"Somatic symptom disorder (SSD) is characterized by somatic symptoms that are either very distressing or result in significant disruption of functioning, as well as excessive and disproportionate thoughts, feelings and behaviors regarding those symptoms. To be diagnosed with SSD, the individual must be persistently symptomatic (typically at least for 6 months)" (American Psychiatric Association, 2013, p.1).

The DSM-V renamed somatoform disorder as somatic symptom disorder (SSD). Clients complain of bodily distress and pain not connected with emotional or psychological complains. Co-morbidity rates are prevalent with other psychological disorders including depression, anxiety, personality disorders, narcissistic and borderline disorder.

We refer to a case in a group of professionals in Shanghai. I met the client in a workshop with other physicians, psychologists, counsellors and social workers in Shanghai at Fudan University, China. She talked about her pain and the severe headache as well as about her specific life situation, characterized by intensively experienced stress especially since she finished her degree as a specialised physician. There was also severe stress in her clinic team related to seeing too many patients by herself and being consciously engaged in adapting concepts of Western medicine.

Chinese cultural perspective

In China, young doctors like this patient are under much pressure in their work routines and day-to-day lives. The patients only trust the big hospitals in big cities, so the doctors are in great demand in such hospitals. This leads to irrational distribution of medical resources: the big hospitals in big cities, especially in Shanghai, are full of doctors. Only a few young doctors are willing to work at small hospitals in small towns because of the impact on their career development. Thus, qualified doctors go to the big cities. At the same time, there's long-term pressure at work in the smaller cities. Work is burdened because the relationship between patients and doctors is intensely stressed and strained. It quite often happens that doctors are killed by their patients, and at the least, they face a high grade of aggression in the doctor-patient-relationship.

Gender perspective

Aside from pressure in working environment, newly-graduated female physicians in Chinese big cities, e.g. Shanghai, face also big challenges in their personal life. On the one hand, the high cost of life in those cities can hardly be covered purely with income of a newly-graduated physician. This leads to chronic anxieties due to a constant feeling of insufficient substantial resources. On the other hand, big pressure from work and a lack of leisure time makes it even harder for them to build up an intimate relationship or even start a family. It has not been a long history, since the society started to accept that women should have the right to live on and for their own, independent from husband and sons. Many females often find themselves in big conflicts, while struggling to pursue an ideal career. This pursue of successful career may be strongly doubted by their family of origin or even unconsciously by themselves, who deeply believe that no happiness could be gained without a husband and a child. Not being able to start a marriage means for many of those young females not being able to psychologically leave their family of origin, and is thus trapped in this phase of family cycle. They could suffer both mentally and physically from being stagnant, which violates to the basic human nature of being dynamic and developmental.

Although SSD has been discussed for decades, there is still a controversially run debate and still uncertainty regarding the physiology and the roots of SSD. This, of course, is due to the fact that somatisation disorder is often seen as a way to cope with emotional and psychological stress, and is further connected with the client's heightened sensitivity to his own bodily and physical sensations just like stress symptoms and pain.

While talking about and explaining her pain and life situation, the client seemed to be quite balanced though she categorized her pain on a scale between 0 and 100 at approximately 85-90. This was astonishing to me as I realized her gradually changing facial expression while she talked about her pain and life-situation. I did not yet refer to the emotional or psychological part of the complaints. I asked her about how she could handle the pain and integrate such a severe life-situation into her professionally well-done and demanding job. She responded spontaneously to the stress of the present situation following, unconsciously, her habit not to show to someone that she had a headache, that she had chronic pain, and how it felt to have such a severe headache. Instead of this she was silent and smiled a little, unconsciously expressing a message to me that I interpreted as "it`s your turn".

The patient could not express her feelings perhaps because of her personality. Forbearance is a virtue for Chinese. Another reason could be that the young doctor does not feel secure in herself. As previously mentioned, young doctors in China are under tremendous pressure. If these young doctors cannot focus on their jobs due to their health-problems, they risk losing their position in the hospital or even the renewal of the contract with the hospital. So, as a young doctor this woman would likely choose to keep silent though she suffered great pain in her body.

"And yet, at the same moment, in the here and now of the situation in the group, she, by talking again, addressed the deep bodily suffering that was connected with her headache. But, just for a slight moment, (as later observed this is part of her pattern of behaviour and can be experienced when she is under stress), I had the impression that the rigidity of her habit not to open up emotionally and nonverbally towards somebody else would resemble the intensity of her pain and suffering. Could it be, I asked myself, that this compensation would make it difficult for her to feel herself as a "victim of the pain", as emotionally and psychologically deeply touched and strained by the chronification? Was she feeling pain, sadness, desperation or even anger towards the ongoing torture and the self-torture and not opening emotionally to somebody else?"

Chinese cultural perspective

As affected by culture and the management system, this patient took her "endurance" for granted. Body psychotherapy could help the patient feel the connection between body and emotion, which can offer the patient a new view on her situation, on her symptoms and on what she takes for granted. By this she can realize that her emotions are expressed on the body level, too. This in an important step for the patient to find out that it is possible to try something new. Doing this and experiencing herself emotionally and bodily in the relationship with the therapist opens a new sense of herself and of her life. This is an important step in personal development and change. Even if bodily symptoms still exist, they are no longer considered as important in the patient's life.

Gender perspective

Women many times find it very hard to unveil some of their physical feelings in front of an opposite gender or in public, especially those that come from body parts, which are not considered to be appropriate to be shown in public. It might bring them too much shame.

Chinese cultural perspective

The patient's behaviour may be viewed as "psychological resistance". Such resistance cannot be overcome easily by other kinds of psychotherapy, since verbal expression of emotions is difficult for her. Body psychotherapy refers to the bodily expression and the interplay of body, feeling and psyche. This perspective is especially necessary and helpful in China; furthermore, body language may be considered more natural and more intuitive. A body-psychotherapist may be able to more readily work on the resistance of specific feelings and inner-psychic conflicts as well as on the perspective of embodiment of somatoform disorders more efficiently.

Gender perspective

The pain can also in a way do her something good, by giving an alarm. The headache comes each time when the client feels stressed. This stress may not necessarily be consciously realized. It gives her in time a break, and provokes reconsideration of her situation. And in this way, the pain protects her from further potential harm.

BPT; working with the functional unity of the person

Many psychological and psychiatric theories explain SSD as highly connected with negative, distorted and catastrophic thoughts and reaction of triggering critical live-events. Currently, cognitive behavioural therapy (CBT) is regarded as the most appropriate treatment for SSD (Schröder, 2012). Clients are helped to experience and to regard their own symptoms as not so catastrophic-like as they experience them. To feel relaxation and less catastrophic thinking would, per CBT concepts, reduce the "worsening" of symptoms.

There's another approach and field of scientific research that states that a high proportion of SSD/MUS patients have undiagnosed and therefore untreated mental disorders (Fritzsche, 2015). A much broader concept of treatment and multi-modal therapy is required for the somatic emotional and functional aspects of SSD/MUS.

Body psychotherapy (BPT) offers a needed integrated treatment intervention.

Bioenergetic Analysis (BA), as a specific school, dates to psychoanalysis and movement therapy in the beginning of the last century. It addresses, as does BPT, the interplay of body, emotion, cognition and behavior in an original way. Therefore, it is closely related to psychosomatic medicine. Its concept of functional unity/functional identity of body and psyche is an essential foundation of and orientation towards the understanding of the interdependency of soma and psyche a well as of its practical application.

Chinese cultural perspective

There is an old Chinese saying:

Only the one who tied the bell knows the way to undo it, meaning that it is better for the doer to undo what he has done. Body psychotherapy is based on depth psychology, so working with the body and the psyche is an integrative approach that helps to feel, to understand and to revitalize the body. This approach may be an appropriate way to work with patients with somatoform disorders. As such, patients are unable to communicate with doctors so it may be necessary to work with the body, the doctor-patients-relationship, and the behavior at the same time. This, of course, is very difficult for doctors in China because they do not have enough time and energy to talk over the details of the discomfort with their patients. Body psychotherapy may be a convenient approach for doctors to treat such patients.

Body psychotherapy begins the treatment with the body and works on the body, which is helpful for the doctor and for the patient. Thus, both the doctor and the patient can feel that they are taken seriously by the other. In this way, good contact within the doctor - patient relationship is created. As the treatment proceeds, body psychotherapy can help the therapist to understand and talk with the patient more about the physical symptoms in relation to the personal experience, their life and their personality. At the same time, the patient begins to appreciate the therapy and can control the situation at the same time. Working on the body, feeling the body and expressing the body helps to accept oneself and the therapy. This is always based, of course, on a body-approach.

Considering that an essential element of psychosomatic disease consists in not being able to perceive and accept one's own emotionality and its underlying psychodynamics connected with the physical symptoms, the popularity of books about BA in Western countries might be understood as an indication that primarily the public of clients, the virtual psychosomatic patient so to speak, has made a first (self) therapeutic step.

The considerable interest in the books about BA from the seventies onward can also be understood as an expression of half-conscious awareness about health and personal well-being. By the clarity found in books by Alexander Lowen or in The Handbook of Body Psychotherapy (Marlock & Weiss, 2006) people want to learn how to better understand themselves and live their lives and their relation with their body. This interest is responded to by the resource-oriented, creative concepts of BA: improvement of one's grounding, body awareness, self-experience, emotional presence and self-expression, sense of coherence and finding of one's identity in the sense of a true authentic (body) self as well as training of resiliency and stress resistance.

BPT involves many of these needed criteria to work on the different levels of personality: body-level, level of emotions, cognitive level and functional level. "The body-psychotherapy approach combines verbal with non-verbal strategies with the focus towards emotional processing/ expressiveness, movement, behaviour and body/self-perception; it's regarded as advantageous for patients with SSD/MUS since the bodily complaints remain the focus of therapy. The therapy is not aiming to 'eradicate' symptoms but to work with and through the body in respect of mental distress, associated with the symptoms. The interventions do not directly address psychological processes associated with bodily experiences, aiming at a subtler integration of the somatic and psychological aspects" (Rohricht & Elanjithara, 2014).

Chinese cultural perspective

CBT may support patient changes by changing their illness behavior. Somatoform symptoms may improve after a period of CBT treatment. But if there is no change of the stress events in life or in the patient's coping style, perhaps the inner conflicts of the patients will transform into other kinds of trouble. Compared to CBT, body psychotherapy seems to make use of body experience and of body language as a bridge between doctor and the inner world of patient. It may help the doctor to explore the true feelings of the patient at an emotional level.

It was important for this particular young female doctor to realize that the physical symptom was an expression of stress. It was also important that she began to understand her own posture, which sometimes produced stress. Finally, it was important for the patient to recognize the situation, in which the stress would appear. Body psychotherapy can help the patient to better understand what indicates "new behaviour". Body psychotherapy can also help the patient have sufficient trust in her own personal experience, which the patient can integrate into her everyday life.

Acceptance of the client in the here-and-now

Of course, I did not talk to her yet about feelings and psychological aspects because she, by herself, had not addressed this issue or perspective of pain symptoms up to that moment. She described the beginning and occurrence of the pain related to the growing intensity of stress in her life and work. Especially then, as she pointed out, she felt a spontaneous impulse, or rigid self-demand, not to give in to this pain but to concentrate more intensely on what she had to do and on her duty to fulfil the needs of others, of her patients, of the clinic and the needs of the next examination, as well the needs of her super ego. And yet, the symptoms, or perhaps it is better to say that her symptomatic reactions to the unconscious experience of more stress were "worsening" the symptoms and her experience of stress. But she remained silent. No complaints but more rigidity in her posture, her back, and the fixed look at me as the therapist.

Chinese cultural perspective

Per the patient, she attributed the rigid self-demand to her high morality. It seemed that she thought only of others but had never cared about herself. She never mentioned her weakness or her fear. It accords with the Chinese cultural pattern that if one puts the benefit of the group above that of the individual, he/she would be regarded as a person with high moral character. For example, when an Olympic athlete wins the championship, he is interviewed in front of a camera. If he expresses gratitude at first to his family but not to the leadership or to his coach, he would be accused by the society as an ingrate or as morally bankrupt. Many Chinese have the conception that the individual is unimportant. Maybe that was why the patient in this case did not expose her own feelings.

Gender perspective

"Never give in" might be a motto of this female client. This strong belief in her own strength and efforts obviously has helped her all the way till this age overcome difficulties and pursue dreams. No matter where she got the motto, it makes her hesitate when receiving an alarm signal of "taking a break". She might feel scared or ashamed to take a break, by thinking that it is a sign of weakness or giving in. On the contrary, her body proves to be so strong that no matter how strong the belief might be, it finally succeeds in showing its existence and attracting her attention.

While talking in detail about her specific situation, she suddenly was touching her upper chest with her right hand to point out that she felt a loss of energy there while being in such a stressful situation. At the same time, she straightened a little bit more yet stayed in this rigid posture. She must have felt very uncomfortable, I guessed in my counter-transference, but she did not express this at all verbally. Her face still showed a slight expression of being touched and a little sad. That was all. Again, I did not refer to her facial expression, her emotionality or the psychological experience/psychological background of the pain because she seemed not yet able to emotionally face this. Especially not yet ready to face this or even talk about it in public, in the group. Though I myself, in the counter-transference, felt the rising and growing pain as well as the rigidity not being able to move. I imagined how it would be for her to experience this so often in her life without being able to talk about her life situation. For a moment, I myself empathized with her pain, her loneliness, and I got a slight impression of the intensity of her unexpressed feeling.

Chinese cultural perspective

Many Chinese therapists have a sense of frustration when they face patients with somatoform symptoms. They find it difficult to build the emotional relationship with the patient. Maybe body psychotherapy is a more convenient way to feel into the patient and to build a relationship emotional and based on body-to-body-communication. Of course, there is a big difference in terms of interacting with the patient or be aware of the countertransference and/or to feel empathy and to express this in the doctor-patient-relationship.

As mentioned above, it is important that the doctor and the patient communicate about the physical symptoms in the beginning, i.e. they take each other seriously in this way. The patient then feels that her symptoms are taken seriously, and the doctor feels that he is taken seriously by the patient as someone who treated the body. It is an essential feature of trust between doctor and patient when both are taken seriously by each other.

Many clients who suffer from unexplained physical symptoms cling to the belief that their symptoms have an underlying physical cause. Many of the patients are still convinced of a medical or somatic explanation for their symptoms though other approaches of understanding the symptoms are explained by the doctors. Patients with SSD believe that their body is dysfunctional, not that there is an associated personal feeling. They are convinced that there is a somatic/physical illness underlying their problems and pain. It is necessary in BPT, as well as in other therapeutic approaches dealing with SSD, to accept this and not to address the experience and the problems too fast, too early, or on the emotional and psychological level. The therapist points out to the patient that he "believes" this and he also believes that the suffering, the pain, and the herewith connected problems are real. Insofar as the psychotherapist does not oppose the patient's explanations, he tries to enrich the experience

and facilitate a new thinking model for the patient via new bodily, emotionally and interactional experiences. Body psychotherapy with SSD can be compared to the navigation in difficult, new, and unexpected fields of experience. There is some evidence supporting the notion that BPT can be helpful for patients with SSD (Loew, Tritt, Lahmann& Rohricht, 2006; Rohricht, 2009).

Gender perspective

In the latest decades, Chinese people tend to belief more and more in personal will power. The attribution of distress to a physical cause may free from the danger of being considered to be weak, of which one should be ashamed. Many Chinese tend to believe that psychological issues are something that could be fully controlled by will power, while physical issues are not. However, this belief could not find its source in traditional Chinese philosophy. Patients, who believe more traditional Chinese medicine, could more easily accept the view, that the body and mind are integrated and interacting parts of one person, and both are not completely under control of will power.

Following this therapeutic strategy, especially in the beginning of the treatment, clients are open for support and improvement of daily functioning, stress-reduction and becoming familiar with the experience that others also suffer from such symptoms. In addition, clients are open for this kind of support if the doctor takes the patient's personal body-experience seriously. The more the client feels respected in this way, the more he can talk about his personal experience and feelings that are connected with the symptoms and with the way he sees himself in his daily functioning. If this can be discussed in a group-therapy-setting, patients also can become familiar with the experience that others also suffer from such symptoms.

Gender perspective

As mentioned above, Chinese people could feel a strong shame of weakness and uselessness, by admitting that what prevents them from functioning as usual is something emotional. If the therapist shows acceptance and shares universality of this distress, it frees the patients from constant self-blaming.

Chinese cultural perspective

Doctors in China are required to see numerous patients; they become anxious and get tired. If the doctor-patient-relationship can be improved by body-psychotherapy, which I can imagine looking at this case-study, it could help to improve this relationship. Only when patients feel that they are understood by the therapist, do they consider staying in the therapy. This of course reduces the doctor's anxiety and the stress and strain on the doctor-patient-relationship. It is not enough to only talk about the body; it is important that the relationship between doctor and patient is "embodied", which may be possible by doing special exercises and by communicating about the symptoms.

Scientific approaches in therapy of SSD

Research, especially in the field of cognitive behavioural therapy (CBT), is done to prove how helpful and effective psychotherapy can be, especially in a group setting. Further research demonstrates the effectiveness of psychodynamic psychotherapy as well. There is no doubt in the evidence of psychotherapy in a group setting, connected with some basic relaxation methods.

There has been little comparative research in the field of multimodal treatment looking at the integration of CBT and psychodynamic therapy (Schaefert, et al., 2013, 2015; Schroder, et al. 2012). There is (probably among others) one current related research project planned and in progress that is focused on working with the body in a group setting promoted by the Sino-German Centre for Research Promotion in Beijing in collaboration between China, Germany and Denmark.

Yet, there is a significant difference in approaching clients with SSD problems visa via CBT and/or psychodynamic therapy in connection with relaxation and body awareness methods in comparison to a BPT approach. There are many BPT schools, all of which are characterized by some main similar principles, strategies and interventions. Though all BPT schools distinguish themselves between a variety of specific perspectives and practical approaches and techniques. Some are more related to movement, some more to body awareness, some more to breathing and feeling.

Bioenergetic Analysis (BA) is clearly based

on the concept of the unity of all levels of personality including body, feeling, psyche, behaviour and decision making. The person is always addressed simultaneously at his integrated patterned level of feeling, thinking and behaviour (Lowen, 1975). The Swiss psychiatrist Luc Ciompi calls it affect logic (Ciompi, 1998). This means that thinking and feeling (and body) are always circularly interacting in all mental activities. Affect, related to Ciompi, is used as an umbrella-notion that covers all kinds of overlapping emotion-like phenomena variably called emotions, feelings, affects, and moods. The term cognition is defined as the mental capacity to distinguish and further elaborate sensory differences (e.g. between black and white, warm and cold, harmless and dangerous, etc). This term, too, is an umbrella-notion covering different cognitive functions such as attention, perception, memorization, combinatory thought and logic in a broad sense. As Rohricht and Elanjithara (2014, p.6) state: "Almost all of them (BPT) refer to developmental psychology in some way (with emphasis on the importance of body experiences for early ego-foundation). They also refer to the basic concept of embodiment (embodied mind theory), affect-regulation and the phenomenology of body experience (relating to the body as: base line reference for any psychological processes, precondition for psychopathology, subject and object of perception, organ of spontaneity/expression and reference point for feelings) and more recently to findings from (affective) neuroscience."

Working with the ambivalence

All workshop participants completed a pair-exercise to experience the ambiguity between standing on one´s own legs and to push the other person away so that he loses the stable standing position. After the feedback on the group exercise, the client and I were still standing while talking together. She, as I described already, was standing rigidly in an upright position, without too much movement in the body. She was looking at me, with the unconscious message: "it´s your turn. Do something." The meaning of course was not to really touch her emotional state of feeling and being. She nonverbally tried to provoke me to go on talking with her about her pain, her headache, her back pain and so on.

Chinese cultural perspective

According to the personality of this patient and her low self-esteem, it is understandable that she might have a sense that she was not allowed to express her own feelings. Expressing oneself in public by expressing bodily what she feels might produce heavy, insecure feelings. The reaction of the therapist is very important in the moment. He can start, develop and guarantee a body-to-body communication and by this he is a kind of new role-model. In this session, when the patient looked at the therapist and nonverbally indicated the message, "It's your turn, do something", the therapist received important information and responded appropriately, with information about the inner-psychic conflict and information about their current working relationship, which helped the therapist react nonverbally, in the same manner that she had addressed him.

Something new happened on the body level for the patient. She felt physically irritated, which enabled her have a new experience. Perhaps this kind of experience was a good starting point for the doctor-patient-relationship to continue with therapy. At the same time, it was not necessary to talk about the feelings with the patient; the important fact was that they could talk just for now.

Of course, I did so. And yet the fact that she, after the exercise, had shared a little about her pain and had looked at me so intensely helped me to address her to talk about her bodily symptoms. I mirrored what she had shared via my words and my impression of her bodily expression (verbally and nonverbally at the same time).

Gender perspective

Through grounding exercise, the female client might have connected better to her whole body. Certain physical feelings could be sensed and accompanying emotions triggered. Those feelings and emotions could hardly be bared by the client, so that her body turned even more rigid to prevent her from negative feelings. The rigidity prevents her from any further action, except for an anxious glance at the therapist, as if calling for a distraction of attention from the arising emotions.

Chinese cultural perspective

In this case, the therapist was aware of the requirement of the patient—he chose to talk about the patient's discomfort. This affirmed her sense of trouble. Thus, the patient could have a more secure feeling and be more willing to create a connection with the therapist.

I experienced our contact as quite stable and trustful though still a little tensed and strained. Therefore, while talking about her symptoms, I moved a little from here to there not standing still as she did. Still, of course, influencing her slightly in the way that she, with her eyes, tried to follow my movement. I did so as I had the fantasy that if I were to stand still we would become stuck in a rigid position of therapist-client-relationship. This could induce more rigidity, less emotionality and less chance of improvement. Moving in this state of experience with she following me with her eyes induced a little irritation in her. She tried to control the situation but could not succeed. Of course, she could control her words, her sharing, but could not really control her bodily reaction. Nobody really can do; nor could she control me. The indication of my spontaneous reaction was to mobilize stress in our relationship, to induce more stress and thus mobilizing her own unconscious patterns of behavior. It seemed to be important to make her move by herself, to make her react to me and to make her lose part of her rigid self-control. Our relationship remained safe because we still related at the body level. Nothing else. We had not yet related to her feelings.

Gender perspective

The female client seems to be in a vulnerable position in front of aroused emotions and other participants. She cautiously tracked with her eyes the therapist's movement, but dared not to make any movement, which could be for her a rather big danger. A slow and regular movement of the therapist might ease the client. For it brings dynamics into the rigid situation and gives the client at the same time a feeling of regularity and safety. A rapid or unexpected move might not be so helpful, for it could elevate the client's stress level

While still talking a little about her experience in the exercise, we consciously addressed her ambivalence. And we addressed her possibility to do something by herself, to stand on her legs and to try at the same time to push her partner away. While talking about this, she experienced that others had done this in another way, of course-everybody does it his own way.

I picked up this aspect and asked her if she would like to do the exercise together with me. She agreed because we still were acting on the body level. And the group functioned as a trustworthy container. I went on irritating her just a little and by that mobilized the ambivalence a bit more. She began to breathe deeper, just for a moment, and stayed in the rigid position right away after that deeper breath. She was activated a little more than before. While we did the exercise, I talked to her, just referring to the body experience and to what happened to her. Still I asked her general questions such as, "What´s happening in your body?", "Where does it happen?", "What changes are you sensing in your body?", "What do you think about right now when this is happening?" and so on.

Chinese cultural perspective

The therapist offered the patient a new way to experience herself. Maybe she had a strong impression that the people around her at work or in her routine life never initiate any "movement" if she does not make the first "movement". If someone would perhaps take an active role in the relationship with her, she was not used to responding in an appropriate way that means also active and initiative. Her old pattern of being non-active and waiting for the others to be active usually had a negative influence on her relationships; the client will not experience a "good relationship". The therapist tried to do some different things with her; it might make her feel uncomfortable at the beginning because it differed from her behavior pattern. But this attempt could lead to a new experience. This is an important first step to creating a new pattern of behavior.

Doctors often hesitate to start the treatment actively in the beginning as patients have expectations about the doctor's doing and acting. They decide quickly whether to proceed with therapy or not. Patients want doctors to give quick answers and they even need quick answers. The sooner the doctor relates to the body-level (sometimes even to the emotional level), the sooner the patient feels respected, in the beginning unconsciously of course. This is an important first step in implementing the doctor-patient relationship.

After some minutes, we stopped, and she had rested to experience the effect of the mobilization of the body via our exercise. She was breathing deeper. Her look was not as fixed on me as before. She showed some changing facial expression and finally put her hand on the chest and talked about her feeling there of less energy.

Gender perspective

By addressing other's feature, the client successfully shifted the attention away from her own arising emotions.

Finally, she could talk about feelings. The patient was not familiar with change. She did not believe that her symptoms or her life would change at all. Sometimes it is difficult to think about change abstractly. Often, if something happens or changes on the body-level, this can be more easily experienced by the client. Being consciously aware of this helps the client to realize that a new experience of change can happen. With the changes of body, the patient experienced new changes. Then she could gradually believe that her symptoms and her life might also be changed.

Chinese cultural perspective

It would also affect her intimate relationships. She may remain the same in her work; she may still work too hard and rarely take time off. But she would be more aware of her feelings and emotions so she would deal with them, not evade.

She could experience and observe more of her feelings and emotions. She would thus be braver to express her emotions. As a psychological defense mechanism, the function of somatization would not be as strong as before. She would try to find more psychological and social support and would realize she did not have to face every situation by herself, alone.

I gave her time to experience and to share what happened in her body and what she was thinking about. Then I gave her feedback about how I had experienced her, especially her ambivalence in her bodily expression. Again, I invited her to do a "little exercise", as I usually call it. I typically introduce these follow-up steps, which are often experienced by the client quite unspectacularly. Again, I told her if she wanted to, she could try, and of course she could stop the exercise whenever she wanted to do. She agreed, and I asked to close her eyes for a moment.

Gender perspective

When pushing against a male therapist, especially with whom she is not yet so familiar with, the female client might first experience a mixture of shame and fear, which leads to some hesitation. However, the usually firm and tough texture of male hands and the strong and stable male body image could gradually transfer strength to the client, this foreign experience gave her a feeling of being supported and in the end, she felt more energy in the chest, where a lack energy had been reported at first.

When she closed her eyes, I held one of my hands in a yes-position as if I was giving her something or I was carrying something. My other hand was in a no-position as if rejecting the other or saying stop. I offered two messages in one position: yes and no, a paradox intervention.

Chinese cultural perspective

The therapist allowed the patient to have the right to choose and to control herself and the situation at all times, which is not common in the Chinese culture but is important for the therapeutic process.

She opened her eyes and of course was irritated. The others in the group were at once aware of this, she, too. She moved her body, especially the upper part of her body; her eyes looked here and there. They were no longer fixed, and her hand touched the upper part of her chest and so on. After some seconds, I asked her to close her eyes again to experience in herself, to feel in herself the effect of what she had seen, the effect of this little irritation. And the effect in her body.

After some minutes, she felt much calmer and showed more facial expression of being touched. Her voice became softer and she talked about the feeling of loneliness and sadness connected with the experience of low energy in the upper chest. She did not cry nor talk much about her life situation. But she did express being touched by this experience, so that I and the others in the group could experience this, too.

Chinese cultural perspective

It would be hard for her to experience herself as a feeling person. The therapist allowed her from the start to feel not only able to make a choice but also to feel the choice. This is an opportunity for the patient to explore a sense of (self-) achievement. The patient realizes that what happens in the here and now could help her. To experience this on the body-level is a convincing part in the doctor-patient-relationship, which helps to improve the treatment and the process.

I realized her emotional ambivalence and the fact that this was the first time she had opened up to this feeling and to herself. To make her feel safe, I told her that it would not be important to talk about herself in more detail now, in that moment; maybe later, or another day. It would be, and I pointed this out, more important that she feel inside herself, that she felt herself. I had supported her to have a new experience, which helped her to feel the connection of body and emotionality. To feel herself and still be in control of herself. Insofar as I had the function of a container, a good object, an embodied symbol of trust and a facilitator or better to say a midwife.

This short case study can only offer a small glimpse into the possibilities of a longer therapy process. And yet, it can show some principles of the BPT approach to work with the body in the field of SSD.

Two remaining relevant questions, or better to say issues that need to be addressed are:

- How can a client be touched in the here and now on the body-level, on the level of experiencing his own body related to the physical complaint, the herewith connected feeling and thinking as well as with his patterns of behaviour?
- How can the client experience his body, his symptoms and his complaint under the perspective of functional identity, of body, emotion, psyche and behaviour?

Strategic aspects of BPT

Recent evidence has supported body-psychotherapy as an appropriate approach when working with patients experiencing unexplained medical symptoms and SSD. "The BPT-model offers a fundamentally different approach connecting cognitive and emotional levels with bodily states through enactment and expressive movement exercises" (Rohricht & Elanjithara 2014 p.5).

Röhricht and Papadopoulos's (2011a) manual for group-body-psychotherapy shows exemplarily a concept of practical body-work and understanding body-awareness and body-experience aiming at a deeper, more personal level self-awareness, self-expression, behaviour modification, and sensing as well as the relevance of emotional and psychological problem-solving.

It is thus considered important, especially in the beginning of therapy, to stay on the body-level. There is no explicit relating to potentially occurring states of awareness, inner psychic conflicts, hyper-arousal, negative cognitions, and so on. Rather, one works with the here and now level of body-awareness and body-experience and on communicating these experiences.

"The chosen intervention strategy must match with both: The client's expectations and the phenomenology of the symptoms" (mostly bodily sensations) (Rohricht, 2011c).

Thus, body-psychotherapy with somatoform disorder symptoms may result in:

- A conscious new awareness and experience of one's own body
- A connected, trustful relationship with the therapist
- A guided, well-contained experience of ambivalence as a way to give up a little control in order to experience an impulse of self-regulation in the body and own acting, reacting
- Specific feedback, if experienced in a group context, by group members in the role of observer
- A complex variety of other approaches.

Sollmann (1988) conceptualizes BPT as a self-help program and shows guidelines for do-it-yourself exercises. He introduces how to perform the exercises and how to connect the various levels of experience and personality. He implements BPT as a creative method to work with the body and the person in private life. This

approach invites people to do the exercises in the beginning, similar to gymnastics or sports. People can explore themselves and become curious about wanting more, having more in life in terms of their feelings, new life-questioning, talking with others about their experiences and so on.

Chinese cultural perspective

In China, many kinds of psychotherapy must deal with compliance issues. Psychotherapy is barely (and rarely) covered by medical insurance so treatment is often discontinued due to patient economics. Patient's traumatic experiences cannot be effectively treated because of the treatment interruption. Body psychotherapy, via a self-help model then, may enable patients have a different experience every time as they develop the ability to help themselves. Thus, body psychotherapy may be faster, more convenient and more secure to treat such patients.

"Provoking" self-regulation by setting an impulse

Later, I tried to refer to her competence of handling stress and painful situations without complaining in public, doing her job professionally and taking responsibility for the need of others. At the same time, I shared my fantasy that she could not get rid of all those needs and expectations though sometimes this could be good for her. She agreed, of course, but again pointed out how necessary it was not to give in and instead to hold herself up because of all the responsibility she had to face and to follow. ("I would if I could"). By this, she referred unconsciously to some life issues, to some patterns of behaviour that could not yet be touched in detail or be opened up.

Chinese cultural perspective

There was more self-exploration of the patient in the treatment. The therapist might not know what happed in their inner world, but the patient had the right to choose when she would tell the therapist about her thinking or not. The patient had more of a sense of security, which supports trust in the therapist. As I mentioned earlier, the patient had a feeling of pressure by the surrounding environment; there was some tension between the relationship of the patient and the therapist. But as the treatment was in-depth, the trust was established by them together. Then she could feel relieved in the relationship with the therapist, and she could more easily talk about her emotions and feelings.

Without any specific spoken expectation and stress, I invited her to repeat this little exercise that she had done in the group. She agreed spontaneously and looked quite interested. She probably felt more and more accepted and respected by me (in the group) because I had followed her in the here and now, in the way as she referred to her life-story and showed up by "self-exposure".

Gender perspective

The therapeutic environment of this case is quite different from those in therapy room. The female client voluntarily fought for a chance to experience her body feelings with male foreign therapist and trainer, whom is often times considered as absolute authority in Chinese culture. This is no way encouraged by traditional Chinese culture. Usually females' efforts of winning attention, especially from males, are negatively seen. Females grew up in this culture are difficult to make this attempt, or to tolerate other females to do so.

Again, I offered her to push away expectations from outside by pushing me away and at the same time to feel strong and stable enough in herself on her own legs. We stood in front of each other, face-to-face, and just held our hands towards the other's hands, just touching. I repeated to her the two rules of the experiment: Stay where you are, keep your stable ground and at the same time try to push me away so that I lose my stable ground.

Chinese cultural perspective

The therapist had realized what had happened a convincing attribute of a good doctor-patient-relationship and of an effective treatment-process. The patient could experience what happened, especially on the body-level as well on the emotional level and could get an impression of what it means: "Something changed in my body and this can create hope that something in my life can change too." As mentioned above, Chinese doctors and therapists often see somatoform disorder as a hard nut to crack. It is hard to establish a trusting relationship with such patients. The treatment for such patients could not go further easily in most cases. It is almost impossible to talk with these patients about feelings or emotions. They leave therapy very easily even after several sessions. Body psychotherapy can initiate such change, even if the change is slight. It indicates a bright future for therapy and deserves recognition.

Suddenly, before we started the exercise, she showed up with a slight impulse to push me away. Nobody could see this, but my hands felt

this impulse. She started to smile just for second. Right away, in that moment, we both knew what had happened and enjoyed the exercise. Sharing our experiences in the group helped the group to understand and helped the client to learn a personal lesson. It also started, within the group, a new way of relating to SSD and to the client as a group. The group members shared their own experience and feelings after the exercise. We also discussed diagnostics and indication of (body-) therapy with these clients.

A BPT-informed experience can induce personal development that starts on the body level and reveals the therapist-client-relationship as trustworthy, which supports the experience of ambivalence on all levels of personality and relationship in the here and now.

Guidelines and rationales of BPT with SSD

To summarize, I offer several guiding principles regarding integrative BPT:

- Human beings are characterized by a complex ambiguity insofar as the embodied Self is subject and object at the same time ("I have a body", "I don't like my body" etc. vs. "I'm this body", "This body is me"). Bodily existence and embodiment and personal experience are characterized by this ambiguity. It is necessary for the patient to explore this and to feel safer in this ambiguity.
- The patient-therapist-relationship is characterized by a specific interactional style of relating to one another and its embodiment. The patient unconsciously reacts also to the nonverbal messages of the therapist. The competence of the therapist is critically judged by the patient (consciously or unconsciously). The patient projects his own ambivalence on the therapist. There is always a tense mood between patient and therapist. BPT must interact via stable contact with the patient. This interaction is one of a body-to-body-communication. The therapist must be empathic. He must register and respect the somatic complaints and the emotional reactions. He talks about the symptoms and works on the body-level with these symptoms. He functions as a living, touching, moving "container". This also makes it possible to verbalize more and more the patient's experience based on his complains and based on the relationship with the therapist, which is connected is another basic principle that can be put into words: "Be your pain and let us listen to what your pain tells us". The main challenge for (body) psychotherapy is the following: "Don't feel good but improve your feeling". This leads to more personal acceptance and integration of the complaint and pain.

Basic strategies and interventions include:

- Activating of resources and supporting self-regulation. This helps to regain partial control of one's own bodily reaction. This also supports a better regulation of hyper arousal and gradually adjusting pain.
- Nonverbal stimulation of bodily self-expression via improvisation of bodily self-expression. It is also supported by the conscious experience of bodily reactions and emotional-affective aspects.
- Movement, motoric self-expression, and bodily reenactment of psychological, emotional and mental states-of-being are used to stimulate conscious experience and half-conscious memories. Insofar this can lead to a corrective emotional body-experience.
- Finally, it is important to experience new re-enforcement styles. This is done by new bodily experiences. The development of awareness to establish new somatic feedback/re-enforcement styles ("bad feeling leads to less bad feeling. This opens up the awareness for better experience, better feelings and more creative, playful experience").

Basic treatment rationales include:

- The improvement of body-awareness, body-perception and experience
- Verbalisation of bodily experiences
- To enable sharing as meaningful experience (within the group)
- Mentalization as sensing one's own and other bodily experience as meaningful
- Connecting cognitive and emotional levels with bodily states through body-experience
- To open to and support the experience of ambiguity.

BPT works with somatic memory and by releasing the restrictions and re-owning the memory a person can dissolve a corresponding

pattern of psychological constraint. On the one hand, the pathological dimension is worked through analytically, focusing on the dialogue in the relationship and in a body oriented way. On the other hand, he places support of basic self-functions in the center of his work. The unfolding "of self-perception and self-affectivity or creatorship as newly transformed patterns of their organizing principles" occurs as an "embodied dialogue in relationship". Furthermore, the following issues are integrated: experience of boundaries; developing unpleasant feelings; feeling of acceptance as a space for change; and awareness of implicit relational knowledge as agency for the change of patterns of mental organization.

As mentioned above, in Chinese culture "tolerance" and "forbearance" are regarded as virtues, and social pressure is big, especially for the young Chinese people. Many Chinese feel that it is not allowed to express their feelings or emotions. It lacks efficacious methods to treat such patients in China. I often hear complaints from my colleagues about the useless works with such patients. High drop-out rates of such patients and the difficulty of establishing therapeutic alliance with them make many Chinese doctors and therapists lose their interest and patience. As a special art of psychotherapy, body psychotherapy fits the Chinese culture and meets the real-life needs of Chinese patients. It is worth generalizing the use of body psychotherapy in China. More Chinese doctors and psychotherapist should learn the thinking and techniques of body psychotherapy.

Conflict of Interests

Authors have no conflict of interests.

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The Relationship between Family Medicine and Psychosomatic Medicine

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Qualitative Study

Abstract

Background: Organizing the health system around family medicine (FM) has been a productive approach for developed countries. The aim of this study, which was concurrent with the Iran Health Transform Plan (HTP) and the establishment of the family physician in Iran, was to discuss the sufficiency of a family physician training program for their roles and increase their competency.

Methods: This descriptive study was conducted in the Psychosomatic Research Center affiliated to Isfahan University of Medical Science, Iran, with the assistance of the Iranian Institute of Higher Health (2015). An expert panel consisting of 6 individuals including specialists, trainers, and researchers in FM and psychosomatic medicine was held for this purpose. Using the World Organization of Family Doctors (WONCA) website for the definition of a family physician, the curriculum developed by the Ministry of Health and Medical Education was studied. Data were summarized in one table.

Results: The current FM curriculum, with this content and method, does not seem to be capable of enabling physicians to perform their multidisciplinary roles. it still has a reductionist approach and disease orientation instead of a clinical reasoning method and systematic viewpoint. The psychosomatic approach is applicable at all prevention levels and in all diseases, since it is basically designed for this longitudinal (between all preventive levels) and horizontal (bio-physical–social-spiritual intervention) integration.

Conclusion: Psychosomatic medicine, not as a biomedical specialty, but rather as a systems thinking model in health, had a rapid rise during previous decades. Now, its services have been integrated into all medical fields. This means that it should be adopted in the core of health care services (i.e., the family physician position) before other sections. This would help the implementation of this approach in the health system, and the reduction of patients' pain and uncertainty and improvement of their health. Thus, psychosomatic approaches for family physicians only emphasize on some of their fundamental acts.

Keywords: Family physician, Psychosomatic medicine, Psychosomatic disease, Curriculum

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Introduction

Organizing the health system around family medicine (FM) has been a productive approach for developed countries. Family physicians can not only help systematic health management for individuals, families, and the society, but can also make a deeper, more interconnected, and more human atmosphere between providers and caregivers. However, criticisms have been presented regarding this centralized referral system such as requiring the training of sophisticated human resources, inability to reach higher medical levels, low people satisfactory rate, and requiring definite fiscal resources. By the consideration of the above-mentioned characteristics and the formal curriculum of family physicians, we can simply account for their roles as community-based management and treatment. Thus, we can have a better understanding of the four fields of a family physician, i.e., screening, health care, referral, and follow-up. Considering the diagnosing, curing, educating, consulting, researching, coordinating, referring, and supporting roles for family physicians, it can be concluded that they play the role of a management figure in the health system. The aim of this study, which was concurrent with the Iran Health Transform Plan (HTP) and the establishment of FM in Iran, was to discuss the sufficiency of the family physician training program for their roles and increase their competency.

Methods

This descriptive applied study was conducted in 2015. In a collaboration between Fribourg University and the Psychosomatic Research Center affiliated to Isfahan University of Medical Sciences, Iran, a psychosomatic primary healthcare (PHC) plan was developed two years ago with the assistance of the Iranian Institute of Higher Health (Danesh-e-Tandorosti Institute) and the financial support of DAAD.

Due to the importance of the family physician position in the health system, an expert panel was held consisting of six individuals including specialists, trainers, and researchers of FM and psychosomatic medicine to discuss the psychosomatic role and its relationships to the family physician. In this panel, three basic questions were discussed:

Who is a family physician and where is his/her work field?

What is psychosomatic medicine and who needs it?

How can the psychosomatic approach help a family physician to better play his/her roles?

All the discussions were noted and gathered in the presence of panel members. Then, it was fortified by other scientific data like that of the World Organization of Family Doctors (WONCA) website for definitions. The recent curriculum developed by the Ministry of Health and Medical Education was also used. Finally, data were summarized in one table.

Results

Who is a family physician and where is his/her work field?

WONCA in 2011 defined the family physician and his/her work field as follows:

"General practice/family medicine is an academic and scientific discipline, with its own educational content, research, evidence base and clinical activity, and a clinical specialty orientated to primary care. The characteristics of the discipline of general practice/family medicine are:

a) family physician is normally the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned.

b) Makes efficient use of healthcare resources through coordinating care, working with other professionals in the primary care setting, and by managing the interface with other specialists taking an advocacy role for the patient when required.

c) Develops a person-centered approach, orientated to the individual, his/her family, and their community.

d) Promotes patient empowerment

e) Has a unique consultation process, which establishes a relationship over time, through effective communication between doctor and patient?

f) Is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient?

g) Has a specific decision-making process determined by the prevalence and incidence of illness in the community?

h) Manages simultaneously both acute and chronic health problems of individual patients.

i) Manages illness which presents in an undifferentiated way at an early stage in its development, which may require urgent intervention.

j) Promotes health and well-being both by appropriate and effective intervention.

k) Has a specific responsibility for the health of the community.

l) Deals with health problems in their physical, psychological, social, cultural and existential dimensions" (WONCA, 2011).

Based on the above definition, a family physician should have communicative, managerial, diagnostic, and treatment skills in addition to sufficient knowledge about sociology, anthropology, and psychology. A family physician is assumed to be a doctor, manager, trainer, and coordinator with a holistic approach to and comprehensive view of health. For example, when a family physician visits a patient with low back pain, he/she should consider multidimensional factors, such as poor ergonomics in the work environment and house, an anxiety disorder which leads to muscle spasm, and even a psychosexual problem with his partner.

Thus, the biomedical education which a GP or a specialist receives through academic courses cannot assist them in reaching this purpose. The Iranian FM curriculum has the following ambiguities:

-Should we insert these skills into the GP curriculum or the FM education course?

-Should a GP enter the FM course after finishing GP courses or before it (for example during the internship period)?

The review of the FM suggested curriculum made clear that there are only few issues to accomplish the GP need to his different roles. The current FM curriculum -with this content and method- does not seem to be capable of enabling physicians to perform their multidisciplinary roles. It still has reductionist approaches and disease orientation instead of clinical reasoning method and systematic salutogenesis viewpoint.

What is psychosomatic medicine and who needs it? Psychosomatic medicine deals with the interactions between physical, emotional, and social processes in the occurrence and course of disease, and the patient's coping with disease and states of suffering (Fritzsche, McDaniel, & Wirsching, 2014).

This definition reveals a background on human and medicine which rooted in Hippocrates (and even before him), who evidently described the effects of these discrepant factors on illness and health albeit upon their knowledge.

In many medical history books, "Abu Zeid Ahmad ibn Sahl Balkhi" is introduced as the first physician who investigated mind-body interaction systematically. He wrote a book named "Masalih Alabdan v Alanfos" that explains the effects of mental disorders on the body and vice versa. He searched for psychosomatic solutions to deal with mind-body illnesses (Deuraseh & Abu Talib, 2005). However, Johan Christian and Agust Heinroth specifically coined the term psychosomatic in 1811. They held the first psychosomatic chair with this approach at Leipzig University. They defined and explained terms such as holistic medicine, medical anthropology, and ego, which later gained popularity, for the first time.

Since then, this branch of science has had many fluctuations. In America and Europe, some phenomenological, psychoanalytical, empirical, behavioristic, and systemic

approaches to this approach have been developed. Presently, it is implemented in the health system of most developed countries, despite different ranges in definition and utilization.

In 2008, the World Health Organization (WHO) published a report with the help of WONCA regarding 10 common principles for the successful integration of mental health care into PHC (World Health Organization, 2008). This document provides some strategies and also some useful experiences for the merging of mental health with PHC in low and moderate income countries (Patel, 2003; Schirmer & Montegut, 2009).

Since 2001, the Department of Psychosomatic Medicine and Psychotherapy of the University Medical Center, Freiburg, has collaborated with Asian countries, such as Iran, in the form of psychosomatic medicine and psychotherapy courses. Many doctors have reported fruitful experiences, especially in their personal relationship with patients, as a result of this collaboration (Fritzsche, McDaniel &Wirsching, 2014).

As illustrated by the changes in the definition of physical, psychosomatic, and practical disorders, there is a systemic and pervasive disorder that can be associated with any illness or distress. Therefore, it should be considered that psychosomatic approach is more than a medical field that deals with psychosomatic disorders. Although even with a disease-oriented attitude, Incidence and comorbidity of psychosomatic disorders vary among various populations. In fact, psychosomatic medicine has been through many ebbs and flows in defining the scope of services; a range from restricted behavioral medicine and psychiatric advisers to macro pattern of the bio-psycho-social-spiritual medicine that covers the entire scope of medical knowledge and practice. Sometimes it is considered as a sub-discipline of psychiatry that deals with psychosomatic disorders and sometimes it is introduced as an approach to all illnesses.

After all, the psychosomatic approach is applicable at all prevention levels and in all diseases. It is purposed essentially for vertical (between levels of prevention) and horizontal (between bio-psycho-social-spiritual treatments) integration. Hence, it is worth mentioning that everyone at any time requires these services at least in the field of education.

Thus, anyone with a disturbance of public compatibility, due to a physical or psychosocial stress, who shows some degree of anxiety, or some defense mechanisms against anxiety, and therefore, some mental, physical, and behavioral symptoms (with or without body reflections), has a psychosomatic illness and needs psychosomatic interventions. These disorders, separately or in comorbidity with mental and physical disorders, especially chronic disorders, are very common and can influence disease prognosis and treatment.

Which functions of a family physician are linked with psychosomatic services? FM and psychosomatic medicine have many similarities in their approaches and methods. Both treat patients through 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. Therefore, it seems that psychosomatic approaches to FM only emphasize on some of its fundamental principles. Unfortunately, these knowledge, attitude, and practices are not mention sophisticatedly in GP or even in family physician training courses in Iran. In the GPs' curriculum and some specialties that are more close to psychosomatic medicine, such as psychiatry, internal medicine, community medicine, and FM, lack of effective training in this area is quite evident.

Table 1 shows a summary of the group discussions held in the present study and studies on the relationship between psychosomatic knowledge and skills according to the main tasks of a family physician. These findings can enrich the FM educational program and be considered as a

basis for family physician empowerment.

Discussion

This descriptive study aimed to investigate the relationship between FM and psychosomatic medicine at the Psychosomatic Research Institute of Isfahan University of Medical Sciences in collaboration with the Wellbeing Institute in 2015. In this study, a panel of experts was used to investigate three main questions which were raised about the current FM curriculum and its relationship with psychosomatic medicine.

To summarize the expert panel discussions, it can be concluded that psychosomatic medicine has many connections with a family physician's different tasks. In other words, if psychosomatic medicine has to be implemented in a health system, the family physician could be the best position for the beginning and even the rest of this process. Psychosomatic medicine, not as a biomedical specialty, but rather as a systems thinking model of medicine, has had continuous growth in the last few decades.

Table 1. The role of family medicine and its relationship with psychosomatic knowledge

Roles	Clauses of duties	Subclauses of duties	Description
Clinical roles	Effective communication	Doctor-patient relationship Doctor-patient relativity Communication skills	
	Screening and referral	Ability to perform psychosomatic evaluation and risk analysis Capability of system analysis (Bio-psycho-socio-spiritual)	The psychosomatic approach provides the physician with a systematic and holistic evaluation. The timely and effective referral of patients to specialized medical centers prevents repeated visits and reduces health cost.
	Health care	Psychosomatic services Health care Family education Patient education Education with the aim of: Changing health and morbidity behaviors Improving the quality of life and lifestyle Salutogenesis improvement	Primary psychosomatic care makes effective physical, psychological, familial, and social management possible for caregivers. Advanced Psychosomatic care like bio-psycho-social-spiritual services could be effective in changing health behavior and improving the psychological and physical symptoms of patients.
Non-Clinical roles	Management and coordination	Team working capabilities Systematic health approach Interdisciplinary resource-based approach Awareness of other community services like: Wellbeing and welfare support	
	Education	Family and social education	
	Consultation	Consultation and Patient Decision Aid	
	Research	Regional epidemiologic reports Case reports	
	Support	Intersectoral advocacy including: Public and nonpublic organizations Patients protection groups Health education media Other institutions to the health of their employees	Psychosomatic interventions in patient follow-ups reduce complications and relapse.

Today, psychosomatic medical services are available in almost all fields of medical services. From this systemic approach to health, diseases (especially chronic diseases) are multifactorial. Biological, psychological, social, and spiritual factors not only affect the disorder formation, but also determine response and tolerance status. It is evident that this viewpoint and its related services should be adopted at the core of the health system, i.e., the family physician position, before its integration into different subspecialties. Thus, it can reduce pain and uncertainty among patients and even provide a plan to improve their health.

Family physicians should know much more about the family, since they take their name from it. A family physician is expected to know the family as a potentially traumatic network that might be involved in the etiology and formation of symptoms. The family physician should also use the dynamics of the family as a source of support, emotion, economics, and spirits for tolerance, prevention, and treatment of illnesses.

It seems that FM could be the first and the most central position of the psychosomatic approach to bio-psycho-social-spiritual health; a position that necessarily requires being health oriented and having the ability to use the systems thinking model. Nevertheless, specialties and subspecialties require psychosomatic services to be coordinated with the core of the health system.

Some consider psychosomatic medicine as a kind of medical services applied for a "whole person medicine". This approach is all that a family physician requires in gathering all the data from an individual into a meaningful whole.

Conflict of Interests

Authors have no conflict of interests.

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Breaking Bad News: Different Approaches in Different Countries of Iran and Germany- an Expert Panel

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Report

In this expert panel report which was held in Isfahan, Iran, the participants were Carl Eduard Scheidt, Alexander Wunsch, Hamid Afshar, Farzad Goli, Azadeh Malekian, Mohammad Reza Sharbafchi, Masoud Ferdosi, Farzad Taslimi, and Mitra Molaeinezhad. Professor Scheidt was the facilitator and coordinator of the discussion. Therefore, he started it with a brief introduction. After all is said and done, he ended the discussion with a conclusion.

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Introduction

The topic is *the different approaches to breaking bad news to the patients in different cultures (Iran/Germany)* and what we have heard yesterday was that the legal framework and certain right which define what doctors has to do with the patients and what are not allowed to do have differences in different countries.

Also, we have different intercultural background because there are also ideas of religion and of course exceptions which influence on how we talk with our patients and what we are allowed or expected to involve. The idea of this discussion is trying to have exchange of ideas about the differences and the common ground of *breaking bad news* in oncological patients in

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Iran and Germany.

We may have a classification on different aspects of breaking bad news, based on different views such as:

- Legal Aspect
- Ethical Aspect
- Cultural Aspect

We should separate these three topics and then, investigate on this in Iran and Germany. After that, we may think about the process of breaking bad news in two countries. For example, in cultural view we are in a transitional mode; because our doctors are gradually being introduced with psycho-oncology perspective. Then, we should study this cultural transitional mode. But, what we study and what we learn as doctors are deviated from legal issues. Legal issues and ethical courses are very close to each other; but they have some differences.

Legal Aspects

Ferdosi: In Iran, we are very silent legally. We do not have any initial legal for telling or not to telling to the patients; but something is happening and we are developing some codes. Maybe, we can influence them.

Scheidt: Maybe it would be entertained to learn a little bit more about the legal frameworks and ethical thinkers in Germany. I wonder if you could explain a little bit how is it in Germany? Are the legal frameworks entrenching with practice in Germany?

Wünsch: I think the legal framework in Germany is quite clear and it is clearly advocating that the patient should be informed; however, there are also some limitations. For example, in our legal framework, the patient has the right not to be informed; and I think this is quite important in this discussion; but it takes the patient's role in Germany very seriously.

For example, about decision-making in Germany, lots of researches were done in all kind of medical fields like oncology and etc. and researches all said about 30% of all patients do not want to participate in decision making.

Scheidt: I think this legal framework also make a program in Germany because as Wünsch said, some people come to us and they do not interested in participating in decision making and also there is an obligation for doctors to inform the patients very extendedly before operation; but side effects and complications might coming up and this obligation can really makes difficulties.

Afshar: Of course, in Iran we have informed content too, for any procedure or surgery, but breaking bad news is another thing.

Malekian: But, may I ask if my understanding is true that even in your country, where doctors are legally obliged to tell the patients about their disease, there still remains the choice for the patient to decide if they like to receive the information at all, by themselves; and that how much and what kind of information they would exactly like to receive? Is this true?

Scheidt: Of course as Wünsch said, if the patient wants to know the diagnosis, it is respected. But, you have the problem with treatment, it is difficult to discuss about treatment with him/her. And this would be an open agreement with the law and family to participating to make decision?

Malekian: Of course we also have legal barriers against not to get the patient informed. So, maybe the legal codes would be a useful starting point. There are conflicts between different legal codes which should be addressed. For example in medicine, we have the privacy issue as a popular ethical principle as well as a known legal code. On the other hand, we do not have a code to advocate disclosure of bad medical news to patients and we have at least one legal code against it. Then, what you see in our practice cannot be in accordance with legal codes. I mean, here almost all doctors tell the cancer diagnosis first to the family; this is true about even those few doctors who intend to tell it then to the patient. This is in opposition to privacy code. Yet, patients generally do not claim legally against the doctor for their broken privacy. Some do not know about

their rights, some see it natural from a considerate doctor; some others avoid legal claims not to make their family disturbed.

There are researches which show that the majority of Iranian patients like to receive medical news, including bad ones, by themselves. Other surveys show most people in general setting had told they wanted to receive bad medical news by themselves in the case they got cancer. There are also studies which show the discordance between what Iranian doctors believe as to be better for their patients (that is mainly not to tell) and what patients believe is better for themselves (that is to be told). So, when people preferences is so similar to that of the people of world's other parts. I think clarification of legal codes might be a better starting point to make the discordance decreased.

Ethical Aspects

Goli: In such clinical situations, we always encounter with an ethical dilemma between the no-harm and the autonomy principles. Without any education in this issue and guideline, Iranian physicians manage these problems based on their individual traits, values, and experiences.

More duty-oriented and less empathic physicians usually do not stay ambivalent. Based on some autonomic beliefs, they straightly pass the buck to the patient and even sometimes inform her/him of some unnecessary statistics and all the possible complications. In my practice, I can remember at least two cancer survivors who even after having been treated successfully, still suffered from the trauma of such catastrophic informing of their illnesses.

The more empathic physicians are more sensitive to patient's hope and their psychological wellbeing. They think more about the way they can communicate bad news. In my experience, they prefer using implicit and indirect ways. They usually engage patient's family and relatives in the process of communicating with the patient. They emphasize more on no-harm principle and believe that if we, as physicians, can protect patients from such allosthatic load and lead them implicitly through their treatment procedure, they can save more of their vital force and be resilient in their life and fighting with cancer.

Wünsch: I would like to add some information about the history of communication. For example, in Germany patients would not informed about diagnosis maybe about 30 to 40 years ago; like about 50 years ago, there were no treatment options; but now it is changed. There are many treatment options and in Germany and many western countries, there is a right that every patient should be informed. However, we all have bad experience with that; and even we had bad experience with some patients had something like a trauma after they were being informed.

That was the reason the communication become more and more important to inform the patient in the way that is not traumatising. It is very important when you disclose a bad news that is depressing and distressing to the patient even with the best treatment options; but we hope to avoid this bad experience of our patient. So, not only the information but also "how" to tell them is important.

Cultural Aspects

Taslimi: I think we can look at this topic biopsychosocially. For example, from biology aspect, is the patient at the end stage of illness? What is the psychological state of him/her? From social point of view, we should notice to the cultural delicacies and transpersonal relationship manners. For example in Iran, sometimes there is a benefit to have a cancer or an illness. For example, when a grandfather could not see his family for a long time, it could be an opportunity or a chance for him when his families come to visit him, when they hear about the grandfather's cancer.

So there is a hidden benefit in "having cancer". However, he is suffered from the illness; but this situation could lead to a good

benefit which is gathering the family together as a social value. As we are discussing intercultural, in Iran most of the patients - especially old uneducated ones- do not decide by themselves. In fact, the family decides for them and decides what to tell or not to tell about the patient's illness. It means that the role of family is very important in our culture and should be applied in treatments protocols.

For example, they ask the doctor not to tell the name of "cancer" to the patient, because they believe he or she could not tolerate that; or they ask doctor not to prescribe chemotherapic medicines for the patient, because it would be very depressing to lose hair for him/her. I think from this point of view, through comparing social values, we can evaluate the differences of these two cultures.

And about the spiritual aspect of this topic, I think in Iran when the religious bases are stronger, like in some religious families, people attach the reason of the illness to some spiritual believes. For example, the reason of an illness in a patient is the reflect of what he/she did before; or sometimes it is known as a part of his/her destiny and sometimes it helps them to face more easily with their illness. But in nonreligious families, because of attenuation of spiritual believes, facing with the problems such as illnesses are a little different.

Sharbafchi: I think in our health system, the cultural background is very important to decide if the patient have the right to hear bad news or not. In many studies, when we ask the doctors they should say to the patient that he/she has cancer or not, about 60 to 80 percent answer that it should be said. And this is the same in eastern and western countries. The remained 20 to 40 percent, who do not agree with trough telling, mainly are who have less experience in palliate care settings; but finally in practice, they act according to the health system rules. In our health system, we have no legal or ethical codes for breaking bad news and the doctors are mainly influenced by cultural background; so, most of them may not tell the truth to the patient completely.

Molaeinezhad: I agree with friends' discussions and I want to add a few points to see these topics in three forms of the cultural scenario of interpersonal and intrapersonal relationships. And during a qualitative exploratory study, we will find these cultural scenarios that govern the rules of human behavior in society. Because every individual, regardless of the therapist, is also affected by these cultural scenarios when it comes to bad news or faces a sensitive subject, such as cancer. For example, in some cases, severe suffering may be interpreted as a way to clean up or punish previous individual's sins. It is a cultural scenario that may affect the individual therapist and the patient and the surrounding people and refer to their interpretation of the situation. Therefore, even interpersonal relationships may also be affected by this cultural scenario and similar scenarios, and affect the patient's individual behaviors, follow-up treatment, and the detection of illness and help from others and therapists. All these can be discovered in a qualitative exploratory study that can possibly be done in a narrative way. Then, in the next step, the ethical code can be extracted by considering the qualitative stage outputs.

Goli: In our culture, covering the shortages and faults are received as a spiritual value because Allah is concealer of faults (*sattaraloyoub*). In my opinion, some misconceptions around this religious belief empowered more passive and implicit coping strategies and denial defenses.

There is a common latent agreement between patients, family, and doctors that they prefer skipping confrontation with death and the other existential experiences. I think in Iran, especially in the traditional subcultures, this trend is more dominant. I have had many cases that I am sure he/she knows his/her problem but deny it and even when everybody plays their helpful role, they are in a deep grief in their inner worlds.

Sometimes both the patient and his/her family, without showing it to the patient, are

aware of his/her critical situation; but they choose such a paradoxical way of coping to protect their family and to keep their lively atmosphere.

For me, as a therapist, such conditions are profoundly complicated and confusing. Should I explode this pink bubble in order to rescue them from their loneliness and paradoxical cathexis? Or is it better to respect their choice or to try to lead them to a more authentic and confrontative way of coping? We know that the patient and family lose many of their opportunities to integrate their narratives and to do their best for healing and personal development.

This strategy, in addition to suppressing active and confrontative coping of patient, forms alliances between relatives and also with their care-givers and induce some sort of isolation and alienation to the patient. Patient percepts some annoying whispering around him/herself. This makes him/her feel deeper loneliness.

Scheidt: I think this is an important point that religion helps patients to coping better with problem.

Wünsch: If we ever think about new recommendation, it is better to invite other religious persons; because they are important in the skills and we should ask them to come and answer about future. It is an extensional philosophical topic and they can add some their experience to the topic.

Malekian: We have some relevant religious rules. Indeed up to around ten years ago, we were banned from any prognosis communication due to Islamic rules. Men of religion at that time had a consensus over the matter that giving patients any estimation about their death time is "Haraam", (i.e.: absolutely forbidden religiously); so, there was no discussion and no training. Around ten years ago for the first time, some of the religious men started to comment otherwise (as a result of doctors' and patients' questions and discussions). Thereafter, some of them recommended to tell the patient about prognosis in limited situations on patient's insisted and practically justified requests and when it is surely for patient's interest; there was also a recommendation about providing a broad estimation not a time-point as well as adopting a never-certain attitude and not a clear-cut answer.

Taslimi: I think one other point is religious belief of people. The people who have more spirituality in their life, it is easier to tell them bad news.

Process of breaking bad news

Afshar: I think the method of communication for telling bad news is very heterogenic in our setting and depends on personality of the doctor. Some oncologists have good ability to communicate with their patients and some of them never try to have communication with them. They already visit the patients and prescribe medications and sometimes they are very harsh at their practice. I think they use mechanism of isolation to separate themselves from painful situation. I see many oncologists who completely separate themselves from the atmosphere of this situation. They visit 60 to 70 patients in a day. So, little by little they should minimize their emotions to separate themselves and the communication will change little by little. They usually try to refer patients as soon as possible to the psychiatrist, psychologist, or psycho-oncologist. I do not know if there is any guideline that could be used in practice for oncologists or not?

Wünsch: Maybe I can add something about this discussion in Germany. Many surgeons in Germany do not like to talk about that and they say we are surgeon not psychosomatist or psycho-oncologist; and we do not like to discuss and go to them to do that. But in Germany, it is not legal. It is up to the physician breaking bad news and does it in a way that is not traumatizing. This is a talent. Many physicians do not have time for extensive interviews for being empathic. In my opinion, they should have some communication skills and they should be able to breaking bad news in 7 to 10 minutes with details.

Scheidt: I want to add something could address one or two more other issues that came up in the discussion. One is what would you think about what patients hope for? Or into which direction should go? And the second question is what do doctors hope to which direction should go?

Malekian: I think the starting point cannot be like training etc. Iranian doctors do not tend to change the way they are dealing with bad news. Getting trained in communication skills will not readily make a big difference. There are problems like time issues, and not being paid for longer sessions. It remains an over-demanding task to the busy oncologists to communicate bad news and to consider patients emotions etc.

If convinced as to be beneficial in the long run, I think we need to start acting legally to get things changed. Maybe even if German doctors could be asked whether they would choose to communicate bad news if there were no legal considerations, many of them would say no and wish they could escape such a demanding process to break bad news.

Taslimi: In Iran, the oncologists have not enough time to explain about bad news and you said in Germany this duty is on the shoulder of general Physicians. Absolutely, it is not possible to have a special part in our health system to tell bad news to the patients; because it will be very horrendous for a patient when he/she is asked to go there. So, I think the best way is to train our general practitioners to learn how to tell bad news.

Afshar: According to my experience during 20 years, the most important part of this problem, not only in oncology and psycho-oncology but also in other parts, even breaking news about other's disease is very dangerous. Most of the doctors have not enough ability to communicate, even about a doctor who wants to tell about diabetes to the patient and give information and reassurance; or maybe they have not enough time or interest to communicate well and sometimes not enough education.

Scheidt: But, maybe this is a good point that you opened which also include other specialties. Some discussion is about that is it necessary to use the word “cancer”? Or can we use other word? Because, it has horrified implication for the patients and the association with the word “cancer” is negative as here.

Wünsch: In Germany, it repeats clearly that should be addressed with cancer. It should not be tumor; it should not be neoplasia; it should not be carcinoma; it is cancer. Some patients do not know the other words. So, it should be clear. For example, the patient who had lung cancer which name was small cell carcinoma, and he thought it is a small problem. To prevent such problem, it should be clearly named cancer.

Our lecture is also very important to adjust the meaning for the patient; what does it mean to the patient? What are the consequences to the patient? And in my opinion, you should do explain the meaning of what you say it cancer or tumor or neoplasia or whatever.

Sharbafchi: Sometimes when we tell the patients that “you have a brain tumor”, they accept it more easily and say “so I have tumor not cancer”!

Malekian: I think that something similar has been getting happened over the time. I mean we are gradually becoming more similar to each other. For example, in the case of breaking bad news, about 30 years ago it would seem so natural to any of us who are sitting here to see a mother is withholding his son from receiving bad news of his father’s death telling: “your father has gone to a very long trip”. While nowadays, I guess, most of us here would readily agree we would better do such a thing differently compared to what was acceptable to us in the past.

Also, there are more and more people who tend to see receiving the bad news related to their disease as their rights. More and more people who say: "it is my right to know and nobody has the right to withhold from me the information which belongs to me".

The main concerns of doctors, both who

agree and disagree with giving bad news to the patients, I think is a good communication. If you could convince oncologist that what you mean by giving bad news is not simply (and some harshly) doing that, but you are intending to do it for the patient's own interest and well-being, most of those who disagree would agree. When talking about letting patients know they have cancer, many oncologists disagree because they assume you mean doing it in the same way it is being done by some of their colleagues at present that is some harshly. But, if they knew in detail how you would assess the patients' information, preferences, and preparedness, and if they could trust you know how best to do it, to prepare the patient and many things else, they would get relaxed and agree.

Conclusion

There is a clear common ground in Iran and Germany and probably in most countries in the world that we want to act in the interest of the patient. Also, we are interested in helping and supporting the patients but the way how we do that may differ between two countries, culturally and legally. I think we should come to the end of discussion and I think maybe we could make a transcript of this discussion and we can see what we have done together. Thank you very much.