



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.

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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, & Bodenstern, 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 related 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 tranquilizers.

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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