



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.

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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 (Bühning, 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 (Bühning, 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. 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
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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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