15 Communication Education in Psychosomatic Primary Care

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> Is it really the case, we must ask, that what long experienced psychoanalysts and family therapists do can be easily and simply communicated to general practitioners and internists with a distinctly medical and scientific identity?
>
> Jansen 1993: 546

Abstract: The introduction of psychosomatic primary care into the psychotherapy guidelines in 1987 was an important step towards improving primary medical care for patients with mental and psychosomatic disorders and problems. In May 1992, the 95th German Medical Congress included parts of psychosomatic primary care in their given example for the ideal structure of further trainings for all clinical areas. The goals of psychosomatic primary care are to recognize psychosocial problems and conflicts as early as possible, to offer a limited number of consultations, and to provide indications for the initiation of etiological-

ly oriented psychotherapy. In the curriculum for psychosomatic primary care, exercises in conversation management (verbal interventions) play an important role. Using the example of a weekly block, the didactics and methodology of medical communication are presented. Topics are: Patient- and physician-centered interviewing, the four-ear model, the explanatory consultation on the diagnosis of cancer with the involvement of relatives, the communication of an alternative understanding of illness in patients with somatoform disorders, the de-escalation interview with angry and demanding patients, recognizing an anxiety disorder, informing and counseling a patient with panic attacks, risk assessment in suicidality and conversation techniques with the involvement of close caregivers.

15.1 Why Psychosomatic Primary Care?

According to ICD-10 criteria, between 25 and 30% of the population develops a mental disorder at least once a year and the lifetime risk is more than 50% (Jacobi et al. 2014). The high prevalence of mental, psychosomatic and somatopsychic disorders in the population unfortunately is accompanied by major deficits and problems in the care of these patients: more than 84% of these patients are treated exclusively on an outpatient basis, and almost three-quarters of those treated for a psychiatric diagnosis are treated exclusively by general practitioners and specialists in somatic medicine (Gaebel et al. 2013).

This special care situation and the associated medical care shortage led to the inclusion of the so-called psychosomatic primary care into outpatient care and further training in the form of the psychotherapy agreement of the National Association of Statutory Health Insurance Physicians, the health insurance funds in 1987 and the exemplary structure for further education of the German Medical Association in 1992.

Psychosomatic primary care represents a necessary building block in a "4-level model" of sustainable care for the mentally and psychosomatically ill“ (Heuft et al. 2014):

Level 1: psychosomatic knowledge and skills should already be acquired in the medical studies
Level 2: all physicians in health care should acquire competencies in psychosomatic primary care (currently obligatory for general practitioners and gynecologists in continuing education)
Level 3: clear positioning of the additional training in psychotherapy for clinically working physicians of all specialties with offers of short-term psychotherapy
Level 4: differential treatment by specialists in psychosomatic medicine and psychotherapy and specialists in psychiatry and psychotherapy

15.2 What is Psychosomatic Primary Care?

Psychosomatic Primary Care in the practice of the general practitioner or in the hospital has three main objectives:

1. The earliest possible recognition of psychosocial problems and conflicts, even in the case of complex clinical pictures (differential diagnosis)
2. A limited number of consultations and, if necessary, relaxation procedures (basic therapy)
3. Indication for outpatient or inpatient specialized psychotherapy or inclusion of the psychosomatic or psychiatric consultation and liaison service (differential indication)

Following the introduction of basic psychosomatic care as a health insurance benefit in 1987, standardized qualification requirements for the billing of these services have applied since January 1, 1994. This means that the National Association of Statutory Health Insurance Physicians also recognizes the need for systematic and structured further training.

The introduction of psychosomatic primary care has led to a significant improvement in the early recognition of psychological and psychosomatic problems and disorders and their treatment (Fritzsche et al. 1994, 1996, 1999, 2000, 2004, 2010, Steger et al. 2020).

Psychosomatic primary care is an independent form of treatment and has several decisive advantages over purely somatically oriented medicine and psychotherapy practiced by specialized psychotherapists:

- Basic psychosomatic care is integrated into the consultation. Physical and mental problems are discussed together and their interaction can be recognized.
- The abstinence from the body, often misunderstood by the psychotherapist, excludes itself from the very beginning. The physical examination is part of the diagnosis and enables a variety of observations and conclusions to be drawn about physical and mental interactions. The approach via the body is less frightening for the patient and the physician, as it is more familiar. The contact, in the double sense, first takes place on the physical level and can then lead the way to speaking about mental experience.
- Usually, the patient has been known to the physician for some time. He or she is familiar with the patient's current life circumstances, family problems and previous crisis situations and how they were overcome. When new complaints arise, it is therefore easier for him than for an outsider to place them in the psychosocial context.
- The patient does not experience a conversation about mental conflicts within the framework of the consultation as a stigma, as is often the case with a referral to a psychotherapist or psychiatrist and is therefore often rejected by the patient.
- In psychotherapy, a helpful, supportive physician-patient relationship is considered one of the most important factors in successful treatment. The long-standing, trusting relationship with the general practitioner or specialist therefore offers an ideal condition for integrating recognized psychological conflicts into a medical treatment plan and making restricted offers for consultations.

Psychosomatic primary care offers the great opportunity to experience body and soul as a unity, and to recognize, understand and treat complaints and diseases in this context. However, it requires a change in the attitude of the physician towards the patient and their illness.

15.3 Communicative Competence

The importance and function of a medical interview have been explained in the "Guidelines of the Federal Committee for Physicians and Health Insurance Funds on the Performance of Psychotherapy" (Box. 15.1).

Box 15.1 „Guidelines“ for Psychosomatic Primary Care

In psychosomatic primary care, verbal interventions are oriented to the current disease situation; they are based on a systematic, introspection-promoting conversation management and seek to convey insights into the psychosomatic connections of the disease and the significance of pathogenic interactions. The physician takes into account and uses the disease-specific interactions between patient and physician, in which the mental illness presents itself. In addition, the aim is to build up the patient's coping skills, possibly with the involvement of people from the patient's immediate environment.

Guidelines 2004: 8

The goals of the basic therapy are:

- Building a sustainable physician-patient relationship
- Promotion of patient autonomy through awareness of his or her resources or those available in his or her environment
- Solution orientation through problem clarification, resolution, acceptance or overcoming
- Symptom relief or cure
- Informing the patient (Psychoeducation)
- Prevention of unnecessary measures, e.g. non-indicated medication, physician consultations, surgical interventions, inpatient stays
- Help in overcoming life crises such as serious illness, loss and separation situations.
- Specific treatment of various mental disorders including psychopharmacotherapy
- Preparation and initiation of indicated further specialized therapy (specialized psychotherapy, psychiatric treatment, psychosocial counseling centers)
- Cooperation with self-help groups

15.4 Curriculum Psychosomatic Primary Care

Courses for qualification in psychosomatic primary care have been held throughout Germany for over 20 years. The German Medical Association has defined key points and guidelines for this (Autorengruppe Psychosomatische Grundversorgung 2001).

15.4.1 Guidelines

1. Practical relevance: the training is oriented towards the most common everyday psychosomatic and psychosocial problems and situations in the practice and in the hospital.
2. Flexibility: The combination of mandatory core subjects and elective or specialization options provides greater flexibility. A minimum standard is ensured and at the same time individual focal points can be set.
3. Balance: knowledge transfer, learning of practical skills in dealing with the patient and self-awareness in the relationship of physician and patient are in a balanced relationship.

15.4.2 Content

The total duration of the course is 80 hours and includes the following three parts:

1. Theory seminars of at least 20 hours duration, in which knowledge of the theory of the physician-patient relationship, knowledge and experience in psychosomatic illness theory and the differentiation of psychosomatic disorders from neuroses and psychoses are taught. Furthermore, knowledge of illness and family dynamics, as well as interaction in groups, coping with illness and differential indication of psychotherapy procedures are acquired.
2. Learning and practicing verbal intervention techniques of at least 30 hours duration.

3. Reflection on the physician-patient relationship through continuous work in Balint or self-awareness groups of at least 30 hours duration (i.e. at least 15 double hours for Balint groups).

The theoretical basis of the curriculum is the biopsychosocial model. Physical, psychological, and social processes interact with each other and contribute in varying degrees to every clinical picture. The aim of this psychosomatic approach is to overcome the body-soul dualism, to emphasize the importance of the interactions between body, soul, and social environment and to build bridges to all clinical disciplines. This requires both a systems perspective and knowledge of psychophysiological interactions.

A consistent element in the course is the exercises in patient-centered and physician-centered interviewing.

15.4.3 Teaching methods

1. Introductory lecture with PowerPoint presentation on the most important aspects of the clinical picture dealt with on that day
2. Live patient discussion, also with the involvement of the partner or other family members. The aim is to demonstrate how to manage a conversation using the example of a detailed biopsychosocial anamnesis.
3. Reflecting Team: Following the live patient conversation, a group of approximately 5 participants forms and provides resource-based feedback to the patient.
4. Observer groups: After a short break, three subgroups are formed, each of which discusses the live patient conversation from three aspects:
   - Contents of the biopsychosocial anamnesis, typical screening questions
   - Conversation management: techniques of patient-centered and physician-centered conversation management
   - The quality of the physician-patient relationship: What did I myself experience during the conversation? My thoughts, my feelings, my body perception, my impulses, how did I feel managing the conversation as a doctor, how would I have experienced myself as a patient? Important and difficult moments in the conversation

5. Small group conversation management exercises with trained acting patients, some with video feedback
6. Small group conversation management exercises with role plays, video feedback and discussion

15.5 Conversation management exercises

Monday

- Collecting difficult physician-patient conversations in the daily work of the participants
- Exercises for patient-centered and physician-centered conversation management
- Introduction of the four ears model by Schulz von Thun

Tuesday

- Cancer: If I was a tumor patient, what questions would I have for the physician?
- Educational talk on the diagnosis of cancer with examples from the participants, the transition from curative to palliative treatment
- Involvement of relatives
- Worksheet: Difficult conversation situation with tumor patients

Wednesday

- Patients with somatoform disorders
- Goal: To convey an alternative understanding of the disease, to motivate for psychotherapy
- Worksheet: Self-experience with somatoform disorders
- Exercises for the step-by-step treatment of somatoform patients
- Teaching of a psychosomatic model of illness, motivation for psychotherapy
- Exercise for conversations with the angry and demanding patient

Thursday

- Anxiety disorders
- Exercises for conversation management with a patient with panic attacks
- Aim: Recognizing the anxiety disorder, informing and advising the patient
- Exercises for conducting conversations in small groups with presentation of the vicious circle model and the vulnerability-stress model as examples of psychoeducation for anxiety

Friday

- Depression and suicidality
- Acting patient on the subject of suicidality in two runs with different scenarios:
  1. Convincing of a necessary admission to the psychiatric hospital
  2. Concluding a non-suicide contract if the patient is able to make an agreement
- Exercises on how to manage a conversation with role plays on own examples
- Differential diagnosis between depression and burnout
- Involvement of partners and family members of depressed patients

Saturday

- The family conversation: Attitudes and techniques of conversation when close reference persons are involved
- Evaluation of the live family conversation

15.5.1 Four-Ear-Model

When misunderstandings or communication problems occur in everyday life, this is often due to the fact that the two dialogue partners hear and act on different levels: e.g., one believes that he is merely clarifying a fact, while the other takes this to be a relationship statement (§ 7). Through medical training, the physician is used to always hearing the

factual level and responding to it. They explain to the patient, e.g., why an examination or an operation had to be postponed and give detailed information to the gathered findings. They don't hear the emotional message, which is contained in questions and expressions of the patient and pay attention to their own emotions.

By learning to perceive and address the underlying aspects, appeals or self-revelations in a conversation with a patient, the physician can lighten up and resolve issues in a conversation. On the listener side, the physician can use the model to direct their perception to a specific level of the communication. This is particularly helpful if the conversation is emotionally tinged with only superficial objectivity. As patients usually only mention psychosocial content cautiously, it is especially important to listen carefully (see examples E 15.1 and E 15.2; Fritzsche, Wirsching 2006).

E 15.1		Example of a conversation on the *factual level*
01	P	I haven't been able to go to work for the last two days and would like to get some proper rest. You can put me on sick leave, can't you?
02	D	I would like to examine you again first, but the way you describe it, I will probably be able to put you on sick leave this week.

With this answer, the physician hears and responds primarily on the *factual level*. On the *relationship level*, he notices that the patient is putting him under pressure and therefore recognizes that the patient himself is under a lot of pressure. His alternative answer could therefore be:

E 15.2		Example of a conversation on the *relationship level*
01	D	You're under a lot of pressure.
02	P	Yes, that's right. I've made a few mistakes at work recently and I'm worried about my job, there aren't many orders at the moment. As I'm also having trouble sleeping, I'm afraid of making even more mistakes, so it's better to stay at home.

By *changing levels*, the physician enables the patient to talk about their work-related stress. The patient mentions current sleep disorders and a possible depression can now be explored.

Case study

A 50-year-old patient is admitted to hospital by his general practitioner due to a suspected serious stomach illness. The gastroscopy scheduled for the first day has to be postponed twice. On the third day, the patient complains during the ward round: "I've been here for the third day now and still nothing has happened, when am I going to be operated, I've had enough now, I want to speak to the head physician."

The physician begins to justify himself. He explains to the patient that a colleague in the endoscopy department has become ill. He mentions that an emergency came up and that he is alone on the ward.

All these explanations only increase the patient's anger, to which the ward physician also reacts with irritation and impatience.

A physician who wants to respond empathetically to the patient first asks himself: "What does my conversation partner feel? What is important to them at the moment? What is bothering them the most?" One way to put into words what is resonating emotionally would be: "I can see that you are quite upset that the gastroscopy has not yet taken place and that you have to remain in this uncertainty. Your general practitioner has referred you here so that we can find out what is behind your symptoms as quickly as possible." Addressing the patient's suspected self-disclosure is a relief for the patient and thus for the rest of the conversation. Figure 15.2 illustrates these four messages.

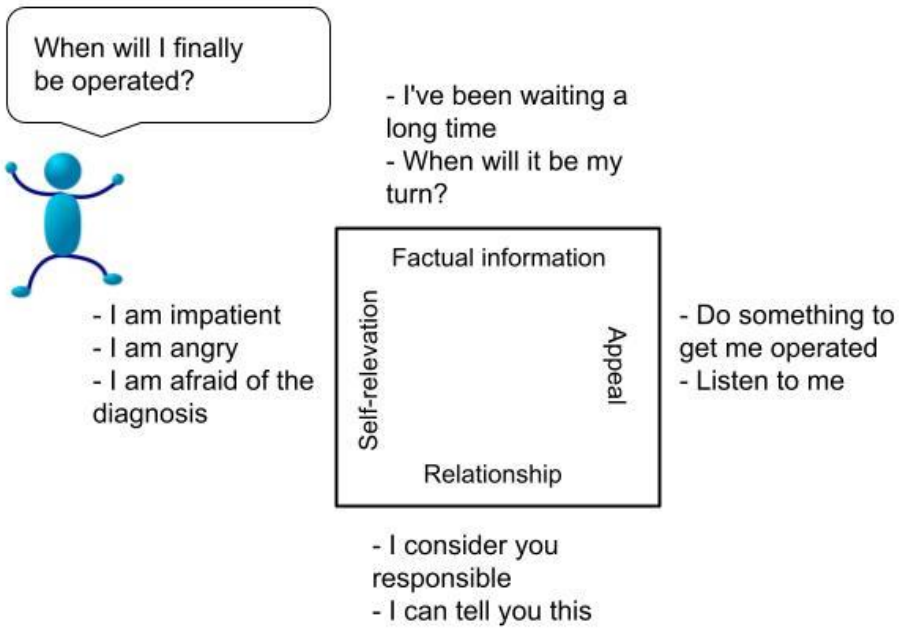

Fig. 15.2: „When will I finally be operated?“

15.5.2 Dealing with aggressive patients – De-escalation model

Annoying, demanding and challenging patients offer another opportunity to apply the four-ear model. De-escalation is presented here using several levels (see Fig. 15.3 CALM model). The CALM model (Schweickhardt, Fritzsche 2023) was developed to de-escalate emotionally charged conversations. The levels are usually run through from bottom to top. In the two lower levels, the physician tries to take the patient's emotions seriously by showing empathy and understanding for the difficult situation, explaining the context, possibly admitting mistakes and, above all, relieving the patient emotionally by mirroring their anger. Body language, facial expressions and a calming voice are also important here. In the two upper levels, the physician tries to find a compromise with the patient and make a decision on how to proceed.

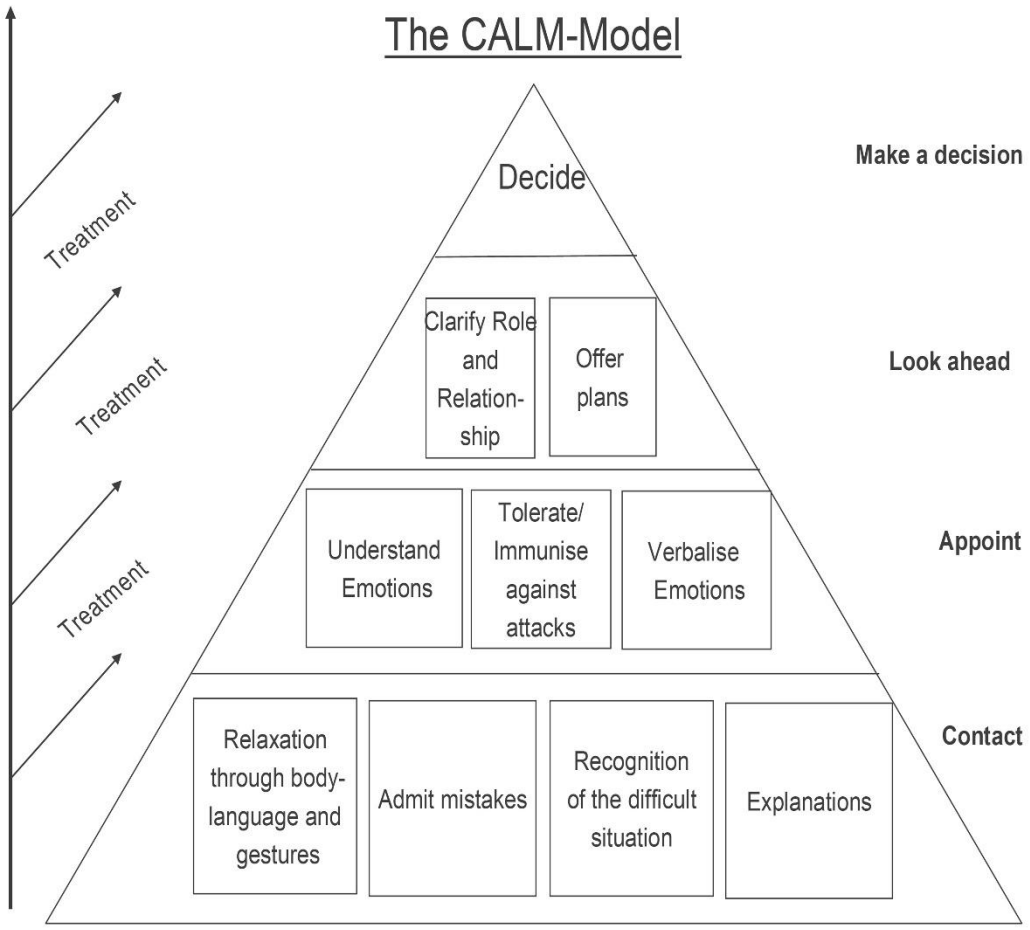

Fig. 15.3: CALM model

Level 1

Level 1 is often used if the patient has had to wait a long time due to unforeseen emergencies, for example, or if the head physician delegates the explanatory discussion about the results of a private patient's coronary angiography to the assistant doctor. Explaining the context, acknowledging the difficult situation and a calm voice and relaxed posture can relieve the situation in most cases. The physician should not confront the waves of aggression but let them run their course and wear out.

Level 2

Level 1 and level 2 often merge into one another. The patient's emotions, such as anger, disappointment, but also helplessness and powerlessness, are named directly: "I can tell from your voice and your posture that you are very angry right now". Even if emotions may flare up again for a short time, they usually calm down afterwards. Now there is room for the fears and worries behind the emotions. If the patient continues to express and behave in an aggressive, demanding, and devaluing manner, the question arises as to what further cooperation can look like. Now level 3 comes into play.

Level 3

The aim of level 3 is to make the professional relationship between physician and patient clear. Are there still common goals between physician and patient? The physician can make offers, but at the same time the limits and rules for working together are stated: "I have the impression that my understanding of your situation is not reaching you and that you are still very upset, even insulting me personally. We should come to a decision now. I will be happy to give you the results of the coronary angiography. I suggest that you take a 15-minute walk in the hospital park, then come back, and tell me your decision".

Level 4

The patient is now responsible for the further treatment. The physician no longer responds to the accusations and demands made but waits for the patient's decision. This decision can be made immediately, after a walk, for example, or after the patient has slept on it for a night.

Mindset

The most difficult thing is not to oppose the aggression of the patient and to become involved in an argument. The four-ears model helps to understand what the patient is saying about himself and what the rea-

sons for his aggression and irritability are. If the physician conveys understanding for the patient's difficult situation, the conversation usually relaxes.

15.6 Further information

Schulz von Thun's books (Schulz von Thun 2014) provide easy-to-read in-depth information on managing conversations in psychosomatic primary care. Many practical examples can be found in the textbook by Schweickhardt and Fritzsche (2023) and in the new edition of the textbook on psychosomatic primary care (Fritzsche et al. 2016). Watzlawick et al. (1967/2011) offers sophisticated in-depth information. Rogers (1983) provides a detailed description of the attitudes and mindsets that apply to every conversation in psychosomatic primary care, such as empathy, appreciation, and authenticity. The reading and exercise book by Weisbach (2001) is a more practical book. Conversation management during anamnesis and physical examination are still best dealt with in the textbook by Adler and Hemmeler from 1992.

References

Further references on doctor-patient communication can be found in other topic-specific chapters and in the complete bibliography of the handbook.

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