



IN-PATIENT PSYCHOTHERAPY IN THE DEPARTMENT OF PSYCHOSOMATICS AT THE BEROLINA CLINIC IN LÖHNE

AN OVERVIEW OF IN-PATIENT PSYCHOSOMATIC REHABILITATION AT THE BEROLINA CLINIC

Some regard psychosomatic rehabilitation as only a part of psychiatric rehabilitation. However, psychosomatic rehabilitation is becoming increasingly important as an entity in its own right (cf. Schmid-Ott and Stock 2008). Seger et al. (2008) state in this context: "When considerable portions of the population are excluded from participating long-term in work life, then numerous follow-up problems occur. These problems have grave consequences for the health of the entire population in terms of secondary damage and impairment. Psychological damage, loss of self-esteem, social isolation, existential crises, limitations in physical activity, and dependency problems all represent significant risk factors for the health of individuals and their ability to function, in the sense of the ICF, which lead to an increase in the need for support." (Seger et al. 2008, page 269 f., translation by Suzanne Albrecht, Berlin, and the authors).

Individuals with psychological or psychosomatic illnesses in adulthood frequently suffer from a chronic course of disease, relapsing deterioration, and often exhibit a vast spectrum of related disorders. Medical rehabilitation often becomes necessary when illness-related damage has led to long-term disability or impairs participation in important areas of daily life. Medical rehabilitation requires a comprehensive, holistic and interdisciplinary approach. In-patient psychotherapy in the Department of Psychosomatics at the Berolina Clinic takes into account the entire background of the affected individual by examining the interactions between the components of functional health and their impairment and also the connections between a person's health problems, their life history and environmental factors.

Psychosomatic patients treated in the Department of Psychosomatics at the Berolina Clinic profit in particular from the group therapy programme. This form of health training serves less to convey information than to the more important transfer of knowledge to act, thus

strengthening personal responsibility, encouraging an individual's potential for self-help, and improving an individual's active collaboration (adherence). Focus of the group therapies are, e.g., symptoms of anxiety or depression and, in addition, of the burnout-syndrome and other stress-induced diseases. Furthermore, several therapy groups focus on age and gender specific problems. Furthermore, every patient gets an individual therapy once a week. Available languages for the individual therapy are in addition to German: English, Polish, and Russian.

At the start of the in-patient psychotherapy, rehabilitation goals are devised as realistic objectives attuned to the patient's daily life (assignment measures), taking into account any specific individual limitations for participation. Patients can strive for goals on various levels: somatic, psychological, and educational, in relation to activities, participation or context. Three groups of therapeutic goals are individually defined at the outset of in-patient psychosomatic rehabilitation at the Berolina Clinic. These goals hold equal importance and are established based on the International Classification (ICF) categories of ability to function, handicap and health. At the end of treatment, the individual patient helps evaluate and document the extent to which the goals have been met.

Psychological rehabilitation goals may include increasing adherence, realistic assessment of the illness, improving patients' ability to cope with the illness, their responsibility for themselves and their motivation to implement the psychotherapeutic and medical treatment, improving self-control and encouraging the understanding of connections between somatic and psychological influences (so-called somatic vulnerability, also in somatoform disorders).

Social rehabilitation goals may include improving integration in the work place, social integration or social competence.

And finally, **educational rehabilitation goals** may include information about risk factors and the course of psychological disorders, as well as coping better with stress by learning systematic relaxation techniques.

The following contextual factors comprise what we regard as the entire background of an individual central to the in-patient rehabilitation based on the International Classification of the Ability to Function (ICF): risk factors (such as abuse of stimulants, tobacco, alcohol), poor nutrition, lack of exercise, inadequate styles of coping with illness (such as denial, depressive withdrawal, blaming others) or personality factors such as the presence of a personality disorder or specific personal styles.

In-patient psychosomatic rehabilitation refers to comprehensive rehabilitation extending over the entire day. General indications for in-patient rehabilitation primarily are given when the performance level in work life is endangered due to psychosomatic and psychological disorders as well as under the following circumstances:

- When continuous support and structure is necessary due to diminished resilience, both mentally and physically
- When conflicts arise in the family or work setting making it necessary to remove the individual from the stressful environment and place him or her into treatment in a protected therapeutic environment, generally away from home
- When an improvement in social skills and interpersonal functioning can only be achieved through integration in an in-patient setting
- When there is a risk that an individual will become instable through therapeutic measures which overtax the person's own ability to cope.
- When sufficient adherence to a medication schedule and constructive participation in treatment can only be ensured through in-patient instruction and supervision
- When the symptoms or behavioural disorder is so pronounced that close supervision, treatment and continuous availability of crisis intervention facilities are indispensable.



THE HOLISTIC APPROACH OF MEDICAL REHABILITATION

Medical rehabilitation encompasses a holistic approach. Beyond recognizing, treating and healing an illness, medical rehabilitation considers the interaction between a person's health problems – described in terms of damage, impairment of activity and participation – and their context in order to achieve the best possible success of rehabilitation in the sense of taking part in social life and work life. Contextual factors can exert a positive, supportive influence (resources) as well as a negative, debilitating influence (risk factors) on all components of functional health. The holistic rehabilitation approach requires the application of complex measures in the medical, educational, occupational and social arenas, differing on a case by case basis. It also entails a tightly woven collaboration of medical, psychotherapeutic, nursing care with physical therapy, occupational therapy, and dietary care. The holistic approach also helps patients to learn how to cope with the consequences of their illness and to change their behaviour with the goal of reducing negative influences. In addition to its curative effects, medical rehabilitation calls for a multi-dimensional and interdisciplinary approach.

INDICATIONS AND COUNTER-INDICATIONS FOR IN-PATIENT PSYCHOSOMATIC REHABILITATION

Indications for in-patient psychotherapeutic treatment in the Department of Psychosomatics at the Berolina Clinic include neurotic, stress-related and somatoform disorders, affective disorders, behavioural abnormalities with physical disorders and factors including obesity, personality and behavioural disorders, psychological factors and behavioural influences on illnesses classified elsewhere, such as essential hypertension, migraines. Moreover, patients with the following illnesses, provided they are not exacerbated by an acute somatic disorder, can be treated under a somato-psychological aspect, for instance with the goal of improving coping with the illness: Crohn's disease, ulcerative colitis, psoriasis, atopic dermatitis, multiple sclerosis or malignant tumours and finally schizophrenia, schizoid and delusional disorder in remission. The following disorders are absolutely counter-indicated: acute suicidal tendencies, florid psychoses, manifest brain damage, deterioration of intelligence with severe impairment of cognitive and emotional comprehension and introspection, metabolic and non-metabolic dependencies, and need for long-term care.

GOALS OF REHABILITATION

The goal of medical rehabilitation is to eliminate or reduce the impending or existing impairment of participation in work and social life, and to prevent deterioration or alleviate its consequences. Through rehabilitation, the person undergoing rehabilitation should be enabled to carry out (again) a job, certain activities of daily life in a manner and to an extent which is regarded as normal for that individual (typical for his or her life).

These goals can be achieved during in-patient rehabilitation for psychological and psychosomatic disorders by eliminating or reducing the damage (including mental functions), reducing the severity of the impairment of activity or reversing disabilities, through compensation or developing adequate adaptation or coping mechanisms.

Rehabilitation goals regarding physical abilities (including mental abilities) include, for instance, mental stabilisation, reducing negative affects such a depression and anxiety, improving



self-perception, improving one's acceptance of oneself and one's self-confidence, correcting dysfunctional cognitive patterns, reducing physical symptoms, and improving one's ability to handle functional disorders.

Further rehabilitation goals related to activity include expanding the individual's repertoire of behaviour, improving communication skills, building up social skills, improving interpersonal skills, employment skills and problem-solving skills, optimising coping strategies, improving the ability to structure leisure time and improving how stress situations are handled.

Goals aimed at participation include maintaining or improving psychological independence, physical independence, mobility and social integration or re-integration in the area of employment and economic independence. To achieve these rehabilitation goals, the care-giver is involved as far as possible. In concrete terms, this means conducting seminars for relatives, such as involvement in educational programmes or individual counselling of relatives and, as appropriate, establishing contact with the employer or company physician.

The type and extent of the problems can be exacerbated or diminished by surrounding factors (factors related to the environment or specific individuals) such that they must be taken into account when determining the rehabilitation goals and designing the diagnostic and therapeutic measures. This can take place, for instance, by adjusting the workplace, changing how the work is organized, planning and introducing measures for participating in work life, occupational re-integration, instruction on healthy nutrition and motivating changes in lifestyle, including reduction of risky behaviour, instruction on how to reduce or cope with stress, plan changes in the domestic environment, and introduce appropriate leisure time activities. Patients undergoing rehabilitation receive support in how to live and cope with the consequences of their illness or handicap and how to avoid negative influences or reduce their effects. Rehabilitation goals in this sense include improving knowledge about the illness, developing strategies to reduce risky behaviour (such as smoking, alcohol and drug abuse, poor nutrition, lack of exercise, inadequate use of leisure time, physical and mental exhaustion), instruction in techniques of self-control and learning relaxation techniques.

Specific rehabilitation goals for somatoform and pain disorders, depression or anxiety disorders are established together with the patient with regard to damage or functional disorders, disabilities, impairment and risk factors, and contextual factors. These goals are also monitored with the patient over the course of the rehabilitation process and follow-up studies for specific groups are performed (cf. e.g., Kobelt and Schmid-Ott 2010).

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Selected Literature

Kobelt A, Schmid-Ott G. Results of long-term follow-up study of inpatient psychotherapy followed by systematic outpatient psychotherapeutic aftercare. *Psychology, Health & Medicine* 2010; 15: 94–104.

Schmid-Ott G., Stock C. Die Bedeutung der stationären Psychosomatischen Rehabilitation unter besonderer Berücksichtigung der internationalen Klassifikation der Funktionsfähigkeit, Behinderung und Gesundheit (ICF). 2008. <http://www.afp-info.de/Schmid-Ott-G-Stock-C-2.164.0.html>, 25.02.2010

Seger, W., Petri, B., Müller-Fahrnow, W., Lay, W., Grotkamp, S., Hüller, E., Seidel, E., Steinke, B., Deetjen, W., Gronemeyer, St., Lübke, N., von Mittelstaedt, G., Korsukéwitz, Ch., Aubke, W., Schian, H-M., Heipertz, W., Wallrabenstein, H., Zelfel, R.C., Cibis, W., Philgus, B. Perspectives in rehabilitation. General position paper on future trends and challenges in rehabilitation by the Health Advisory Board of the German Federal Association for Rehabilitation. *Gesundheitswesen* 2008; 70: 267-280.

