WORKSHOP: SOMATOFORM AND BODILY DISTRESS SYNDROMES AS CHALLENGE TO MEDICAL DELIVERY SYSTEM

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Somatoform disorders and bodily distress syndromes comprise a group of heterogeneous disorders whose prevailing clinical complaints are somatic symptoms without sufficient medical explanation. The concept of "somatization" referring to special illness behaviour is underpinning both these disorders and also other primary psychiatric disorders such as anxiety and disorders presenting with pronounced bodily symptoms. Causes, eliciting situation, and maintenance of somatoform disorders and bodily distress syndromes are mediated by multifactorial factors that have to be considered. Acute and chronic stressors play a role and have to be assessed within a complex biopsychosocial model. There exist various grades of severity and types of courses. Significant rates of psychiatric comorbidity, psychosocial disability, reduced health-related quality of life, and intensive utilization of medical and social facilities have to be reflected. Quite often the basic doctor-patient relationship is heavily hampered by serious emotional conflicts additionally contributing to a chronic course of illness. Meanwhile a series of evidence-based disorder-oriented psychotherapeutic approaches have been established in clinical practice. Some guidelines have been developed for psychopharmacological interventions.

The workshop is aiming to give a survey on basic theoretical knowledge and clinical treatment approaches to this group of patients very often considered as "difficult patients" by the doctors. Clinical vignettes will illustrate the various aims of the workshop.

References:

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ESTABLISHED AND NEW MODELS OF CARE IN THE INTERFACE OF PSYCHIATRY AND MEDICINE

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Psychiatric/ psychosomatic consultation/liaison (CL)-services in hospitals have to address the needs of patients, their families as well as the needs of the somatic treatment teams. Furthermore, it is important to take institutional structures and general conditions into account. Prevalence rates of psychiatric co-morbidity in chronically somatic ill in-patients are about 44% and, depending on the somatic diagnoses, psychiatric co-morbidity can reach even higher rates. Besides the treatment of psychiatric co-morbidity, one has also to consider the importance of psychosomatic support for developing adequate coping strategies. In order to develop a good psychiatric/psychosomatic CL-service, it is important to focus on interdisciplinary co-operation between different professionals in the daily clinical routine (such as somatic specialists, psychologists, psychiatrists, social workers, physiotherapists etc.)

The best known example of a CL-service is the „classical" consultation (C) service which has a rather long history dating back into the 1950s. This kind of C-service is quite easy to establish but on the other hand a „one-person consultation service" cannot cover all complex needs described above. A better quality of this service could be provided by a multiprofessional team working together within a consultation structure.

In psychiatric/psychosomatic liaison services the co-operation between somatic specialists and PSYCH-specialists is mostly very well integrated within a comprehensive treatment concept. Liaison services have shown high efficacy for patient groups with high levels of psychological distress and /or high psychiatric co-morbidity, for instance in the field of oncology, cardiology and transplantation medicine.

Another service with a long standing tradition for intensive co-operation between somatic and psychiatric teams can be found in the outpatient clinic for psychosomatic medicine, where patients with a complex medical history can be diagnosed and offered individual treatment options as well as follow-up care.

Interdisciplinary outpatient clinics – so called integrated facilities – consisting of a clear structure for patients´ management and interdisciplinary communication provide an ideal setting for achieving a high degree of satisfaction for patients as well as for doctors and nurses.

Increasing numbers of older patients with somatic multimorbidity who also suffer from psychiatric syndromes often require an intense psychiatric and somatic co-operation, which can be offered best by an unit run by specialists of internal medicine and psychiatrists together.

A concomitant quality assurance is vital for establishing successful psychiatric/psychosomatic CL-services. The results of this process can be used for an interdisciplinary training program offered to both psychiatrists and somatic specialists together. Furthermore, daily interdisciplinary clinical discussions and interdisciplinary research are important for achieving a high level of satisfaction for all co-operation partners involved.

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COGNITIVE SCHEMAS AND COPING MECHANISMS IN BREAST CANCER SURGICAL TREATMENT

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Surgical treatment in breast cancer, mastectomy and breast reconstruction following mastectomy, is associated with a series of defense mechanisms and particular cognitive schemas.

Objective: the purpose of our study is to identify differences in coping mechanisms and cognitive schemas, as well as the association between the two factors, both variables studied depending on the type of surgery performed.

Subjects and methods: 100 patients admitted to the Oncology and Plastic Surgery Departments were examined. The two lots consisted of 40 patients who underwent mastectomy and another group of 40 patients who underwent breast reconstruction, both of which were based on the diagnosis of breast cancer (according to ICD-10). The applied scales were: COPE -Coping Scale and YSQ-S3 Cognitive Schemas Questionnaire.

Results: the findings revealed the presence of four core schemas (defectiveness, dependency, vulnerability to disease and failure) and two defense mechanisms (splitting and rationalization) in the group of patients with mastectomy and three predominant cognitive schemas (subjugation, need for approval and unrealistic standards), as well as three defense mechanisms (acceptance, use of emotional support and focus on emotions) in the group of patients who have chosen breast reconstruction.

Conclusions: The identification of coping mechanisms as well as dysfunctional cognitive schemas in patients following breast cancer treatment is an important element in the development of techniques, therapeutic intervention and support tools to improve the quality of life, self-esteem, as well as family, social and professional reintegration.