Consultation-Liaison Psychiatry in Germany, Austria and Switzerland

Editor
A. Diefenbacher
Consultation-Liaison Psychiatry in Germany, Austria and Switzerland
Advances in
Psychosomatic Medicine

Vol. 26

Series Editor

T.N. Wise  Falls Church, Va.

Editors

G.A. Fava  Bologna
I. Fukunishi  Tokyo
M.B. Rosenthal  Cleveland, Ohio
Consultation-Liaison Psychiatry in Germany, Austria and Switzerland

Volume Editor

Albert Diefenbacher  Berlin

11 figures and 24 tables, 2004
Advances in Psychosomatic Medicine

Founded 1960 by
F. Deutsch (Cambridge, Mass.)
A. Jores (Hamburg)
B. Stockvis (Leiden)

Continued 1972–1982 by
F. Reichsman (Brooklyn, N.Y.)

Library of Congress Cataloging-in-Publication Data

A catalog record for this title is available from the Library of Congress.

Bibliographic Indices. This publication is listed in bibliographic services, including Current Contents® and Index Medicus.

Drug Dosage. The authors and the publisher have exerted every effort to ensure that drug selection and dosage set forth in this text are in accord with current recommendations and practice at the time of publication. However, in view of ongoing research, changes in government regulations, and the constant flow of information relating to drug therapy and drug reactions, the reader is urged to check the package insert for each drug for any change in indications and dosage and for added warnings and precautions. This is particularly important when the recommended agent is a new and/or infrequently employed drug.

All rights reserved. No part of this publication may be translated into other languages, reproduced or utilized in any form or by any means electronic or mechanical, including photocopying, recording, microcopying, or by any information storage and retrieval system, without permission in writing from the publisher.

© Copyright 2004 by S. Karger AG, P.O. Box, CH–4009 Basel (Switzerland)
www.karger.com
Printed in Switzerland on acid-free paper by Reinhardt Druck, Basel
ISSN 0065–3268
ISBN 3–8055–7749–4
Contents

VII Foreword
Wise, T.N. (Falls Church, Va.)

IX Preface
Diefenbacher, A. (Berlin)

Consultation-Liaison Psychiatry

1 Consultation-Liaison Psychiatry in Germany
Diefenbacher, A. (Berlin)

20 Consultation-Liaison Psychiatry in Austria
Riessland-Seifert, A. (Vienna)

25 Consultation-Liaison Psychiatry in Switzerland
Caduff, F. (Thun); Georgescu, D. (Windisch)

General Section

31 Prevalence of Psychiatric Disorders in Physically Ill Patients
Arolt, V. (Münster)

52 Mental Disorders in Primary Care
Linden, M. (Teltow/Berlin)

66 Geriatric Consultation-Liaison Psychiatry in Germany
Stoppe, G. (Basel); Staedt, J. (Berlin)

74 Screening Instruments for General Hospital and Primary Care Patients
Wancata, J.; Weiss, M.; Marquart, B. (Vienna); Alexandrowicz, R. (Klagenfurt)
**Special Section**

**98 Depression in Medical Patients**  
Arolt, V.; Rothermundt, M. (Münster)

**118 Alcohol-Related Interventions in General Hospitals in Germany: Public Health and Consultation-Liaison Psychiatry Perspectives**  
Kremer, G.; Baune, B.; Driessen, M.; Wienberg, G. (Bielefeld)

**128 Delirium in General Hospital Inpatients: German Developments**  
Reischies, F.M.; Diefenbacher, A. (Berlin)

**137 Suicide Attempts: Results and Experiences from the German Competency Network on Depression**  
Lehfeld, H. (Nürnberg); Althaus, D.; Hegerl, U.; Ziervogel, A. (München); Niklewski, G. (Nürnberg)

**144 Somatoform Disorders in Primary Care and Inpatient Settings**  
Rief, W.; Nanke, A. (Marburg)

**159 Therapeutic Approaches to Chronic Pain and the Role of the Consultation-Liaison Psychiatrist**  
Radanov, B.P. (Zürich)

**171 Are Sleep and Its Disorders of Interest for Psychiatric and Psychosomatic Medicine?**  
Staedt, J. (Berlin-Spandau/Basel); Stoppe, G. (Basel)

**Debate Section**

**177 Consultation-Liaison Psychiatry and Psychosomatics in Germany: Futile Dispute or Lesson to Be Learned? Introductory Comment**  
Diefenbacher, A. (Berlin)

**181 Psychosomatic Medicine and Psychotherapy: On the Historical Development of a Special Field in Germany**  
Deter, H.-C. (Berlin)

**190 ‘Psychiatry and Psychotherapy’ and ‘Psychotherapeutic Medicine’. A Unique Situation in Germany**  
Schmauss, M. (Augsburg)

**192 Psychosomatic Medicine and Psychiatry: The German Situation**  
Niklewski, G. (Nürnberg)

**196 German Psychosomatic Medicine: An International Perspective**  
Malt, U.F. (Oslo)

**203 Author Index**

**204 Subject Index**
Foreword

It is fitting that the 26th volume in this series reviews Consultation-Liaison Psychiatry in Germany. In 1960 the first volume of *Advances in Psychosomatic Medicine* began with a statement from Prof. Jores: ‘The psychosomatic approach to disease is still fighting for genuine recognition and a firm place in the teachings of modern medicine’. Four decades later, the statement can still be considered valid. Nevertheless this is a very exciting time for consultation psychiatry in Germany as well as the rest of Europe. The vigorous role of the European Association of Consultation-Liaison Psychiatry and Psychosomatics underscores how significant a role this subspecialty plays in forming a bridge from psychiatry to the rest of medicine. The evolution of consultation psychiatry in Germany is unique within Europe due to the role of a distinct specialty of psychosomatics. Only because of pioneers such as Dr. Diefenbacher, has this distinct subspecialty of psychiatry itself become important in Germany today. While North American psychiatrists are familiar with the contributions of Griesinger, Kraepelin, Bonhoeffer and Schneider to psychiatry, they are rarely aware of the psychosomatic influence of German internists who founded psychosomatic divisions within their departments of medicine. Volume 11 of *Advances in Psychosomatic Medicine* reviews the German psychosomatic medicine model that utilizes internal medicine specialists and psychologists. Their clinical forums include dedicated inpatient units and outpatient clinics. Their theoretical model is strongly psychodynamic and psychophysiological. The parallel medical liaison divisions were established in the United States, wherein internists, such as George Engel in Rochester and Franz Reichsman in Brooklyn, never achieved formal specialty status. Their role in the education of medical
students, however spawned the biopsychosocial approach which continues today as an important message for health care personnel in providing comprehensive treatment. Within North America consultation-liaison psychiatrists evolved to carry on the biopsychosocial tradition and work as ambassadors of psychiatry to the rest of medicine. Dr. Diefenbacher trained with James Strain and returned to Berlin to lead this movement which is now a recognized subspecialty in the United States. This volume demonstrates his vigorous activity and tremendous achievements. It is thus that these dual traditions of a unique psychosomatic department and consultation-liaison psychiatry within traditional psychiatric departments lead to such interesting clinical and research experiences.

Consultation-liaison psychiatry in Germany has received relatively less attention than psychosomatic medicine. To this end, it is a great delight to have this volume that reviews a wide variety of important topics that have become a focus in Europe, North America, Australia and Japan. The concluding section on the debate ‘The relationship of consultation-liaison psychiatry and psychosomatics in Germany’ should be a fascinating topic for those not familiar in the nature and history of these two parallel disciplines. Prof. Malt’s international perspective makes this a particularly valuable section.

In conclusion, this 26th volume of *Advances in Psychosomatic Medicine* represents the extraordinary advances we have made in our field. Although Prof. Jores’ hopes have not been fully realized, we are far closer to them now than in 1960.

_Thomás N. Wise_
Series Editor
As psychiatry is no longer confined to state mental asylums but has become integrated into general hospitals, consultation-liaison (C-L) psychiatry is increasingly being regarded as its foothold within the realm of somatic medicine. The beginnings of the field were in the USA during the 1920s and 1930s [1], but nowadays it can be regarded as an international approach to the treatment of patients with psychiatric and somatic comorbidity [2].

The publication of this volume coincides with the publication of the first German textbook on Psychiatry within Medicine, the first of its kind written in the German language [3]. It attempts an overview of the development of C-L psychiatry in Germany, Austria and Switzerland.

First, the aspects of C-L psychiatric service delivery are presented, beginning with reviews of national developments within the 3 countries. Psychiatric comorbidity in general hospital inpatients as well as mental disorders in the outpatient setting are discussed, followed by psychogeriatric C-L service delivery in elderly patients. The section is concluded by an overview of screening instruments for psychiatric disorders in somatically ill patients.

The Special Section features disorders relevant to C-L psychiatry, beginning with depression, alcohol abuse, and delirium, such disorders being crucial to inpatient (as well as outpatient) C-L service delivery. The chapter on suicide attempts delineates part of a nationwide effort in Germany to establish so-called competence centers for several psychiatric disorders, such as schizophrenia, dementia and, of special relevance to C-L psychiatry, depression and suicide. An important topic of outpatient service delivery, somatoform disorders, is presented by medical psychologists: The field of behavioral medicine that is
about to emerge, at least in Germany, has been pushed forward mostly by this non-physician professional group [4]. The section is concluded by the topics of chronic pain syndromes and sleep disorders.

Finally, there is a Debate Section. Non-German readers are usually not aware that in Germany there are two distinct board-certified physician specialties dealing with patients with psychiatric illnesses, usually referred to as ‘psychiatrists’ and ‘psychosomaticists’. Hence, C-L services in some hospitals may be provided by two different physician-run service types, e.g. ‘C-L psychiatry’ (what this book is about) and ‘C-L psychosomatics’. This special German way is not well understood abroad. The discussants, psychiatrists, as well as psychosomaticists, German as well as international, provide succinct viewpoints of this situation from different angles to enable the reader to form his or her own opinion about whether, or to what extent, this dichotomy is helpful or not in the practical clinical care of patients with psychiatric and somatic comorbidity.

Finally, I would like to thank Thomas Wise and Steven Karger for the invitation to publish this book; Thomas Nold and the staff of Karger Publishers for their editorial assistance and, with special emphasis, my co-workers, Hans Hübner, MD, for translating and editing several chapters, and Kerstin Herrmann for her, as usual, exemplary way of running the secretariat.

Albert Diefenbacher

References

Consultation-Liaison Psychiatry in Germany

Albert Diefenbacher

Abteilung für Psychiatrie und Psychotherapie, Evangelisches Krankenhaus Königin Elisabeth Herzberge, Berlin, Deutschland

Introduction

Consultation-liaison (C-L) psychiatry is the term used to describe the psychiatric care of patients who are primarily in medical treatment for somatic reasons in non-psychiatric departments of a general hospital or in ambulatory care of a non-psychiatric physician. ‘Consultation psychiatry’ means that the psychiatrist sees such patients only when called upon to give advice to the consultant, whereas ‘liaison psychiatry’ denotes a more direct involvement in the treatment of physically ill patients with psychiatric comorbidity, assuming more responsibility in joint patient care with the psychiatrist, e.g. having the prerogative of seeing patients admitted to an internal or surgical ward without being specifically endorsed to do so in every given case anew, as well as starting and following through psychiatric or psychotherapeutic treatments. In everyday practice there is a continuum between consultation and liaison approaches and a worldwide consensus has developed to use the phrase ‘consultation-liaison psychiatry’ (or C-L psychiatry), with the notable exception of Great Britain, where ‘liaison psychiatry’ is used for both approaches [1].

In this chapter, the history and current status of C-L psychiatry in Germany are described.

History of C-L Psychiatry in Germany

In Germany, as in many countries, the integration of psychiatric departments into general hospitals has paved the way for psychiatry to be increasingly taken
note of as a discipline by medical-surgical physicians and patients alike. This integration is the cornerstone of C-L psychiatry.

**Beginnings**

The first comprehensive report on the problems of integrated psychiatric services in a general hospital in the Federal Republic of Germany was presented by Radebold [2] from Berlin in 1971, and is reminiscent of the work of Henry [3] in the USA in 1929. It describes the path from initial opposition to a growing acceptance by the staff of somatic departments wherein, as important factors, elements of liaison activity are mentioned such as joint visits at the bedside. A first systematic overview of ‘practical’ consultation psychiatry was published in the second edition of the German handbook of ‘Contemporary Psychiatry’ in 1975 by Bönisch and Meyer [4] under the title ‘Extreme situations of medical treatment’. It entails the expectation for an increasing importance of psychiatric liaison activity in a general hospital in view of the technology of modern medicine.

The first ‘conceptual presentation’ of modern consultation psychiatry in Germany stems from Böker [5–7] who, in a series of articles, attempted to delineate tasks and opportunities for psychiatry within the general hospital. He pointed out that the life-event crisis of acutely somatically ill individuals triggered by a faulty balance of habitual social communication in connection with, e.g., myocardial infarction or hepatitis or generally through the ‘entry into the technical labyrinth of the diagnostic mill’, represents a serious stress of adaptation for every sick individual. This may lead to severe psychopathological reactions especially in connection with ‘fears of being overwhelmed’ through the complex, increasingly anonymous diagnostic and therapeutic technology of the hospital environment, which shows characteristics of a total institution, the administrators of which have lost sight of the ‘anthropological framework’ (a phrase coined by the German medical historian Schipperges) of the encounter between patients and hospital employees [7]. With reference to US-American models and against the background of his own consultation activity at the Mannheim University Hospital in Baden-Württemberg, Böker postulated that it is not sufficient for modern psychiatry ‘to focus on the singular patient isolated from his environment. The traditional pattern of occasional visits by the specialist at the bedside appears not to be sufficient for the new tasks’. Collaboration with all workers in the hospital therefore was not a fashionable demand but an absolute necessity because it offered information for a more precise diagnosis and efficient therapy. In accordance with this paraphrased definition of psychiatric C-L activity, the psychiatric consultation team, which in Mannheim also included a social worker and a nurse, also increasingly offered services to the employees of the hospital and with this, a psycho-hygienic contribution, e.g., in the form of Balint groups [7].
Wherever, rarely enough in those days, psychiatric departments were installed in general hospitals, the opportunity to call a psychiatrist as a consultant was frequently used by the somatic disciplines. In 1970 at Steglitz University Hospital in Berlin, which at the time did not have a psychiatric department of its own, a psychiatric consultation service was created which, 6 years later, encompassed a volume of 1,571 initial consultations and 2,687 repeat consultations for 1,300 somatic beds [8].

‘Psychiatrie-Enquête’ and the Implementation of Psychiatric Departments in General Hospital in Germany

Different from the USA, where the establishment of psychiatric departments in general hospitals was already started to a larger extent in the 1920s [9], the establishment of such departments in general hospitals in Germany was an iron too hot to handle until the 1960s [10]. In the year 1970 there were just about 21 departments of this kind [11]. In view of the minimally satisfying situation at the large state mental hospitals, this started to change when, at the initiative of the German federal government, an expert commission was created to make an inquiry into the care of psychiatric patients in the Federal Republic of Germany at the time and make suggestions for improvement (this inquiry is one of the cornerstones of modern psychiatry in Germany and is widely known under the name of ‘Psychiatrie-Enquête’) [Niklewski, pp 192–195]. Among other things it was criticized that inpatient psychiatric treatment was almost completely absent near or close to communities (which meant that institutes could be reached with a maximum commute of 1 h using public transportation) [12]. The remote location of psychiatric hospitals interfered with the collaboration with other medical disciplines, which, due to the fact that approximately one third of psychiatric inpatients suffer from additional somatic illnesses, was tantamount to a loss of quality of care [13]. As a solution to the problem, the expert commission urgently recommended the establishment of psychiatric departments in general hospitals. In this context the implementation of permanent psychiatric C-L services was explicitly demanded for every larger hospital in which patients were treated after a suicide attempt [12]. Similarly the opportunity for a psychiatric-psychotherapeutic primary prevention of risk groups in somatic medicine was also recommended as an important service of the psychiatric consultation services:

‘A psychiatric and psychotherapeutic primary prevention for risk groups and for psycho-social stress situations in the area of somatic medicine should be further expanded. Within this realm belong the care of hospitalized children and adults, accident victims as well as the incapacitated or chronically ill. Large psychological problems also occur in the context of dialysis, the treatment with cardiac pacemakers, transplantation surgery and the aseptic isolation in the care of extensive burns. The increase in technology in medicine as is
practiced in intensive care units (ICU), the dependence of many patients on complicated, frequently poorly understood instruments, their forced isolation and immobility represent a significant psychic stress situation and make preventive care necessary which would be best handled by psychiatric-psychotherapeutic or psychosomatic departments at general hospitals’ [12, p 392].

In a status report 5 years after the ‘Psychiatry-Enquête’ Häfner [14] stressed that

‘the psychiatric department in a general hospital is not only a prerequisite for the elimination of the separation of inpatient psychiatric care. It also provides the mentally ill with simultaneous somatic illness a collaborative treatment through other medical disciplines and the somatically ill a psychiatric therapy of high standards’ [p 17].

The important role of the general hospital and local psychiatric consultation and emergency services as a path of entry into inpatient psychiatric care is emphasized by the example of the city of Mannheim in Baden-Württemberg [15].

In order to document the development which was initiated by the ‘Psychiatrie-Enquête’ and in order to check on the transformation as well as to take into account newer developments, a psychiatric model program was initiated by the German government in 1979. In its final report the expert commission focused again on the care of mentally ill in the general hospitals:

‘Through the community-centered location and also physical integration into the general hospital, the hurdle of admission is much lower than with regard to specialized psychiatric hospitals. … This is of significant importance because many patients after suicide attempts, alcohol- and drug-dependent individuals as well as old people with psychic disorders are treated in medical-surgical departments in general hospitals’ [16, pp 280–281].

In view of the high prevalence of mental disorders on medical-surgical units, the expert commission did not intend to establish additional psychosomatic/psychotherapeutic inpatient units at general hospitals, but suggested another mode of cooperation:

‘Differing models are in existence: (1) the consultation model, (2) the liaison model and (3) the workgroup model (extended model of the liaison service that provides continuity). The consultation model is considered among experts as the least convincing because unrealistic faulty expectations give rise to later disappointment. For this reason the expert commission recommends the establishment of liaison services at general hospitals staffed by specialists. Under this term one understands physicians with specific areas of continuous education in psychotherapy or psychoanalysis who have qualified knowledge of the respective medical discipline to be served’ [16, pp 554f].

The commission pointed out that a (psychosomatic) liaison service close to a medical unit at the University of Ulm in Germany reached a relative consultation rate of 11% of all patients, whereas a year later a consultation project
away from a medical unit was only utilized by 4% of all patients at the same location [17]. Liaison models with part-time employment of medical psychotherapists who otherwise work out of their own ambulatory office were considered especially worthwhile under the aspect of continuity of care.

From other psychiatrists, however, it was pointed out that in view of the faulty placement of 51.4% mentally ill patients in somatic hospitals, as was true for patients insured by the Allgemeine Ortskrankenkasse (Germany’s largest medical insurance organization) in Bavaria, from a specialty point of view these mentally ill should be treated in psychiatric institutions and that the contributions of C-L psychiatry in their care should not be overestimated [18, 19].

**In the Wake of the ‘Psychiatrie-Enquête’**

A survey of psychiatric units in general hospitals at the beginning of the 1980s showed the considerable extent of C-L psychiatric activities: for a typical psychiatric department with approximately 70 beds in a medium-sized hospital, one could assume approximately 600 consultations per year. In a large medical center, the frequency of consultations was found to be up to 4,000 per year [20]. But scientific contributions to consultation psychiatric themes remained rare until the end of the 1980s [21, 22]. They were confined mostly to the clinical aspects of singular disease entities, where the necessity of interdisciplinary studies, especially in areas of oncology, hemodialysis and heart surgery, with respect to the occurring psychopathological syndromes and psychological problems was proposed [23–26]. Occasionally an orientation towards the US-American model of C-L psychiatry was suggested [24].

Contributions on the organization and functioning of psychiatric consultation services remained rare [21]: some described the functioning of singular C-L psychiatric services [27] or investigated aspects of C-L service delivery in the context of models of inpatient crisis intervention in general hospitals [28]. A remarkable exception was the aftercare of suicidal patients: a series of publications urgently demonstrated the necessity of continuous aftercare of patients after suicidal attempts. This care seemed to be given most reliably in the context of a psychiatric liaison service which works with in- as well as outpatients [29, 30].

A survey performed in 1988–1989 attempted to give a representative overview on the extent of psychiatric, psychosomatic and medical psychological C-L activity in the Federal Republic of Germany. It turned out that 98% of the psychiatric departments at general hospitals offered C-L services. Predominantly (in 84%) a pure consultation model was used, and in 14% a C-L mode was practiced. The psychotherapeutic orientation at general hospitals was psychodynamic, only rarely behavioral therapeutic. An average of 29 h of C-L activities per week accumulated [31].
C-L Psychiatry in the German Democratic Republic

In the former German Democratic Republic (GDR) C-L activity was practiced by neuropsychiatrists, whereas medical specialists for psychotherapy and inpatient psychosomatic-psychotherapeutic facilities, which also were located in centers for internal medicine, were utilized more rarely for C-L services [30]. A more biologically oriented psychiatric approach, with additional responsibility for neurological consultations, was the norm: The contributions of a workgroup around Greger in Gera belong to the few published reports on consultation psychiatric activity in emergency services at all [31, 32].

Recent Developments

Since the beginning of the 1990s the interest in C-L psychiatric questions has increased both in the university-based as well as general hospital-based psychiatric departments. A series of reports about the activities of psychiatric C-L services in Germany was published (table 1).

Epidemiological studies regarding the prevalence of psychiatric comorbidities of internal medical and surgical patients were performed with a special focus on alcohol-dependent and geriatric patients [Arolt, pp 31–51]. In total an increase in academic involvement was observed in aspects of the care of special patient groups in the general hospital with increased mental comorbidity, e.g. geriatric [46–48; Stoppe and Staedt, pp 66–73; Reischies and Diefenbacher, pp 128–136], alcohol-dependent individuals [49; Kremer et al., pp 118–127], neurological-epileptological [50, 51], pain [52, 53] and oncological patients. For the care of the latter groups significant contributions also came from medical psychological services [54–56].

As the number of psychiatric departments in general hospitals doubled from 61 in 1979 to 125 in 1995, C-L psychiatric services increasingly lived up to the function of making the field of psychiatry with its diagnostic and therapeutic possibilities transparent for the somatic disciplines, also in order to reduce prejudice against the mentally ill and the (pessimistic) ignorance about psychiatric treatment success [57]. The workgroup of the directors of psychiatric departments at general hospitals (http://www.ackpa.de) has established a solid position for the theme of consultation psychiatry in the context of its annual meetings [58]. Since 1992 at the scientific meetings of the German Society for Psychiatry, Psychotherapy and Neurology (‘Deutsche Gesellschaft für Psychiatrie, Psychotherapie und Nervenheilkunde’, DGPPN), a C-L psychiatric symposium has regularly been held [59]. Consultation psychiatry and psychotherapy are receiving increasing attention in psychiatric textbooks [60, 61]. Concise guides on ‘Practical Consultation Psychiatry and Psychotherapy’
have been published [62, 63], as well as a comprehensive textbook [64]. With increasing tendency, consultation psychiatry is being conceptualized as part of a community psychiatric care system and emphasis is being placed on the filter function of the general hospital and implicit role of psychiatric consultation services in the diagnosis of heretofore unrecognized treatable mental disorders [36, 65, 66]. Also, reports on C-L activities performed by departments of child and adolescent psychiatry, which is a separate physician specialty in Germany, have been published [67, 68].

In a memorandum, the German Psychiatric Association (DGPPN) emphasized the importance of psychiatric-psychosomatic C-L services for the general hospital [69].

**Other Approaches to C-L Service Delivery in Germany**

It is not well understood that ‘psychiatry and psychotherapy’ and ‘psychotherapeutic medicine’ have in fact been two separate physician specialties in Germany since 1992. This two-stranded system has a long history. Other than in the USA [70] for instance, classical psychosomatic thinking in Germany largely developed, though not exclusively [22, 71], outside academic psychiatry, mostly in cooperation with some interested internal medical departments [72] (for further clarification see the chapters in the Debate Section of this volume).

**Psychosomatic Medicine and C-L Psychiatry in Germany**

Outside Germany, for many years there was the erroneous assumption that German psychosomatic medicine was responsible for C-L service delivery in general hospitals. In fact, this was never the case, and for a long time those psychosomatic specialists who were primarily active in C-L work even expressed their disappointment that

‘the psychosomatic consultation service … has to be regarded in several ways as the neglected child of psychosomatic medicine. Therefore many colleagues are glad when they can delegate this work which often appears senseless, frustrating, and does not seem to lead to much feedback’ [73].

Wirsching and Herzog [74] emphasized that the ‘so far rather problematic perhaps even neglected area of cooperation of psychosomatic medicine with general clinical medicine in so-called consultation-liaison services (experienced) an unexpected boost’ only at the end of the 1980s. Recently, guidelines for C-L psychosomatics and psychotherapy have been published [75].

Discussions between C-L psychiatrists and their psychosomatic counterparts in Germany remained rare during that period: single psychiatrists tried to define
Table 1. Consultation psychiatry in general hospitals in Germany and Austria (with permission from Diefenbacher et al. [35])

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate of referral to consultation psychiatric services, % of all admissions</td>
<td>3.6</td>
<td>About 3–5a</td>
<td>2</td>
<td>About 1c</td>
<td>1.52</td>
<td>2</td>
<td>0.8</td>
<td>About 1</td>
<td>0.5–9.1</td>
</tr>
<tr>
<td>Proportion of referrals from general medicine, %</td>
<td>58.8</td>
<td>23.5</td>
<td>29</td>
<td>–</td>
<td>47</td>
<td>58.7</td>
<td>About 10f</td>
<td>–</td>
<td>47.7–90</td>
</tr>
<tr>
<td>Proportion of referrals from surgical specialties, %</td>
<td>29.3</td>
<td>31</td>
<td>11.6</td>
<td>–</td>
<td>12.5</td>
<td>25.5</td>
<td>About 2.4f</td>
<td>–</td>
<td>7–34.7</td>
</tr>
<tr>
<td>Proportion of referrals from other specialties, %</td>
<td>5.8</td>
<td>(gynecology)</td>
<td>25.5</td>
<td>(neurology)</td>
<td>20.3b</td>
<td>(neurology)</td>
<td>–</td>
<td>17</td>
<td>4.3</td>
</tr>
<tr>
<td>Diagnoses, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organic psychoses</td>
<td>20.7</td>
<td>40.7</td>
<td>11.8</td>
<td>30.2</td>
<td>23.3</td>
<td>49</td>
<td>20.1</td>
<td>About 1</td>
<td>1.6–57</td>
</tr>
<tr>
<td>Neurotic, adjustment and somatoform disorders, personality disorders</td>
<td>34.8</td>
<td>13.2</td>
<td>63.6c</td>
<td>19.5</td>
<td>32.3</td>
<td>44.7</td>
<td>–</td>
<td>About 72b</td>
<td>2–48</td>
</tr>
<tr>
<td>Affective disorders</td>
<td>7.7</td>
<td>23.9</td>
<td>15</td>
<td>13.9</td>
<td>16.9</td>
<td>9.9</td>
<td>29.3</td>
<td>About 18</td>
<td>4–62</td>
</tr>
<tr>
<td>Substance-related disorders</td>
<td>24.6</td>
<td>28.3</td>
<td>5.6</td>
<td>17.4</td>
<td>23.3</td>
<td>–</td>
<td>7.9</td>
<td>About 2</td>
<td>0.6–28</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------</td>
<td>------</td>
<td>-----</td>
<td>------</td>
<td>------</td>
<td>---</td>
<td>----</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Treatment recommendations, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychotherapeutic measures</td>
<td>19.1</td>
<td>–</td>
<td>27.4</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>9</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Psychotropic medication</td>
<td>41.3</td>
<td>–</td>
<td>41.8</td>
<td></td>
<td>57e</td>
<td>69</td>
<td>–</td>
<td>72.4</td>
<td>3</td>
</tr>
<tr>
<td>Transfer to a psychiatric ward</td>
<td>28.7</td>
<td>–</td>
<td>5.6</td>
<td>–</td>
<td>14</td>
<td>15.7</td>
<td>26</td>
<td>–</td>
<td>5–31</td>
</tr>
<tr>
<td>Reasons for referral, %</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide attempt/suicidal ideation</td>
<td>25.1</td>
<td>–</td>
<td>14.4</td>
<td>10</td>
<td>7</td>
<td>24.7</td>
<td>–</td>
<td>2</td>
<td>5.1–47</td>
</tr>
<tr>
<td>Addiction</td>
<td>19.8</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>11.5</td>
<td>3</td>
<td>28.3</td>
<td>–</td>
<td>0</td>
</tr>
<tr>
<td>Acute psychiatric symptoms</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>42.2</td>
<td>57</td>
<td>–</td>
<td>–</td>
<td>31</td>
<td>–</td>
</tr>
<tr>
<td>Physical symptoms with no organic explanation</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>10.3</td>
<td>18</td>
<td>–</td>
<td>–</td>
<td>55</td>
<td>12–22</td>
</tr>
</tbody>
</table>

aGeneral medical, surgical and neurological patients.
bOutpatient pain clinic and physical medicine 14.3% (liaison work).
cOf these, 21.7% were somatoform disorders.
dData from 2 hospitals: Urban-Krankenhaus and the Universitätsklinikum Rudolf Virchow of the Freie Universität (FU) in Berlin.
eData only for the Universitätsklinikum of the FU in Berlin.
fPercentages each refer to all hospital admissions.
gPsychosomatic medicine consultation service of the Universitätsklinikum Benjamin Franklin of the FU in Berlin.
hSomatoform disorders about 16%, organic mental disorders (ICD-10F5) about 22%.
iEach entry gives the range of percentages in the reviewed publications.