

## RESEARCH ARTICLE

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# Spectrum, rate and unmet needs of sociomedical interventions in outpatient psychotherapy

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**Abstract**

**Objective:** Psychological disorders often take a long-term course, resulting in impairment in daily life and work. Treatment must therefore target not only symptoms of illness but also capacity limitations and context restrictions, as outlined in the International Classification of Functioning, Disability and Health (ICF). This includes sociomedical and interdisciplinary interventions like coordination with other specialists, contact to employers and employment agencies, social support agencies, debt counselling, self-help and leisure groups. There are no data on the spectrum, rate and unmet needs of sociomedical interventions in outpatient psychotherapy.

**Method:** Following a semistructured interview schedule, 131 psychotherapists in private practice were asked to report on unselected patients. The interviewer assessed to what degree 38 predefined sociomedical interventions were applied so far or should be considered in the future.

**Result:** Reports for 322 patients were gathered. All sociomedical interventions were applied, depending on the sick leave status and course of illness. Cognitive behaviour therapists used more sociomedical interventions than psychodynamic therapists.

**Conclusion:** The data show that sociomedical interventions are a frequent part of psychotherapy. They are used preferably in patients with participation restrictions. Psychotherapeutic concepts and education should include sociomedical aspects.

**KEYWORDS**

bio-psycho-social treatment, chronic mental disorders, psychotherapy, social medicine, sociomedical interventions

## 1 | INTRODUCTION

Many mental disorders take by their very nature long-term, persistent or recurrent courses, as this is the case in addiction disorders, psychoses, anxiety disorders, depressive disorders, somatoform disorders or personality disorders (Linden, 2017). Mental disorders and especially those with a chronic course often lead to social impairment, be it at work, in the family, in social interactions or in daily activities (Druss et al., 2000; Merikangas et al., 2007). The

International Classification of Functioning, Disability and Health (ICF) (WHO, 2001) defines “functioning” in the context of a person’s body functions, activities and social as well as professional participation. The term “disability” refers to impairments in any of these dimensions (Lehmann et al., 2002). Thus, many mental disorders can be seen as “disabilities,” as they are characterized by long-term health impairments and also by participation restrictions and impairment (Bhattacharya et al., 2006; Brieger et al., 2004; Druss et al., 2009).

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Following the definitions of the ICF, treatment should follow a bio-psycho-social treatment concept and support functioning, capacity limitations and context restrictions alike (Egger, 2005; Linden, 2017; WHO, 2001) to support social and professional participation and thus promote an independent life and inclusion (UN, 2006). Psychotherapy is the only treatment mode that can work similarly on impaired functions/symptoms (e.g., reduction of anxiety), capacity limitations (e.g., training of social competence) and context restrictions (e.g., family-related problems). The simultaneous consideration of personal and environmental factors is indispensable to achieve the best outcome (Fjeldheim et al., 2015; Steeves et al., 2014; Yang et al., 2008).

In such a multilevel treatment, sociomedical interventions are indispensable and a core element of treatment (Muschalla & Linden, 2011). They can be defined as all measures that help the patient to achieve the best functional status and social participation in daily life and work. They target not only the illness but even more so help to master daily demands, to overcome environmental barriers and to provide support and resources in daily life. This encompasses a variety of measures: (a) Therapists should guarantee multiprofessional treatment and cooperate parallel or in succession with other therapists of all kinds, such as medical specialists, occupational therapists, social workers and others. (b) There are additional treatments like psychoeducation courses, drug counselling, family and education counselling, debt counselling and sport activities (Brieger & Bernhard, 2012; Meltzer et al., 2011; Rethorst et al., 2009). (c) Further cooperation partners are the medical departments of the health insurance, work agencies, sociopsychiatric services or case managers of the social security office. (d) To support work ability and job security, therapists can cooperate with company physicians, the employer, employee representatives, the job centre or the integration office. Further work oriented measures exist in the form of occupational integration management, stepped job reintegration, in-company integration management or operational health management (Høgelund et al., 2010). (e) Therapists can support the patient by sick leave certificates or certificates of disability (Borgart et al., 2008; Niehaus et al., 2008). (f) Additionally, there are also sociomedical interventions to support patients in their daily life such as individual case work, sociotherapy and assisted living. Ergotherapy can help to improve physical activity, subjective well-being or work-life balance (Danielsson et al., 2014, 2019, 2020). (g) Finally, there are interventions to increase social contacts or enrich life in general. Some of all these interventions may be done by therapists themselves. Others will have to be initiated, guided and supervised by the therapist.

There is a lack of data on the role of sociomedical interventions in psychotherapy and to what degree they are or should be applied (Borgart et al., 2008). The primary focus of psychotherapists is traditionally directed to the improvement of illness processes and symptoms. Although this can indirectly improve participation, it does not include measures to directly change environmental conditions (Salomonsson et al., 2018). There are indicators that such interventions may even not be known and used by many psychotherapists (Schymainski et al., 2021). This could be caused by barriers which sociomedical interventions encounter in

### Key Practitioner Message

- Psychotherapy patients are often suffering from long-term disorders, which result not only in symptoms of illness but also in participation restrictions.
- Treatment must follow a multidimensional, interdisciplinary, bio-psycho-social concept, including sociomedical interventions in regard to cotherapies, work integration and daily life.
- Sociomedical interventions are known and implemented by psychotherapists in many of their patients.
- A sociomedical perspective and training of psychotherapists is needed.

the context of psychotherapy. There are, for example, some psychotherapeutic schools that allow only little variation in treatment procedures. Others require therapeutic abstinence in regard to day-to-day problems. There is often not enough time to deal with such additional aspects.

Objective of the present study was to investigate the spectrum, rate and need of sociomedical interventions in a sample of patients in routine ambulatory psychotherapy. Questions to answer are which sociomedical interventions have already been applied or should be applied. Such data are needed to discuss how sociomedical interventions can be integrated into the daily psychotherapeutic work, how this can be reimbursed and how psychotherapists should be trained. This is to our knowledge the first survey of this kind.

## 2 | METHOD

### 2.1 | Psychotherapists and cases

All citizens in Germany are covered by health insurance. This allows unlimited psychotherapeutic counselling by general practitioners or psychiatrists on a primary level free of costs. Additionally, there is on a secondary level specialist psychotherapy, either psychodynamic (PD) or cognitive behaviour therapy (CBT) for up to 80 CBT or 100 PD weekly 50-min sessions. They are fully reimbursed by health insurance. Patients can contact the specialist psychotherapists directly or on referral by other physicians.

Based on official lists from the Association of Statutory Health Insurance, we contacted psychotherapists in private practice without any preselection, apart from sampling a similar number of cognitive behaviour therapists and psychodynamic psychotherapists. The study was supported by the Association of German Psychotherapists (DPtV), which sent out an e-mail to motivate their members to participate.

Therapists were asked to report on the last two to four patients they had seen, who were in the working age of 20–60 years and had at least 10 treatment sessions.

**TABLE 1** Sociomedical interventions**Coordination of multidimensional/multi-professional treatment**

Case manager of health insurance  
 Supervises individual care of insured persons  
 Medical service of health funds  
 Assessment of individual patients by medical specialists of the health insurance  
 Sociopsychiatric services  
 State institution for crisis intervention and care for patients with severe mental disorders  
 Medical specialist  
 Medical specialists of different medical disciplines for somatic or mental disorders, working in private practice or hospitals  
 Occupational therapists  
 Therapists providing training of somatic, psychological and occupational capacities  
 Drug counselling  
 Institutions providing counselling and treatment for alcohol and drug addiction  
 Psychoeducative courses  
 Courses and seminars, as provided by health insurance and others for informing patients on many health related topics  
 Self-help groups  
 Meeting of patients with similar problems  
 Day-care institutions  
 Institutions which take care of mentally ill or handicapped persons during the day  
 Inpatient medical rehabilitation  
 Hospitals with a special focus on the treatment and rehabilitation of chronic disorders  
 Post rehabilitation treatment groups  
 Group treatment in the aftercare following medical inpatient rehabilitation  
 Patient transportation  
 Transportation of patients to treatment, which is paid by health insurance  
 Hospital treatment  
 Inpatient hospital treatment  
 Consultation with hospital therapists  
 Consultation with therapists in hospitals and other inpatient units  
 Withdrawal treatment  
 Treatment option for patients with addiction disorders

**Work participation**

Certificate of disability  
 Official certification of degree of impairment  
 Sick-leave certificate  
 Official certification of acute inability to work  
 Stepped occupational reintegration  
 Reintegration in the job with progressive increase of working hours  
 Company doctor/employer  
 Employers and company doctors who are responsible for work inclusion of sick and/or disabled employees  
 Works council  
 Representatives of the employees in a company  
 Company integration management  
 Statutory procedure in the company to organize work reintegration for disabled employees  
 Employment agency  
 State agency for administration and support of jobless persons  
 Integration office  
 State agency to provide help of all kinds for disabled persons

**TABLE 1** (Continued)

Rehabilitation information service
Counselling centres of the health and pension insurance
Training for job reintegration
Institutions which provide training for job reintegration
Disability pension
Early retirement pension
<b>Participation in daily life</b>
Sociotherapy
Care and counselling for severely impaired patients by social workers and other health care specialists
Home-psychiatric care
Support for severely impaired patients in regard to housekeeping and treatment at home
Family support
Financial and psychological help for families
Assisted living
Sheltered living
Debt counselling
Counselling service for patients with financial problems
Individual case support
Individual support by a counsellor with regard to daily routines
Home visits
Therapist sees the patient at home
Legal guardian
Legal representative of the patient in different areas of life
County counselling services
State counselling services which give help in all areas of life
Family counselling
Counselling services for problems with partner and children
Contacts to relatives
Therapist contacts with family members of a patient
Sports club
Sports clubs which allow physical activities and social contacts, paid by health insurance or the patient himself

## 2.2 | Instruments

Therapists were asked for their own gender, age, professional education, years of practice, number of patients and focus of disorders. In order to prepare for the interview, they were given a glossary with extensive definitions of 38 sociomedical interventions, which can be grouped in coordination of multidimensional treatment, professional participation and participation in daily life (Table 1).

Therapists were then interviewed in their office by researchers who were themselves psychotherapists. They followed a semistructured interview schedule, which allowed asking additional questions and clarifying possible misunderstandings. The interrater reliability showed a high agreement between the two raters ( $\kappa = .803$  [95% CI],  $p < .0005$ ).

Assessed were age of the patients, gender, family status, diagnosis, severity and course of illness, work problems and status. There was a list of 38 predefined sociomedical interventions, as outlined in the

glossary. The interviewer discussed each item with the therapist by asking for details such as “How did you get in contact with sociopsychiatric services?” or “Was the intervention initiated by yourself?” or “What are the reasons that you think debt counselling is needed?” The interviewers, who are experts in sociomedical matters, then made a rating: “done and not indicated again,” “done and should be considered again,” “not done but should be considered” and “not done and not indicated.” This procedure allows a validation of the answers of the therapist. In this paper, we report the interviewer ratings.

## 2.3 | Ethical considerations

Therapists were informed in writing and orally about the study and were remunerated for their time according to official remuneration guidelines for therapists. There was no direct involvement of patients and no interference with treatment.

The study was done with a research grant from the State Pension Insurance Berlin-Brandenburg. The study was reviewed and approved by the ethical committee of the Charité University Medicine Berlin (register-no. ethical-votum: EA4/027/18) and the data and research surveillance department of the State Pension Insurance Berlin-Brandenburg.

### 3 | RESULTS

We contacted 365 psychological psychotherapists by phone and included 131 in the study, of which 56.5% were cognitive behaviour therapists (CBT) and 44.3% psychodynamic therapists (PD). There were 74% female therapists. The average age was 54 ( $\pm 11$ , min: 32, max: 74) years, and they were working as psychotherapist for 17 years on average ( $\pm 10$ , min: 1, max: 45). On average, they treat 39 patients ( $\pm 24$ , min: 5, max: 150), including acute contacts, short-term (>24 sessions), long-term (>24 sessions) and prophylactic treatment.

In total, 322 case vignettes were discussed, of which 58.4% were from CBT and 41.6% from PD therapists. Case vignettes referred in 65.8% of cases to women with a mean age of 41.64 years ( $\pm 10.99$ , min: 20, max: 64), 8.6% being on early retirement, 29.2% on sick leave, 10.0% on sick leave and unemployed and 8.3% unemployed. In total, 56.1% of cases were out of work. Clinical diagnoses were in 61.2% affective disorders, in 30.1% anxiety and obsessive-compulsive disorders, in 24.8% trauma- and stress-related disorders, in 16.1% personality disorders and in 15.8% somatoform disorders. According to the judgement of therapists, patients suffered from first episodes of mental disorders in 22.6%, from recurrent disorders in 37.9%, from chronic-exacerbating disorders in 10.3% and from chronic-persistent disorders in 29.2% of cases. In total, 77.4% of cases were long-term disorders.

Frequencies of sociomedical interventions in regard to “coordination of multiprofessional treatment” are shown in Table 1. Most frequent were contacts to other medical specialist in 50% of cases, followed by inpatient medical rehabilitation (27.9%), contact to medical services of health funds (24.2%), hospital treatment (15.5%), self-help groups (11.8%), psychoeducative courses (11.2%) and contacts to case managers of the health insurance (11.2%). Least frequent were drug counselling (5.0%), post rehabilitation treatment groups (4.3%), day-care institutions (3.1%), withdrawal treatment (2.8%) and patient transportation (0.9%). From all 15 preset interventions on average, 1.76 (SD: 1.73; min: 0, max: 9) were already done per patient.

Most often recommended were psychoeducative courses (44.1%), followed by self-help groups (33.5%), post rehabilitation treatment groups (30.7%), inpatient medical rehabilitation (23.3%), consultation of hospital therapists (17.1%), consultation of medical specialists (15.8%), occupational therapists (10.6%) and medical service of health funds (9.6%). Least frequent taken into consideration were day care (6.5%), sociopsychiatric services (6.5%), case manager of health insurance (6.5%), drug counselling (4.3%), hospital treatment (4.0%), withdrawal treatment (3.4%) and patient transportation (2.2%). From all 15 interventions on average, 2.09 ( $\pm 1.79$ ; min: 0, max: 8) were recommended per patient.

Regarding working participation, most frequently already done were sick leave certificates (28.0%), certificates of disability (27.9%), contacts to the employment agency (16.8%), stepwise occupational reintegration (13.1%), disability pension (11.8%) and contacts to the rehabilitation information service (10.9%). Least frequent were contacts to the company doctor or the employer of the patient (9.3%), contacts to the company integration management (7.1%), contacts to the works council (5.9%), training for job reintegration (5.6%) and contact to an integration office (1.2%). From all 11 interventions on average, 1.38 ( $\pm 1.64$ ; min: 0, max: 8) per patient were already done.

The highest rate of recommended interventions in regard to work participation is found for contacts to the rehabilitation information service and training for job reintegration, both with 22.4%, stepped occupational reintegration (17.8%), contacts to the employment agency (13.7%), company doctor/employer (13.0%), certificate of disability (12.4%), disability pension (10.2%), contacts to works council (9.3%), sick leave certificates (8.7%), company integration management (8.4%) and integration office (6.2%). From all 11 interventions on average, 1.44 ( $\pm 1.89$ ; min: 0, max: 10) were recommended per patient.

Regarding participation in daily life, most frequent were consultation of a legal guardian (40.0%), attending a sports club (27.3%), contact to relatives (9.0%), family counselling (7.8%), county counselling services (6.5%), family aid (5.3%), assisted living (4.0%), debt counselling (4.0%), sociotherapy (3.7%), individual case support (3.1%), home care (1.9%), psychiatric care (1.9%) and home visits (0.6%). From all 12 interventions on average, 0.78 ( $\pm 1.03$ ; min: 0, max: 5) per patient were already done.

In this group of interventions, most often recommended were sports clubs (45.7%), contacts to relatives (26.7%), legal guardians (26.4%), family counselling (10.6%), individual case support (10.6%), sociotherapy (8.7%), home visits (7.1%), county counselling services (5.6%), assisted living (4.0%), debt counselling (3.7%), family aid (3.1%) and home care and psychiatric care (2.5%). From all 12 interventions on average, 1.33 ( $\pm 1.49$ ; min: 0, max: 8) were recommended per patient.

Relating the rate of already done or recommended sociomedical interventions to the course of illness (first episode, recurrent, chronic exacerbating and chronic persisting), analysis of variance shows significant overall differences (Table 2) in regard to “coordination of multidimensional treatment” for done and recommended interventions (“done”:  $F_{3,318} = 8.13$ ,  $p < .001$ ; “should be considered”:  $F_{3,318} = 3.78$ ,  $p < .01$ ), to recommended “professional participation” (“should be considered”:  $F_{3,318} = 4.66$ ,  $p = .01$ ) and to recommended “participation in daily life” (“should be done”:  $F_{3,318} = 8.70$ ,  $p < .001$ ).

Post hoc comparisons using the Tukey HSD test indicated for already done multidimensional treatment significant differences between “first episode” ( $M = 1.15$ ;  $SD = 1.25$ ) on one side and “chronic exacerbating” ( $M = 2.71$ ;  $SD = 2.16$ ) and “chronic persisting” ( $M = 2.05$ ;  $SD = 1.70$ ) on the other and between “recurrent course” ( $M = 1.64$ ;  $SD = 1.73$ ) and “chronic exacerbating” ( $M = 2.71$ ;  $SD = 2.16$ ). Post hoc comparisons for recommended multidimensional treatment showed significant differences between “first episode” ( $M = 1.75$ ;  $SD = 1.57$ ) and “chronic exacerbating” ( $M = 2.80$ ;  $SD = 2.01$ ) and between “recurrent course” ( $M = 1.90$ ;  $SD = 1.83$ ) and “chronic exacerbating” ( $M = 2.80$ ;  $SD = 2.01$ ).

Post hoc comparisons using the Tukey HSD test indicated for recommended professional participation significant differences between “first episode” ( $M = 0.97$ ;  $SD = 1.35$ ) and “chronic exacerbating”

( $M = 2.23$ ;  $SD = 2.43$ ) as well as “chronic persisting” ( $M = 1.73$ ;  $SD = 2.08$ ) and between “recurrent course” ( $M = 1.28$ ;  $SD = 1.77$ ) and “chronic exacerbating” ( $M = 2.23$ ;  $SD = 2.43$ ).

**TABLE 2** Rate of sociomedical interventions in relation to course of illness

	Done mean (standard deviation)	Should be considered mean (standard deviation)
Coordination of multidimensional treatment		
First episode	1.15 (1.25)	1.75 (1.57)
Recurrent course	1.64 (1.73)	1.90 (1.83)
Chronic exacerbating	2.71 (2.16)	2.80 (2.01)
Chronic persisting	2.05 (1.70)	2.32 (1.73)
Analysis of variance	$F_{3,318} = 8.13$ , $p < .001$	$F_{3,318} = 3.78$ , $p < .01$
Work participation		
First episode	1.37 (1.68)	0.97 (1.35)
Recurrent course	1.16 (1.60)	1.28 (1.77)
Chronic exacerbating	1.91 (1.72)	2.23 (2.43)
Chronic persisting	1.47 (1.60)	1.73 (2.08)
Analysis of variance	$F_{3,318} = 2.05$ , $p = .10$	$F_{3,318} = 4.66$ , $p < .001$
Participation in daily life		
First episode	0.51 (0.60)	0.88 (1.13)
Recurrent course	0.85 (1.11)	1.15 (1.24)
Chronic exacerbating	0.89 (1.13)	2.26 (2.34)
Chronic persisting	0.85 (1.13)	1.57 (1.48)
Analysis of variance	$F_{3,318} = 2.18$ , $p = .09$	$F_{3,318} = 8.70$ , $p < .001$

**TABLE 3** Rate of sociomedical interventions in relation to sick leave

	Sick leave mean (standard deviation)	No sick leave mean (standard deviation)	
Coordination of multidimensional treatment			
Done	1.35 (1.53)	2.35 (1.70)	$t_{289} = -5.06$ , $p < .001$
Should be considered	1.61 (1.59)	2.81 (1.91)	$t_{289} = -5.61$ , $p < .001$
Work participation			
Done	1.02 (1.50)	1.88 (1.75)	$U = 6176.5$ , $p < .001$
Should be considered	1.02 (1.50)	2.82 (2.34)	$U = 4008.5$ , $p < .001$
Participation in daily life			
Done	0.67 (0.98)	0.78 (0.92)	$t_{289} = -0.928$ , $p = .35$
Should be considered	1.03 (1.25)	1.81 (1.67)	$U = 6406.5$ , $p < .001$

Post hoc comparisons using the Tukey HSD test indicated for recommended participation in daily life significant differences between “first episode” ( $M = 0.88$ ;  $SD = 1.13$ ) and “chronic exacerbating” ( $M = 2.26$ ;  $SD = 2.34$ ) as well as “chronic persisting” ( $M = 1.57$ ;  $SD = 1.48$ ) and between “recurrent course” ( $M = 1.15$ ;  $SD = 1.24$ ) and “chronic exacerbating” ( $M = 2.26$ ;  $SD = 2.34$ ).

We also compared patients who were on sick leave or not (Table 3). Significant differences were found for already done and recommended regarding “coordination of multidimensional treatment” and “work participation.” For “participation in daily life,” significant differences were found for “should be considered,” but not for “done.”

To answer which role the professional orientation of the therapist has, we compared patients in psychodynamic therapy and cognitive behaviour therapy (Table 4). The results show that cognitive behaviour therapists include more sociomedical interventions. For their patients also, more such interventions are recommended by the expert interviewer.

## 4 | DISCUSSION

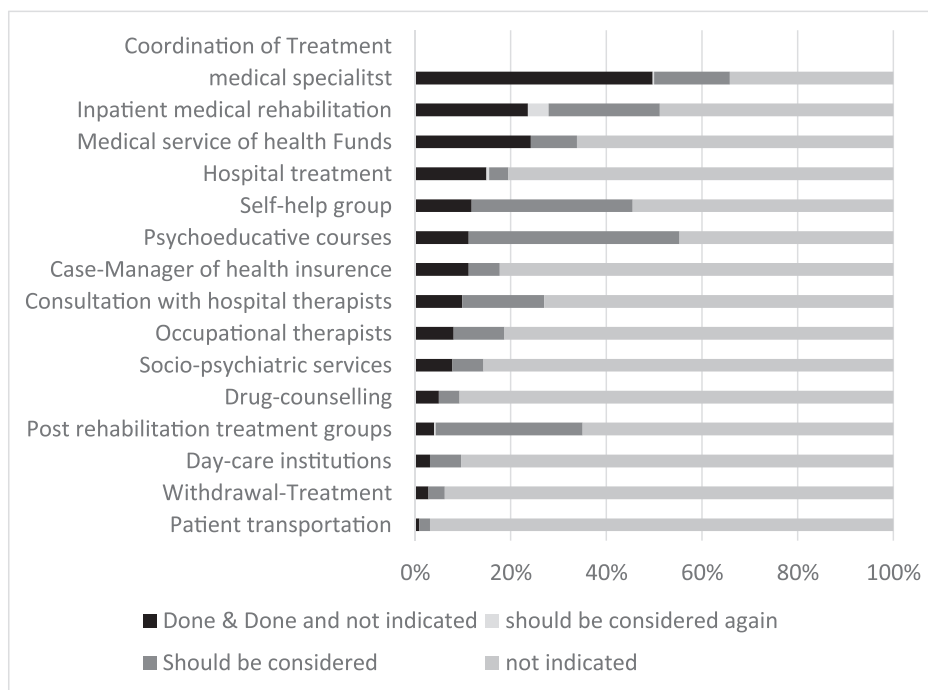
Treatment of patients should be guided by their needs. As mental disorders often take a chronic course, resulting in participation restrictions, treatment must follow the bio-psycho-social concept as outlined by the ICF (WHO, 2001). This includes not only interventions that target symptoms of illness but also actions to help the patient overcome impairment and improve participation in life (Kealy et al., 2020).

To our knowledge, the present study is the first and only study to report data on the role of sociomedical interventions in psychotherapy. In this context, it is of relevance that the data on what has been or should be done are not only coming from questionnaires but are based on a detailed glossary with definitions of all sociomedical interventions and on reports and judgements of the therapists themselves



**TABLE 4** Rate of sociomedical interventions in relation to psychotherapeutic school

	<i>Psychodynamic Th.</i> mean (standard deviation)	<i>Behavioural Th.</i> mean (standard deviation)	
Coordination of multidimensional treatment			
Done	0.61 (0.89)	0.89 (1.11)	$t_{297.82} = -3.24, p < .001$
Should be considered	1.98 (1.80)	2.16 (1.77)	$t_{318.87} = -3.55, p < .001$
Work participation			
Done	0.99 (1.53)	1.66 (1.66)	$t_{300.14} = -3.78, p < .001$
Should be considered	1.22 (1.81)	1.61 (1.94)	$t_{298.07} = -1.85, p = .07$
Participation in daily life			
Done	1.40 (1.64)	2.02 (1.76)	$t_{315.28} = -2.52, p < .01$
Should be considered	1.00 (1.23)	1.56 (1.63)	$t_{283.86} = -0.92, p = .34$

**FIGURE 1** Percentage of cases with "Coordination of multi-professional treatment"

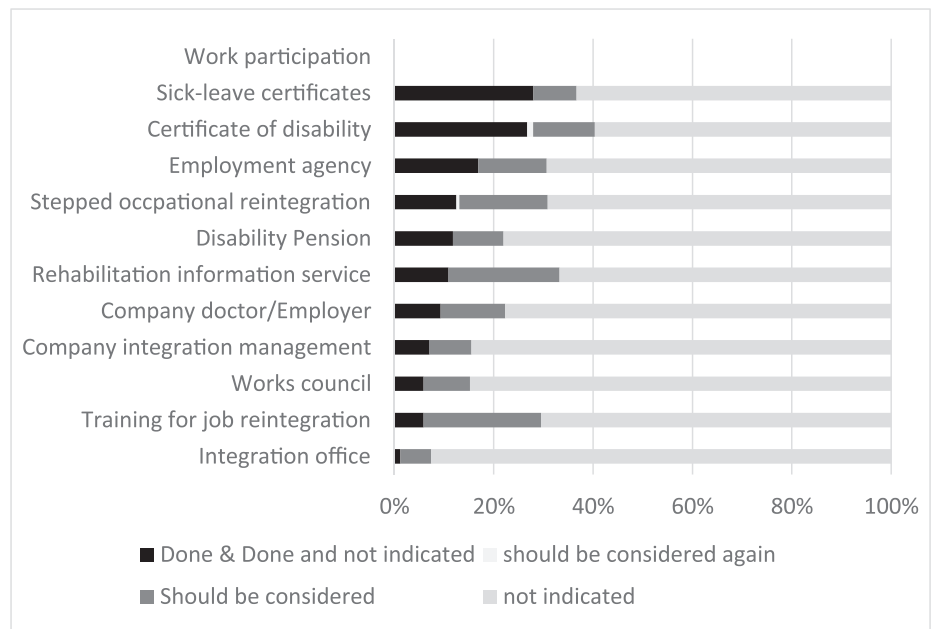
that have then be validated by the expert interviewers to clarify possible misunderstandings.

The list of 38 sociomedical interventions summarizes most of what can or should be done for patients with impairment. It cannot be assumed that all interventions are applied to all patients, as these are very specific measures. For example, debt counselling is only indicated in patients who have financial problems because of their illness. Counting interventions that have been done or should be considered, Figures 1–3 show that the different sociomedical interventions are indicated not in all but only some patients. Home visits or drug counselling are rarely indicated, while coordination with cotherapists, or sick leave certificates are rather a daily routine. Sociomedical interventions may be done by therapists themselves, but also by other cooperation partners. Still, it can be seen as a therapeutic duty of psychotherapists to initiate such measures and make sure that

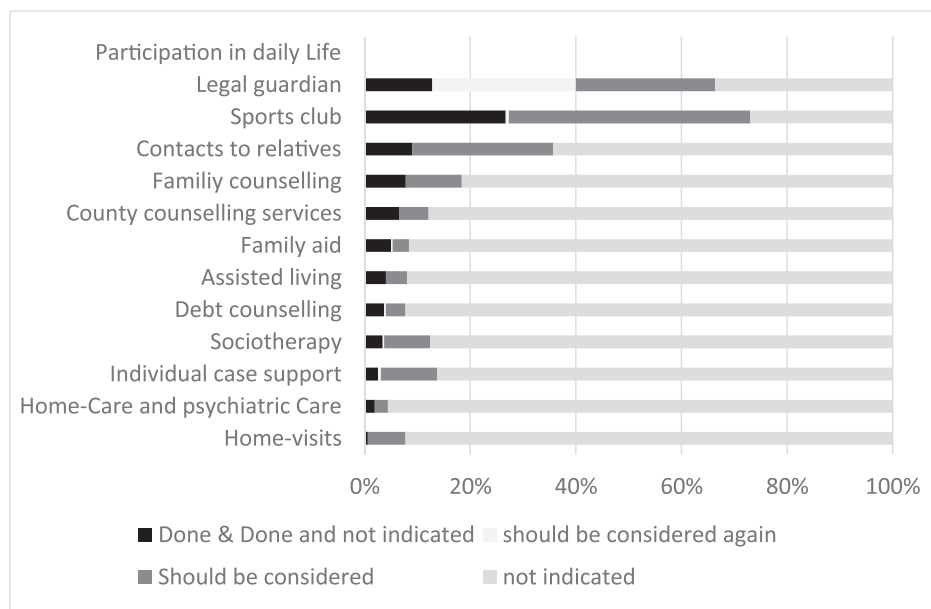
they are done properly, if they are needed by the patient (Muschalla et al., 2016).

Looking only on what has been done, the data show that all sociomedical measures are known to psychotherapists and are elements of their psychotherapeutic work. The data on the needs of sociomedical treatments correspond with subjective estimates of therapists on their daily work, which also showed that they consider such interventions as part of their routine (Linden, 2009). Sociomedical interventions are evidence based, similar to other therapeutic actions that can support psychotherapeutic treatment and have an impact on the patient's social and economic environment (i.e., workplace, financial situation and situation at home). There are studies which show that the quality of life of patients, self-efficacy in coping with the environment, and functioning at work can be improved by sociomedical interventions (Borgart et al., 2008;

**FIGURE 2** Percentage of cases with “Work participation” interventions



**FIGURE 3** Percentage of cases with “Participation in daily life” interventions



Brieger & Bernhard, 2012; Danielsson et al., 2014, 2019, 2020; Høgelund et al., 2010; Leuteritz & Landl, 1996; Meltzer et al., 2011; Salomonsson et al., 2018; Schmid, 2015; Svanberg et al., 2010).

One aspect in the treatment of chronic illnesses is a need for multilevel and interdisciplinary interventions. Many of the sociomedical interventions cannot be applied by the psychotherapists themselves but require the collaboration with other professional contributors such as physicians, social workers, sport therapists, administration employees or inpatient and rehabilitation facilities. Nevertheless, it is the responsibility of the therapists to initiate what has to be done and coordinate the collaboration. For example, they can admit patients to inpatient rehabilitation but provide follow-up treatment. The data suggest that psychotherapists have a view beyond the horizon and are team players.

The comparison of patients with different courses of illness and of patients who are presently on sick leave or not shows that patients with chronic illnesses and with participation problems get sociomedical help preferably. These are also more often applied in patients in cognitive behaviour therapy, for whom also more respective recommendations are made. It may be concluded that this is due to differences in the type of patients.

Nevertheless, there is some concern that sociomedicine may be underrepresented in psychotherapeutic treatment and should get more attention (Borgart et al., 2008; Kobelt, 2006). The recommendations of the interviewees on what should be considered in further treatment show that there may be some treatment reserves. This concerns preferably self-help groups, psychoeducative courses, job reintegration measures, legal guardians, and sports clubs. However, it is



important that sociomedical interventions within psychotherapy have to be understood as individualized/personalized treatment options, which can differ in their usefulness and their meaning from one patient to the other. The same sociomedical intervention can have a different effect and indication depending on the needs, context and also the cooperation of the patient (Gazzillo et al., 2020). For example, while the contact to the patient's employer, in order to optimize cooperation and thus positive long-term health consequences for the patient, can be interpreted as an act of care by one patient, another patient might interpret this intervention as an act of violation against his autonomy and privacy. Therefore, a good and thorough planning and implementation of sociomedical items has to be done the same way as psychotherapeutic treatment itself has to be individualized.

Limitations of the study are that it was done in Berlin, Germany, an area with many psychotherapists and provision of all types of sociomedical treatment options. In other regions, the situation and the results may be different. The data therefore show what is done and can be done under optimal environmental conditions. There may also have been a response bias by the participating psychotherapists, as it could be a selection who agreed to participate in a study on the role of patient social problems in psychotherapy.

There are several conclusions which can be drawn from our data: (a) Sociomedical interventions are needed in many psychotherapy patients. (b) Psychotherapists are aware of such treatment needs and apply sociomedical interventions. (c) The data suggest that there may be some unmet treatment needs, so that the awareness for these treatment options should be increased. (d) The education of therapists should include sociomedical interventions. (e) Reimbursement of such treatments should be adapted as these may be time consuming and often require work outside of the individual treatment sessions.

Given the number of patients in need and the diversity and complexity of respective interventions, more research is needed to address the structural aspects of psychotherapeutic work including sociomedical aspects by, for example, comparing different work models like cooperation with a central institution of specialists trained on sociomedical aspects and needs, in order to relieve psychotherapists, as the sociomedical aspects consume an intensive amount of time, which often cannot be provided in daily practice. Furthermore, our data cannot tell whether sociomedical interventions, psychotherapy or both are responsible for an increase in the well-being of patients. Further, research could focus on longitudinal studies with patients in psychotherapeutic treatment with prior identified sociomedical needs. That would allow a comparison in different points in time with regard to change in the well-being of the patients.

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## CONFLICT OF INTEREST

D. Schymainski, J. Solvie, M. Linden and M. Rose have no conflict of interest.

## DATA AVAILABILITY STATEMENT

Data are stored at the Charité University Medicine Research Group Psychosomatic Rehabilitation and be retrieved from the authors.

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## REFERENCES

- Bhattacharya, J., Choudhury, K., & Lakdawalla, D. N. (2006). Chronic disease and trends in service disability in working age populations. In M. J. Field, A. M. Jette, & L. Martin (Eds.), *Workshop on disability in America: A new look* (pp. 113–142). National Academy Press.
- Borgart, E. J., Okon, E., & Meermann, R. (2008). Sozialmedizinische Aspekte in der Verzahnung von ambulanter und stationärer Psychotherapie. *Das Gesundheitswesen*, 70, 29–36. <https://doi.org/10.1055/s-0028-1086265>
- Brieger, P., & Bernhard, B. (2012). Psychoedukation in der Gruppe ergänzt medikamentöse Therapie. *DNP-Der Neurologe und Psychiater*, 13, 57–63.
- Brieger, P., Blöink, R., Röttig, S., & Marneros, A. (2004). Disability payments due to unipolar depressive and bipolar affective disorders. *Psychiatrische Praxis*, 31, 203–206. <https://doi.org/10.1055/s-2003-814806>
- Danielsson, L., Elf, M., & Hensing, G. (2019). Strategies to keep working among workers with common mental disorders—A grounded theory study. *Disability Rehabilitation*, 41, 786–795. <https://doi.org/10.1080/09638288.2017.1408711>
- Danielsson, L., Papoulias, I., Petersson, E. L., Carlsson, J., & Waem, M. (2014). Exercise or basic body awareness therapy as add-on treatment for major depression: A controlled study. *Journal of Affective Disorders*, 168, 98–106. <https://doi.org/10.1016/j.jad.2014.06.049>
- Danielsson, L., Waem, M., Hensing, G., & Holmgren, K. (2020). Work-directed rehabilitation or physical activity to support work ability and mental health in common mental disorders: A pilot randomized controlled trial. *Clinical Rehabilitation*, 34, 170–181. <https://doi.org/10.1177/0269215519880230>
- Druss, B. G., Hwang, I., Petukhova, M., Sampson, N. A., Wang, P. S., & Kessler, R. C. (2009). Impairment in role functioning in mental and chronic medical disorders in the United States: Results from the National Comorbidity Survey Replication. *Molecular Psychiatry*, 14, 728–737. <https://doi.org/10.1038/mp.2008.13>
- Druss, B. G., Marcus, S. C., Rosenheck, R. A., Olfson, M., Tanielian, T., & Pincus, H. A. (2000). Understanding disability in mental and general medical conditions. *American Journal of Psychiatry*, 157, 1485–1491. <https://doi.org/10.1176/appi.ajp.157.9.1485>
- Egger, J. W. (2005). Das biopsychosoziale Krankheitsmodell. Grundzüge eines wissenschaftlich begründeten ganzheitlichen Verständnisses von Krankheit. *Psychologische Medizin*, 16(2), 3–12.
- Fjeldheim, S., Levin, I., & Engebretsen, E. (2015). The theoretical foundation of social case work. *Nordic. Social Work Research*, 5(sup1), 42–55.
- Gazzillo, F., Dazzi, N., Kealy, D., & Cuomo, R. (2020). Personalizing psychotherapy for personality disorders: Perspectives from control-mastery theory. *Psychoanalytic Psychology*.
- Høgelund, J., Holm, A., & McIntosh, J. (2010). Does graded return-to-work improve sick-listed workers' chance of returning to regular working hours? *Journal of Health Economics*, 29, 158–169. <https://doi.org/10.1016/j.jhealeco.2009.11.009>
- Kealy, D., Aafjes-van Doorn, K., Ehrenthal, J. C., Weber, R., Ogrodniczuk, J. S., & Joyce, A. S. (2020). Improving social functioning

- and life satisfaction among patients with personality dysfunction: Connectedness and engagement in integrative group treatment. *Clinical Psychology & Psychotherapy*, 27, 288–299. <https://doi.org/10.1002/cpp.2427>
- Kobelt, A. (2006). Sozialmedizinische Probleme in der Psychotherapie. *Psychotherapeut*, 3, 224–231.
- Lehmann, A., Alexopoulos, G., Goldman, H., Jeste, D., & Ustun, T. B. (2002). Mental disorders and disability: time to reevaluate the relationship? In D. Kupfer, M. First, & D. Regier (Eds.), *A research agenda for DSM-V* (pp. 201–218). American Psychiatric Association.
- Leuteritz, R., & Landl, R. (1996). Lebensqualität durch Soziotherapie. In R. Strobl (Ed.), *Schizophrenie und Psychotherapie* (Edition pro mente ed.) (pp. 243–259). Linz.
- Linden, M. (2009). Rehabilitationspsychotherapie. Definition, Aufgaben und Organisationsformen nach ICF und SGB IX. *Praxis Klinische Verhaltensmedizin Rehabilitation*, 84, 137–142.
- Linden, M. (2017). Definition and assessment of disability in mental disorders under the perspective of the International Classification of Functioning Disability and Health (ICF). *Behavioral Sciences & the Law*, 35(2), 124–134. <https://doi.org/10.1002/bsl.2283>
- Meltzer, H., Bebbington, P., Brugha, T., Jenkins, R., McManus, S., & Dennis, M. S. (2011). Personal debt and suicidal ideation. *Psychological Medicine*, 41, 771–778. <https://doi.org/10.1017/S0033291710001261>
- Merikangas, K. R., Ames, M., Cui, L., Stang, P. E., Ustun, T. B., Von Korff, M., & Kessler, R. C. (2007). The impact of comorbidity of mental and physical conditions on role disability in the US adult household population. *Archives of General Psychiatry*, 64, 1180–1188. <https://doi.org/10.1001/archpsyc.64.10.1180>
- Muschalla, B., Bengel, J., Morfeld, M., & Worringer, U. (2016). Herausforderungen einer teilhabeorientierten Psychotherapie. *Psychotherapeut*, 15, 37–42.
- Muschalla, B., & Linden, M. (2011). Sozialmedizinische Aspekte bei psychischen Erkrankungen. *Der Nervenarzt*, 82, 917–931. <https://doi.org/10.1007/s00115-011-3305-8>
- Niehaus, M., Marfels, B., Vater, G., Magin, J., & Werkstetter, E. (2008). Company integration management: Study on the implementation of company integration management according to Paragr. 84 (2) of the Ninth Code of Social Law (SGB IX). Social Science Open Access Repository, <https://nbn-resolving.org/urn:nbn:de:0168-ssoar-265779>
- Rethorst, C. D., Wipfli, B. M., & Landers, D. M. (2009). The antidepressive effects of exercise. *Sports Medicine*, 39, 491–511. <https://doi.org/10.2165/00007256-200939060-00004>
- Salomonsson, S., Hedman-Lagerlof, E., & Ost, L. G. (2018). Sickness absence: A systematic review and meta-analysis of psychological treatments for individuals on sick leave due to common mental disorders. *Psychological Medicine*, 48, 1954–1965. <https://doi.org/10.1017/S0033291718000065>
- Schmid, P. F. (2015). Person and society: Towards a person-centered sociotherapy. *Person-Centered & Experiential Psychotherapies*, 14, 217–235. <https://doi.org/10.1080/14779757.2015.1062795>
- Schymainski, D., Linden, M., Schmitt, G., & Rose, M. (2021). Sozialmedizinische Aufgaben in der Richtlinienpsychotherapie. *Psychotherapeut*, 66, 156–162. <https://doi.org/10.1007/s00278-020-00467-1>
- Steeves, E. A., Martins, P. A., & Gittelsohn, J. (2014). Changing the food environment for obesity prevention: Key gaps and future directions. *Current Obesity Reports*, 3(4), 451–458.
- Svanberg, J., Gumley, A., & Wilson, A. (2010). How do social firms contribute to recovery from mental illness? A qualitative study. *Clinical Psychology & Psychotherapy*, 17, 482–496. <https://doi.org/10.1002/cpp.681>
- UN. (2006). Convention on the Rights of Persons with Disabilities. <http://www.un.org/socdev/enable/rights/convtexte.htm>
- World Health Organization (WHO). (2001). *International Classification of Functioning, Disability and Health (ICF)*. WHO Press.
- Yang, L. Q., Che, H., & Spector, P. E. (2008). Job stress and well-being: An examination from the view of person-environment fit. *Journal of Occupational and Organizational Psychology*, 81(3), 567–587.

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