A Primary Care Psychologist together with the Family Physician: the experience of the Health Psychology School of Rome

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Abstract

It is known that at least 50% of the requests that people make to family physicians, behind the proposal of a somatic symptom, express relational/existential distress, often in very early phases, in which the intervention could be short and easy: the doctor, however, is not always in the position to offer an answer, and therefore ends up carrying out analyses and administering drugs whose uselessness he is the first to recognize. A response by referral to a psychologist appears problematic given the difficulty in identifying both the patients to be referred and the appropriate referring methods. Anyhow, the acceptance of the referral by the patient appears unlikely, since contact with a psychologist is still burdened by strong social stigma.

An initiative is then described, implemented by the postgraduate Health Psychology School of the Rome University Sapienza, implying the presence of psychologists in training in the consulting rooms of family physicians, in the usual ambulatory hours, in co-presence with the doctor. This practice has allowed to achieve a holistic and early approach to the distress presented, without the need for a specific request from the patient. In a small number of cases, a more formal clinical approach was proposed and implemented by the psychologist in separate times and spaces. Clinical cases have always been discussed between the two professionals and supervised in meetings at least fortnightly by a member of the School Faculty.

So far the experience, which has lasted for 20 years, has involved 31 psychologists in postgraduate training, for 3 years each, in medical practices in different regions of Italy; it has shown to be entirely feasible, though it requires a certain period of adaptation between the two professional figures. Patients welcomed the presence of the psychologist with great favor and, as expected, spontaneously adopted a much broader approach to their distress. In two cases in which it was possible to obtain the data, there was a significant decrease in pharmaceutical expenditure, respectively by 17 and 14%. An illustrative case shows how the discovery and discussion of a difficult life situation staying behind a somatic symptom not only led to the resolution of the symptom itself, but also facilitated the crossing of an important phase of the life cycle.

Keywords: Psychologist in primary care, Family physician, somatic symptoms, psychological request

Introduction: clinical, empirical, theoretical assumptions of experience

The proposal for the inclusion of a Psychologist in primary care together with the Family Physician (FP) and not as a separate service stems from a careful analysis of:

- the request that reaches the FP and the current response ensuing;
- the problems inherent in physician-psychologist cooperation.

The psychosocial request reaching Family Physicians

Several investigations, from Balint's pioneering studies (1957), to more recent and systematic empirical investigations (e.g. Katon, 1985), have confirmed a datum that is well known to healthcare professionals: at least 50% of the requests received by Family Physicians express a relational/existential type of distress rather than a somatic problem. A study by the Italian National Health Institute (Lega and Gigantesco, 2008) shows that 38% of people turn to their FP only for (clearly recognized) mental distress.

Furthermore, a vast amount of research in what is commonly called psychosomatics (see for example Solano, 2013) has found that even the distress that takes somatic forms (including organic ones) recognizes in most cases causes which are also (or mainly) psychosocial: relational, intrapsychic, historical/traumatic, linked to the life cycle.

It therefore appears evident that the request received by the Family Physician also needs to be accepted at a level other than somatic. In the absence of such response, symptoms may persist or worsen, with an exponential increase in requests for intervention and therefore in expenditure for the patient or the health service (Bass and Murphy, 1990; Shaw and Creed, 1991). In an attempt to provide answers on a biological level only, it can often happen that the doctor *resorts to carrying out investigations and administering drugs whose uselessness he is the first to recognize* (1). Balint's historic work (1957) offers extremely illuminating reports of the long, sometimes incessant, wandering of patients between specialist visits, x-rays, hospital admissions, sometimes unnecessary surgery; until someone - within the experience of supervision described in the text - comes to talk about different topics.

Of particular interest to the goal of early intervention, the psychosocial distress that comes to the FP's office is often in its nascent state, or in any case it is the first time that a request for help is formulated (where in the common clinical psychological practice one is generally faced with a distress that has been dragging on for years). Studies have shown that people who have committed suicide had consulted their family physician in about 55% of cases in the previous month (Pirkis & Burgess, 1998; Louma *et al.*, 2002; Rodi et al. 2010), a frequency well above average. If listening available in primary care was not limited to the physical conditions of clients, this would open up possibilities for

suicide prevention probably greater than any other type of initiative in this regard (Palma, 2013).
The subsequent fate of the individual, after the first manifestation of distress, depends on the response (s)he encounters. In many cases, as mentioned above, the answer – due to lack not of professional commitment but of competence - is biological. If the different analyses show nothing, the patient finds him- or herself with a label of "imaginary invalid" which adds to his/her pre-existing problems; if anything is found, the patient can find refuge in the belief that (s)he has a "real" disease. At any rate, to the extent that the original psychosocial distress is not addressed, more serious somatic illnesses may occur or obvious mental disorders may appear, which only at this point, with serious delay (Lega and Gigantesco, 2008), might eventually can be treated.
How to offer a more global listening? Entrusting everything to a psychological training of the doctor proposes to a professional the difficult task of carrying out two very different functions at the same time and of finding himself exposed to a transference of doubled intensity; this task appears increasingly difficult today due to the ever growing theoretical differentiation between Medicine and Psychology and to the considerable increase in the notions to be learned in both fields.
A meta-analysis of several scientific papers (Bower and Gilbody, 2005) has shown that significant improvements in patient health are not achieved with psychological training or counseling to the doctor, while they are achieved through *some form of interdisciplinary cooperation between physicians and psychologists*, which therefore appears inescapable.

Cooperation between physicians and psychologists
The most common ways of cooperation are the referral of the patient to a psychologist by the doctor or the request for a consultation (in the hospital). However, these appear to be problematic due to two types of factors:

1) the progressive differentiation and communication difficulties between Medicine and Psychology:

a) Different models *on the origin* of health and pathology.

The medical model tends to favor the importance of biological and physical environmental factors in determining somatic pathology.
The psychological model also tends to consider a psychological and social component for any disorder (Engel, 1977), which therefore deserves to be addressed from all these points of view. Furthermore, health and disease are seen not only in terms of individual pathology, but as connected to the relationship between the individual and his/her relational context (Solano, 2013, chapters 13 and 16) and to the relationship between the individual and the moment of its life cycle. Health is seen not only as the absence of disease, but linked to the *resources* available to the individual: concepts such as life skills

(Bertini *et al.*, 1999); dimensions of well-being (Ryff, 1989); ability to identify, process, regulate emotions (Taylor *et al.*, 1997).

b) Different models regarding the *indications* for a psychological intervention.

When the doctor accepts the importance of psychosocial factors, (s)he tends to represent them in terms of *explicit psychic distress*; or of situations that require frequent interventions for somatic symptoms without organic causes (frequent attenders); or of patients who do not follow prescriptions or who induce other types of relationship problems. Doctors therefore tend to refer this type of patient to psychologists.

Referral to a psychologist appears highly improbable in cases of:

- highly alexithymic patients (Solano, 2013, chapter 11), therefore highly at risk of even serious somatic pathologies, who can be seen as very calm and balanced;
- patients with clear and overt organic diseases, in which a psychosocial origin is not hypothesized (Solano, 2013, pp. 439-440);
- subjects who show "only" a lack of fulfilment in respect to the moment of their life cycle (e.g. a 30-year-old man without a partner and a job, who still lives at home with his parents).

c) Different models compared regarding referral methods.

In Medicine, referral (specialist visits, analyzes) is a prescription; the patient only needs to adhere, and to give his/her own passive cooperation. Consulting a psychologist, on the other hand, can only be a proposal, and the patient needs to find a personal motivation to work on him/herself that is anything but passive.

A referral cannot take place only "by exclusion" of the organic origins of the problem, but after having identified the psychological problems which motivate the proposal to the patient; the doctor does not always have the necessary skills to carry out this assessment.

2) The social position of Psychology:

a) How difficult it is *to decide to consult a psychologist*.

Access to a psychologist still appears to be very problematic due to very little public presence (in Italy) and *persistent social prejudice* against those who utilize a mental health worker.

The prejudice is based on the assumption that this use concerns only some people, considered more or less benevolently according to historical periods, but always seen as a *separate category*, in which no one aspires to enter. The concentration of interventions in the most "serious" forms of distress only reinforces the prejudice.

These difficulties mean that the use of a psychologist generally takes place dramatically late compared with the onset of the problem. At this point, long and intensive interventions are necessary, with reinforcement of prejudice.

A study conducted by the National Health Institute (Lega and Gigantesco, 2008) found that only 16% of people who admitted having suffered from mental disorders had turned to some operator for help.

b) How easy it is *to talk to a psychologist who is there*.

We refer to situations in which an individual finds him- or herself in front of a psychologist without having to seek for one, that is, without having to acknowledge a need in the first place.

A historical episode is the case of Katharina (Breuer and Freud, 1892-1895, p.285 ed.it.), where the girl accidentally met Freud as a client of an alpine refuge where she worked. Among the cases I contacted more directly, I wish to recall a 45-year-old woman (Solano, 2011, pp. 72-73) who, after a dramatic chain of events that began with an abortion at the age of 20 and culminated in a hospitalization at 45, managed for the first time - and with apparent ease - to tell her story to a psychologist whom she found right in front of her because she was called for consultation by the physicians of the ward.

The Primary Care Psychologist

The need was therefore recognized to bring psychology closer to the general population, who generally does not access specialist services because they are insufficient and in any case burdened by strong social prejudice.

Among the different national and international experiences we can mention:

- The Dutch experience of the Primary Care Psychologist (Derksen, 2009)
- The Improving Access to Psychological Therapies (IAPT) project in Great Britain (Liuzzi, 2016, pp. 128-130)
- A project of the municipality of Carmignano and some neighboring municipalities of Veneto (Carolli and Bogoni, 2013).

All these experiences use the *"Consultation Model":* the subject accesses the psychologist *through recommendation of the physician* to whom the request was primarily addressed. While they certainly achieve the purpose of bringing the psychologist closer to the population, they do not, however, offer a solution to many problems described in this paper, since, as described above, the physician tends to refer almost exclusively people *with explicit mental distress.*

Users are therefore *people* who have already managed to *clearly express their distress in psychic terms*, and to accept to define themselves as "in need of psychological assistance". In fact, most of the users of these services are - as expected - carriers of *DSM defined disorders*. Therefore, distress that takes only a somatic form or in any case different from psychic symptomatology remains unheard. Last but not least, the interdisciplinary exchange is very limited.

How to respond adequately to the psychosocial request that comes to Primary Health Care: a Psychologist next to the Family Physician.

In order to adequately respond to the psychosocial request that comes to Primary Healthcare, an intervention mode has been experimented in which the psychologist is placed next to the FP. This allows to create a Primary Care Psychology service:

- directed *to the entire population*, not to a particular category of unfortunate people, thus avoiding users being labeled as "mentally ill";
- where people can be helped to *solve problems* - which can happen to everyone - not where "pathologies" are "treated";
- where a *specific psychological request* by the patient *is not necessary*;
- where the opportunity of intervention of the psychologist is *not subject to decision* by the Physician;
- where, on the other hand, the intervention takes place as closely as possible in close connection with that of the Physician, in order to achieve a *re-integration* of knowledge and skills;
- capable of making the figure of the psychologist *more familiar*, also in view of further interventions during the life span;
- capable of intervening *in a phase of initial distress*;
- capable of considering, in addition to the biological condition, also the relational, intrapsychic, life cycle situation of the patient;
- capable of *limiting the expenditure in* drugs, clinical tests and consultation of specialists, to the extent that these derive from an attempt to read any kind of distress within an exclusively biological model.

The Experience of the Postgraduate School of Health Psychology in Rome: general framework

Since 2000, *31 Psychologists*, specializing in Health Psychology, have guaranteed their presence *for 3 years each* in the office of a Family Physician (in: Orvieto, Rome and surroundings, Rieti, Pordenone, Florence, Siena, Pisa, Nuoro, Avezzano) as a form of training.

The psychologist is present for one work shift a week sitting at the same desk with the physician (co-presence model). On a different day the psychologist conducts individual interviews in selected cases. A sign in the waiting room communicates the initiative to patients, indicates on which day of the week the psychologist is present, and clarifies the possibility, if desired, of being received only by the physician.

The clinical cases and the general progress of the initiative are discussed in *fortnightly meetings* coordinated by two Faculty members of the Postgraduate School, in which the trainees psychologists and, when available, also physicians participate.

Over time the project has been described in several national and international publications. The most complete report is contained in the volume *Dal Sintomo alla Persona* [From Symptoms to Subjects] (Solano, 2011).

The co-presence model has also been adopted in General Practice by: Department of Human and Social Sciences, University of Bergamo (Prof. P. Braibanti); Primary Care Psychology (PCP) - Research Centro Studi, ASL TO2, Turin (Liuzzi 2016, pp. 262-271); Master: "The Family Psychologist in Primary Care" (2014-2015), Sapienza, Rome; Social Territorial Area of Galatina, LE (Esposito et al., 2019).

Results of the experience

The needs outlined in the previous paragraph were largely fulfilled in the experience. We wish to underline that the main purpose of the initiative was not to practice "minor psychiatry" in cases with obvious mental illness, but to try *to make sense in any case of the distress brought by the patient*, both in the psychic and in the somatic sphere, within its relational and life cycle situation. The figure of the Health psychologist appeared particularly suitable for this task due to the tendency to approach situations in terms of *problems to be solved and not pathologies to be identified*, and to intervene above all in terms of *promoting* personal *resources*.

Illustration of the experience through the analysis of a typical vignette
(narrated in first person by the psychologist, Dr. Antonietta Dattola)

I meet Philip on a day of co-presence at the doctor's office: he is 32 years old and has two blue and dull eyes.
He comes to the physician weekly to check his blood pressure because he has had mild hypertension episodes in the last period. This time in particular he felt pain in his left arm during the night and feared the "beginning of a heart attack".
The doctor visits him: the pressure is normal and the pain in the arm appears due to inflammation of the cervical area. Philip also complains of stomach discomfort immediately after eating. He is prescribed an anti-inflammatory drug for the neck and an antacid drug for the stomach.
The presence of the psychologist, however, allows Philip to express a sense of agitation and the search for a space within which to talk about himself. I propose that he try to explain better how he feels at this moment, since I have the feeling that the pharmacological answers no longer contain his requests, which are perhaps not only for "attention" but to be helped to understand a situation.
Philip shows a giant folder full of clinical tests and medical records and tells of three anxiety attacks he has developed in the last three months: in each of the situations he experienced a violent throbbing in his heart, a feeling of suffocation, the fear of losing control, the fear of illness or sudden catastrophe.
He works at the reception of a hotel and is about to receive a job promotion from which he hopes not to escape as he has in the past. In addition, he is about

to marry his girlfriend, who has been suffering from rheumatoid arthritis since the age of fifteen. He feels quite agitated about this as well. He is very attached to his family of origin, but he feels that his father, mother and two brothers often call him just to ask him to solve their problems.
There is a clear tendency to systematically avoid the events that worry him and above all the emotions that disturb him, taking refuge in the idea of a new disease to be discovered and defeated with a pill or a "perfect" behavior. Philip has difficulty naming his emotions, communicating them to others and living his own identity as different from a salvific role within relationships. I propose a series of separate sessions with me.
We have eight interviews in all. In recent sessions, Filippo shows that he has understood that talking can produce real change and that the ability to think about what is happening allows him to manage events better. "*If I don't speak my body does it for me*", he acknowledges. He accepted the job promotion and got married, feeling quite happy with his decision. He hasn't been to the physician for some time.

Philip is an example of an apparently well functioning, calm, "hypernormal" subject: he has a job, a girlfriend, he does not bring explicit psychic distress to the doctor. Hardly a physician would have sent him to a psychologist, hardly Philip would have thought himself of this possibility. In fact, the risks for his physical health were quite high, having only the body as a way of expressing his distress, given his alexithymic characteristics, especially a difficulty in identifying and communicating emotions.
The presence of a psychologist in the office, without the need to look for one, *allowed Philip to deal with issues other than physical ailment*. In the sessions, the young man had the opportunity to elaborate on a series of past and present issues which therefore found a way of mental rather than somatic expression. It was possible to frame the symptoms not as something to be eliminated but as an *alarm signal*, an evolutionary movement, an activator of resources (2) in relationship with a difficult and conflicting life situation. An important notation, however, is how this evolutionary value can be expressed *only when the symptom finds an adequate container*, capable of developing emotions and thoughts around the symptom itself; such a container is rarely found in mainstream medical care.
The cost of clinical tests and of consultation of specialists has been reduced: Philip has stopped going to the physician weekly to ask for prescriptions and clinical examinations as he had been doing for fourteen years.
The physician's work was relieved from a series of requests to which he was unable to offer an adequate response, not for his own responsibility but for the specificity of his competence and his role.

One can be amazed or incredulous at the effectiveness of such a short intervention. In reality, this effectiveness is linked to the possibility of *intervening near the first manifestation of a symptomatology* and in a highly evolutionary phase of life. It would be absurd to argue in general that hypochondria can be "treated" with 8 sessions of counseling or of brief psychotherapy, whatever one prefers to call them.

General Results

The initiative turned out to be feasible, from all points of view. The great majority of patients showed appreciation for the initiative. Only in 2 cases on average, throughout the course of the 3 years of each experience, a patient requested to be received by the Physician alone.

The main result of the initiative was not to practice "minor psychiatry" in cases with evident mental distress, but to *make sense of the disorder brought by the patient*, both in the psychic and in the somatic sphere, within his relational and life cycle situation. The figure of the Health Psychologist appeared particularly suitable due to the tendency to approach situations in terms of *problems to be solved and not pathologies to be identified*, and to intervene above all in terms of promoting personal resources. Most of the work was therefore carried out, in co-presence with the physician, in terms of finding a meaning to the disorders that were presented, of *promoting personal resources*, of accompanying the patient along evolutionary steps.

In each doctor's office about 700 patients, more or less half of the physician's clients, had the opportunity to meet a psychologist. Each psychologist carried out significant interventions around 120 cases on average over the course of 3 years. Approximately therefore, in 20 years 3,600 psychological interventions were carried out in people who, often by their explicit admission, would never have been able to formulate an autonomous request in this sense, for fear of a social stigma, for economic reasons, but above all for *an unwillingness to enter a culturally foreign territory.*

Clinical notations (from interviews with the professionals involved, Solano, 2011)

The simple presence of a psychologist in General Practice, evidently accepted and organized by the physician, has substantially changed the patients' expectations *on what topics they could bring and discuss* there and therefore their willingness to investigate non-physical issues. Furthermore, the patients felt encouraged to *tell the story of their disorders*, even of long standing, in a different way, with the addition of new elements, not only for the different professional role of the new figure, but also for *the presence in any case of a "third" in the physician-patient relationship*. Doctors often said they felt the

atmosphere of the study "relieved". Relieved, we can hypothesize, from the weight of a strictly dual relationship.
Beyond the specific areas of intervention, an omnipresent theme was the difficulty of accepting a quota of autonomy and detachment from significant people (usually parents or children), necessary to live a sufficiently fulfilled life.
It has been noted that the physician/psychologist couple represents a pair of "good" parents who promote growth and development rather than hinder it (Bonfiglio, 2012).
On the other hand, the integration of the psychologist's figure in the office required an adaptation period of several months, which were necessary to achieve a sufficient level of attunement and understanding among professionals.
In several cases, an important turning point was no longer feeling like two professionals sitting behind the same desk, but like a multidisciplinary team.

Effects on the professionals concerned
As expected, through working jointly, an integration of medical and psychological knowledge was achieved, to an extent that appears difficult to obtain in any other way.
Physicians were able to verify how emotional and relational dynamics - highlighted by the psychologist's contribution - can affect health and disease states; they were able to understand the importance of a climate of listening and participation to the experience brought by the patient.
Psychologists have learned a lot about the biological aspects of the human being, about drugs, about clinical investigations, and how all of this can interact with intrapsychic and relational dynamics. They had the opportunity to witness conflicts and other human problems at the time of their origin, and to experience the effectiveness of their intervention in such situations. They had the opportunity to come into contact with a very high number of life situations compared to other types of psychological activity.

Effects of the joint Physician-Psychologist work on health expenditure
In two cases in which it was possible to know the pharmaceutical expenditure related to two practices before and after the psychologist's entry and compare it with the average trend of the Health District, a saving of 17% was found in one case, equal to 75,000 euros in one year, in the other of 14%, equal to 55,000 euros (Solano, 2011, pp. 139-143).
It should be noted that the available results concern only pharmaceutical expenditure, while it has not been possible so far to obtain data on hospitalizations, visits, instrumental examinations, etc. Furthermore, the results obtained relate to the use of psychologists in training.

If these results were confirmed by a broader experimentation, it would show the possibility not only of amply repaying the expenditure relating to psychologists, but *of realizing an substantial net saving for the National Health Service*.

Different initiatives relating to the figure of the primary care psychologist
The social territorial context (a consortium of municipalities) of Galatina funded in 2018 an experience very similar to that described in this work, where 3 psychologists were paid by the consortium for a period of one and a half years (Esposito *et al*., 2019).
In May 2019, a draft law of parliamentary initiative (Boldrini *et al.*) was presented for the establishment at a national level of the figure of Primary Care Psychologist.
On 27 July 2020, the Campania Region approved a law that establishes the Primary Care Psychologist, intended to work in cooperation with General Practice Doctors and with pediatricians. For the first time at the regional level this is not a mere statement of principle, but financial coverage is also provided, albeit rather limited for the moment.

Future perspectives
Of course, many open problems remain.
How to transfer what until now has been almost exclusively a training experience into a fully professional context? The reflections of these twenty years lead us to believe that the optimal solution is a psychologist who is hired and paid by the health service and who works in various structures (mental health services, clinics, hospitals) including the office of a Family Physician, for the necessary hours (about 12 per week). This would allow the development of an increasingly articulated competence as well as a facilitation of any transfer of patients to specialized services, when the need arises. In this case, it is clear that the psychologist must be licensed to practice psychotherapy.
In perspective, it can be imagined that this psychologist may perform occasional consultations also for other physicians, FPs or specialists, always applying the co-presence model, that is carrying out a consultation with the doctor rather than receiving a referral.
However, the problem of adequate training arises. This can be optimally guaranteed by a School of Health Psychology, due to its orientation to working with the entire population, to solving problems and promoting resources rather than treating diseases. It is necessary to think of a second level training for specialized psychologists at different schools, such as a Master that also includes an internship at a FP's office.

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Notes

(1) The percentage of unnecessary health interventions has been estimated around 30% of the total (Brody, 2012).

(2) This way of considering the symptom, well known to psychologists as regards the psychic sphere, can also be applied to symptoms involving the body (Winnicott, 1953; Balint 1957; Bucci 1997; De Toffoli, 2014).

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