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CO-PRESENCE OF A FAMILY DOCTOR AND PSYCHOLOGIST IN THE MANAGEMENT OF PATIENTS WITH PSYCHOSOCIAL AND SOMATIC SYMPTOM DISORDERS

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A – study design, **B** – data collection, **C** – statistical analysis, **D** – interpretation of data, **E** – manuscript preparation, **F** – literature review, **G** – sourcing of funding

ABSTRACT

Background: Patients often seek out the help of general practitioners for problems that need a holistic, biopsychosocial approach. Having a psychologist present to support the GP in treatment allows for a more complete response to the patient's distress, which is aided by the integration of the two specialists' areas of expertise.

Aim of the study: The aims of the study were to ensure all patients had direct access to a psychologist during treatment, even if they had not put in a specific request for one, to take care of accidental crises in real time, to reduce spending on inappropriate pharmaceutical prescriptions and diagnostic examinations, and to facilitate health promotion.

Material and methods: The experiment took place between January 2014 and December 2015, in Pordenone, Italy. The psychologist was present in the GP practice every Thursday. The psychologist was present to provide consultation for each person who went to the GP practice for treatment. The study also explored the significance of any request, the psychological framework of the observed situations, and included an additional meeting with the psychologist in the GP practice, for individual interviews.

Results: Of about 1,300 consultations with both the psychologist and GP present, the majority of the patients accepted the psychologist's presence favorably. The most frequent source of discomfort for patients related to the grieving process during separation from people to whom the individual has a strong emotional attachment. 30 patients (6 males, 24 females) took part in individual follow-up meetings, 5 abandoned the project, 21 completed the full series of meetings, and 4 were sent to a mental health facility. Because of this holistic approach, spending on medical investigations was reduced by 6%, and the cost of pharmaceutical expenditure decreased by 10%.

Conclusions: The joint medico-psychological treatment prevented, even at early stages, the appearance of somatic and psychic symptoms. This study has positively promoted health and well-being and shown that this type of treatment can help to limit expenses for pharmaceutical prescriptions and specialist diagnostic examinations.

KEYWORDS: family medicine, psychology, psychosocial distress, functional somatic symptoms, biopsychosocial treatment

Background

Sometimes people go to their family doctor/general practitioner (GP) and complain about non-specific symptoms that need to be correctly interpreted. The GP must assess whether these symptoms need further investigation or should be considered functional disorders that manifest themselves through body language and require a biopsychosocial and holistic type of approach. Numerous studies, beginning with Balint [1], have shown that at least 50% of the requests received by GPs express relational/existential discomfort rather than a somatic problem. Despite enormous progress from a technical point of view, current medicine tends to neglect the doctor-patient relationship. In the last 150 years, there has been a progressive differentiation between general medicine and psychology, that is, between an approach to the body and an approach to the mind. Medicine has moved away from

a global vision of the human being, which was one of its characteristics in the 19th century, focusing on biological and genetic aspects. The way the GP relates to the patient and his or her psycho-social context can be considered a real therapeutic tool, often "at no cost", and sometimes more effective than drugs or surgical interventions.

The GP is, at times, unable to satisfy the patient's complex requirements and therefore tries to provide answers only on a biological level, by prescribing specialized medical examinations and medications. In certain cases, the GP may also recognize that this type of treatment falls short of addressing the patient's holistic needs. This not only fails to adequately and appropriately help the patient, but may also lead to an unnecessary increase in costs.

In 1948, the World Health Organization (WHO) defined health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Clinical practice guidelines recommend cognitive-behavioral therapy as the treatment of choice for affective and mood disorders [2]. There is strong evidence that the efficacy of psychological therapy, in particular, is the same as or greater than pharmacological treatments of the most common affective and anxiety disorders [3-5].

Physical illness is socially considered to be inevitable for all, to the point that, at least in Europe, every citizen is required from birth to have a reference doctor, whose services are offered free of charge. Psychological distress, on the other hand, is considered as something that only concerns certain people, to be treated with specific services. Consultations with a psychologist capable of responding to psychic distress are made extremely difficult by ongoing social prejudice [6], and therefore, even if the patients recognize the signs of their distress, they do not ask for help and do not go to a psychologist, even if they have only to cross the street to do so.

The patients that the GP sends to the Department of Mental Health for a specialist intervention are people who have managed to express their psychic discomfort to a family doctor, regardless of social stigma or prejudice. People who, despite being in situations of particular psychological suffering, cannot express their discomfort except through body language, remain outside the realm of appropriate care. However, this changes if the patient finds the psychologist in front of him or her, sitting next to the family doctor, without having been specifically requested.

It is therefore necessary to provide easy access to psychologists for everyone, and not only for a particular category of people who have sought out specialized treatment. The inclusion of a psychologist alongside the GP allows us to respond more completely to the discomfort of patients, through the integration of complementary skill-sets, and also encourages the exchange of training and information between the two professionals [7-13]. These findings were the foundation for the primary care study carried out here. This study involves the GP and the psychologist in co-presence with the patient in the same room, side by side behind the same desk.

Aim of the study

The primary aim of the study was to ensure the GP's patients had direct access to a psychologist, even without having specifically requested one be present, so the patient could be seen without the risk of being labelled as "psychologically disadvantaged".

The study also aimed to explore the meaning of any request made by a patient, regardless of how it was expressed, and view it in the context of the patient's present and past relationship situation and in the context of his/her life cycle. The study also hoped to take care of accidental crises in real time, including marital or employment difficulties, loss or illness, and to respond to significant life moments (e.g. adolescence, beginning of university, marriage, parenthood, retirement). Finally, the study hoped to reduce spending on inappropriate pharmacological therapy and diagnostic specialist medical examinations and hospital admissions, to the extent that these derive from an attempt to read any type of discomfort within an exclusively biological model, which is inappropriate for functional disorders.

Material and methods

Study design

This initiative falls under the umbrella of work which began years earlier with a group led by Prof. Luigi Solano of the Department of Dynamic and Clinical Psychology of the University "Sapienza" of Rome, where this model of co-presence of a GP and psychologist was developed through the internship experiences of psychologists participating in the Master's program, "The psychologist in primary care". The psychologist carried out the work in the form of an internship related to the Master's course of study.

A notice was displayed on the information board at the GP's office specifying the details of this collaborative project, in order to inform the patients before the beginning of the appointment that a psychologist would be present

The patients were also informed that they could still request to be seen only by the GP. The psychologist would not ask for any compensation from the patients for the collaboration provided within the medical office. As required by the code of professional ethics, the psychologist was obliged to maintain doctor-patient confidentiality.

Verbal informed consent was obtained from all project participants.

The intervention of the psychologist envisaged:

– Psychological listening for each person visiting the GP practice.

– Exploration of the significance of any request.
– Psychological frameworking of the observed situations.
– Exploratory intervention when needed.

The main purpose of the psychologist's intervention was not to replace the Mental Health Service for cases with evident psychic distress, but to try to give a meaning, in any case, to the patient's disorders, both in the psychic and somatic domains, within his or her relationship situation and life span.

Table 1. Intervention modality by the psychologist.

Intervention modality
– Psychological listening for each person visiting the GP practice. – Exploration of the significance of any request. – Psychological frameworking of the observed situations. – Exploratory intervention when needed. – Eventual further meeting in the GP practice for individual interviews. – Sending a proposal for an additional visit, approved by the GP and the patient, if necessary, to the mental health specialist. – Debriefing with the GP at the end of the day.

When necessary, patients were given access to an individual interview of one hour with the psychologist alone, usually by appointment on Mondays, in the family doctor's office.

It was also possible to offer listening and assistance to those patients who expressed their discomfort in somatic form, without explicit psychic discomfort, but through poor contact with their emotions, characterized by low emotional significance, colorless style, and poor expression of their needs (alexithymia).

Setting

The project, "Co-presence of a family doctor and psychologist in primary care" was conducted from January 1, 2014 to December 31, 2015 in Polcenigo in the province of Pordenone. One family doctor and one psychologist participated in this research. The psychologist sat next to the GP in their office every Thursday, for two consecutive years. A sufficiently long period of co-presence and collaboration is fundamental to establish the necessary harmony between the two professionals involved. Participation in this initiative was free and voluntary for both. Data collection was carried out from January 1, 2016 to February 28, 2016.

Participants

On Thursdays, the psychologist listened to all the patients who came to the family doctor›s office, regardless of the reason for their appointment. No patient was, therefore, a priori «excluded» from the project.

Access to individual interviews was provided in situations where the patient expressed psychological distress/suffering. The decision to take this further step was agreed upon by the psychologist, the GP and the patient himself/herself. Diagnostic criteria were used according to the classification of areas of psychosocial distress by Solano [14].

Data sources

We used the Millewin computerized archive's database of Mille Utility software (Millenium s.r.l.) to collect data on co-presence access, individual interviews with the psychologist, cost of hematochemical tests, instrumental tests and specialist visits. No statistical correlations were made.

Results

Participants

During the two years of co-presence, about 1,300 consultations were carried out. Individual interviews with the psychologist alone were proposed to a cohort of 30 patients (6 males and 24 females), who were more or less aware of having a form of psychosocial distress (Tab. 2). In total, 4 of these patients were sent to the Department of Mental Health, 5 abandoned the project after the first interview, and 21 ultimately benefited from the interviews, managing to make themselves more aware of any symptoms or disorders at that particular moment in their lives (Fig. 1). In most cases, psychologists held 4/5 individual interviews (from a minimum of 1 interview to a maximum of 13).

Table 2. Age and gender of patients involved in individual interviews.

Age	0-14	14-24	25-34	35-44	45-54	55-64	65-74	>75
Male	1	0	1	2	1	1	0	0
Female	0	2	3	6	4	4	3	2

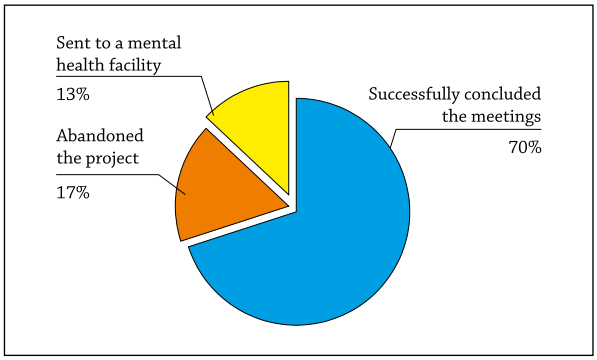

Figure 1. Results after individual interviews.

The age range of the patients who undertook individual interviews was rather wide, with the youngest being 14 to the oldest being 86. The most represented group was made up of patients between 35 and 44 years.

Main results

Most patients willingly accepted the initiative. The patients were accustomed to seeing other young doctors in training working alongside the GP. Given the many years of experience of Tutor for Family Medicine, this has perhaps facilitated the presence of the psychologist, who was well received. It simultaneously showed patients were able to understand perfectly the specific function of the psychologist compared to the GP.

In the space of two years, only one person asked to be received by the GP alone. Most of the work was carried out in co-presence (about 1,300 visits). Although the psychologist did not necessarily intervene in each of the family doctor's interactions with the patients, the lengths of the medical examinations on a co-presence day were inevitably longer, as was expected. The effort to ensure listening for every patient, on some occasions, was hampered by the workload. However, prolonged co-presence was beneficial in these situations as it gave people the opportunity to return to the office to integrate, or resume from where they had been previously interrupted, knowing when they would also find the psychologist at the appointment once again.

In certain situations, patients were given the opportunity to have an individual appointment with the psychologist, in order to deepen what was introduced and to better explore the psychosocial aspects and the relational or life experiences of the patients. The necessity of these types of individual consultations was evaluated by the GP and the patient, along with the psychologist. Despite having a greater or lesser awareness of their discomfort, the majority of the patients welcomed the proposal of having an individual interview, which was supported by both the doctor and psychologist.

The greatest number of interventions arose from patients' concerns about family relations (58%). One issue that emerged several times during the interviews was patients' difficulty in accepting detachment from significant people in their lives (usually parents or children), both living and deceased, necessary to live a sufficiently fulfilled life. In other words, patients experienced difficulty in mourning a separation (Fig. 2).

During the appointments that included the co-presence of the psychologist and GP, there was a 6% decrease in the rate of expenditure for medical investigations (hematochemical examinations, specialist visits, instrumental investigations) compared to the previous period. According to the data provided by the Pharmacy Department of Local Health Authority (ASS5) the daily defined doses (DDD) prescribed by the GP decreased by 7%, with a reduction by 10% in pharmaceutical expenditures, compared to the period prior to the presence of the psychologist (Tab. 3).

Discussion

Prolonged co-presence gave the patients an opportunity to meet the psychologist several times, gradually allowing them to get closer with the professional. Additionally, the psychologist was able to do follow-ups with patients.

The objective is to put the somatic symptom into the context of the patient's life. The disappearance of the symptom will eventually depend on finding, where possible, adequate solutions to the problems

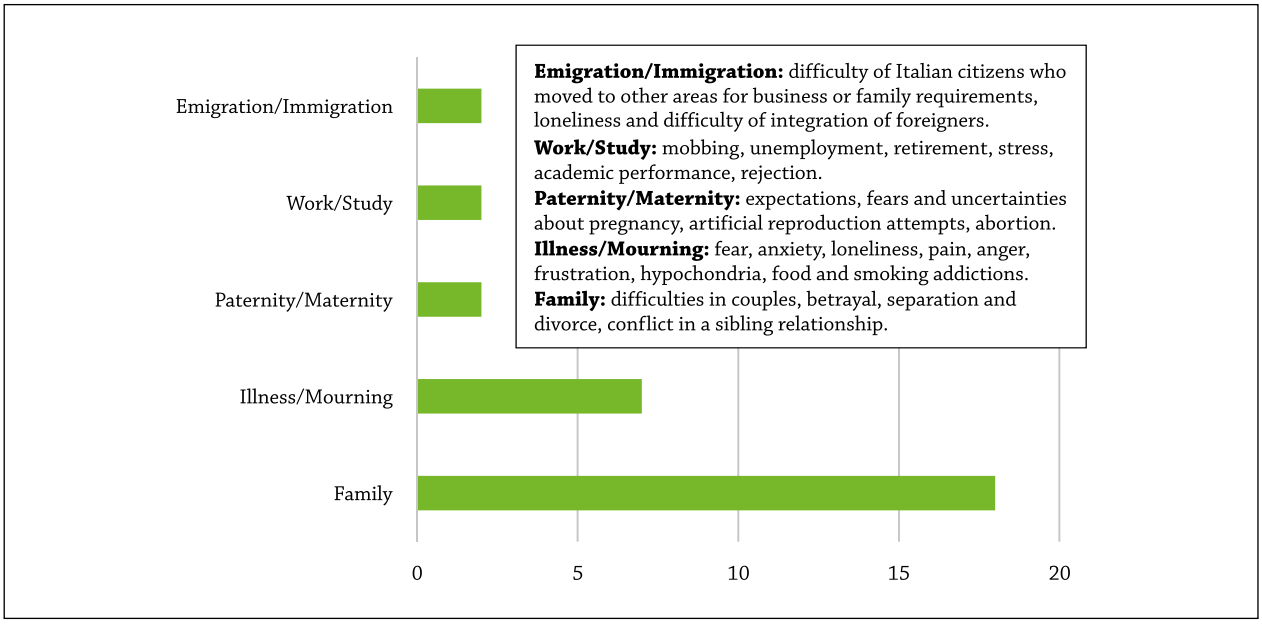

Figure 2. Areas of psychological distress in individual interviews.

Table 3. DDD variation and GP pharmaceutical expenditure (2013-15).

Year	Number of prescription packs	% variation of packs from 2013	Daily Defined Dose (DDD)	% variation DDD from 2013	Net prescription amount	% change in expenditure
2013	24.535		500.562		€ 198.200,67	
2014	22.927	-7%	464.425	-7%	€ 180.587,10	-9%
2015	23.117	-6%	467.241	-7%	€ 178.009,34	-10%

as they relate to the patient's inner and outer wellbeing. Even if the disorder does not disappear, it will not acquire the meaning of a "disease" but rather, a reaction to a problematic or unsatisfactory life situation. Over the course of months, a suitable working relationship formed between the GP and the psychologist, supported by mutual respect and esteem, trust and complicity, both from a personal and professional point of view.

The presence of the psychologist was accepted by patients because of the way it could holistically enhance the medical encounter, and because, of the addition of another medical professional's authority. The GP, likewise, found it beneficial to have support from the psychologist in dealing with those patients for whom a repetition of exclusively medical solutions could lead, over time, to a chronicity of the problems.

Mental disorders are one of the top public health challenges in the WHO European Region, affecting about 25% of the population every year. The European Mental Health Action Plan 2013-2020 proposes effective actions to strengthen mental health and wellbeing. Investing in mental health is essential for the sustainability of health and socio-economic policies in the European Region and recommends improving access to mental health services.

A Primary Care Psychologist (PCP) can reduce the gap between the need of psychological treatment and its provision. In the Netherlands, there has been a strong increase in consultations of a Primary Care Psychologist during the last years [7]. In England, there have been efforts to initiate an integration between health and psychology services [15]. In Italy, our experience with the co-presence model with the GP and the psychologist in the same room has an added value in comparison with the Dutch and the English models and their coordinated (remote team collaboration) or co-located services (where GP and psychologists operate in the same setting, but in different rooms).

In addition to effectiveness studies, economic impact assessments have also been carried out for some years. Various studies have suggested that the introduction of psychological interventions in primary care may significantly reduce health care costs related to mental disorders [16-18].

An analysis conducted by the Centre of Mental Health (UK) shows that early interventions in children in various situations of psychological distress provide an enormous economic benefit [19].

Also, a study involving adults with psychological distress carried out by the London School of Economics arrived at the same conclusions. Spending on evidence-based mental health services is an investment that will pay in quality of life and economic dividends across much of society, over many years [20].

In Italy, in the Lazio region, in an experiment similar to ours, after two years of co-presence of the psychologist in the office of a family doctor, there was a reduction of about 15% in pharmaceutical expenditures [10]. Our findings demonstrate a clear need to find a more human approach to understand the ways in which people suffer. Sometimes, it helps to understand their (and our) holistic life experiences.

Limitations

The limitations of this study included its small sample size. No statistical correlations were made. There was no parallel group for a randomized controlled trial. The data was collected in 2016.

Conclusions

This joint medical-psychological action, intervening even in the initial stages of a patient's concern, has developed as a prevention and health promotion mechanism, which can, in the most critical situations, prevent the worsening of psychic or somatic symptoms. During the visit, all of the physical and mental elements of the patients' lives were taken into consideration. Equal dignity was afforded for both and this allowed the patients to return to a more integrated vision of themselves. Thus, this encouraged them to feel free to talk more openly about themselves and their emotional experiences, without the fear of being labelled.

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