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Article

The family physician and the psychologist in the office together: a response to fragmentation

Luigi Solano
Associate Professor, Scuola di Specializzazione in Psicologia della Salute, Università di Roma 'Sapienza', Italy

Enzo Pirrotta
Family Physician, Distretto Socio-sanitario n. 4 di Roma ASL B, Regione Lazio, SNAMID Rome, Italy

Veronica Ingravalle
Postgraduate Fellow

Paolo Fayella
Junior Faculty

Scuola di Specializzazione in Psicologia della Salute, Università di Roma 'Sapienza', Italy

ABSTRACT

It is well known that motives for consulting the family physician, though expressed as physical symptoms, often derive from problems needing a holistic, psychosocial approach. Progressive differentiation between medicine and psychology makes co-operation through referral to the psychologist by the physician quite problematic, in terms of both which patients are referred and the modalities of referral. Acceptance of psychological referral may, in any case, be difficult, due to the social stigma that still surrounds mental distress.

The authors report a possible solution in an experiment implemented by the postgraduate Health Psychology School of the Rome University 'Sapienza', entailing joint, direct co-operation between a family physician and a psychologist through the psychologist's presence in the doctor's office during consultations. This allowed direct access to a psychologist in the absence of any filter and without the need for a formal request on the patient's part and a biopsychosocial approach to distress. In a small number of cases, more formal consultation with the psychologist was proposed. Cases were always discussed between the two professionals. To date, the experiment has involved nine psychologists and seven physicians over a period of nine years. It appears to be entirely feasible, though requiring a period of adaptation between the two professionals. Patients have welcomed the presence of the psychologist and, as expected, take a broader approach in reporting their distress.

An illustrative case is presented, in which finding the meaning of a symptom avoided unnecessary and costly investigations, and facilitated the patient in taking a new direction in his life.

Keywords: family medicine, family psychologist, somatic symptoms

Introduction and aims

Both doctors and healthcare officials are well aware that motives for consulting the family physician, though expressed as physical symptoms, often derive from problems that are not somatic in origin. This topic was extensively addressed in Balint's pioneering work,[1] and confirmed by several additional investigations.[2,3] In the absence of a capacity on the part of the physician to meet this request on a non-somatic level, symptoms may persist or worsen, with repeated consultations and increased expenditure for the patient or the national health services, where present.[4,5] Such situations have, in fact, been shown to lead to a utilisation of health services that is nine times greater than that of the general population.[6]

In order to address this problem, we experimented with a form of physician/psychologist co-operation through the joint presence of these two professionals in the office. This proposal stems from the following considerations:

(a) Differentiation between medicine and psychology and consequent need for integration

Progressive differentiation has taken place throughout the past century and is actively continuing. Medicine (apart from individual exceptions) has departed from a holistic consideration of the human being, which was one of its prominent features before the second half of the 19th century, and has become increasingly concentrated on biological and genetic factors affecting health and disease. This focused approach has brought enormous, previously unthinkable, benefits in the prevention, diagnosis and treatment of disease in the course of the 19th and 20th centuries, but has entailed disregard of emotional and relational factors. This latter attitude, in spite of common statements to the contrary, is far from subsiding, reinforced by such constructs as evidence-based medicine and universal diagnosis and treatment protocols.

Psychology, on the other hand, as synthesised in Engel's notion of a 'biopsychosocial model',[7] tends to view health and pathology (both mental and physical) as linked to: (i) the relationship between the individual and his/her past and present social environment, as exemplified for instance in the psychobiological regulation model;[8] (ii) the relationship between the individual and the specific moment in his/her lifecycle; and (iii) specific resources of the individual, such as coping styles, or the capacity to identify, process and regulate emotions.[9] Psychologists are generally mindful of Balint's legacy, where every disease is defined as a co-construction between patient and physician;[1] conversely, they lack the competence to fully understand the pathophysiology of physical disease and its possible biological determinants, and may tend to disregard these components.

This strong differentiation therefore calls for a corresponding effort at integration, which should not be left as a burden to the patient alone, subjecting him/her to such widely different types of input.

One possibility is the training of family physicians in a more comprehensive, biopsychosocial approach to patients, as originally proposed by Balint. (As extensively reported in his well-known volume, *The Doctor, his Patient and the Illness*,[1] Balint proposed weekly meetings of groups of family physicians with a mental health expert ('Balint groups'), for some years, in which cases with more obvious psychosocial implications were to be discussed.) This appears much more difficult today than in Balint's time, firstly due to the very differentiation we are considering. A recent survey among family physicians in an Italian city showed that, while the need for a psychosocial approach was widely recognised among doctors, they tended to consider themselves barely suited for this, for reasons related to: (i) time limitations; (ii) the possible presence of conflictual dynamics around drug compliance and certification of absence from work, which might hinder interaction on other levels; (iii) reluctance of the patient to enter into a dialogue with the physician on a more personal level, in view of his established role in physical examination and drug prescription; and (iv) insufficient training on the physician's part.[10] We might add that specific training in psychology for physicians may also be more difficult today, in view of the remarkable increase in the amount of strictly biomedical material a doctor needs to know. (Training physicians to recognise and treat pharmacologically moderate states of mental distress, such as minor depression, is of course perfectly feasible, and is being done worldwide. We believe this has nothing to do with the challenge we are addressing here – that is, achievement of the capacity to locate every kind of complaint brought to the family physician within the patient's life context.)

The other road to integration is co-operation between the physician and the psychologist. A range of levels of collaboration is widely discussed in the literature, including informal consultation, formal consultation, joint sessions (the latter recommended for 'somatisation disorders', seen as difficult to refer[11]), 'co-provision of care' (involving frequent discussions of cases between physician and psychologist) and 'co-therapy'.[12] This last situation is recommended when 'co-morbidity' of biological and psychological

distress is present.[13] Tovian recommends, in all cases, meetings between physicians and psychologists to discuss referrals.[14] A training model at Massachussets Medical School, explicitly designed to promote collaboration between psychologists and physicians,[15] entails a large number of 'dual interviews' with patients at various points in clinicians' training. The East Virginia Medical School also implemented joint training of physicians and psychologists, involving co-ordinated treatment of a large number of patients, under the supervision of senior psychologists and physicians.[16]

Though all these proposals appear reasonable and useful and meet some needs, they leave open two kinds of problems:

1 in spite of commonly alleged adherence to the biopsychosocial model, the sharp distinction between somatic disease – under the rubric of the physician's competence – and psychic distress – under the psychologist's – appears not to have abated much. We still find reference to 'somatisation disorders',[12] presumably as opposed to (true) 'somatic' ones, and to 'co-morbidity'[13] as an indication for co-operation, as if the presence of somatic disease *per se* had nothing to do with a psychologist's intervention
2 in most proposals, probably in all, the decision to request co-operation (consultation, referral, joint sessions, etc) rests on the decision of the physician, who judges a patient – one who requested consultation with him/her – as in need of a psychologist's competence. In order to be effective and optimally useful, this would require deep knowledge and understanding on the physician's part of psychological theories, modalities and possibilities. Strong differentiation between the two disciplines, as described above, makes this seldom the case.

Referral to psychologists on the part of physicians mainly takes place, in fact, when explicit mental distress is present, or when problems arise in the doctor/patient relationship (as in lack of adherence to treatments), or in diseases for which medicine is partially or totally impotent in helping the patient, where psychological intervention is seen as a synonym for 'humanitarian assistance'.[17] Very seldom is psychological intervention requested in the initial phases of physical illness, where its beneficial effect could be much greater, or as an adjuvant to effective medical treatment when this is available, in spite of the literature showing the heightened effects of combined treatments.[18–20]

Furthermore, the physician's tendency to recognise only explicit mental distress often causes neglect of the best-known psychic risk factor for somatic disease or illness – that is, a deficit in the identification and expression of emotions, as described in the construct of alexithymia or affective dysregulation.[9] This condition generally results in a colourless, boring, 'hypernormal' style of communication, totally opposite to the style commonly present in mental distress as commonly viewed. For this reason, those very patients who tend to express their life problems through the body, more so than others, are those less likely to be referred to a psychologist.[21]

Physicians and psychologists also have very different views surrounding psychological referral. Doctors in general tend to view referral to a psychologist as similar to referral to a medical consultant, that is, a decision based on a *need* of the patient, for which something can be *prescribed*. Psychologists, on the contrary, are well aware of the importance of a personal *request* (or *acceptance)* on the patient's part, in addition to the presence of a need that is (albeit correctly) seen by someone else; they are well aware that psychological consultation cannot be 'prescribed', but must be 'negotiated' and 'accepted', since the patient is required to do much more than in cardiologic consultation, for example. Referral, therefore, even in appropriate situations, may be not appropriately proposed to the patient.

(b) The social position of psychology (at least in some countries)

While physical disease is seen as inevitable for everyone, sooner or later – to the point that, in European countries, every citizen from birth is assigned a physician – psychic distress is seen as pertaining only to a certain subset of people, who are to be treated (more or less benevolently, according to the historical period) in specific services, following a specific request on the part of the patient or of someone else. Moreover, due to the difficulty of objectively defining psychic distress (except in cases causing security problems), an individual is socially defined as distressed essentially when a consultation with a mental health specialist has taken place.

Given all the above, in spite of any official or individual statement to the contrary, *a heavy stigma* is attached to people requesting this kind of consultation. The effect is that a psychologist (let alone a psychiatrist) is often consulted as a last resort, only after everything else has failed, when problems have become inveterate, entrenched in interpersonal or work situations, and thus require long, intensive treatments, the results of which are not always as positive as might have been the case with earlier intervention.

The introduction of a 'family psychologist' or a 'first-level psychologist', working jointly in the same

office with a family physician – not requiring, therefore, any specific request on the patient's part – may thus offer the following possibilities:

- intervention in an initial phase of distress, before the structuring of severe and/or chronic somatic diseases or psychic disorders
- direct access to a psychologist for the whole population, avoiding the filter of medical referral – which, as described above, is not always appropriate – and without the risk (or certainty) of the patient's being stigmatised as 'mentally ill'
- an approach to symptoms of any kind taking into consideration, in addition to the patient's biological condition, his/her relational, intrapsychic, and lifecycle situation
- in a few, specific cases, correct referral to a mental health specialist
- an integration of the competency areas of the physician and the psychologist
- a reduction of costs for tests, consultation of specialists, and drug treatments, to the extent that these derive from an effort to find a solution to problems that lies exclusively within a biological model.

For further clarity, the main aim is not to implement 'first-level psychiatry' for patients with patent mental distress, but to explore the meaning of every complaint brought by patients, be it in the physical or mental sphere, in the context of the individual's past or present relational and lifecycle situation.

Methods

In the last nine years, nine qualified psychologists attending the Postgraduate School in Health Psychology of the University of Rome have guaranteed their presence, one day a week for three years, in the office of a family physician in Rome or in an adjacent town. A poster in the waiting room informs patients of the initiative and of the possibility of consulting only with the physician if they so prefer. Clinical cases and the functioning of the initiative are discussed in group meetings, which are attended by all psychologists involved and open to physicians, who also occasionally join the meetings and are co-ordinated by a teacher of the school (the senior author).

Intervention on the psychologist's part is implemented through the following means:

- assessment of requests and of the doctor/patient relationship for every patient coming to consultation
- discussion with the physician of cases observed
- further exploration/clarification with the patient in the context of ordinary medical consultation
- in some limited and selected cases, further exploration through separate interviews with the psychologist (ordinarily one to five in number)
- in some of these latter cases, referral to mental health specialists.

Results and discussion

Overview of the initiative

The first experience, entailing three years of co-operation of a family physician in Orvieto, Giovanni Iacarella, and resident psychologist Monica Tomassoni, was reported in a paper,[22] and in a volume.[23]

Results of the present study may be summarised as follows:

- the joint presence of a family physician and a psychologist appeared feasible and helpful, from all points of view
- integration of the psychologist in a physician's office, however, took several months, necessary primarily to reach a sufficient level of attunement and understanding between the two professionals
- most patients showed and/or directly expressed appreciation for the initiative
- in the whole experience, in only four cases did a patient request consultation with the physician only
- the number of separate interviews with the psychologist was very small (six cases a year, on average, for each psychologist)
- the number of referrals to mental health specialists was negligible (about two cases per year for each office)
- the latter two points show that, at least in the theoretical/clinical view we adopted, there is no risk of 'psychiatrisation' of the population, or of an increased burden for mental health services
- on the other hand, in the course of three years of experience, each psychologist met with about 700 patients, one-half of the physician's clients (which were about 1500 in all for each physician). This is a measure of the large extent to which the general patient population had access to a psychologist through this experience, in spite of the low frequency of the psychologist's presence (once a week). A higher frequency was not feasible since participation in the experiment on the psychologists' part was voluntary and unpaid. We believe that a psychologist's presence twice a week, during one morning and one afternoon,

would be the optimal frequency with which to reach a higher proportion of patients, without making encounters with the psychologist more or less unavoidable, short of explicit refusal. Freedom for the patient to choose to meet with the psychologist or not by simply scheduling his/her appointment on a particular day of the week, without the need to take full, official responsibility for a request or refusal in advance, appeared to be one of the strong points of the initiative, though an unplanned one.

Clinical notations and case report

Both physician and psychologist were initially quite worried about 'what each should do' to avoid conflict or overlapping; they wondered how they should 'introduce this new figure' to patients and define his/her role in a place where, for many years, only one person had been present. Most, possibly all, the professionals involved in the initiative soon discovered that, if on one hand some negotiation was certainly necessary between physician and psychologist, on the other, the relationship with patients in most instances was not in the least jeopardised, and very often it was enriched.

On several occasions, it was apparent that the simple presence of the psychologist in the office encouraged patients to tell the story of their ailments, even when they were from long ago, in a different way, with the addition of new elements – due not only to the new figure's different professional role, but also to the presence of a 'third' in the doctor/patient relationship. Lack of previous acquaintance with patients on the psychologist's part often led the physician to formulate more specific questions for the patient and to reconstruct past history in a more careful way. Patients, for their part, felt more entitled to sit down and talk about things they previously had not thought could find space in a physician's office.

After an initial period in which a tendency to implement the old 'referral' model emerged, separate consultation with the psychologist came to be the result of mutual, well-motivated agreement between the two professionals. It came to be proposed in a very 'natural' way, when both a need and a readiness on the patient's part for deeper understanding of his/her life situation became apparent to both professionals. As reported above, however, most of the work was performed jointly.

We shall now present a case, recently seen jointly by a physician and psychologist who participated to this experiment (see Box 1).

This case is highly illustrative of the meaning and usefulness of our initiative. A patient comes to a physician's office complaining of a physical symptom that the doctor assumes to be 'functional'; the patient is worried about his health, anxious to find a cause, and requesting sophisticated investigations. In some such cases, physicians collude with this request (or are the first to propose it). The patient enters the unfortunate pathway well described by Balint:[1] most often, in spite of the number and quality of tests (nowadays much more numerous and sophisticated that in Balint's time), nothing is found. The patient becomes progressively more resentful and embittered at the powerlessness of medicine in failing to find what is wrong with him; in his peregrinations, he may start to get the feeling of being considered a malingerer, someone who is looking for excuses to avoid work, or a 'psychiatric case'. Or maybe something will be identified that will eventually result in a casual finding, unrelated to his symptoms, but leading to further, more invasive investigations, leaving the patient with the impression of 'having something wrong'. Quite often, after a period of time, new symptoms develop.

The physician in our case, possibly supported by the presence of the psychologist, was very firm in avoiding this pathway. (Another physician participating in the initiative in the past expressed this point very clearly: 'When I was alone, and a patient came to me with symptoms that I could not think of a cause for, I would often request a CT scan, perhaps just to break the impasse; now that I know there is another possibility of finding out what's wrong, I can afford to wait'.) Still, Dino would probably not have been fully satisfied with learning only that his symptoms were 'commonly associated with stressful situations'.

Meeting with the psychologist led to rapid unfolding of the stressful situation we were dealing with: Dino, the youngest child in the family, as often happens, was probably destined by the family system – at least since his father's premature death if not before – to take care of his mother for life. We can suppose that breaking up with his girlfriend may have been connected with his reluctance, due to this ordeal, to be fully involved in the relationship (marriage, children, and the like). Dino's struggle against the risk of inheriting diabetes from his mother may be seen as a struggle against this chain of obligations.

We cannot know how much of all this, foreshadowed in Dino's narrative, reaches the patient's full awareness. At this point, however, Dino is quite ready to accept the idea that his physical symptoms are a signal his body is sending to him; and, without further meetings, he probably realises that the signal has to do with the danger of his ending up in a life composed only of obligations (work and the gym) and no personal achievements. He therefore plunges into a different life, astonishing his mother.

Box 1 Case report

Dino is a 41-year old man, tall, neat and of juvenile appearance. He comes to the office complaining of episodes of intense dizziness, appearing a few months ago. Vomiting, nausea and tachycardia are absent (making an organic lesion highly improbable). He is very disturbed by the ensuing reduction in his work capacity. Though he admits that these symptoms are associated with more stressful periods, this connection is put aside in favour of a forceful request to find an organic cause through a computerised tomography (CT) scan or some other sophisticated brain-imaging technique. At the same time, he is very frightened at the idea of discovering some dangerous health problem.

Physician and psychologist enquire together more carefully about the circumstances of this dizziness. It takes place only in specific situations: at work, especially during meetings, and at the gym.

Blood parameters, recently measured, are all normal; 'perfect!' says the physician. This gives little relief to Dino, who wonders in a more anxious tone 'what is wrong with me, then?'. The doctor performs a physical examination, finding no neurological implication; he excludes the usefulness of a CT scan; he tells the patient that dizziness is commonly associated with highly stressful situations and, in agreement with the psychologist, proposes a separate meeting with the latter to elucidate what stressful situations may be present in his life.

In this encounter, very significant details of Dino's life quickly emerge. He is an engineer and has a high-level job, but still lives with his mother, who is 84 and suffering from diabetes and renal insufficiency. A caretaker is also present in the house. His father died when Dino was 22. He is the youngest of four brothers; the other three are all married and living on their own, including one who was disabled following an accident and who lived with him and mother until two years ago. When this brother left home his mother's diabetes worsened greatly.

Dino is single; a few months ago he broke up with his girlfriend of 12 years. His days consist mainly of work, gym and mother. He rarely goes out. He does not particularly like the gym, but says he attends it three times a week, in addition to following a diet, in order to avoid the possible onset of diabetes that he could inherit from his mother.

The psychologist suggests that physical symptoms are often signals our body gives us, in relation to life situations; that rather than following the urge to suppress symptoms as disturbing, the two of them could work together in trying to figure out what these signals might be about. Dino appears surprised but interested and says he will consider the idea.

A few days later, on a day when the psychologist is absent, Dino shows up at the office, officially only to ask for some prescriptions for his mother. 'Marginally', though, he tells the physician he found meeting the psychologist quite helpful and asks how he can meet with her again. The doctor tells him to phone on the day she is present.

For some weeks there is no further word from Dino. One day the doctor goes to Dino's house (while Dino is at work) for a home visit to the mother, who is also his patient. 'What have you two done to my son?' cries the mother. 'Since he broke up with his girlfriend he was always at home, but now he is going out every night!'

Time will tell us the end of the story. One advantage of working in a family physician's office is that one usually doesn't lose track of patients, as ordinarily happens in psychological practice. What we can definitely say is that giving meaning to Dino's dizziness has allowed him to avoid entering a pathway of physical examinations that would have brought nothing helpful to him, as described above, and would have caused a useless drain on the health services.

Possible limitations of this study

It could be objected that the presence of the psychologist on a certain day of the week could lead to selection of some patients rather than others, resulting in a bias in the results. However, all physicians in the study agreed that they had never noticed major differences in types of consultations or patients according to the day of the week. On the other hand, a major difference was present in that the working population seldom asked for consultations in the morning; for this reason, the psychologist's

presence was scheduled for afternoons, whenever possible, in order to access the broadest patient population. By contrast, a strong, unavoidable bias – but also an asset, as described above – comes from the patients' opportunity to choose either to meet with, or to decline meeting with, the psychologist through their choice of the day of consultation.

Another question that can be raised is the possible usefulness of this initiative in countries other than Italy. While medical training and the doctor/patient relationship, with their corollary of mutual expectations, do not appear to be very different among Western countries, there might be differences in attitudes towards consultations with psychologists. Since, as outlined above, suspicion and fear of stigma with respect to meeting with a psychologist appear to be very high in this country, the initiative may be even more feasible in countries where these obstacles are less present, though possibly not so needed, since people might more easily find access to psychologists through other routes.

Our cross-cultural knowledge is not sufficient for us to discuss the possible application of the model in non-Western countries. A relatively small number of immigrants from Eastern Europe, Africa, and South America (present in Italy in increasing numbers) came into contact with the initiative and did not respond differently than did the local population.

Conclusions and future perspectives

In our study, joint consultation with a family physician and a psychologist appeared feasible and effective in affording the possibility to explore and more fully clarify the meaning of physical symptoms or other kinds of problems brought to the physician's attention. The mere presence of a psychologist in the office, accepted and arranged by the physician himself, powerfully changed patients' attitudes about what topics they were allowed and expected to bring up. Direct access to a first-level psychologist, in the absence of any filter and without the need for a formal, specific request on the patient's part, also appeared as one of the main assets of this initiative.

Integration of medical and psychological knowledge about the cases observed allowed a holistic approach. Working together for a number of years enriched each professional's competence to an extent which, we believe, may be difficult to obtain with any kind of formal training. Physicians could deepen their knowledge about the impact of relational and emotional dynamics on health and disease; psychologists not only learned a lot about the organic aspects of the human being, but they also had the occasion to witness the very birth of conflicts and other life problems, and to experience the effectiveness of their intervention in these instances; moreover, they had the opportunity to become acquainted with and involved in a number of life situations that would be unthinkable in any other kind of psychological practice.

A 31% reduction in drug expenses pertaining to patients attending one office, in comparison to the preceding years, confirmed our intuition that health costs might be reduced by implementing this initiative. Further investigations, therefore, will involve measurement of differences in health costs (not only those related to drugs) before and after the psychologist's arrival in each physician's office.

We are also planning to measure differences in wellbeing[24] and affective regulation[9] between patients having access to a psychologist in their family physician's office and patients who utilise common assistance.

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Professor Luigi Solano, Dipartimento di Psicologia Dinamica e Clinica, Università di Roma 'Sapienza', Via dei Marsi 78, 00185 Roma, Italy. Tel: +39 (0)6 49917989; fax: +39 (0)6 49917903; email: luigi.solano@uniroma1.it

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