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Health Psychology Work in Primary Care

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1. Introduction

Primary care is probably one of the unavoidable areas of the healing activities by applied health psychologists, but so far little attention has been paid to the field. According to Kovács and Mészáros (2006), every tenth person who visits his/her GP suffers from psychological symptoms. These patients typically report to their GP a variety of physical symptoms, which have been proven to be the reason behind or accompanying a psychological problem. The lack of time and the predominantly somatic approach of the doctor make it significantly difficult to recognize these problems (Torzsa et al., 2017). Surely, this can also contribute to the fact that the focus of the healing work of many GPs is not on disease prevention, but on patient care. Psychological healing work and the recognition of psychological problems in physical symptoms are primarily the task and competence of psychologists, but integrated mutual work is also needed to understand the complex process of symptoms emerging and to cure them.

As a typical trend in European countries, the development of primary care activities is moving towards a preventive approach. Experts highlight the important role of prevention and health promotion, which is implemented in close cooperation with the involvement of co-professions related to the medical profession in primary care. Psychologists are also present in primary care in a number of countries, such as the Netherlands, the United Kingdom, Denmark and Finland, making a significant relieve on specialist care (KPMG, 2014).

2. Psychologists in Primary Care: Lessons Learned from a Hungarian Methodological Development

In Hungary, the first program to involve psychologists in primary care was the "Primary care model program utilizing public health care resources with public health focus involving the support of Virtual Care Centres" (*"Az egészségügy forrásainak felhasználásával népegészségügyi fókuszú alapellátás-szervezési modellprogram Virtuális Ellátó Központ támogatásával",* i.e. Swiss Model Program, supported by the Swiss Contribution Hungary S/H/8/1). This program took place between 2013 and 2017, has in-

creased and complemented the competence of primary care through the cooperation of GPs and other professionals, as well as the assistance of psychologists. The modeling program lasted for nearly 5 years in Northern Hungary and the Northern Great Plain regions, in four practice communities (Jászapáti, Heves, Borsodnádasd, Berettyóújfalu). The communities provided new additional services (health check, lifestyle advice, physiotherapy, dietetics, health psychology counselling, prevention ordering, community health promotion programs) with the involvement of various professionals for the local population (Martos et al., 2017).

Cseh and colleagues (2021) in *Experiences and current affairs of practice community model programmes* describe that a total of 194 practice communities were established in Hungary between 2018 and 2021, based on the operating methodology of the practice communities established during the Swiss Model Program. A total of 72,000 people received psychological counselling during the program. In the summary of their article, the authors claim that the praxis communities are functioning as the cornerstone of the development of primary health care in Hungary. They explain that in the framework of multidisciplinary teamwork the practices, with public and other health departments, are able to implement health promotion and prevention programs by making additional services (e.g. health psychology) available to the population.

3. Application of Psychodynamic Theories in Primary Care Work

One of Michael Balint's main ideas and goals was the practical application of the principles of psychotherapy to everyday medical healing work. Balint linked the appearance of physical symptoms to, among other things, conflicts of object relations, so he applied object relations principles in their treatment (Balint, 1957; Csabai, 2010). In my own work and experiences in the practice of general practitioners and clients, I found that early object relationship patterns and relationships were often recognizable behind the scene, which coincided with those described in the *"psychosomatic integration model"* (Stephanos, 1975).

The first step in our work with clients is the development of the *"primary experiential space"* as described by Balint in the psychosomatic integration model (Balint, 1957). This space is characterized by a secure, predictable relationship for the client, which creates the medium where feelings and thoughts that can be verbalized as our sessions progress. The client can let go of the burdens of trauma through recounting of what has happened and expressing feelings in this safe space. The so-called "flash" created in our cooperation is an emotional connection allowing the client to find a connection between his/her negative feelings and his/her physical symptoms (Balint, 1957). In patients with physical symptoms, the task of the psychologist is therefore not to analytically explore the unconscious, underlying causes of symptoms, but to establish the primary, safe experiential space, an empathetic relationship, where the patient can

relive and reinterpret his/her experiences with the creation of *"flash"* and can shape his/her own interpersonal relationships based on the model of a secure relationship with the therapist (Balint & Norell, 1973; Csabai, 2010).

Overall the *"psychosomatic integration model"* and the *"flash technique"* contribute to the understanding and reduction of physical symptoms through the understanding of the patient's subject relationships, which is why they can be used in primary care. However, the process of therapeutic work is much more effective – unlike exploratory, psychoanalytic therapy – through biopsychosocial, complex-approach therapy technique, because it takes a relatively shorter time to achieve decreasing in symptoms and development of a more self-reflective way of life.

4. The Importance of Exploring Illness Representations

In the 1970s, these psychological researches first began to address the study of individual beliefs about the disease and the issue of cognitive representations related to health. Leventhal and colleagues (1980) described the concept of *illness cognition.* In their opinion, patients would develop implicit disease theories when detecting and evaluating their symptoms. *Illness representations* indicate cognitive representations – derived from perceived symptoms, healing and previous experiences in the field of illnesses – and determine information processing. They play a prominent role in adapting to chronic diseases, in understanding the symptoms that come with it (even at the beginning of the onset of symptoms) and in the degree of willingness to cooperate in the process of treatment (Leventhal et al., 1980). According to Tiringer and colleagues (2007), individual representations influence how an individual becomes an active contributor to his/her own treatment, how he/she perceives the symptoms, how he/she can adapt to them and how he/she fights them. The individual representations also influence the person's psychological and behavioral reactions to symptoms and illness.

5. "I Don't Know What I Can Do with this Pain" – a Case Study from the Field of GP Care

Judith is 33 years old, working in visual arts as a painter. She was born in a small town in the countryside (the Great Plain) and has been living in Budapest with her husband for 8 years. She comes to see her GP with clinical test results because of stomach and abdominal pains that have existed for a year and a half. The family doctor thinks that her diffuse abdominal complaints may be related to psychological problems. Judit agrees, and after the medical check-up, the doctor accompanies her to my room. According to the recent results, among the tumor markers in Judit's blood samples, C19-9 levels were slightly elevated. It is actually a cancer antigen, the appearance of

which may indicate the presence of a malignant tumor. However, it may also show an increase in case of other diseases (e.g. gallstones, pancreatitis, cystic fibrosis or various liver diseases). Small amounts of CA 19-9 can be found in healthy people, too. Judith is currently waiting for an ultrasound scan in 2 months, which will reveal the exact diagnosis. She struggles with her physical pain and insecurity about her condition, which is why her GP decided to involve a psychologist in her treatment.

Judit was sitting in the hallway visibly tormented by the pain of her symptoms. When I saw her, I felt really sorry for her and almost felt her physical pain. I wondered what was causing her physical symptoms, what might be behind her pain, and why she was so desperate while she hadn't got an exact diagnosis yet. Maybe there were gastrointestinal illness cases in her family? I thought that I need to explore her family history extensively in order to be able to reveal the causes of her fears.

Judit is short and has a thin, lean build. Her hair is long and black, which she wears in a tied knot – this is how she wears it during every session. Her face is a little pale. Her posture suggests fear, anxiety, she holds her hands together on her lap, her legs crossed all the time. According to her, she was a little scared of the situation, she had never been to a psychologist before. Nevertheless, the rapport quickly develops, and she begins to talk about her condition. In her opinion, her symptoms may be related to stress. She feels an insurmountable nervousness – she just can't calm down. She says she's mostly afraid of cancer. During our first meeting, she reports that stomach pain also sets her back in her life. It occurs many times that she prefers not to eat at all or skip social meals, simply because she is afraid of the following pain. During holidays, when she could rest more, she was almost asymptomatic, she could enjoy all the programs. The method of mind-shifting has been a proven stress management technique for her, she tried to keep herself busy with leisure programs, work or hobby, but now she feels that this is no longer working, she cannot control her symptoms. She often wakes up at night, she is plagued by disturbing thoughts, she can't sleep. She also reports that her family has had several gastrointestinal illnesses, which makes her fears well-founded. Her mother had previously been diagnosed with ulcers, her father had a thin stomach wall of hereditary origin, and her grandmother had pancreatitis.

At the end of the first interview, we looked at what she wanted to achieve, why she wanted to see a psychologist. In her view, she should take things much more lightly. She's trying strictly to meet up to requirements – her friends and family have already signaled this to her. According to her, she also "chases" her own expectations, often unrealistic ones, in her professional life. She always wants to meet her own too ambitious expectations and cannot let these ideas go. She wants to overcome her anxiety and fears and develop her low stress tolerance. She also asks me, if in the course of our collaboration, an old trauma or unreacted event comes to light, I should let her know because she wants to know what could cause her symptoms. At this point, I think that Judit really wants to heal with all her strength, with the greatest determination and

aims to leave her physical pains. However, the question arises in me: what negative life event, what kind of loss is she thinking about, what may be underlying her illness? I think she may have an idea about what's the deep lying reason of her symptoms, but lacks the means to be able to face it.

5.1. Start of Therapy

Judging from the experience of the first meeting, Judit was obviously motivated to work together. Her physical symptoms make her daily life difficult and she has set several goals for herself. At the end of the first meeting, we decided to have 10 meetings, for which we sign the therapy contract. I declare that I am obliged to keep secrecy, and I wouldn't release any information about our meetings to a third party. I will maintain the consultation with her GP because of her somatic examination results. I also talk about the fact that an important part of collaboration would be to find out about an accurate diagnosis. We need to know or exclude possible organic reasons that could cause physical symptoms, as I would choose psychotherapeutic tools accordingly. With these psychotherapeutic tools, Judit will be able to reduce everyday tension, become more efficient in receiving and processing life events, which can contribute to improve her quality of life and maintaining her health for long-term context also.

Aims:

1. Exploration of illness representations, verbalization of physical sensations
2. Clarifying the client's relationship with herself, increasing self-knowledge
3. Use of an effective stress management method

Devices:

1. Autogenic training (relaxation)
2. Brief Illness Perception Questionnaire (BIPQ)

On the second meeting, I ask how she felt after our first meeting, what thoughts she had. She reports that when she got home, she told her husband she had been referred to a psychologist. She had long been contemplating the idea that it would be worth visiting a specialist considering her symptoms. Her husband supported her in that. She also had previously been recommended for autogenic training and yoga, but at that time she missed those opportunities. She explains that after the first meeting, she had mixed feelings, she felt ambiguity. On the one hand, she was very tense when she arrived at her GP with the results of the blood test and was also extremely tormented by her abdominal symptoms that day. Looking back on the events, now she is able to see her symptoms as having caused by stress. On the other hand, she felt a little relief because she thought she could finally talk to a specialist.

5.2. The Loss of the Father – Helping the Entangled Grieving Process

Judit tells me that her stomach symptoms emerged about three years ago, after her father's death. At this point, I think that this is most likely the life event that she was referring to earlier. After her father's death, she was very concerned about how the family structure would "stand up", how the family relationships would be settled, how her mother would handle the situation, nor did she know how to settle it in her own life. She thought time would sort it out, but on All Soul's Day, she couldn't get out of the car in the cemetery and go to the grave because she was crying so hard. In her hometown her paternal grandmother lives in the same household as her mother. According to her, her grandmother and her mother didn't get along. She describes ongoing tensions between them, where the father used to serve as the "buffer zone". Judit often felt the tension between her parents because of her grandmother's bullying. She shares with me her memory of when her mother was in the kitchen, her father was in the room, and she didn't hear them talking to each other for days. Then, continuing to remember, she explains that after her father's death, she was very concerned about how her mother could handle the new situation, how she would be able to live with the grandmother. Looking back, she now sees that the initial few months were very difficult, and now she sees peace between them, which in her opinion was depending on her mother' s past. In the beginning, they both had to face the fact that they had lost the most important person in their lives, but they already know how to talk to each other about it. For her, too, the most painful event is the loss of her father. Then her voice breaks, she begins to cry and tells me that her father died suddenly at work, without any warning sign. She starts shaking when we discuss this. At this point in therapy, an unreacted loss has surfaced, and I'd like to know where she is at the moment in working through her grief. I assume that Judit is stuck in the mourning process. In the period following her father's death, her attention was not on herself, but on the development of the relationship between her mother and grandmother, and its impact on her own life. I'm trying to find out who could be Judit's real support in those days, who she could have counted on, and how she feels now in her family. At a few meetings, we talk about her relationship with her father. Based on the memories, a healthy, loving father-daughter relationship appears in front of me. Colorful childhood experiences, a providing young adult, a proud father-daughter dance at her wedding, and finally an unexpected and cruel departure. When we talk about the loss of her father, Judit's feelings are difficult to understand, and she finds it difficult to verbalize them. Then, as our sessions progress, I find that when she talks about her father, recalling her childhood memories brings a smile to her face. As if the sadness and the pain would be overtaken by the loving memories that Judith herself articulates. She explains that the feeling of pain is present every day because of the loss, but by being able to remember and express her feelings about her father, she now feels a good warmth in her heart.

5.3. Illness Representations, Life Events and Social Relationships

We have dealt with what she herself thinks about her illness and its background over the course of several meetings. She shares with me that during her college years, she didn't care much about her way of life. She believes her wild college years may have contributed to her symptoms. She says that she partied a lot, often skipped several meals, there were times when she studied until dawn, even though she could have done it during the day. She feels like she has really harmed her health, which she is about to restore. Judit finds it difficult to be alone. In the beginning of her time in college, she felt she couldn't be alone, just by herself. She mentions her friends several times during our meetings. She and her husband socialize with a group of friends, they meet regularly. She reports on good-spirited encounters and programs. Her friends know about her illness and provide her real support. She also explains that she feels difficult to adapt to the constantly changing events around her. She also reports panic symptoms. At the beginning of her symptoms, she was given an anxiolytic and sedative. After reading the leaflet, she became unwell, started to produce several side effects within a short period of time, and her heart rate quickly increased with fear. She told me that when the panic symptoms occurred, her husband calmed her down. She thinks during the graduation and state exam period was the first occasion when she felt a degree of stress that she could not do anything about. During these periods she was often plagued by severe headaches. She has been examined, but they didn't find any bodily symptoms. She now knows that her headache at that time was also due to the nervousness regarding her studies, but she had no way of coping with the stress. She says she set too high goals for herself and couldn't relax due to that. Because of this, she felt very stressed and tense for years. At the moment she and her husband are thinking about buying a house, and the duties around all that also worry her. She considers herself a too tight personality among artists. During her university years, she was often advised to be more relaxed, but she had a strong desire to conform, both to herself and her parents. She says she would like to *"bring home"* the glory to her mother and would find it difficult if something did not go as planned. She feels that if she were to take her tasks a little more lightly, she wouldn't be able to move forward and things wouldn't go ahead in life. She adds that when she feels that way, things aren't going well, things aren't going anywhere inside, then she can't digest. During these periods she feels a cramp in her abdomen, a severe pain. Based on what has been said, I tend to think that since Judit was not able to cope effectively with the changes and stress situations in her life, her physical symptoms increased.

When I ask her how she can describe her pain, she says she feels cramping, compressive pain in her stomach, as if she couldn't digest. *"I don't know what can I do with this pain,"* she says.

She describes feeling uneasy, spastic and compressive in her stomach that she cannot get rid of. Most of the time, she tries to calm herself down with deep breaths and/or start massaging her belly.

The group supervising session reinforced me that one of the aims of our cooperation is to reduce stress, to learn the right stress-management techniques. With the help of the autogenic training method, I help to raise her awareness that she can exercise control over her symptoms and stress levels. The method can also help to develop a vision that is characterized not by convulsive compliance and chasing, but by self-acceptance and calmness. Judit sees a connection between her psychological state and her symptoms, which naturally determines the motivation for our cooperation.

5.4. Presentation of the Applied Interventions, Tests and Tasks

During our sessions I used an abbreviated version of the autogenic training relaxation. Relaxation consisted of exercises of the weighting and then warming of the arms, legs and the whole body, as well as exercises for the warmth of the heart, breathing and abdomen. After the second meeting, we practiced relaxation every time, followed by a meeting. At this time, we discussed the physical sensations experienced during the exercise and asked how well she managed to relax, how she felt during the exercises, what feelings were related to the physical processes. I also asked for home practice, the lessons of which we discussed on the following occasions.

During the first few exercises, Judit reported that conscious attention to her belly, relaxing it and warming her belly were difficult. She felt uncapable of indulging into the exercise much. During the abdominal exercise, she experienced her tension, cramping and the physical pains as usually associated. I tried to reassure her about that. I told her that relaxation is based on practice and the first few times is about getting acquainted with the exercises. From the feeling of tension in the abdomen, it is clear that due to the increased stress, Judit finds it difficult to relax her belly. Her attention is on the tense, cramped sensation. However, as practice progressed and her conscious attention was directed to her body parts, she managed to relax and reduce her tension more and more.

The nine-item Brief Illness Perception Questionnaire (BIPQ) enables the rapid identification and evaluation of cognitive and emotional representations of the illness (Broadbent et al., 2006; Látos et al., 2021).

Judit scored 44 points in the questionnaire, which proves to be a high value. Her replies to the questionnaire items and the final result are entirely in line with what she said. She believes her illness affects her life, but she does not control her daily life and recovery will take a considerable amount of time. She is particularly concerned about her illness and symptoms, which has an emotionally significant effect on her. Because she sees a link between her symptoms and her psychological state, she believes she understands her symptoms. As a cause of her symptoms, she describes herself as stressed and anxious, but in her opinion her previous lifestyle also contributed.

In addition to the Brief Illness Perception Questionnaire, I also used the Spielberger State Trait Anxiety Inventory (STAI) (Spielberger et al., 1970). As I assumed from our meetings, Judit scored very high on the questionnaire. Not only is the level of momentary anxiety due to the situation high, but also the level of propensity for it.

5.5. Progression of Therapy, Improvement of the Client's Condition

Halfway through the planned therapy, Judit reports that with the help of relaxation exercises at home and in the sessions, she can relax herself more and more, her stress level has decreased, and her abdominal complaints and pain are gradually decreasing. With the gradual reduction of pain, the improvement of her quality of life can be felt in everyday life, and this has been cited by her partner. She reported feeling calmer, feeling her whole body wasn't stretched. Her control over her symptoms has been strengthened by relaxation and she felt more confident. She sees that discussing her thoughts about her illness has helped her to actually realize that cramping abdominal pain is in fact a symbol of the convulsive compliance that characterizes her life. She feels that by discussing these thoughts with a specialist and discovering connections, she has freed herself from stress, which has enabled her to exercise more control over her symptoms. In my view, this is mainly due to her calmness, which I signal to her. She incorporated not only relaxation into her daily life, but also yoga, which, according to her, also helped her to develop the current positive state. She experienced that if there is a positive change in her mental state, at the same time her physical complaints and symptoms decrease and then disappear. She also told me about her professional goals that are more exactly set and more realistic. She said she wanted to match the expectations at her workplace. We were at the end of our work together when the ultrasound was scheduled. She feared that a tumor or inflammatory process would be diagnosed by the examination – but the test results were negative. When I asked her about the course and circumstances of the investigation, I noticed that she was calm. She reported that she had gone to the investigation on her own, unaccompanied, and that she had not let fear overwhelm her. As she talks about it, I see peace and balance about her. Her posture is visibly comfortable, suggesting calmness.

I consulted with Judit's GP several times about the progress of work and its results. At the beginning of therapy, Judit asked her GP for antispasmodic medication on a few occasions, but these requests gradually became obsolete. The GP was relieved with the case, because in previous encounters he often saw the patient hopeless and desperate. He welcomed the fact that Judit was able to exercise more control over her symptoms with the help of relaxation, discover a link between her mental state and the onset of her symptoms, her stress level decreased, thus her quality of life improved, and pain and stress no longer complicate her daily life. Her GP summed up our work saying so: *"You have healed her!"*

5.6. Closing the Case, Summary, Conclusion

My client showed repeated physical complaints lacking any organic disease or reason. Her constant worry was typical, her stressed state of mind was due to unexplored trauma and unexpected life events. She has realized that a connection between her psychic condition and her physical symptoms exist, which she managed to make even more aware of during therapy. Physical pain without organic problem significantly impaired her quality of life. She tried to treat her own symptoms (pre-planned schedule for meals, massage), but she was not able to overcome anxiety, nor stress. In the background there was a trauma that had not been worked through, as well as the desire to conform and get forward in life, while feeling the constant worrying, high levels of stress. This condition was greatly enhanced by the antigen found in her blood. Arriving for the ultrasound examination, Judit's stress level decreased significantly as a result of the relaxation she had learned, she was calmer and able to control her symptoms more effectively. As therapy progressed, the chronic symptom began to decrease and then disappear (flash – emotional connection) by exploring and processing psychological factors. Judit had considered visiting a psychologist several times before. At the end of the therapy, summarizing the results of our meetings, she said that in her opinion the well-directed questions highlighted important connections for her. As a result of the non-judgmental empathic communication experienced in the therapeutic relationship (Balint's primary experiential space), she was able to mobilize in herself an internal force that contributed primarily to the reduction and later elimination of her psychic and then physical symptoms.

During our therapy sessions, Judith barely spoke of her husband. She shared some pieces of information and talked about events, but she didn't talk about her marriage, nor about their relationship. During therapy, she did not appear to me in the role of a wife. She mentioned her husband as a supportive partner, but I didn't get any insight into the life of the couple. This made me think. Since she didn't bring this side of her life into therapy, I decided not to ask her about it. However, I had doubts about how she would be able to cope with being on her own while her husband would go abroad. But as Judit started to live a more confident and more balanced life, I am convinced that she will be able to cope with difficult situations in life and unexpected events that would occur in the future.

6. Discussion

When Judith was referred to me by her GP, I was delighted that the doctor recognized the symptoms with which make directing a patient to a psychologist sensible. It was an extremely positive experience for me to see a GP practice where the GP also pays

attention to the discovery of psychological factors related to the disease during the course of the treatment.

Until now, psychological services in primary care have only been available for certain periods in Hungary. Therefore, we cannot talk about a working, "well-established" or institutionalized system, where the professional could confidently carry out effective healing work as a stable member of the professional team. Therefore, a psychologist working in a GP practice faces a lot of challenges, problems and tasks requiring new competences in order to cooperate effectively with primary care professionals. A professional who has the opportunity to work in a GP practice can certainly consider him/herself a pioneer in this field. He/she must clearly see the responsibility of this work as a contribution to the development and awareness-raising of primary care. The fact that a psychologist has to cooperate with the employees of the general practice professionally, but as a member of a working group, share and receive information, and conduct continuous consultations with medical colleagues – this only partially determines the success of your work. It is important that the psychologist is able to achieve his/her own esteem, to represent authentically all the knowledge through which he/she can provide a higher level of additional service to the given practice community (e.g. patients, doctors, relatives), for which the doctor must also have sufficient openness. They should be able to transcend the biomedical concept, to be willing to work with a psychologist, to protect his/her own and other colleagues' mental health, and to be motivated to provide complex and cost-effective care. There are many tools available to the psychologist on how to shape the attitude of professionals working in the practice. For example, you can provide training for GPs working in the practice community on when and to send your patient to a psychologist – in what case, what complaints and symptoms – how to explore in order to decide if a psychologist is needed; and how to support the patient in visiting a specialist. It is also important to inform the GP about what he/she can ask from a psychologist to do. How can a psychologist help the patient in acute or chronic conditions, for example, or how he/she can do health and prevention work in the practice, what tools and competences he/she has and works with. For the work of a psychologist, material conditions are also required. In order to create an atmosphere of trust and discretion, a consultation room is required, where overhearing is impossible. This room should be suitable for individual and group consultations, it should have equipment to help create a pleasant atmosphere. It is important to ensure undisturbedness and regular ordering times. Since at present the material conditions are only partially or not given at all, it depends on the creativity or rather the generosity of the family doctor on how he/she is able to provide the necessary infrastructure conditions for the psychologist.

In addition, it is essential to ensure that the client can contact the psychologist directly without referral from a GP if he or she feels the need.

7. Practical Experience

The case presented highlights exactly how important the presence of a health psychologist is in primary care and how important it is in the healing process that the specialist can support the client in the tense wait for a specialist examination. Judit had planned seeing a psychologist several times before due to her symptoms, but in fact she did not do anything to get to a specialist. In the current situation, however, the specialist was available locally in the GP practice.

Patients with medically unexplainable physical symptoms initially turn to their GP, overloading primary care, after which they are directed to a number of specialist clinics to obtain various exclusionary diagnoses, which usually do not describe what the reasons of the physical symptoms are, rather exclude the factors that do not cause it. It is important that the psychologist can support the client in the use of the specialist examination, since the symptoms can be formed by prolonged stress effects, life-style conflicts, traumas. Therefore, the treatment of this group of patients is much more effective at the level of primary care with the involvement of a health psychologist than in specialized care, where the client can only be admitted for the purpose of seeking special diagnoses. In addition, the process of healing should not, of course, be carried out without the mapping of the personality, the diagnosis or exclusion of a large number of mental disorders in primary care, which is the scope of competence of the clinical psychologist. In future practice communities, therefore, it is not possible to circumvent the process of establishing a cooperation between clinical psychology care and health psychology.

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