Service of clinical psychology for Padua University's employees.

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The beginning.

Ten years ago the University of Padua decided to organize a clinical psychology service for all employees and their families with the aim to prevent tensions and conflicts: in 1999 two tragic events had taken place in a very short time inside our buildings: the murder of his father, a University professor, by his son, researcher and, a few days after, some shots by an employee during a meeting, which caused the immediate death of a technician and of a professor, the permanent disability of an administrative employee, and another professor's coma that lasted 4 years till death.
Alberto Mazzocco, Director of DPSS (Social and Developmental Psychology Department), and Vincenzo Milanesi, a philosopher, that within a year became the Rector of our University, were immediately aware that such events were severe symptoms of personal and institutional distress and disease, for the place where they happened and the violence that perhaps could, if not avoided, at least be limited, on the basis of the murderers' previous behaviors.
So, they started this service and asked the clinicians of the Faculty of Psychology, to work in it.
The service is supposed to answer to different manifestations of psychic difficulties (individual, relational, in the family and at work) but it is also aimed to prevent general distress.
No doubt that those tragic events were symptoms of diffused psychic difficulties also if individually the murders were the possible consequences of an ignored illness.
The most common diseases referred to us were at the beginning: personal dissatisfaction, anxiety and depression, psychosomatic symptoms and/or poor mental and physical balance with the emergence of functional disorders (frequent headaches, migraines, gastritis, etc.), almost always related with a worsening of family and social relationships associated with a bad quality of individual life.

The University was at a turning point where the "business profits" started entering the logic of the *turris eburnea* of the past, showing more and more how the employees' psychological distress had an effect on the amount and quality of work performed by people: neglect, errors and bad results in their performances, as well as absences from work, worsened relationships with colleagues, difficulties in managing the relationship with authorities and colleagues, the mobbing and terrible unended conflicts at the workplace (Kreiner, Sulyok & Rothenhäusle, 2008, Magrini, 2008).
In recent years many Companies have felt the very strong need to offer psychological assistance in different parts of Italy: they have created services that deal with the mental health of employees, with the aim to better the way of working.
Within the universities, the counseling services are directed especially to students, who often have difficulties in their study, connected with a wider situation of psychological distress: special services dedicated to take care of different problems (learning difficulties, lack of motivation, poor communication, performance anxiety, relationship difficulties, psychopathological disorders, problems with their family and on the separation).
In Italy, employees psychological needs in the universities have been considered mostly for the emerging issue of mobbing, as the law requires.

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The innovation introduced by the University of Padua was a broader counseling and psychotherapeutic service (usually managed by local and private services), without a waiting list with the extension of the assistance to the relatives of employees (mainly children, but also spouse).
The DPSS and the DPG (Department of General Psychology) have provided space and staff.
The first group of clinicians, all specialized Psychotherapeutic professors, who organized the service, belonged to different theoretical schools of origin and had different clinical background. That is why we could create a service not only for adults but also children and adolescents, a service which provides individual, dyadic, family and group interventions.

Psychological and psychodiagnostic evaluations, counseling as well as psychological interventions for Parenting, Pregnancy, postpartum and family relationships are a part of the functions as well as the most usual psychotherapeutic interventions in individual, family and group.
Obviously the privacy is guaranteed, but at the beginning some doubts about it created some resistance in access by employees, who feared both a form of control by the institution and a spread of sensitive data concerning them. The first shy approaches started in the first two years (2000-2001). Later, satisfied users were inviting other colleagues whose access increased exponentially. Help was asked for different problems little by little as we 'll see later .

Service organization

Actually three Departments of Psychology are providing clinicians to the service.
The Department of Developmental Psychology and Socialization, provides technical and administrative staff for the organization and management.
Psychological services are provided by the teaching staff and researchers that, in addition to the specific role played within the University, must also have the title of psychotherapist.
The clinicians' different theoretical models and their specific experience in different fields allows a range of therapeutic offers covering all the ages development, as well as different treatment modalities (individual, dual, couple, family, group). The richness of the therapeutic offer is accompanied by autonomy of each therapist in management of clinical cases.
The main decisions of the service are taken on a regular basis of monthly meetings, during which we discuss organizational and clinical trends of the service.
The Legal head of the Service, currently Prof. Massimo Santinello, Director of the Department of Developmental Psychology and Socialization, decides a coordinator who is responsible for internal organization, and relations with the external context.
The need to adopt a common language in the clinical management of patients, and to collect meaningful data given the different backgrounds of the therapists, has obliged to program specific training in the use of diagnostic procedures and outcome evaluation. This allowed to safeguard the autonomy of the individual therapists in case management, and provides a common basis that allows to understand what is going on in the service, and to compare the different ways of working and efficiency of different therapies on the basis of patients' request.
Rules of access, payment and end of treatment are the same for all users.
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The potential client calls the technical-administrative secretariat that asks some preliminary data and gives a first interview. The first interview is conducted by a well trained psychologist that works in the technical secretary of the Service, collects the basic informations about the patient and his needs, and after a discussions with the coordinator in order to decide which therapist could fit better and would be able to start a treatment in a very short time according to the characteristics emerged in the first interview, presents the situation to the clinician.
This preliminary interview made by the same Psychologist for all patients, prior to the meeting with the therapist, has several advantages.
First, it allows to answer promptly to the request, regardless the immediate availability of a therapist. It also provides a space in which the patient feels an immediate psychological support and he is offered a first working through of the problem that allows his thinking over what the

service can offer. Thus, most patients experience that their problems have found a place where can be taken care of and feel a decrease anxiety related to fears and fantasies about the psychotherapeutic treatment, which are often mentioned in the first interview and in many cases worked through.
This applies either to people who are at their first treatment and do not know what to wait for, either for those (quite a high percentage) who already had experiences, in some cases positive, who have created a hopeful attitude on the treatment, in other cases negative, creating a general feeling of distrust and resistance to the requested care.
The time before the beginning of the previewed therapy (never longer than one month) allows quite a few modifications of expectations, fantasies and fears of the patient who will often refer to that first interview during treatment.

The choice of the therapist is very complex: it is necessary to consider the therapist specific area of interest, couples rather than childhood or specific disorders (obsessive, sexual issues, personality, depressive disorders, etc.), but also the therapist's personality and his particular way of working, which may seem more fit to the characteristics of each patient.
In the preliminary meeting the psychologist and after the secretary perform bureaucratic aspects, fill the informed consent for processing personal data, give instructions about payment - Patients may ask questions and clarify doubts in a space that is not emotionally connoted as the therapists space.
The administrative secretary takes care of payment. Employees receive preferential economic treatment, as they must pay a little part of the quota provided for each psychological session; the University provides the remaining quota, employing part of the funds for social interventions. The part paid by the patient is highly meaningful for the therapeutic work. When the patient doesn't attend to a session without informing or informing too late, it is impossible to require payment, because the university will have in such cases to pay the therapist anyhow. Fortunately this is a problem only for a small group of patients, generally people who have long lasting problems in their attendance at work or severe personality disorders.
The end of treatment requires a formal communication to the secretariat for the regularization of the payments. This organization allows to work through the rare situations of dropout, since the contact with the psychologist in the secretariat, perceived as more neutral, allows, generally, to stress the importance of making at least one final session with the therapist limiting the complex experiences of abandoning the therapy. With some rare exceptions, this procedure allows a final session, during which the patient can actually say goodbye, giving a meaning to the interruption and maintaining an image a less persecutory of the therapist, which in some cases also allows a further easier treatment.

Another exception is made for situations where clients seek to change therapist.
This rare event is always motivated by a difficulty in working with the therapist. Usually, the request usually is asked directly to the psychologist who made the first interview and it is discussed carefully to try to understand the reasons implied. If the patient wants to continue psychological treatment in our service, we take time in order that he can realize weather he was trying to escape from a very sensitive point of treatment disguised as a request to change therapist.
Anyhow, this request is always welcomed with gentleness, considering the difficult time that the patient is going through, but this process may lead to an effective change of therapist or to keep on the status quo ante, then the meaning will be reviewed within the therapy itself.
Some patients come back after a while with other problems, asking a few sessions of consultation with their therapist or in order to refer to us some other members of the family.

Peculiarities of the service

The Service is characterized by a gradual change of referrals over the years. In the first period, when there was not yet sufficient trust on privacy, mostly people who had repeated access to public services or endless private psychotherapies asked for help, usually for very complex problems. There were few children, more teenagers, who also had had several unsatisfactory

relationships with other clinicians. Actually we have referrals similar to those of public local services, but patients arrive with a model of intervention, usually transmitted by colleagues who were helper beforehand by us (Table 1).

Reason for request	Total
Mood disorder	66
Anxiety disorder	48
Difficulties of parenting	48
Family relational difficulties	39
Difficulties at school	32
Relational difficulties	28
Difficulties in couple relation	26
Behavioural difficulties	26
Difficulties at work	23
Processing mourning	10
Difficulties related to separation	6
Eating disorders	4
Sleep dirsorders	3
Speech disorder	3
Drug addictions	3
Character disorders	2
Obsessive ideas	2
Sexual disfunction	2
Disfunction of sexual orientation	1
Autistic traits	1
Educational guidance	1

Table 1. Reasons for the request (in many cases, multiple problems presented at the first interview).

There are some departments that have more referrals and we are inclined to believe, without, however being able to prove it, that the transmission of satisfaction with the service from some of our former patients is very important.
Also interesting is the increase of referrals when we have changes in the authorities, that can move people from one charge to the other or make competitions for careers if the expectations of possible changes were left disappointed.
Over the years, the number of accesses to the Service remains more or less constant (Table 2), but there is a rise in the number and kind of sessions, in reality gradually diversified (Table 3).

Year	Number of performance
2002	72
2003	47
2004	35
2005	38
2006	33
2007	38
2008	39
2009	42

Table 2. Number of patients by year.

Year	Number of sessions
2002	412
2003	1.006
2004	1.136
2005	1.317
2006	1.580
2007	1.265
2008	1.524
2009	1.850

Table 3. Sessions per year.

The difficulties of children, and the numberless problems in transition to parenthood, along with the gradual impoverishment of the local national health service answers, has created a situation of more children referring to service. Useless to say that school children needs of children, is often concentrated in diagnoses made by parents or teachers. "dyslexic, dysgraphic, learning disabilities, hyperactivity". There is always some work to do to help parents to agree to work with us in a more global way that allows to involve the family in diagnosis and prognosis so that they can become our best allies, and to shorten intervention as usually required.

A peculiarity of our service is to employ cycles of groups (about ten sessions) children and preadolescents of an hour, running in parallel with meetings with parents, usually the couple, and at least once per cycle with all parents of the group. Before the next cycle to which will participate only the children who need them a period of about 60 days. During this period, parents have the time to test and practice the new situation and, often, with their child and with us to decide whether it should continue. This period is important to develop what the child has perceived in the group, but he has not been able to integrate and s personal adult help to do it. Often, children in group dynamics are not yet able to express the reasons for their discomfort felt through what friends say or do, but they individual help, taking them with the help of individual an adult.
The presence of expert therapists from schools more concerned with cognitive, interactive, family, parenting, and group behavior, allows to reach in a relatively short time to complete diagnosis with prognosis that is the parents' main interest always .
Working with teachers is an necessary part of this function and also if our service is unable to move in schools, teachers are still grateful for the help that we offer and move from far away to receive it.

Year	0-5	6-12	13-19	20-29	30-39	40-49	50-59	60-69
2002	1	6	5	4	20	25	10	1
2003	0	2	5	5	13	15	7	0
2004	0	3	4	4	7	10	5	2
2005	0	8	5	2	5	11	5	2
2006	1	4	8	3	5	10	2	0
2007	0	5	3	2	12	7	8	1
2008	1	7	4	3	8	9	7	0
2009	0	6	1	3	14	10	7	1
Totale	3	41	35	26	84	97	51	7

Table 4. Age of patients divided by year of arrival

Beyond the fact that this way of organization depends on the reality situation that induced us to employ the available resources in term of clinicians and to adapt our work to the referred patients, we think that at this historical moment in the melting pot of different habits, cultures, needs, changes of families and transition to parenthood, with the fundamental pillars of reality time and space, modified by internet, a service with so many different approaches to patients is extremely useful and perhaps can be considered a model of service when clinicians are well trained. Opposite to what happens in a number of services, in which we assist to religious wars between clinicians of different backgrounds in the Apad there has never been this kind of mistrust and now patients often do not arrive asking a clinician they heard about, but rather a therapist of a certain school.
Working with the children, we realize, more than with adults, we need to have a very large vision and that the responsibility for their future forces us to read the problems 360 degrees.

References

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