

## Research Article

# Primary Care Psychologist: A Research in the Province of Turin

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### ABSTRACT

In the last few decades the traditional concept of illness has changed towards the idea of health as an integrated process: in this overview a new professional figure emerges, the primary care psychologist.

**Objective:** The main objective of this research is to verify to what extent sample subjects consider feasible the cooperation between general practitioner and psychologist.

**Method:** A survey was conducted with the sample subjects: 93 psychology students between 20 and 45 or more years old, both male and female. After the statistical analysis the results have been

compared with a pilot study conducted in 2016 which involved general practitioners.

**Results:** It emerges that both general practitioners and psychology students consider important the launch of a new collaboration between these two professional figures.

**Conclusions:** Three needs emerge: a better psychological knowledge for general practitioners, a better medical knowledge for psychologists and a structured collaboration between these two figures.

**Keywords:** Integrated medicine; Primary care; Clinical health psychology, Psychology and medicine.

### Introduction

Both physicians and medical officers claim that the reasons why people first make contact with the so-called “family doctor” often do not come from issues and problems of somatic nature, even though they manifest and express themselves as physical symptoms [1].

In Italy, a general practitioner treats on average 1500 patients; during the calendar year, he/she receives from 45 to 75 patients suffering from depression, from 53 to 60 patients with anxiety disorder, 4 or 5 patients with severe depressive symptoms or bipolar disorder, 2 or 3 schizophrenic patients, 3 or 4 patients suffering from dementia, and 3 or 4 patients with alcohol or drug addiction [2].

Very often, the traditional training of physicians prevents them from meeting the requests of their patients, which are not necessarily related to the somatic aspect.

Such an approach may lead to the persistence of symptoms or even to their worsening, with subsequent and repeated

requests for help and a higher expense for the individual and/or the National Health System.

The general practitioner very often recognizes only explicit psychic disorders and does not consider psychic risk factors in the development of somatic illnesses and diseases. Patients who tend to express their problems through physical symptoms are those who are not advised to see a psychologist [1].

Moreover, it should be pointed out that general practitioners are often the first contact point for those patients who experience emotional and psychosocial difficulties.

As a matter of fact, the available data remind us that of all the people with a diagnosable mental disorder, only a third goes to a mental health professional; 68% of them go only to his/her family doctor [3,4].

General practitioners play obviously an essential role in the early identification and treatment of mental disorders; in fact, a large number of primary care visits (25-40%) are directly related to mental health [3,5,6].

These last data clash with a significant reality: access to primary care usually does not involve mental health [7-9].

In order to solve this problem, many possible solutions have been suggested. One of them is the integration of the two professional figures of the physician and the psychologist. Such an integration has to be the expression of a concrete, cultural, and scientific renewal of the care system; it cannot be considered merely as the addition of psychological consultations in these contexts: instead, it is vital to recognize first a clear definition and difference between the two roles, and then to find common grounds on the scientific, organizational, and operational level [10].

For this reason, in order to facilitate a correct and optimal integration, it is necessary to define the tasks of the psychologist, the structure and the organization of his/her presence, and the services he/she has to provide.

First of all, this kind of professional is able to elaborate and provide meanings related to the biographic, cognitive, emotional, relational, and social aspects of the patient. His job consists in recovering anything that could have been overlooked by the traditional medical assistance, in particular events regarding the psychological, social, and relational side of the individual [10].

The role of the primary care psychologist allows him/her to develop and try innovative methods in order to integrate mental and psychological health; moreover, teams of professionals should develop screening strategies inside the practice in order to meet the goal of global population screening for development and behavior [11].

The cooperation between a primary care psychologist and a general practitioner inside the same medical practice would provide several advantages [1]:

- the patient would not have to ask for a consult with the psychologist at a later time;
- the patient could have direct access to the psychologist, avoiding the risk of being stigmatized as “mentally ill”;
- the immediate intervention during the early stage of the psychic or somatic disorder, before it becomes profoundly structured or chronic;
- the symptoms would be analyzed not only by their biological component, but also by their relational, intrapsychic and life-cycle related ones;
- the integration of the specific skills of the physician and the psychologist;
- the opportunity to ask for help and request a consult to a mental health professional, in case the psychological disorder is more severe.

As stated previously, almost half of the patients who have access to primary care are diagnosed with a mental disorder or show behavior-related symptoms; in the light of the fact that

every medical problem has got a psychosocial dimension, one can say that the presence of behavioral health professionals is an especially effective strategy to increase access to support groups, programs for parents and other local medical services.

Moreover, such an integration would make it possible to find a common language between the two different branches of knowledge and to understand the central role of the patient and the family in the expression of his/her needs and in the development of a treatment plan [12].

A pilot project conducted in Flanders has confirmed the positive aspects mentioned above regarding the introduction of the psychologist in primary care contexts; as a matter of fact, the feedbacks of the patients have underlined how this innovation could fill the existing gap in the current health care system. This project confirms that the primary care psychologist could contribute to the improvement of the supply of health care, accessibility, and the cooperation with specific mental health care and welfare services [13].

Integrated care can be an efficient method to significantly decrease symptoms of mental illnesses; it improves mental health functioning and satisfies patients, considering the prevalence of psychological problems in primary care contexts, especially anxiety and mood disorders. The integration of mental health in primary care contexts is the reasonable requirement to provide an efficient health care: with more accessibility and shorter wait times, primary care clinics play a crucial role in screening, identification of problems related to mental health, and early intervention [14].

## Theories and methods

For more than 300 years, the biomedical model was the one most used to comprehend the state of health of people [15]. According to this theoretical model, based on Charles Darwin's theory of evolution and René Descartes' philosophical thinking, the body was a physical entity entirely separated from the mind. In this perspective, pathologies were exclusively caused by organic damage and were an abnormality derived from a virus, a gene, an anomaly in development, or an injury; according to the model, only medical science could intervene to cure a disease.

People did not have any responsibility in the development of the pathology, and medical intervention was focused only on the treatment of symptoms related to the disease, without fostering the welfare and health of the patients.

Health is actually a dynamic force made of different kind of systems (physical, biological, psychological, social, and cultural), all interdependent and intercommunicating. This kind of awareness is what led to the transition from a linear cause-effect model to a circular bio-psycho-social model. This dynamic scheme of a mind-body unit allows patients to have an active and central role [15], and not a passive one like they used to have in the biomedical approach, now considered insufficient to face the current health challenge [16].

The Biopsychosocial Model (BPSM) was first theorized in 1977 by the American psychiatrist George Engel; nevertheless, most of the national health care systems continued to use biomedical models until more recently [17].

The main assumption is that the development of illnesses and diseases in a patient is profoundly influenced by different kinds of factors: biological (genetic predisposition, exposure to the disease, brain and nervous system development), psychological (thoughts, emotions, actions, behaviors, lifestyles, stress and beliefs on health), and social (environment, cultural influences, family relationships, social support and economic factors).

Health is no longer considered as a state, but as an ever-changing process. As a matter of fact, in 1986 the World Health Organization suggested in the Ottawa Charter an orientation focused on health promotion, that represents the extent to which a human being is capable of satisfying his/her needs, changing, facing efficiently the surrounding environment, and achieving his/her ambitions. Therefore, health becomes a resource for daily life and can be understood better as the combination of biological, psychological, and social factors, rather than in solely biological terms [17].

In this perspective, health promotion, diagnosis, and treatment of the disease are on the same multidimensional continuum and primary care psychologists, therefore, need to guide the patients throughout the above-mentioned stages.

Finally, comprehensive therapy is biopsychosocial by nature since it acknowledges the essential unit of biomedical and psychosocial health; it also takes into consideration chronic and acute issues and preventive treatment needs. Therefore, it is a treatment focused on the individual as a whole, taken both in the family and the community contexts. The conducted studies prove a greater satisfaction of patients towards this kind of treatment, a greater consistency to quality guidelines on chronic diseases, a decrease of medical errors, a decrease of requests for medical exams, a decreased use of emergency departments, hospitals, and prescribed medications, and a decrease of health care costs in general [18,19].

## Results

Shown below are the data derived from the pilot research, which was conducted in 2016 in order to make a first comparison with the data obtained from the current research project. The first difference regards the method of administration of questionnaires: in the previous research, the questionnaires have been sent via e-mail in order to reach as many physicians as possible; in the current one instead, they have been printed out and distributed because it seemed a more direct and efficient way to receive an immediate response by the selected sample.

The research projects have been conducted on the basis of two samples of different subjects: the first research involved 54 general practitioners of A.S.L. TO3 (in the Susa Valley) working for the National Health System, while the second one involved 93 students of the postgraduate course in Psychology

of IUSTO (Salesian University Institute of Turin) and UNITO (University of Turin) (Table 1).

Table 1 shows the main demographic features of the samples involved in the two research projects: the general practitioners and the future psychologists. The samples appear to be very diverse as they represent subjects of different age, mindset, and profession.

In the first research, the figures regarding the gender of the subjects are quite homogeneous (48.1% men vs. 51.9% women), while in the second one, the female percentage seems to exceed considerably the male one (26.9% men vs. 73.1% women).

As far as chronological age is concerned, the subjects of the first research are certainly older (57.5% is more than 55 years old) than the subjects of the second one (49.5% is between the ages of 20 and 24 years old) since the first sample includes physicians who have been practicing their profession for years, and the second one involves students (Table 2).

Table 2 shows the percentage of the answers given by the subjects of the two research projects regarding the efficacy of the psychological intervention.

The numbers are quite homogeneous: 79.6% of physicians and 90.3% of future psychologists state that psychological intervention can be helpful to the treatment of mental issues; 96.3% of physicians and 95.7% of future psychologists affirm that it can be useful for solving emotional problems; 94.4% of physicians and 93.5% of future psychologists claim that such an intervention can help with interpersonal issues; finally, 57.4 of physicians and 59.1% of future psychologists argue that physical problems can be faced with this kind of intervention. As already stated, the latter percentage is useful for reflection since it appears to be lower than the others in both of the samples.

**Table 1:** Comparison between the samples of the two research projects.

Sample features	Category	A.s.l. to3 – general practitioners results	Postgraduate students of psychology results
Sex	Male	48.1%	26.9%
	Female	51.9%	73.1%
Age	20-24	0%	49.5%
	25-34	1.9%	34.4%
	35-44	13.0%	3.2%
	45-54	27.8%	12.9%
	More than 55	57.5%	0%

**Table 2:** Efficacy of the psychological intervention in the two research projects.

Efficacy of psychological intervention	A.S.L. to3 – general practitioners results	Postgraduate students of psychology results
Mental problems	79.60%	90.30%
Emotional problems	96.30%	95.70%
Interpersonal problems	94.40%	93.50%
Physical problems	57.40%	59.10%

**Table 3:** Reasons why patients are referred to the psychologist.

Reasons why patients are sent to the psychologist	A.S.I. to 3 – general practitioners results	Postgraduate students of psychology results
Confidence in psychotherapy	77.80%	67.70%
Patient request	29.60%	64.50%
Acquaintance with a psychologist	16.70%	26.80%
Lack of interest in practicing psychotherapy	5.60%	7.50%
Need to complete the diagnosis	53.70%	61.20%

The figures mentioned above have been further examined through the statistical chi-squared test; the analysis showed a large discrepancy between physicians and psychologists (the former in a lower percentage than the latter) in the answer regarding the “mental health issues”: ( $X^2(1) = 4.0, p = 0.045$ ).

Table 3 shows the main reasons why, according to the two different samples, general practitioners might refer their patients to see a psychologist.

In this case, in contrast to what was revealed in the previous chart (1.2), the figures do not seem to be homogeneous; the discrepancy is probably due to the different role and type of studies of the subjects involved.

However, one of the queries showed a mild similarity in the percentages: as a matter of fact, 77.8% of physicians and 67.7% of future psychologists believe that one of the main reasons why a general practitioner might refer his/her patients to have a consult with a psychologist is his/her confidence in appropriate psychotherapy.

In general, the other data show that:

- fewer physicians (29.6%) in comparison with future psychologists (64.5%) claim that practitioners need an explicit request from the patients in order to refer them to have a consult with a psychologist;
- a relatively low share of physicians (16.7%) and future psychologists (26.8%) affirm that the patient might be refer to a psychologist because of the acquaintances of the practitioner;
- a small percentage of physicians (5.6%) and future psychologists (7.5%) believe that if a patient is referred to the psychologist is because of the lack of interest in practicing psychotherapy;
- both physicians (53.7%) and future psychologists (61.2%) claim that therapy sessions can help the general practitioner in the patient’s diagnosis.

The statistical analysis made through the chi-squared test showed a significant discrepancy between physicians and psychologists (the former in a lower percentage than the latter) in the answer regarding the “explicit request of the patient”: ( $X^2(1) = 15.2, p < 0.001$ ).

## Conclusion

According to the bibliographical research and the data obtained from the conducted research projects, some important needs emerged:

- more training in psychological subjects for Italian physicians;
- more training and medical knowledge for Italian psychologists;
- the need of an organized and regular collaboration, instead of a merely occasional one between the two different professional figures in order to foster the welfare of the patients.

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