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SOCIODEMOGRAPHIC CHARACTERISTICS AND PSYCHOPATHOLOGICAL SYMPTOMS OF PATIENTS SEEN BY CLINICAL PSYCHOLOGY IN PRIMARY CARE: A DESCRIPTIVE STUDY

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Summary. The aim of the study is to evaluate the formal aspects of the psychological intervention and the sociodemographic characteristics of the referred patients. Methodology. Descriptive study of patients referred by their primary care physician to Clinical Psychology for the presence of psychopathological symptoms. Information was collected by means of a clinical interview, a questionnaire for sociodemographic variables and ad hoc clinical aspects, and the GHQ-28 general health questionnaire. The population served was 123 patients, with a total of 95 women. Results. The most common reason for referral was life situations that decompensated their psychological state (51.2%). A total of 29.3% of patients attended Clinical Psychology with psychopharmacological treatment prescribed by their primary care physician. The range of sessions ranged from 1 to 12, with a sample mean of two. The intervention by Clinical Psychology favors that during an average of 2.3 sessions, 30.9% of patients were discharged due to improvement and 13.8% are still in follow-up, being relevant that only 8.9% of patients were referred to the second level of specialized care, thus reducing the care burden in this one. 21.1% of the patients showed psychopathological symptoms acutely (last month) and 30.1% chronically. The latter data were statistically significant only in relation to mental health history, the use of psychotropic drugs and evolution during the intervention. Discussion. Psychological intervention in a few sessions provides a better psychological adjustment and avoids the chronification of psychopathology.

Keywords: Clinical Psychology; Primary Care; Mental Health; Mental Health

CARACTERÍSTICAS SOCIODEMOGRÁFICAS Y SÍNTOMAS PSICOPATOLÓGICOS DE PACIENTES ATENDIDOS POR PSICOLOGÍA CLÍNICA EN ATENCIÓN PRIMARIA: UN ESTUDIO DESCRIPTIVO

Resumen. El objetivo del estudio consiste en evaluar los aspectos formales de la intervención psicológica y las características sociodemográficas de los pacientes derivados. Metodología. Estudio descriptivo de pacientes derivados por su médico de atención primaria a Psicología Clínica por considerar la presencia de síntomas psicopatológicos. La recogida de información se llevó a cabo mediante entrevista clínica, un cuestionario para variables sociodemográficas y aspectos clínicos ad hoc, y el cuestionario de salud general GHQ-28. La población atendida fueron 123 pacientes, habiendo un total de 95 mujeres. Resultados. El motivo de derivación más común fueron situaciones vitales que descompensaron su estado psicológico (51,2%). Un total de 29,3% de pacientes acudían a Psicología Clínica con tratamiento psicofarmacológico prescrito por su médico de atención primaria. El rango de sesiones osciló entre 1 y 12, siendo la media de la muestra de dos. La intervención por Psicología Clínica favorece que durante una media de 2,3 sesiones se produjesen un 30,9% de altas por mejoría y un 13,8% siguen en seguimiento, siendo relevante que sólo un 8,9% de pacientes fuese derivado al segundo nivel de atención especializada, reduciendo así la carga asistencial en éste. El 21,1% de los pacientes mostraban síntomas psicopatológicos de forma aguda (último mes) y un 30,1% de manera crónica. Estos últimos datos sólo fueron estadísticamente significativos en relación con los antecedentes en salud mental, a la toma de psicofármacos y a la evolución durante la intervención. Discusión. La intervención psicológica en pocas sesiones proporciona un mejor ajuste psicológico y evita la cronificación de la psicopatología.

Palabras Clave: Psicología Clínica; Atención Primaria; Salud Mental

Introduction

The General Council of Clinical Psychology shows a prevalence of around 25-55% of consultations related to a mental disorder in Primary Care (PC), 80% of which are of mild to moderate severity, in the form of anxiety or depressive states. Around 10% are referred from PC to specialized care, with the remaining percentage falling on primary care physicians (PCPs) (Prado-Abril, 2016).

This situation has led to an approach in which specialized care (SC) has been given preference to patients with moderate to severe mental health pathologies, leaving the rest, a large volume of patients with mild symptomatology, oversaturating primary care staff. This means that, in order to provide a rapid and effective response to the population, in accordance with health criteria and following clinical practice guidelines, the MAPs need to resort to drugs, which means more expense for the health system and chronifies the pathology, without previously offering the possibility of a specialized psychological intervention (WHO, WONCA, 2008).

Mental health units could run the risk of becoming increasingly overcrowded if clear criteria for referral to a second level are not established. The figure of the Clinical Psychologist in Primary Care could reduce this saturation by taking on patients with mild or moderate affective symptomatology that until now has been assumed by the MAP or referred to the second level.

The oversaturation of mental health units has led to the optimization of resources and to consider the inclusion of the clinical psychologist in PC (Consejo General de Psicología Clínica, 2017). Also relevant is the need to maintain coordination between both levels, PC and specialized care, in order to analyze referrals or to strengthen specialized follow-up and thus prevent the patient from returning to PC without resolution of the condition (Gálvez-Llompart et al., 2021). It is worth mentioning that the organizational and functional deficiencies of the National Health System partly hinder

cooperation between the different levels of health care, causing problems in the balance of the health care burden between devices (Moreno and Moriana, 2012).

Internationally and nationally, the implementation of coordination programs between mental health units and PA for intervention with people with a mental disorder is increasingly being carried out. In the UK, the "Improving Access to Psychological Therapies" program was implemented incorporating clinical psychologists in PA services, showing long-term recovery outcomes of 50.9-66.6% (Community & Mental Health team, NHS, 2017).

At the national level, we find the pioneering study by Cano Vindel with the PsiCAP project, which analyzes the implementation of psychological care in PC, showing that psychological treatment is up to three times more effective than the usual treatment in PC (pharmacological, MAP care) for anxiety disorders, depression and somatization (Plataforma APPI. PsiCAP, 2017).

An increasing number of primary care centers, in coordination with mental health units, are establishing a project for the inclusion of clinical psychology in PC, as can be seen in the evidence collected in this section. The projects that have been developed have favored positive results in terms of the effectiveness of early psychological intervention in primary care, thus avoiding the collapse of mental health units, the chronification of disorders, or the overmedicalization of patients with mild or moderate psychopathology (APPI Platform. PsicAP, 2017; Alonso et al., 2019).

PC bears more than 50% of the burden of mental disorders, the most common being those related to anxiety, depression and somatization (49.2%). Two out of three patients are treated by the PC physician, usually with drugs, with a low rate of remission and frequent relapses. In the British initiative, a greater efficacy of the application of cognitive-behavioral interventions performed by the Clinical Psychologist in PA was appreciated, following the recommendations of the NICE guideline (Infocop, 2019).

Psychological intervention in PA using behavioral activation or cognitive-behavioral interventions for depression produced improvements in symptomatology, had longer-lasting effects than with psychotropic drugs, and were better regarded by patients (Cuijpers, Quero, Dowrick, & Arroll, 2019).

The inclusion of specialized psychological care in PC is an act of quaternary prevention, limiting unnecessary or excessive activity of the health system. In this way, not every human suffering is turned into a pathology, with the clinical psychologist having the role of pointing out functional coping strategies or reinforcing certain behaviors (Alonso et al., 2019).

In Retolaza's study, an analysis of the most prevalent psychiatric disorders in PC was carried out using questionnaires such as Goldberg's GHQ-28 General Health Questionnaire and the Current State Examination (PSE) on a sample of about 500 patients, highlighting the diagnostic limitations in PC and concluding the need to establish a set of standardized measures to be used as a way of measuring psychopathology in PC (Retolaza, Márquez and Ballesteros, 1995). There are many studies that highlight the most prevalent disorders treated in PC, one of the most frequent being depression. A

meta-analysis of 41 studies from different countries showed that the prevalence of depression in PA was 19.5% (Retolaza, 1993).

Emotional disorders account for two thirds of the most frequent diagnoses of mental disorders seen in PC and in which there is an association between stress and negative emotionality. The most common treatment is pharmacological, not adequate to the mild symptomatology or adjusted to the criteria of clinical practice guidelines, with greater relapses and a tendency to become chronic (Cano Vindel, 2011a; 2011b). Villalva and Caballero (2006) report that antidepressant treatment in PC is started in 76% of cases, the rest being referred to Mental Health; 32% of patients abandon treatment before recovery, the most cited cause of abandonment (88%) being the patient's perception of not needing to continue with treatment.

It is indicative that patients with depression may become frequent visitors to health centers, suffering from different pathologies, somatizations or a diversity of non-specific symptoms, which, if properly evaluated, would fall into the category of depressive disorder, and therefore would require specialized care (Dowrick, Bellón, & Gómez, 2000; Mitchell, Vaze, & Rao, 2009; Cano-Vindel et al., 2012).

Several experiences are being collected in Spain on the characteristics of the population that is referred to Clinical Psychology in health centers. The most relevant diagnoses were depressive disorders, anxiety disorders, adaptive disorders and Z codes (factors influencing health status and contact with health services). Standardized measures are used to evaluate the effectiveness of the intervention, showing improvements in an average of three sessions, thus appreciating an effectiveness in the comprehensive application of the biopsychosocial model by including the clinical psychologist in PA (Gutiérrez-López, 2020; Sánchez-Reales, 2015).

Primary Care (PC) is the first level of the healthcare system accessed by people with various psychological and/or somatic complaints. It is the staff representing this institution who must respond to this discomfort, either by assuming the care of the person themselves or by knowing the different services to which to refer for more specialized care. It coordinates with specialized care services and other services in order to respond to the problems posed by the population. They exercise a vertebral function in the health institution, being responsible for the supervision and integral continuity of care to the population under the paradigm of the biopsychosocial model.

The present study presents the first results obtained by the author during the rotation at a Primary Care Center during the PIR (Psychologist in Residence) training. The health center where this experience took place employs about twenty doctors and another twenty nurses, a social worker, auxiliary and administrative personnel, orderlies, cleaning and service personnel. During the first month of rotation, the resident contemplated the doctor-patient relationship, learning about the disease process and its approach from the primary care point of view. Once the rotation was completed, psychological care continued during the "continuous care" period of the training, two afternoons a week, attending a total of eight patients a week. Therefore, the data collection period was about 15 months, located between the last quarter of 2019 until December 2021.

The psychological intervention carried out with the patients followed the cognitive-behavioral paradigm, with cognitive techniques as a means of identifying and questioning the most frequent cognitive distortions in the disorders treated, and behavioral techniques to improve coping with symptoms and the ability to adapt to them. In general, the therapeutic process has always started with psychoeducational tools and the reduction of physiological activation, so that with lower levels of anxiety or dysphoria, cognitive or behavioral techniques could be introduced to manage the symptomatology. In all cases, in the first consultation, once the reason for concern was exposed, a functional analysis was returned with hypotheses about the symptomatology and, from there, psychoeducation was connected. The intervention had a limit of about eight sessions, and in specific cases it could be longer.

Method

Objectives

The main objective of the study is to describe the sample of patients referred by primary care physicians to Clinical Psychology, a pioneer study in Huelva capital and province, in order to assess the sociodemographic characteristics, health status and the most prevalent type of mental pathology in Primary Care. The specific objectives proposed in this study are as follows:

- To study the reasons for referral from the primary care physician to clinical psychology at the health center.
- Analyze the number of patients referred to Clinical Psychology.
- To assess the number of patients who are referred to Clinical Psychology and who are previously medicated with psychotropic drugs.
- To study the sociodemographic characteristics of patients referred to Clinical Psychology.
- Check general health status prior to psychological intervention at the health center.
- Analyze the number of psychological intervention sessions needed to successfully complete a treatment.
- To assess the follow-up of referred patients and to study the number of discharges due to clinical improvement and the number of dropouts.

The hypotheses put forward in this study are as follows:

- The number of referrals of patients with psychopathological symptoms to a second level of specialized care (USMC) will be reduced with the intervention of the Clinical Psychologist in primary care.
- Patients referred by primary care physicians to Clinical Psychology at the health center will have an affective psychopathological diagnosis of mild and/or moderate severity.
- Patients will need an average of eight sessions to be discharged from Clinical Psychology.

Design and Procedure

The Clinical Psychology intervention began with an information session with the medical team, reaching a consensus and establishing the criteria for referral to the PIR. Referrals from professionals were channeled through the rotation's MAP tutor. Even so, in more complex cases, a prior meeting was held between the referring MAP and the PIR to determine whether the referral was appropriate, the type of intervention that could be

provided or whether the patient should be referred to the second level. The criteria for referral from the MAP to the (resident internal psychologist) PIR are reflected in Table 1.

Table 1

Referral and exclusion criteria

Inclusion	Anxiety disorders Mood disorders (mild, moderate) Adaptive disorders
Exclusion	Personality disorders Substance use disorders Current assistance by Mental Health or other specialized services, public or private Recent admissions to Psychiatric Inpatient Unit

The MAP referral was agreed with the patient in his or her consultation. The physician indicated on a printed "Consultation follow-up sheet" the patient's personal data, the most relevant physical data and briefly the reason for referral. The referral was transferred to the PIR who proceeded to assess the physician's request. The analysis of the demand assessed the urgency of the case, whether it met the requirements for care at the Health Center, whether it corresponded to referral to a second level of specialized care or the criteria for urgency. If it did not meet the requirements, the PIR met with the corresponding MAP or provided a report with the result of the demand analysis, the reason for non-compliance and an alternative care for the patient. If the request was accepted, the patient was contacted and an appointment was made (see Table *2*).

Table 2

Intervention conditions

MAP Demand	*Informs the patient of the existence of the Clinical Psychology Unit and shows the need for referral.* *He/she makes a "consultation follow-up sheet" where he/she specifies the contact data, initial diagnosis, brief reason for referral and current pharmacological treatment.*
Previous contact	This was done by telephone where she introduced herself as the Resident Psychologist of the health center, informing her of the receipt of the referral form by her MAP. He was asked if he agreed to make an appointment. The framework was established, informing them of the conditions of the appointments, absences, the form of contact with the center, the day of clinical attention and the schedules.
Inquiries	First consultations: if they did not attend the first consultation, they were discharged for non-appearance, leaving a printed sheet to their MAP for information purposes. Similarly, if the patient was called twice and did not answer, the same procedure was followed. If you would like to return for an appointment in Clinical Psychology, you would have to return to your MAP to request it. Check-ups: if they did not attend two check-ups, they were discharged for non-appearance. If, during the intervention, a patient was referred to the second level, the intervention was stopped, leaving a "consultation follow-up sheet" with the most relevant data of the therapeutic process with his or her MAP.
Number of sessions	A maximum of 8 individual sessions were offered. If there was no clinical improvement, the patient was referred to the second level.

Duration sessions	*of*	First consultations: 1h Revisions: 45 min
Frequency sessions	*of*	Biweekly.

A morning clinical schedule was established, four days a week, with a maximum of five patients per day. Upon completion of the rotation period established in the PIR program, clinical care has been continued in the same manner in the afternoons, two days a week, from October 2019 through December 2021. During this time, the Clinical Psychology Unit attended to a maximum of eight patients per week during two afternoons. During this period of time there has been a critical situation that we have to point out as a possible interference in the beginning of this Unit, which is the pandemic by COVID-19, where this attention has been prioritized, where the consultations were telematic and the requests for referral to Psychology decreased considerably, to later increase again once the face-to-face consultations were resumed.

Population

The study population consists of 123 patients from the same Primary Care Center, seen by a PIR during 2019, 2020 and 2021. These patients were referred by their Primary Care Physicians upon detecting symptoms of origin to receive psychological intervention instead of direct referral to a second level of specialized care (Community Mental Health Unit). Of the 123 patients assigned to a PIR, 30 patients did not attend the first consultation, so 93 patients will be assessed in some of the results.

Variables and Instruments

- *Information and informed consent form*. It is administered by the psychologist at the first consultation.
- *Clinical interview*: an open interview is conducted to collect sociodemographic and autobiographical data, personal and family psychiatric history, the reason for consultation, previous mental health experiences and expectations for the current intervention.
- *Goldberg and Hilier's* (1979)*GHQ-28 general health questionnaire* : is a questionnaire validated and adapted to the Spanish population by Lobo and Echevarría and Artal (1986). It shows high reliability, with a Cronbach's alpha of 0.97 (Godoy-Izquierdo, Godoy, López-Torrecillas and Sánchez-Barrera, 2002). It is self-administered and has 28 items that are answered with a Likert scale from 0 to 3 points. They assess the perception of health as for example in this item "*Have you felt exhausted and without strength at all?*" The questionnaire provides an overall score and a score for each of the four subscales: A (somatic symptoms), B (anxiety and insomnia), C (social dysfunction) and D (severe depression). It is also possible to obtain data on the chronification of symptomatology and to detect cases of acute onset (non-case/case score): 5/6) or chronic (non-case/case score: 12/13).
- *Ad-Hoc questionnaire of sociodemographic variables and clinical aspects*: collects data such as age, gender, marital status, employment status, academic level, reason for referral to clinical psychology, total number of sessions attended, ~~number of sessions of psychological intervention~~, diagnosis and mental health history (including previous and current pharmacological treatment).

Data analysis

An analysis of sociodemographic, clinical and evolution variables of psychological intervention in primary care was carried out using the SPSS version 25.0 statistical package. Descriptive statistical analyses were performed on variables such as: age, gender, marital status, academic level, employment status, reason for referral, mental health history, previous and current pharmacological treatment, number of sessions, type of patient evolution, diagnosis and data from the GHQ-28 questionnaire. Likewise, statistical tests such as *Chi-Square* (X^2) were performed to contrast the data of the variables collected and those of the GHQ-28.

Results

Sociodemographic data

The sample of patients seen in Primary Care during 2019, 2020 and 2021 (123 people) has an average age of 47.29 years, with a range between 15 and 83 years. In relation to gender, the sample consisted of 95 women (77.2%) and 28 men (22.8%). Marital status shows the following variability: 54 people with a partner or married (43.9%), 19 single (15.4%), 13 divorced or separated (10.6%) and 7 widowed (5.7%). There are a total of 30 missing values, which are the people in the entire sample who do not attend the first consultation.

The academic level shows a majority of patients with secondary education (40.7%), followed by those with higher education (25.2%) and finally, those with primary education (9.8%).

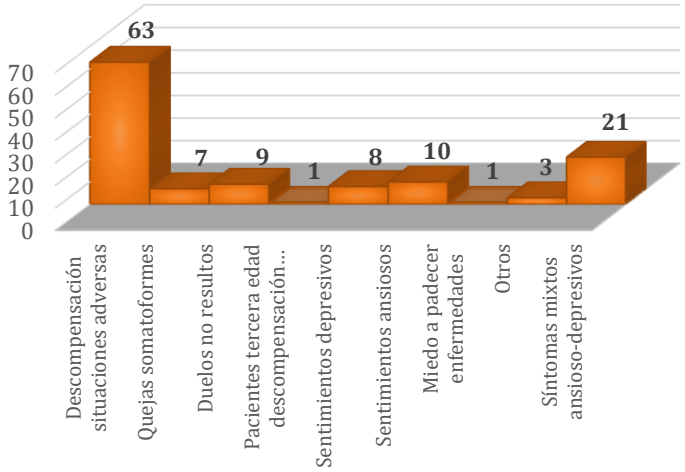
Analysis of employment status indicates that the highest percentage corresponds to patients who are working at the time of clinical care (39%), followed by those who are unemployed (16.3%), retired persons (11.4%), students (8.1%) and, finally, disabled pensioners (0.8%).

Assistance data

The main causes of referral by Primary Care Physicians (PCP) to the Clinical Psychology Unit were collected, categorizing them after data collection into nine categories. *Figure 1* shows the cases or frequency of each of the reasons for referral in the sample of 123 patients, with two of them being the most frequent: "decompensations in the face of stressful life events" with 51.2% and patients with complaints of "mixed anxious-depressive symptoms".

Figure 1

Reasons for referral to Clinical Psychology



This set of data includes both those who have received clinical care and those who did not attend the first consultation, but the reason for referral indicated by their MAP was collected.

As relevant data for the initiation and evolution of the psychological intervention, we considered whether the patients referred by the Primary Care Physicians had previously received psychological care, either privately or publicly, and whether they had been under psychopharmacological treatment or were taking any psychopharmacological treatment at the time of the psychological care. The 30 cases that did not attend the first consultation have been excluded, making a total of 93 cases. Some 33.3% of the patients reported having a history of mental health or having seen a psychologist and/or psychiatrist at some point in their lives. Twenty-six percent of the patients had at some time taken psychopharmacological treatment and 29% attended the first session with a previously prescribed psychopharmacological treatment.

As can be seen, it is revealing that prior to referral to the Clinical Psychology Unit of the Health Center, Primary Care Physicians usually start prescribing antidepressants and/or anxiolytics in a large percentage of cases. Patients presenting with prescribed psychotropic drugs comprised 29.3% (36) of the total 93 cases in psychological treatment. A total of 33.3% (41) of the cases had a public or private mental health background.

This study considers the evolution of patients during psychological intervention, categorizing it into eight possible situations: "discharge due to improvement", "does not go to first consultation", "change of health center or city", "continues in follow-up", "referral to second level USMC", "abandonment", "already goes to USMC", "goes to psychology at private level". This is relevant data for analyzing the therapeutic process and the possible causes of abandonment or successful aspects of the intervention. The 123 cases were taken as a whole, with the highest percentage corresponding to patients who were discharged due to improvement (30.9%), followed by dropouts (21.1%) and those who did not attend the first consultation and therefore did not initiate follow-up in Clinical Psychology (18.7%). 13.8% remain in follow-up. During this period of time, 8.9% of the cases were referred to specialized care (USMC). 4.1% abandoned treatment or did not start because they moved to a different city, Autonomous Community or health center. 1.6% of the patients were attending psychology in a private setting, so the

intervention was completed at the center. And 0.8% were already attending USMC when referred, so the case was not assumed at the center.

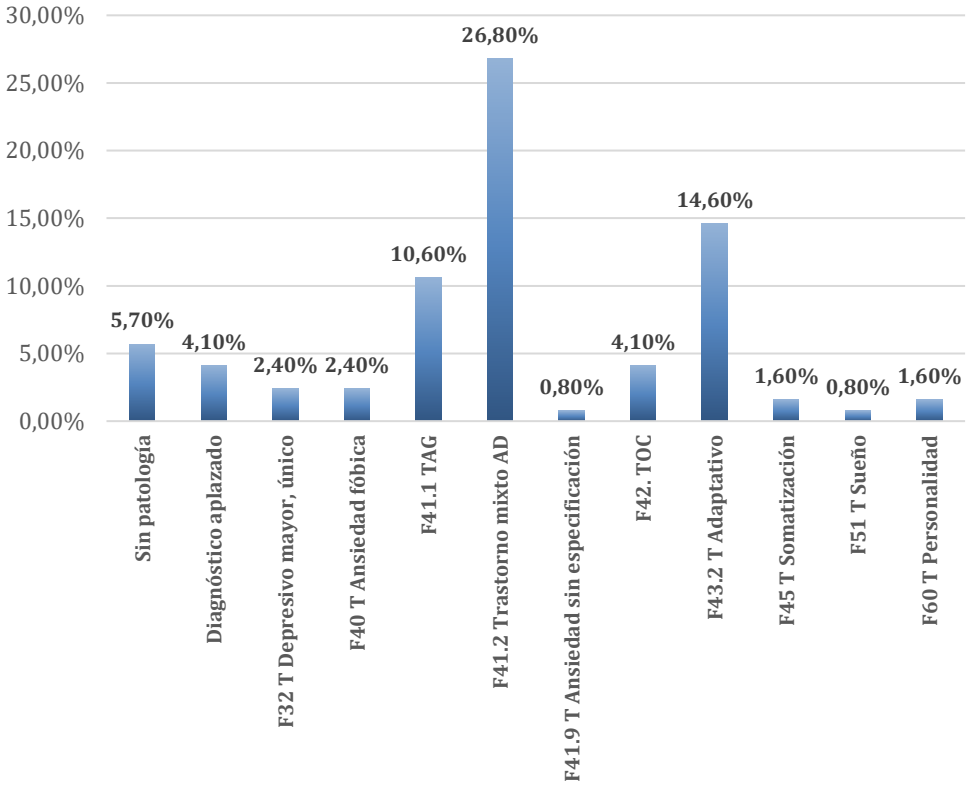
Analysis of the number of sessions in this sample indicates that the most frequent number of sessions was a single session (26.8%), followed by two sessions (22%). There are a total of 5 people who have received between 9 and 12 sessions, for a total of 4%. The average number of sessions is 2.33, with lower and upper limits of 0 and 12, respectively.

The number of sessions is significantly related to patient evolution*(*X^2 = 13.003, *p* = ,043). More patients were discharged for improvement having received less than 5 sessions than those who received more. More cases were also referred in the first sessions and those who dropped out of follow-up did so within the first five sessions.

Finally, one of the most relevant aspects of psychological intervention in primary care is the diagnostic evaluation and application of this type of intervention to emotional disorders of mild to moderate severity. For this purpose, the interventions included the administration of clinical interviews and diagnostic coding according to ICD-10, in addition to assessing affective symptomatology by administering the GHQ-28 questionnaire. The most prevalent disorders in the sample are shown in Figure 2.

Figure 2

Diagnostics



The GHQ-28 questionnaire provides a different score if it is a symptomatology of recent onset or if it is already chronic. Of the 93 patients attended, 90 were taken into account, since three did not answer or stopped attending the sessions and did not provide their answers. The number of acute cases detected by this questionnaire was 64 (52%) while the number of clinical cases of chronic evolution was 53 (43.1%).

The GHQ-28 questionnaire provides an insight into the symptomatology presented by the population seen at the health center during this period of time. The mean of the total scores of the questionnaire is 16.74. The mean of the "somatic symptoms" scores is 6.41, that corresponding to the "anxiety-insomnia" subdimension is 4.74. Finally, the means of the subdimensions "social dysfunction" and "severe depression" are 4.36 and 0.91 respectively.

Contiguity tables were made using the Chi-Square statistic as a contrast criterion for the different sociodemographic and clinical variables and the cases detected by the GHQ-28 (Tables 3 and 4). 21.1% of the patients showed psychopathological symptoms acutely (last month) and 30.1% chronically. The latter data were statistically significant only in relation to mental health history, the use of psychotropic drugs and evolution during the intervention.

Table 3

Chi-Square Chi-Demographic and clinical variables and acute clinical cases detected with the GHQ-28

VARIABLES		VALUES	CHI-SQUARE (SIG.)	*P*
AGE	15-35	14	,664	*p* = ,717
	36-55	28		
	56-90	22		
GENRE	Man	14	,078	*p* = ,781
	Woman	50		
E. CIVIL	Single	13	1,191	*p* = ,755
	Married-Couple	36		
	Divorced	10		
	Widower	4		
EMPLOYMENT STATUS	Unemployed	13	,598	*p* = ,897
	Work	33		
	Retired	11		
	Student	6		
ACADEMIC LEVEL	Primary	8	,766	*p* = ,682
	Secondary	32		
	Superiors	23		
BACKGROUND MENTAL HEALTH	Yes	28	,793	*p* = ,673
	No	36		
PREVIOUS PHARMACOLOGICAL TREATMENT	Yes	24	,680	*p* = ,712
	No	40		
CURRENT PHARMACOLOGICAL TREATMENT	Yes	23	2,4176	*p* = ,337
	No	41		
EVOLUTION	High improvement	33	22,423	*p* = ,001
	Continua	9		
	USMC referral	2		
	Abandonment	18		
	CAP / CAAC change	2		
NUMBER OF SESSIONS	1-5	50	,022	*p* = ,881
	6-14	13		

Table 4

Chi-Square Chi-Demographic and clinical variables and chronic clinical cases detected with the GHQ-28

VARIABLES		VALUES	CHI-SQUARE (SIG.)	*P*
AGE	15-35	16	4,509	*p* = ,105
	36-55	22		
	56-90	15		
GENRE	Man	11	,010	*p* = ,921
	Woman	42		
E. CIVIL	Single	13	3,135	*p* = ,371
	Married-Couple	27		
	Divorced	8		
	Widower	4		
EMPLOYMENT STATUS	Unemployed	9	,976	*p* = ,807
	Work	28		

	Retired	9		
	Student	6		
ACADEMIC LEVEL	Primary	5		
	Secondary	25	4,663	*p* = ,097
	Superiors	22		
BACKGROUND MENTAL HEALTH	Yes	19	6,116	*p* = ,047
	No	34		
PREVIOUS PHARMACOLOGICAL TREATMENT	Yes	17	1,618	*p* = ,445
	No	36		
CURRENT PHARMACOLOGICAL TREATMENT	Yes	15	8,797	*p* = ,012
	No	38		
EVOLUTION	High improvement	32	23,447	*p* = ,001
	Continua	6		
	USMC referral	2		
	Abandonment	11		
	CAP / CAAC change	2		
NUMBER OF SESSIONS	1-5	42	,077	*p* = ,782
	6-14	10		

Discussion and conclusions

This work contemplates an analysis of the project of the inclusion of the Clinical Psychologist in Primary Care in Huelva (capital), as a pilot experience carried out by the figure of the Resident Internal Psychologist and supervised by the superiors of the training and the Primary Care attendants. One of the objectives of the study was to assess the patients referred to Clinical Psychology, to analyze the sociodemographic characteristics of this population and the reasons for referral, as well as the common diagnoses.

In this sense, the population shares characteristics with other ~~populations~~ analyzed in other studies, in terms of sociodemographic or clinical variables such as diagnoses of an affective nature and mild or moderate severity or use of psychopharmacological medication prior to referral to psychology (APPI Platform). PsicAP, 2017; Gutiérrez-López et al., 2020). Analyses on the reasons for referral reflect that the highest percentage of referrals correspond to decompensations and reactions to stressful situations and patients presenting diffuse anxious-depressive symptomatology (WHO WONCA, 2008; Cano-Vindel et al., 2012).

It should be noted that the diagnoses found in this study that appear in the referrals of primary care physicians are, in order of appearance and frequency, those related to anxious-depressive symptomatology, adaptive disorders, anxious disorders and mild depressive disorders, data that are similar to those found in other previous studies; results that are in line with other studies (APPI Platform. PsicAP, 2017, Infocop, 2019).

Likewise, the exploration carried out through the GHQ-28 questionnaire shows symptoms of recent affective character in half of the population studied, being mostly somatic symptoms, anxiety and insomnia and interference in the social sphere, with minimal severe depressive symptoms. These results respond to one of the objectives and hypotheses raised in the present study in relation to the reasons for referral and mild-

moderate affective diagnoses (Cano-Vindel, 2011b; Platafroma APPI. PsicAP, 2017; Sánchez-Reales et al., 2015).

In line with other studies that place women as the population that most demands psychological care and that represents higher percentages of referrals in Primary Care, the present study, in accordance with the objectives of exploring the sociodemographic characteristics, finds a percentage of more than 70% of women attended (APPI Platform). PsicAP, 2017; Sánchez-Reales et al., 2015).

The coordination that occurs when the Clinical Psychologist is included in Primary Care allows the referrals made by the physician to be analyzed and optimized. In relation to the stated objective of assessing whether care at the center would reduce referral to a second level, a reduction in the number of referrals to specialized care has been contemplated, about 8% of the total referred by MAPs coordination with primary care physicians and the subsequent review and analysis of the cases concluded that this minimum percentage had a more severe symptomatology or needed a more extensive treatment by Clinical Psychology to achieve a remission of symptoms (Alonso et al., 2019).

Coordination at the health center itself has allowed a reduction in referrals to specialized care, hence the benefits of incorporating clinical psychology into health centers, assuming the psychological interventions of a large number of patients with mild to moderate symptomatology, and as a consequence, providing a filter function by severity or resources to specialized care, avoiding collapses in the latter. Also, the presence of the Clinical Psychologist in the first link of the health system, in Primary Care, allows the population to reconsider the stigmatization of mental illness and to appreciate psychological interventions as an accessible, necessary and useful tool in their disease process (Gálvez-Llompart et al., 2021; Alonso et al., 2019).

Psychological interventions in primary care have their own characteristics that are different from those of specialized care, both in terms of the techniques used and the time allocated to their administration. Clinical Psychology implements low-intensity psychological interventions aimed at mild or moderate emotional alterations in a limited number of sessions, which in the present study showed an average of 2. The objective of this work was to study the number of sessions required to complete an intervention with clinical improvement, and it is significant that the patients who were discharged due to clinical improvement progressed in less than five sessions, which is congruent with other studies. In addition, discharges due to clinical improvement or remission of the initial symptomatology for which they consulted, comprise the highest percentage in relation to all discharges in the study, being congruent with the efficacy of psychological interventions exposed in previous experiences and studies (Gutiérrez-López et al., 2020; Sánchez-Reales et al., 2015; Infocop, 2019).

One of the objectives of the study was to explore whether patients referred to Clinical Psychology in Primary Care had previous psychopharmacological treatment. A high percentage of patients were found to have already had a first psychopharmacological approach by their MAP, considering the subsequent psychological approach, consistent with previous studies (Sánchez-Reales et al., 2015; Platafroma APPI. PsicAP, 2017; Gutiérrez-López et al., 2020; Villalva and caballero, 2006).

However, more research is needed to overcome the current limitations. For example, there are few studies on the use of a series of instruments that are standardized and can be replicated in clinical psychology studies in primary care (Retolaza et al., 1993). The Goldberg general health questionnaire in its Spanish adaptation has been used in several Spanish clinical samples and in recent years it is being used in samples of patients in health centers (Retolaza et al., 1993). This questionnaire allows to obtain global results of the symptomatology of the patient who is referred to Primary Care, obtaining a screening, to then focus on more specific questionnaires and establish a diagnosis. In the present work it has been possible to detect patients with mild to moderate psychopathology of both acute and chronic onset, being of great utility in the diagnosis and evolution of the patient (Cano-Vindel, 2011a; Retolaza et al., 1993; Mitchell, Vaze and Rao, 2000).

In conclusion, this study highlights some sociodemographic characteristics of patients who are referred by primary care physicians to the Clinical Psychologist, being mostly women, married or in a couple, with secondary education and who are working. The information on the reasons for referral is relevant, with the most important data corresponding to adaptive reactions due to stressful situations or periods of life change. The most frequent diagnoses are mixed anxious-depressive disorders, anxiety disorders and adaptive disorders. On the other hand, it is relevant that the average number of sessions in the whole sample is two, being statistically significant that the discharges due to clinical improvement occur in less than five sessions. The Goldberg general health questionnaire provides data on acute and chronic clinical cases, which are shown to be significantly related to mental health history, pre-intervention psychopharmacological intake or evolution, with the clinical cases detected being those who were taking medication, who had a history and who dropped out more or were under follow-up.

Primary Care, as the first link in the healthcare institution and, therefore, more accessible to the general population, is the one that receives the complaints and demands of the general population. It receives the demand, intervenes, orients, coordinates and refers to other links where specialized care is available. Primary care physicians absorb a large number of psychological problems that sometimes, because of their mild nature or reactive to physical or social circumstances, are not considered to meet the criteria in specialized care. Thus, they take on a large number of psychological problems derived from physical pathologies or that influence the evolution of a pathology treated in the health centers, and therefore provide a comprehensive approach to the patient. However, this high demand for care generates an overcrowding of primary care, an increase in the use of pharmacological resources as a means of alleviating symptoms and a chronification or aggravation of the psychopathological symptomatology.

Therefore, as a result of the general exploration of some variables involved in psychological care in primary care in this study, we may consider that new lines of research are necessary, expanding the number of sociodemographic variables or the type of intervention and the characteristics of the psychological approach, as well as the referral protocols, with the aim of further reducing the number and type of patients referred to a second level. In this way, to further strengthen the criteria for primary care and referral to a second level of specialized care. The improvement of protocols could consider a first psychological approach to patients with mild or moderate symptomatology, prior to the psychopharmacological approach, being able to analyze the economic consequences of a possible reduction in pharmaceutical expenditure.

References

Alonso, R., Lorenzo, L., Flores, I., Martín, J. & García, L. (2019). The clinical psychologist in health centers. A joint work between primary care and mental health. *Primary Care, 51*(5), 310-313. doi: 10.1016/j.aprim.2018.08.012.

Cano-Vindel A. (2011a). Emotional disorders in Primary Care. *Anxiety and Stress, 17,* 73-95.

Cano-Vindel A. (2011b). Theoretical bases and empirical support for psychological intervention on emotional disorders in primary care. An update. *Anxiety and Stress, 17,* 157-184.

Cano-Vindel, A., Salguero, J.M., Mae Wood, C., Dongil, E. & Latorre, J.M. (2012). Depression in primary care: prevalence, diagnosis and treatment. *Papeles del Psicólogo, 33*(1), 2-11.

Community & Mental Health team, NHS Digital. Improving access to psychological therapies (IAPT) (2017). Retrieved from: https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/improving-access-to-psychological-therapies-data-set-reports

General Council of Clinical Psychology. More and more Autonomous Communities are joining the demand for psychologists in PC. (2017). Infocop online. Retrieved ~~January 12, 2022~~ from http://www.infocop.es/view article.asp?id= 6563.

Cuijpers, P., Quero, S., Dowrick, C., & Arroll, B. (2019). Psychological Treatment of Depression in Primary Care: Recent Developments. *Current psychiatry reports, 21*(12), 129. doi.org/10.1007/s11920-019-1117-x

Dowrick, C.F., Bellón, J.A. & Gómez, M.J. (2000). GP frequent attendance in Liverpool and Granada: The impact of depressive symptoms. *British Journal of General Practice, 50,* 361-365.

Galvez-Llompart, A.M., Valor Gisbert, M., Perez-Almarcha, M., Ballester-Gracia, I., Canete-Nicolas, C., Reig-Cebria, M.J. & Hernandez-Viadel, M. (2021). Impact on mental health care following collaboration between primary care and mental health, *Family Medicine*. *SEMERGEN*, *47*(6), 385-393. doi.org/10.1016/j.semerg.2021.04.006.

Godoy-Izquierdo, D, Godoy, J.F., López-Torrecillas, F. and Sánchez-Barrera, M.B. (2002). Psychometric properties of the Spanish version of the "Goldberg General Health Questionnaire-28". *Journal of Health Psychology, 14*(1), 49-71.

Gutiérrez López, M.I., López Alonso, N., Alonso Gómez, R. & Veiga Martínez, C. (2020). Clinical Psychology in Primary Care: the experience in Asturias [Psicología Clínica en Atención Primaria: la experiencia en Asturias [Clinical Psychologist in Primary Care: The work carried out in Asturias]. *Semergen, 46*(2), 101-106. doi.org/10.1016/j.semerg.2019.09.002.

Infocop (2019). Proposal to have clinical psychologists in Primary Care in all autonomous communities. Retrieved from https://www.infocop.es/view_article.asp?id=7987

Lobo, A. A., Pérez-Echevarría, J.M. & Artal, J. (1986). "Validity of the scaled version of the General Health Questionnaire (GHQ-28) in a spanish population", *Psychological Medicine, 16,* 135-140.

Mitchell, A.J., Vaze, A. & Rao, S. (2009). Clinical diagnosis of depression in primary care: A meta-analysis. *Lancet, 374,* 609-619.

Moreno, E. & Moriana, J.A. (2012). The treatment of psychological and mental health problems in primary care. *Mental Health, 35,* 315-328.

APPI Platform. PsicAP. Psychological intervention in primary school, more effective than usual treatment. Plata- forma por una Atención Psicológica Pública e Integrada. (2017). Retrieved from: https://plataformaappi.wordpress.com/2017/03/05/psicap- la-intervencion-psicologica-en-primaria-mas-efectiva-que-el- tratamiento-habitual/.

Prado-Abril, J. (2016). Facilitators and barriers of a computer-assisted psychotherapeutic intervention for depression in primary care: a qualitative study (Doctoral dissertation). University of Zaragoza, Zaragoza, Spain. Retrieved from https://zaguan. unizar.es/record/58557/files/TESIS-2017-003.pdf.

Retolaza, A., Mostajo, A., De la Rica, J.R., Días de Garramiola, A., Pérez de Loza, J., Aramberri, I. & Markez, I. (1993). "Validation of the Goldberg General Health Questionnaire (28-item version) in primary care consultations." *Revista de la A.E.N.*, *13*(46), 187-194. Retrieved from http://ww.revistaaen.es/index.php/aen/article/view/15340

Retolaza, A., Márquez, I. & Ballesteros, J. (1995). Prevalence of psychiatric disorders in Primary Care. *Revista Asociación Española de Neuropsiquiatría, 15*(55), 593-608.

Sánchez-Reales, S., Tornero-Gómez, M.J., Martín-Oviedo, P., Redondo-Jiménez, M. & Del-Arco-Jódar, R. (2015). Clinical Psychology in Primary Care: description of one year of attendance. *SEMERGEN - Medicina de Familia*, *41*(5), 254-260. doi.org/10.1016/j.semerg.2014.06.001.

Villalva, E. & Caballero, L. (2006). Study on the use and follow-up of antidepressant treatment by primary care physicians. *SEMERGEN-Medicina de Familia, 32*(9), 427-432. doi.org/10.1016/S1138-3593(06)73310-X

WHO, WONCA. (2008). Integrating mental health into primary care. A global perspective. Retrieved from http://www.who.int/mental health/ resources/mentalhealth PHC 2008.pdf.

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