PSYCHOLOGISTS AND MEDICALISATION: NEGOTIATING THE PROFESSIONAL ROLE IN PRIMARY CARE MENTAL HEALTH

INTRODUCTION

For decades, **global mental health agendas** have prioritised the expansion of community-based services to reduce a 'treatment gap'.

This has been reflected in Chile, where national policies have driven an important **expansion of Primary Care Mental Health**.

To achieve this, **psychologists** have been positioned as central actors. Yet there is little sociological insight about how they navigate this institutional context and its implications.

OBJECTIVE

Drawing on **medical sociology** literature, I used Chile as a **case study** to examine **how psychologists** in primary care settings negotiate their professional role, and what this reveals about the medicalisation of everyday life.

METHODOLOGY

Policy analysis of key official documents to understand how the role of psychologists in primary care mental health has been officially constructed.

Additionally, a **qualitative research** to understand how psychologists negotiate their professional role in everyday practice. 29 interviews were analysed using RTA.

ROLE EXPECTATIONS

We were always taught to be clinical psychologists, like for private practice (Psy04)

What is expected of the primary care psychologist is that they solve the world's problems (Po03).

I think what psychologists expect to do in primary care is psychotherapy, and that's not going to happen, and it's not expected to happen, really (Po06).

PRODUCTIVITY PRESSURES

I come in at 8:00 in the morning—patient, patient, patient, patient, patient, lunch, patient, patient, patient, patient, meeting, patient, patient, patient (Psy03).

The program receives funding based on the number of patients treated, the number of patients with certain diagnoses (Psy15).

Then, the whole work gets reshaped around meeting certain targets so that they don't take away your resources (Po05).

CARE CONTINUITY

Appointments tend to be like once a month, um, usually, or sometimes even less… for those who managed to get an appointment (Psy08).

The guarantee is access. Continuity? Arm yourself and fight (Psy06).

Generally, and very unfortunately, the process is seeing them… once a month, and then they disappear (Psy06).

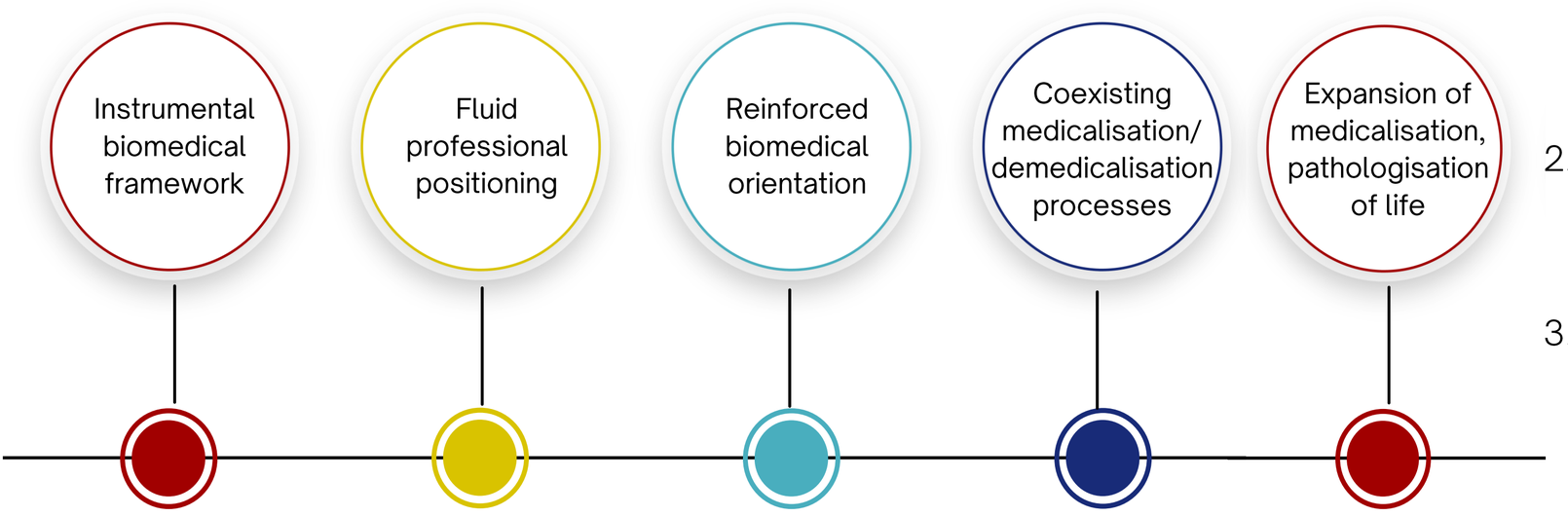
HIERARCHICAL TENSIONS

The doctor is the health professional, and the rest of us are, I don't know, the rice, the chips, the tomato, right, it's like we're the side dish, the entourage (Po03).

The psychologist isn't going to come and tell how (others) should do their job (Psy06).

The schedules are controlled by the managers (Psy12).

FINDINGS



1. Psychologists in primary care work within an **instrumental biomedical framework** marked by institutional expectations and constraints that limit their autonomy and expertise.
2. They navigate fluidly these pressures through **adaptive strategies** such as (re)skilling and boundary work that reinforce the biomedical orientation of their practices
3. Psychologists' role negotiation shapes **coexisting processes** of medicalisation (pathologise) and demedicalisation (discharges without care), and ultimately favor the **expansion of medicalisation**.

CONCLUSION

1. Professional roles are **fluidly** negotiated amid contrasting institutional logics and constraints.
2. Medicalisation, demedicalisation and the pathologisation of everyday life unfolds through **complex and unexpected pathways**.
3. Sociological research can illuminate these situated processes by tracing **tensions in professional roles and practices**.

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