

Research paper

Beyond symptoms: A person-centered approach to psychological assessment using transdiagnostic factors. Insights from the PSYCARE study on Italy's 'psychological bonus' policy

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ABSTRACT

Mental health disorders and limited care access are global challenges. In Italy, the Psychological Bonus (PB) aims to increase access to psychological care. As part of the PsyCARE project, this study explores the characteristics of the PB's participants, using a person-centered approach to investigate patients' psychopathological and transdiagnostic profiles. Cross-sectional data from 2261 patients were analyzed, focusing on clinical characteristics, treatment reasons, and differences between patients already in therapy and new patients. Latent Profile Analysis (LPA) identified psychological profiles based on symptoms and transdiagnostic factors (emotion regulation and epistemic trust). Anxiety and depressive disorders were the most common diagnoses. Patients already in treatment were more likely to be on medication, have a history of non-suicidal self-injury, and have experienced hospitalization for psychological problems. LPA identified four profiles: Profile 1 (19.79 %) with the highest distress, poor emotion regulation, and significant interpersonal difficulties; Profile 2 (28.89 %) and Profile 3 (22.82 %) with above-average distress but varying emotion regulation behaviors and interpersonal dispositions; and Profile 4 (28.50 %) with the lowest distress, adaptive emotion regulation, and more adaptive interpersonal dispositions. Significant Sex and age differences were observed across profiles, but no differences between patients already in therapy and new patients. This study emphasizes the value of integrating transdiagnostic elements into psychological assessment beyond symptom-focused approaches. While different profiles presented similar levels of psychological distress, they differed substantially in emotion regulation strategies and interpersonal dispositions. These findings underscore the need for tailored interventions addressing symptomatology and the transdiagnostic mechanisms that shape individuals' psychological functioning.

1. Introduction

Mental health disorders represent a significant public health concern globally, with an estimated one in eight people living with a mental health condition (World Health Organization [WHO], 2022). This global emergency has been recently exacerbated by the COVID-19 pandemic, which led to a significant increase in depression and anxiety disorders (Bower et al., 2023). This condition is more complex and worrying if we consider the high frequency of sub-threshold disorder manifestations

and psychopathological comorbidities (Krueger and Eaton, 2015). Despite the high proportion of individuals suffering from mental health disorders, the lack of access to adequate mental health treatment remains a significant challenge worldwide, especially after the COVID-19 emergency (Knapp and Wong, 2020): epidemiological studies have consistently shown that the proportion of people with mental disorders who receive minimally effective treatments is alarmingly limited, especially in low- and middle-income countries (Alonso et al., 2018; Thornicroft et al., 2016).

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This prominent treatment gap is not solely due to the scarcity of available public mental health services but also to the low rates of help-seeking behaviors among those in need. Data from the World Mental Health Survey indicate that 41.3 % of individuals with anxiety disorders and 56.7 % of those with depression reported not needing any treatment (Clement et al., 2015). Barriers to help-seeking include perceived stigma, poor mental health literacy, lack of self-awareness, and financial constraints (Thornicroft et al., 2017; World Bank, 2016; Osman et al., 2023). Indeed, economic factors, such as the high costs of private psychological services and limited access to publicly funded mental health services, further exacerbate disparities in access to psychological treatments (Knapp and Wong, 2020; World Bank, 2016). This is especially true for individuals from disadvantaged socioeconomic backgrounds, who are at a higher risk of developing psychological disorders and should be subject to specific monitoring (Kirkbride et al., 2024).

In response to these accessibility-related challenges, several welfare initiatives have been implemented globally to improve the accessibility of psychological therapies. One prominent example is England's Improving Access to Psychological Therapies (IAPT) program (Clark, 2018). The IAPT program represents a pioneering effort to address the longstanding issue of limited access to psychological therapies. A vital feature of the IAPT program is the systematic collection and reporting of data on patient outcomes. At every session, patients undergo assessments using standardized symptom measures for depression and anxiety, and therapists use their scores to guide treatment planning and supervision (Clark, 2018). Similar financial incentive programs have been implemented in other countries, including Australia's "Access to Allied Psychological Services (ATAPS)" and "Better Access" programs, France's "Chèque Psy," Norway's "Prompt Mental Health Care" (PMHC) (Littlefield and Giese, 2008; Bassilios et al., 2016; Knapstad et al., 2020; Ministère des Solidarités et de la Santé, 2021), and Spain's PsicAP program, that adapted the IAPT framework to deliver brief transdiagnostic group cognitive-behavioral therapy for emotional disorders in primary care, demonstrating its clinical effectiveness and cost-efficiency (Cano-Vindel et al., 2022a; Cano-Vindel et al., 2022b; Muñoz-Navarro et al., 2022).

In Italy, the Ministry of Health introduced the "Bonus Psicologo" (Psychological Bonus), aimed at supporting individuals experiencing anxiety, stress, or depression who could benefit from psychological interventions (Benzi et al., 2023; Italian Ministry of Health, 2022). This initiative provides financial assistance to eligible individuals, covering some of the costs of accessing psychological services. The objective is to address the longstanding challenges within the Italian public mental health system, motivate and incentivize those who lack the financial means to access psychological services and broaden the dissemination of psychological awareness and the destigmatization of mental health issues.

Governmental policies must be supported by evidence of effectiveness to justify public investments; thus, it is customary to assess symptom reduction as a primary indicator of efficacy.

However, as the limitations of a solely symptom-focused approach have been extensively highlighted, recent literature suggests that mental disorders research should adopt a dimensional approach to evaluate psychopathology and focus on the core underlying cognitive and emotional dimensions of different mental disorders, known as transdiagnostic factors (Caspi et al., 2014, 2024; Aldao et al., 2016; Benzi et al., 2024a, 2024b). The dimensional approach to mental disorders, recognizing the internalizing-externalizing model, has shown an excellent fit to data and has been replicated globally (Krueger and Eaton, 2015). These factors include cognitive emotion regulation strategies such as rumination, suppression, cognitive reappraisal, and problem-solving (Aldao et al., 2010; Cludius et al., 2020; McLaughlin and Nolen-Hoeksema, 2011; Yapan et al., 2022), and epistemic trust (Fonagy and Allison, 2014).

Expressive suppression and cognitive reappraisal are significant emotion regulation strategies with robust empirical support. Expressive

suppression, an approach that involves inhibiting the outward display of emotions, can be maladaptive and is known to be associated with increased physiological stress and poorer psychological outcomes (Gross and John, 2003). On the other hand, cognitive reappraisal involves changing the way one thinks about a situation to alter its emotional impact and is linked to more adaptive outcomes (Gross and John, 2003; Haga et al., 2009; McRae et al., 2012). For instance, research on cognitive-behavioral treatments for PTSD highlights the relevance of emotion regulation and cognitive reappraisal as fundamental mechanisms of change that contribute to symptom reduction across different disorders (Gallagher, 2017). Similarly, transdiagnostic therapy approaches in primary care settings have shown that focusing on these underlying factors can effectively reduce emotional disorders (Newby et al., 2016).

Epistemic trust (ET) is the capacity to trust others based on the perceived relevance and reliability of the information they provide. This concept has attracted considerable theoretical and clinical interest, highlighting its importance as a crucial element in effective psychotherapy, impacting the therapeutic alliance and facilitating better treatment outcomes (Fisher et al., 2023). Indeed, ET has been identified as a crucial factor influencing treatment outcomes and underscores the importance of cognitive and emotional processes beyond symptomatology (Fisher et al., 2023; Campbell et al., 2021; Mulder et al., 2017). Studies have demonstrated that these transdiagnostic factors play a critical role in the onset and maintenance of various mental disorders and offer a promising pathway for developing more effective therapeutic interventions (Liotti et al., 2023). Overall, accounting for these factors can enhance mental health assessment and intervention by addressing underlying mechanisms rather than focusing solely on symptomatology (Haga et al., 2009; Caspi et al., 2014, 2024; Fonagy et al., 2017; Fisher et al., 2023).

This study is part of the "Assessing Impact, Cost-Effectiveness, and Transdiagnostic Factors of the Italian Ministry of Health's 'Psychological Bonus' Policy" (PsyCARE) project, a 36-month national study aimed at monitoring access and evaluating the effectiveness of the Psychological Bonus (PB) policy in Italy (see the protocol Benzi et al., 2023). In this study, in line with the project's first objective, we aimed to explore access to the Psychological Bonus by analyzing the characteristics of participating patients. More specifically, the manuscript's aim is twofold.

First, we examine the relevant characteristics of the patients who were granted this financial support (i.e., reasons for treatment request, psychiatric diagnoses), with a focus on differences in primary care physician visits, hospitalizations for psychological or psychosomatic problems, lifetime suicide attempts, non-suicidal self-injury (NSSI), medication use, and workday loss between those who were already in treatment when they accessed the Psychological Bonus and new patients.

Second, we identify patients' psychological profiles by adopting a person-centered approach that considers both psychopathological symptoms and transdiagnostic factors. We will also examine how these profiles vary considering different demographic characteristics (e.g., sex, age) and therapy status (e.g., those already in treatment vs. new patients).

Given that this is a first-time initiative, we are not guided by a priori hypotheses; indeed, we aim to gather comprehensive data that can provide a descriptive overview of the patient demographics and psychopathological characteristics associated with the Psychological Bonus policy.

2. Materials and methods

2.1. Design and procedures

This study utilizes cross-sectional data gathered from the baseline assessment of the PsyCARE ("Assessing Impact, Cost-Effectiveness, and

Transdiagnostic Factors of the Italian Ministry of Health's Psychological Bonus Policy") study (Benzi et al., 2023).

This study collected data from patients benefitting from the Psychological Bonus and their therapists, who provided diagnostic and clinical information as part of the initial assessment. While the broader PsyCARE study includes data from therapists and patients, the present manuscript focuses exclusively on patient-level data. Therapists were recruited via online newsletters and web news promoted by the National Board of Italian Psychologists, and patients were recruited via their therapists, who participated in the study. Before data collection, informed consent was secured from all participants. Data collection for the baseline sample started in January 2023 and ended at the beginning of March 2024. For further details on the sampling procedure, see Benzi et al., 2023.

The research study strictly adheres to the ethical guidelines outlined by the American Psychological Association (APA) and the principles outlined in the Declaration of Helsinki (seventh revision, 2013). The Ethical Committee of the University of Milano-Bicocca approved all materials and procedures.

2.2. Participants

2261 patients participated in the initial assessment: 74.7 % were females assigned at birth, with a $Mage = 33.7$ and $SD = 11.3$ (age range 8–79). 68.0 % of participants identified as Caucasian, 8.2 % as Hispanic/Latino, 1.9 % as North African, 0.8 % as Asian, 0.5 % as Central/South African, and 0.2 % as African American, 15.1 % identified as Other/Multi-ethnic, and 5.3 % preferred not to respond. 13.2 % of participants completed lower secondary education, 50.3 % completed upper secondary education, 15.7 % had a bachelor's degree, and 15.5 % had a master's degree. Smaller percentages held PhDs (2.2 %) or had completed high-level artistic training (3.1 %). Regarding employment, 42.2 % of participants were employed, 26.0 % were students, and notable portions were unemployed, with 12.6 % receiving financial aid and 13.0 % not receiving any. Most participants reported being single (74.7 %), while 10.7 % were married, 13.4 % were divorced, and 1.2 % were widowed. Living arrangements showed that 31.9 % lived with others, 22.6 % lived alone, 19.5 % lived with a partner, and 13.6 % lived with their children. Additionally, 10.3 % lived with partners and children, and smaller percentages had other specific living arrangements.

The Yearly Equivalent Economic Situation Indicator (ISEE) (Gallo, 2021) was <15,000 € for 97.8 % of the sample, between 15,000 € and 30,000 € for 1.8 %, and over 30,000 € for 0.4 % of the sample.

71.6 % of participants were not currently in treatment. Among them, 30.7 % had never attended therapy before, and 69.3 % had participated in some form of psychological intervention in the past. Reasons for never attending therapy included financial reasons (75.2 %), lack of information (4.9 %), personal reasons such as shame (3.8 %), or feeling they did not need it (7.1 %), other reasons (2.3 %), or no particular reason (6.8 %).

Information on the PB initiative was primarily obtained through TV and social media (42.6 %), search engines (19.2 %), word of mouth (17.0 %), or via their therapists (10.8 %).

2.3. Materials

2.3.1. Patients' assessment by therapists

After an initial consultation with new patients or when starting the sessions funded by the PB, therapists provide a baseline assessment of their patients, including demographic data, clinical history (i.e., previous psychological treatment), reason for contact, and diagnostic information (APA, 2022).

2.3.2. Patient's self-assessment

Patients provided information on demographics, number of primary care physician visits, hospitalization for psychological or psychosomatic

problems, lifetime suicide attempts and/or non-suicidal self-injury (NSSI), medication use, and productivity (i.e., "In the last month, did you lose workdays because of your psychological problems?" "In the last month, did someone you live with or a family member lose work days because of your psychological problems?"). Also, they self-reported psychological distress, emotion regulation, and epistemic trust.

For psychological distress, patients over 18 years old filled in the CORE-10, and patients up to 18 years old filled in the YP-CORE.

The *Clinical Outcomes in Routine Evaluation-10* (CORE-10) (Barkham et al., 2013; La Tona et al., 2023) is a 10-item self-report assessing psychological distress, encompassing three domains: problems (depression, anxiety, physical symptoms, and trauma), functioning (general, social, and relational), and risk to self. Items are rated on a 5-point Likert-type scale (0 = not at all to 4 = most or all the time), and higher total scores (i.e., the sum of all items, ranging from 0 to 40) indicate higher distress. The scale showed good internal consistency (Cronbach's $\alpha = 0.82$).

The *Young Persons' Clinical Outcomes in Routine Evaluation* (YP-CORE) (Twigg et al., 2016; Di Biase et al., 2021) is a 10-item self-report measure on a Likert scale, ranging from 0 = "Not at all" to 4 = "Most or all of the time." It assesses psychological distress in adolescents. The items are similarly inspired by the CORE-OM, exploring how the adolescent felt in the past week. The scale showed good internal consistency (Cronbach's $\alpha = 0.79$).

The *Emotion Regulation Questionnaire* (ERQ) (Gross and John, 2003; Balzarotti et al., 2010) is a 10-item self-report on a Likert scale ranging from one (strongly disagree) to seven (strongly agree), measuring two emotion regulation strategies: cognitive reappraisal (i.e., the attempt to change the emotional impact of a situation by reinterpreting its meaning), and Emotional Suppression (i.e., the effort to inhibit the overt expression of emotions). Both scales have acceptable to good internal consistency (Expressive Suppression $\alpha = 0.72$; Cognitive Reappraisal $\alpha = 0.85$).

The *Epistemic Trust, Mistrust, and Credulity Questionnaire* (ETMCQ) (Campbell et al., 2021; Liotti et al., 2023) is a 15-item self-report questionnaire assessing Epistemic Trust, Mistrust, and Credulity toward communication or communicated knowledge. Epistemic trust refers to an adaptive attitude in relatively benign social circumstances in which the individual is selectively and appropriately open to social learning opportunities in relationships. Epistemic mistrust reflects the tendency to treat any source of information as unreliable or ill-intentioned, trying to avoid being influenced by the communication of others. Epistemic credulity refers to a marked lack of vigilance and discrimination, signaling a general lack of clarity about one's position and resulting in vulnerability to misinformation and the potential risk of exploitation. Higher scores indicate a higher presence of the relative trait for each dimension. The ETMCQ showed acceptable to good internal consistency in this sample (Mistrust $\alpha = 0.65$; Epistemic Trust $\alpha = 0.72$; Credulity $\alpha = 0.79$).

2.4. Statistical analyses

Statistical analyses were conducted using R Core Team version 4.3.1 (R Core Team, 2022). Descriptive statistics were computed for all study objectives using the *psych* package (Revelle, 2023) to examine the participants' general characteristics. Differences between participants not in therapy and those in treatment across various demographics and health-related behaviors were explored. Chi-square tests were conducted to assess the distribution of Sex, age categories, primary care physician visits, hospitalization for psychological or psychosomatic problems, lifetime suicide attempts, non-suicidal self-injury (NSSI), medication use, loss of workdays, and loss of workdays by housemates/family members. Fisher's exact test was employed when expected cell counts were too low.

Latent Profile Analysis (LPA) was conducted using the *mclust* package (Fraley, 2012) to identify latent profiles based on psychological

distress and transdiagnostic factors (Scrucca et al., 2016; Williams and Kibowski, 2016). Measures for CORE and YP-CORE were merged and standardized before running the LPA. Models with one to nine profiles were estimated, and the Bayesian Information Criterion (BIC) was used to determine the best-fitting model. Posterior probabilities for each profile were inspected to ensure accurate classification and model fit. The bootstrap likelihood ratio test (BLRT) validated the chosen model (Nylund et al., 2007).

Using Chi-square tests and ANOVA statistics, differences in profile distributions based on Sex, age, and therapy status were explored.

3. Results

3.1. Clinical characteristics of patients

Table 1 shows the distribution of DSM-5-TR disorders among the participants. Anxiety Disorders were the most common diagnosis (31.29 %), followed by Depressive Disorders (13.83 %), Trauma- and Stressor-related Disorders (13.64 %), and Personality Disorders (6.62 %). Unknown diagnoses accounted for 16.50 % of the cases.

Table 2 shows the frequency of reasons for treatment requests. Psychological symptoms were the most frequently reported reason (25.55 %), followed by family relationships (17.68 %) and a desire for deeper self-knowledge (14.62 %). Single responses primarily included psychological symptoms (44.33 %), a desire for deeper self-knowledge (15.89 %), and family relationships (11.21 %). Multiple reasons for therapy were reported in 66.87 % of the responses.

3.2. Differences between patients in treatment vs. new patients

Table 3 provides the distribution of relevant clinical and psychological variables between groups (in therapy vs. not in treatment) and

Table 1

Frequencies of DSM-5-TR disorders (N = 2261).

DSM Category	Frequency	Percentage (%)
Anxiety Disorders	1007	31.29
Depressive Disorders	445	13.83
Trauma- and Stressor-Related Disorders	439	13.64
Personality Disorders	213	6.62
Feeding and Eating Disorders	118	3.67
Obsessive-Compulsive and Related Disorders	94	2.92
Somatic Symptoms and Related Disorders	74	2.3
Substance-Related and Addictive Disorders	55	1.71
Disruptive, Impulse-Control, and Conduct Disorders	48	1.49
Sleep-Wake Disorders	39	1.21
Bipolar and Related Disorders	35	1.09
Neurodevelopmental Disorders	28	0.87
Dissociative Disorders	27	0.84
Schizophrenia Spectrum and Other Psychotic Disorders	21	0.65
Gender Dysphoria	19	0.59
Sexual Dysfunctions	17	0.53
Neurocognitive Disorders	5	0.16
Elimination Disorders	3	0.09
Unknown diagnosis	531	16.5

Note. Multiple answers were allowed to account for comorbidities. Of the patients, 69.92 % (1581) had a single diagnosis, and 30.08 % had multiple comorbidities (680). Single diagnoses: Anxiety Disorders: 31.50 % (498), Trauma- and Stressor-Related Disorders: 11.39 % (180), Depressive Disorders: 8.60 % (136), Personality Disorders: 6.01 % (95), Feeding and Eating Disorders: 1.90 % (30), Bipolar and Related Disorders: 1.39 % (22), Obsessive-Compulsive and Related Disorders: 1.39 % (22), Substance-Related and Addictive Disorders: 1.08 % (17), Schizophrenia Spectrum and Other Psychotic Disorders: 0.95 % (15), Neurodevelopmental Disorders: 0.89 % (14), Disruptive, Impulse-Control, and Conduct Disorders: 0.82 % (13), Somatic Symptoms and Related Disorders: 0.82 % (13), Gender Dysphoria: 0.51 % (8), Sexual Dysfunctions: 0.19 % (3), Sleep-Wake Disorders: 0.13 % (2), Dissociative Disorders: 0.13 % (2).

Table 2

Frequencies of reasons for therapy requests (N = 2261).

	Frequency	Percentage (%)
Psychological symptoms	1319	25.55
Family relationships	913	17.68
A desire for deeper self-knowledge	755	14.62
Relationship with partner	604	11.7
Traumatic events	474	9.18
Difficulties in study/work	435	8.43
Psychosomatic symptoms	299	5.79
Relationships with friends	251	4.86
Other	113	2.19

Note. Multiple answers were allowed to account for multiple reasons for treatment requests. Of the patients, 33.13 % (749) had a single reason, and 66.87 % (1512) had multiple reasons. Single responses: Psychological symptoms: 44.33 % (332), Desire for deeper self-knowledge: 15.89 % (119), Family relationships: 11.21 % (84), Traumatic events: 8.68 % (65), Relationship with partner: 8.01 % (60), Other: 4.41 % (33), Difficulties in study/work: 4.27 % (32), Psychosomatic symptoms: 2.54 % (19), Relationships with friends: 0.67 % (5).

the chi-square statistics. The analysis revealed significant differences in the distribution of several variables. Notably, the proportion of participants currently taking medications was significantly higher among those already in therapy ($\chi^2 = 9.20$, $df = 1$, $p = 0.0024$, $V = 0.071$). Similarly, the proportion of participants reporting lifetime non-suicidal self-injury (NSSI) ($\chi^2 = 30.41$, $df = 1$, $p < 0.001$, $V = 0.129$) and hospitalization for psychological or psychosomatic problems ($\chi^2 = 9.61$, $df = 1$, $p = 0.0019$, $V = 0.073$) was significantly higher among those already in therapy. However, the analysis did not show significant differences in the distribution of Sex, primary care physician visits for somatic problems, lifetime suicide attempts, loss of workdays in the last month, and loss of workdays by housemates/family members between the groups.

3.3. Patients' profiles for psychological symptoms and transdiagnostic factors

LPA showed that a four-profile model provided the best balance between model fit and parsimony, as indicated by the lowest BIC value (Fig. 1). The bootstrap likelihood ratio test (BLRT) confirmed the selection of the four-profile solution as the most robust model, with all comparisons yielding significant p -values below 0.01. This suggests that the four-profile model accurately represents the underlying structure of the data, even though models with up to 6 profiles were also statistically plausible.

Fig. 2 includes the mean profile plot for the considered variables across the four profiles. Table 4 summarizes the standardized mean values for each profile.

- Profile 1 (19.79 % of the sample, $n = 436$) was characterized by high levels of psychological distress. Individuals in this profile exhibited lower-than-average scores on cognitive reappraisal. They also showed higher-than-average use of expressive suppression and credulity alongside very high levels of mistrust. Trust was lower than average.
- Profile 2 (28.89 % of the sample, $n = 637$) was marked by above-average psychological distress. Individuals in this profile showed slightly below-average use of cognitive reappraisal and higher-than-average levels of expressive suppression, trust, mistrust, and credulity.
- Profile 3 (22.82 % of the sample, $n = 503$) showed above-average psychological distress. These individuals showed average levels of cognitive reappraisal and slightly lower levels of expressive suppression. Trust levels were notably lower in this profile, with a slight tendency toward mistrust. Credulity was higher than average.
- Profile 4 (28.50 % of the sample, $n = 628$) was characterized by low psychological distress. These individuals showed higher-than-average cognitive reappraisal and lower expressive suppression.

Table 3

Distribution of relevant variables between groups (in therapy vs. not in therapy) and χ^2 statistics.

Variable	In therapy (%) (N)	Not in therapy (%) (N)	χ^2 (df)	Cramer's V
Sex			Fisher's Exact Test (not significant)	
Female	73.8 % (426)	76.3 % (951)		
Male	26.0 % (150)	23.6 % (294)		
Non-binary	0.3 % (2)	0.2 % (3)		
Primary care physician visits in the last month			Fisher's Exact Test (not significant)	
0 - Never	1.3 % (4)	0.6 % (7)		
1 - Once	50.6 % (315)	53.6 % (668)		
2 - More than once	24.4 % (152)	28.0 % (349)		
3 - Weekly	15.4 % (96)	15.2 % (189)		
4 - Daily	0.8 % (1)	0.3 % (4)		
Lifetime hospitalization for psychological/psychosomatic problems			9.61 (1)**	0.073
No	93.1 % (538)	96.5 % (1204)		
Yes	6.9 % (40)	3.5 % (44)		
Lifetime suicide attempt			0.128 (1)	0.008
No	95.7 % (553)	96.1 % (1200)		
Yes	4.3 % (25)	3.9 % (48)		
Lifetime non-suicidal self-injury (NSSI)			30.41 (1)***	0.129
No	88.1 % (509)	95.3 % (1189)		
Yes	11.9 % (69)	4.7 % (59)		
Currently taking medications			9.20 (1)**	0.071
No	45.6 % (262)	53.4 % (663)		
Yes	54.4 % (312)	46.6 % (578)		
Workdays lost in the last month			2.74 (1)	0.039
No	56.7 % (322)	59.9 % (748)		
Yes	43.3 % (256)	40.1 % (500)		
Workdays lost by housemates/family members			3.10 (1)	0.041
No	93.5 % (534)	94.6 % (1181)		
Yes	6.5 % (44)	5.4 % (67)		

Note. Categories "Prefer not to say" for Sex and "Not sure" for other variables were excluded from the analyses. Fisher's Exact Test was used for Sex and Primary care physician visits in the last month due to low expected cell counts.

** $p < 0.01$.

*** $p < 0.001$.

Mistrust and credulity scores were low, while trust was slightly lower than average.

3.4. Differences in profile distributions by sex, age, and therapy status

Chi-square tests revealed significant sex differences in profile distributions ($\chi^2 = 28.33$, $df = 3$, $p < 0.001$). Females were more likely to be classified in Profiles 1 (adjusted residual = 2.28) and 3 (adjusted residual = 2.48), while males were more likely to be in Profile 2

(adjusted residual = 3.05). No significant sex differences were found in Profile 4 (adjusted residuals for females = -0.71, males = 1.27). Pairwise comparisons confirmed significant differences between Profiles 1 and 2 ($p = 0.011$) and Profiles 2 and 3 ($p = 0.007$).

ANOVA results indicated significant age differences across profiles ($F = 256.1$, $df = 3$, $p < 0.001$), with younger participants more likely to fall into Profile 1 and Profile 3.

In contrast, no significant differences were observed in the distribution of profiles by therapy status ($\chi^2 = 2.68$, $df = 3$, $p = 0.444$), suggesting that the identified profiles were consistent regardless of whether participants were currently in therapy.

4. Discussion

This study aimed to explore access to the Psychological Bonus by examining the characteristics of patients who adhered to the Italian Psychological Bonus (PB) policy.

First, we aimed to describe the relevant characteristics of the patients who benefited from this financial support. We also considered differences between those already in treatment when they accessed the Psychological Bonus and new patients. Indeed, approximately 7 out of 10 patients were not currently in treatment before receiving the bonus, underscoring the PB's crucial role in expanding access to psychological care, particularly for individuals who may have previously faced economic barriers to accessing mental health services.

The clinical profiles showed that anxiety disorders were the most prevalent diagnoses, followed by depressive disorders, trauma- and stressor-related disorders, and personality disorders. Considering the reasons for seeking treatment, psychological symptoms were the most frequently reported, followed by issues related to family/partner relationships, a desire for deeper self-knowledge, and traumatic events. Notably, while many patients cited a single reason for seeking therapy, the majority reported multiple concerns, reflecting the complex and multifaceted nature of their needs. These findings are consistent with recent reports by the Italian Ministry of Health, which highlight that anxiety and depressive disorders are among the most common mental health conditions treated in the national health system and provide similar distributions for personality disorders (Italian Ministry of Health, 2022). Moreover, the complex interplay between psychological symptoms and external stressors is a pattern well-documented in the literature exploring the reasons for psychological treatment behaviors (Aguirre Velasco et al., 2020; Sheldon et al., 2021).

Significant differences emerged when comparing patients already in therapy to those new to treatment. Those already in therapy were more likely to be taking medications and exhibited higher rates of non-suicidal self-injury and hospitalization for psychological or psychosomatic problems. These findings suggest that patients already in therapy may represent a segment of the mental health population that has already been in contact with mental health services, consistent with research indicating that individuals with more complex clinical presentations often require ongoing treatment and more intensive interventions (Moreno-Agostino et al., 2021). Interestingly, the lack of significant differences in other factors (i.e., primary care visits and work-related outcomes) suggests that the Psychological Bonus might effectively reach a population who would not be able to access psychological treatment otherwise (Benzi et al., 2023; Wakefield et al., 2021).

Second, we aimed to explore patients' psychological profiles by adopting a person-centered approach that accounts for patients' reported psychological distress and transdiagnostic factors such as emotional regulation and epistemic trust.

In line with the literature that shows that transdiagnostic characteristics are associated with psychological distress (Eftekhar et al., 2009; Aldao et al., 2010; Locati et al., 2023; Li et al., 2023), Latent Profile Analysis identified four distinct psychological profiles.

Profile 1 emerged as the group with the highest psychological distress. This group showed the lowest cognitive reappraisal and highest

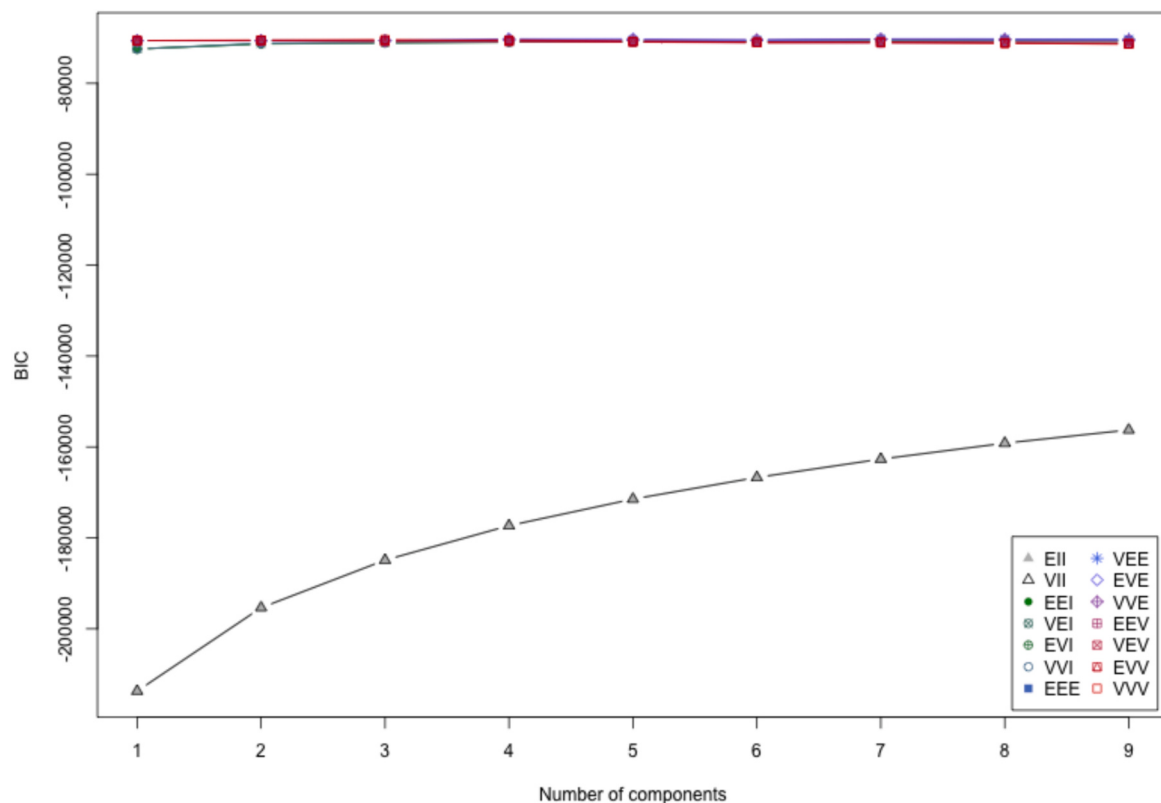


Fig. 1. Bayesian Information Criterion (BIC) Values for Models with 1 to 9 Profiles

Note. BIC values were used to assess the fit of models with varying numbers of latent profiles. Lower BIC values indicate a better fit.

expressive suppression. Moreover, patients with this profile showed the highest mistrust and credulity and slightly lower-than-average trust. These characteristics suggest that individuals in this profile may struggle with finding adaptive emotion regulation strategies and navigating interpersonal relationships, as their heightened mistrust and credulity could make them more susceptible to suspicion and gullibility.

Profile 2 was characterized by above-average psychological distress. Considering emotion regulation, cognitive reappraisal was only slightly below average, thus signaling the presence of some abilities in reframing emotionally challenging experiences. On the other hand, these patients showed higher-than-average levels of expressive suppression.

Similarly, these patients showed a complex profile for interpersonal dispositions, showing higher-than-average scores for trust, mistrust, and credulity. This complexity could indicate difficulty in maintaining stable relationships, as their tendency to trust, mistrust, or be gullible might fluctuate depending on the situation or their emotional state. This ambivalence in interpersonal interactions might contribute to their psychological distress, as it could lead to confusion and insecurity in social relationships.

Profile 3 showed similar levels of psychological distress as Profile 2. Again, these patients showed average cognitive reappraisal resources. However, they exhibited slightly lower than average levels of expressive suppression, thus portraying patients with better emotion regulation skills than in Profile 2. Interestingly, these patients had the lowest trust, higher than average mistrust, and higher credulity. As these patients show a more balanced emotional regulation and a tendency to be skeptical in their interpersonal dispositions, they also display a paradoxical tendency to believe or be influenced easily in certain situations.

Profile 4 showed the lowest psychological distress and more adaptive transdiagnostic characteristics. Individuals in this profile showed higher cognitive reappraisal, lower expressive suppression, and low levels of mistrust and credulity. This profile might represent a group that, despite potential challenges, shows resilience and adaptability. Their ability to

effectively regulate their emotions and maintain balanced relationships suggests psychological flexibility and the ability to cope with stress more adaptively.

Profiles 1 and 4 represent two ends of a spectrum, with Profile 1 individuals experiencing high distress, poor emotion regulation, and interpersonal difficulties. In contrast, Profile 4 individuals showed lower distress and more adaptive transdiagnostic characteristics. Profiles 2 and 3 occupy a middle ground between these extremes, highlighting the nuanced ways psychological distress can manifest in emotion regulation and interpersonal dynamics. Indeed, although Profiles 2 and 3 both experience above-average psychological distress, they differ in their emotional and interpersonal characteristics. Profile 2 individuals may be more rigid in their emotional responses and experience fluctuations in their interpersonal dispositions; in contrast, Profile 3 individuals might experience interpersonal dynamics that may leave them vulnerable to setting adequate boundaries in certain situations despite their relative emotional stability.

These findings underscore the importance of assessing mental health beyond symptom severity. While Profiles 1, 2, and 3 all exhibited moderate to high levels of distress, their differing combinations of transdiagnostic factors (i.e., emotion regulation strategies and epistemic stances) suggest distinct psychological configurations. This aligns with dimensional models of psychopathology (Caspi et al., 2014, 2024) and transdiagnostic frameworks (Barlow et al., 2020; Aldao et al., 2010) that emphasize core emotional and interpersonal processes over diagnostic labels. Similarly, it is in line with recent person-centered, transdiagnostic studies like Spain's PsicAP program, which delivered brief group CBT for emotional disorders in primary care, confirming that targeting shared mechanisms such as emotion regulation can improve outcomes across diagnostic categories (Cano-Vindel et al., 2022a; Cano-Vindel et al., 2022b; Muñoz-Navarro et al., 2022).

Examining the differences in the distribution of profiles by Sex, age, and those already in treatment compared to new patients might help

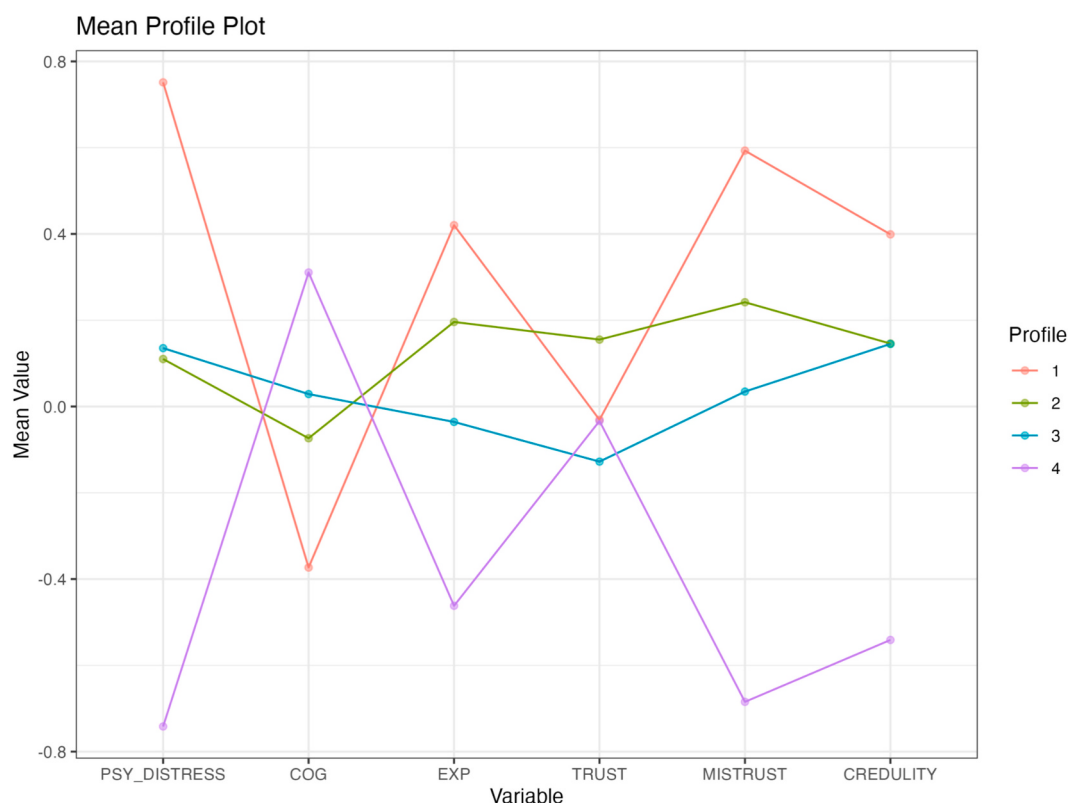


Fig. 2. Mean Profile Plot for Psychological Distress and Transdiagnostic Factors Across Four Profiles

Note. The mean profile plot displays the average values for the following variables across the four latent profiles: PSY_DISTRESS (psychological problems, CORE-10; Barkham et al., 2013; La Tona et al., 2023; YP-CORE; Twigg et al., 2016; Di Biase et al., 2021), COG (emotion regulation cognitive reappraisal, ERQ; Gross and John, 2003; Balzarotti et al., 2010), EXP (emotion regulation expressive suppression, ERQ; Gross and John, 2003; Balzarotti et al., 2010), TRUST, MISTRUST, and CREDULITY (ETMCQ; Campbell et al., 2021; Liotti et al., 2023).

Table 4
Standardized Mean Values of Psychological Distress and Transdiagnostic Factors by Profile.

	Profile 1 (n = 436)	Profile 2 (n = 637)	Profile 3 (n = 503)	Profile 4 (n = 628)
PSY_DISTRESS	0.75	0.11	0.14	-0.74
COG	-0.37	-0.07	0.03	0.31
EXP	0.42	0.20	-0.04	-0.46
TRUST	-0.03	0.16	-0.13	-0.03
MISTRUST	0.59	0.24	0.04	-0.69
CREDULITY	0.40	0.14	0.14	-0.69

Note. PSY_DISTRESS (psychological problems, CORE-10; Barkham et al., 2013; La Tona et al., 2023; YP-CORE; Twigg et al., 2016; Di Biase et al., 2021), COG (emotion regulation cognitive reappraisal, ERQ; Gross and John, 2003; Balzarotti et al., 2010), EXP (emotion regulation expressive suppression, ERQ; Gross and John, 2003; Balzarotti et al., 2010), TRUST, MISTRUST, and CREDULITY (ETMCQ; Campbell et al., 2021; Liotti et al., 2023).

clarify these profiles further.

The significant differences in profile distribution by Sex suggest that males and females may experience and express psychological distress differently. The higher likelihood of females being classified in Profiles 1, which are characterized by high distress and varying levels of trust and mistrust, aligns with existing literature indicating that women are more likely to report higher levels of internalizing symptoms such as anxiety and depression (Seedat et al., 2009; Nolen-Hoeksema, 2012). The higher likelihood of males being classified in Profile 2 could indicate that men may struggle with emotional regulation and experience ambivalence in social interactions. These findings are consistent with research suggesting that men may be more likely to use avoidant coping

strategies, such as suppression (Flynn et al., 2010), which can exacerbate distress over time (Rogier et al., 2019). On the other hand, females might be more likely to use adaptive emotion regulation strategies, as in Profile 3, albeit resorting to credulity as a prevalent interpersonal disposition.

Similarly, younger participants were more commonly found in Profiles 1 and 3, and older participants were more frequently classified in Profile 4, with lower psychological distress and more adaptive transdiagnostic characteristics (Livingstone and Isaacowitz, 2021). These age-related patterns suggest that as individuals age, they may develop more effective coping strategies or benefit from life experiences that help mitigate psychological distress and promote resilience (Hamarat et al., 2002; Zapater-Fajari et al., 2021).

Interestingly, no significant differences were found in the distribution of profiles based on therapy status. This indicates that the psychological profiles identified in the study are consistent regardless of whether participants were already in treatment or new to therapy.

While this study provides valuable insights into the psychological profiles of patients accessing the Psychological Bonus in Italy, its results should be considered in light of its limitations. First, the cross-sectional design limits our ability to draw causal conclusions about the relationships between psychological distress, transdiagnostic factors, and the identified profiles. Longitudinal studies are needed to examine how these profiles may change over time and relate to treatment outcomes (see study protocol, objective 2; Benzi et al., 2023). Second, the use of self-reported data may introduce bias, particularly in reporting psychological symptoms and treatment history, as social desirability and recall bias could affect the accuracy of the data. Third, while informative, the study's focus on specific transdiagnostic factors may fail to capture the full complexity of patients' psychological functioning; future

research should consider including a broader range of factors, such as perceived social support and health literacy, to provide a more comprehensive understanding of patient profiles. Finally, while the Latent Profile Analysis (LPA) identified distinct profiles, it is essential to replicate the results in different cultural and clinical contexts.

In conclusion, this study offers novel insights into the psychological profiles of individuals accessing the Psychological Bonus in Italy by integrating transdiagnostic factors with traditional measures of psychological distress. Identifying four distinct psychological profiles highlights how distress, cognitive-emotional processes, and interpersonal dispositions interact, underscoring the need for tailored interventions. By incorporating transdiagnostic factors like emotion regulation and epistemic trust, this research moves beyond a symptom-focused approach, offering a more comprehensive understanding of mental health. Indeed, by focusing exclusively on symptoms, we might underestimate meaningful differences between individuals who report similar levels of distress, thus impacting our treatment choices (i.e., focusing more on emotion regulation or interpersonal dispositions). These study findings align with recent requests to shift from diagnosis-based, “one-size-fits-all” models toward person-centered, transdiagnostic frameworks that recognize psychopathology emerging from dynamic interactions among symptoms and underlying processes (Roefs et al., 2022). As O’Driscoll et al. (2022) argued, the dense connectivity among symptoms and their relative stability during psychotherapy underscores the importance of understanding how symptoms co-evolve rather than assuming a single latent disorder construct. Moreover, epistemic trust and emotion regulation are not merely associated with symptom severity but may reflect mechanisms that sustain or buffer psychological distress across diagnostic boundaries (Fonagy et al., 2025). Thus, integrating transdiagnostic dimensions into clinical assessment can better inform intervention targets, ensuring that policies such as the Psychological Bonus expand access and tailor support to individuals’ unique psychological needs.

Future research should continue exploring these dimensions to refine mental health assessment further and improve patient outcomes.

CRedit authorship contribution statement

Ilaria M.A. Benzi: Writing – review & editing, Writing – original draft, Methodology, Formal analysis, Data curation, Conceptualization. **Antonino La Tona:** Writing – review & editing, Writing – original draft, Conceptualization. **Cristina Zarbo:** Writing – review & editing, Conceptualization. **Angelo Compare:** Writing – review & editing. **Santo Di Nuovo:** Writing – review & editing. **David Lazzari:** Writing – review & editing. **Vittorio Lingiardi:** Writing – review & editing. **Gianluca Lo Coco:** Writing – review & editing. **Laura Parolin:** Writing – review & editing, Supervision, Project administration, Conceptualization.

Declaration of competing interest

The authors declare no financial interests/personal relationships which may be considered as potential competing interests. The National Board of Psychologists (CNOP) has provided funding for the development of a dedicated online platform to manage communication with all participants and to provide them with updates on the study’s progress. The CNOP also supports an optional training course on psychological assessment, which every participant can enroll in as an incentive for their participation. University departments are providing funding to cover the project’s costs.

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