CHALLENGES OF PSYCHOANALYSIS IN THE 21ST CENTURY

Psychoanalysis, Health, and Psychosexuality in the Era of Virtual Reality

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Tizón JL. Psychoanalysis and Primary Health Care: Our Participation as Psychoanalysts in a Long-overdue Change in the Health Services. . En J. Guimón y S. Zac (eds.). **Challenges of Psychoanalysis in the 21st Century**. New York: Kluwer Academic / Plenum Books 2001 (pp. 83-101).

Psychoanalysis and Primary Health Care

Our Participation as Psychoanalysts in a Long-overdue Change in the Health Services

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1. PRIMARY HEALTH CARE

From a health care point of view, the second half of the 20th century, and especially the 1960s and 1970s, brought with it a significant rise in the number of visible problems in modern Western medicine and in its exportation to the countries of the 'Second' and 'Third Worlds'. Certain counter-cultural criticisms have also underlined some of the more difficult to solve shortcomings of the dominant health-care system. These criticisms include those of the French May of 1968 movement, those of Ivan Illich (1975), those of traditional medicines in many countries, those of revolutionary health organisations, such as the Spanish (1931-1939), the Chinese, the Cuban, and so on.

At the same time, also during the same period, a creative parallel and afterwards convergent movement was developed *from general practice*, from British *general practitioners* and American *general physicians*, and by some *paediatricians of social or psychosocial orientation*. This movement coincided with other types of - very different - criticisms and contributions, coming in this case from economists, health service administrators, politicians and more- or less-alternative leaders. From one side or the other they criticised the unstoppable costs of the system, its bureaucratisation, its lack of equality and solidarity, its inefficacy, inefficiency, lack of safety, inaccessibility, its strengthening of the heteronomy of patients, rather than their autonomy (a basic component of health) and so on. In 'underdeveloped' countries, budget insufficiencies of the health systems

themselves were criticised as well as their orientation and their ways of working, which involved the crushing of native cultures and medicines. Moreover, the health systems in these countries were unable to escape many of the criticisms which were valid for systems in the 'First World'. The conclusion of such a flood of criticism was the need to *move away from the hospital-centred and specialist-centred model*, which remained dominant until then, and to create the type of health-care model and mechanisms known as *Primary Health Care* as from the Alma-Ata conference (WHO, 1978, 1992, and Tables 1-3).

Table 1. Conceptual elements of primary health care

CONCEPTUAL ELEMENTS OF PRIMARY HEALTH CARE
• Comprehensive
• Integrated
• Continuous
• Permanent
• Active
• Accessible
• Interdisciplinary and bio-psychosocial teams
• Community-based and participative
• Programmable-assessable (able to evaluate).
• With teaching and research

But as *Primary Health Care* began to be applied and set into operation, with the intention of putting the proposed features of the model into practice, problems began to appear (WHO, 1992; González y Levav, 1991; Martín, 2000; Tizón, 2000). The first of these, a ceaseless increase in the demand (and, in some cases, the frequentation) which the *Health Centres* had to bear in every location (from the first- to the fourth-worlds). Another problem which arose was that a significant number of the visits to these centres were... because of mental health problems (25-30%: Goldberg and Huxley, 1980, 1992) or because of «biologically inexplicable complaints» (more than 10%) (Tizón, 1992, 1997; Epstein, 1993, 1996). This has led to the need for contacts, joint consultation and efforts at shared work, between family doctors/GPs or paediatricians on the one side, and mental health staff on the other. Significant difficulties soon appeared regarding this co-operation (WHO, 1992; Tizón, 1992, 1996). From this standpoint a complementary line of health care has had to be developed, which some have called *Primary Mental Health Care* (Tizón, 1990, 1992, 1996, 1997, 2000).

Table 2. Characteristics of primary health care

Characteristics of Primary Health Care (from the psychosocial point of view)
1. Moving health care closer to the population.
2. Integrating it into territorial and individualised teams.
3. Diachronic perspective.
4. Theoretical, technical and biopsychosocial model
5. Integrating prevention-promotion and care (= **"Attention"**)
6. Not opposed to "lay" or "non-professional" systems (but improves their efficacy, effectiveness and efficiency).
7. Should it avoid making the "professional health systems" indispensable.
8. Therefore pays special attention to
iatrogeny }
iatrogenic chronicity } = heteronomise
medicalised chronicity }
therefore, **CENTRIPETAL WITH REGARD TO THE COMMUNITY**
(=usual experiential groups or nucleus)

A third problem arising from the first years in which PHC has been running has to do with the very aims of the reform. To aim for a wide-ranging «bio-psychosocial» view of the patient; to encourage the professional to achieve an overall perspective (Table 3) implies, of course, a significant increase in the anxieties and conflicts facing that professional.

Table 3. The change which the development of PHC involves

	TRADITIONAL MEDICINE	PRIMARY HEALTH CARE
AIMS	Illness	Health and Illness
	Healing	Prevention and care
CONTENT	Treatment	Health promotion
	Occasional care	Continuing care
	Specific problems	Comprehensive care
ORGANISATION	Specialists	General practitioners
	Doctors	Inter-professional
	Individual practice	Teamwork
RESPONSIBILITY	Health sector	Inter-sector co-operation
	In isolation	Community participation
	Professional control	Self- responsibilisation
	Passive reception	Prevention in General Population
FOCALISATION	Biological	Bio-psychosocial

As well as trying to keep up-to-date with the biological techniques of medicine, PHC professionals must also, by obligation, improve their psychological and psychosocial techniques and capabilities. All this at a time when the professional feels more personally «committed» to the patient-doctor relationship (and in each relationship with each patient) than does his/her hospital-based counterparts. Resulting from this significant increase of anxiety among the professionals of the said health centres is a generalised state of worry, which often takes on a «reparatory» aspect («depressive» in the sense of M. Klein), but which in other cases is overcome by persecutory or confusional experiences and anxieties (Bofill and Tizón, 1994; Tizón, 1996).

This is one of the paramount reasons why psychoanalysis, and the psychoanalyst who is appropriately interested, trained and integrated in PHC psychoanalysis, can be so useful for the development of PHC. Psychoanalysis (some psychoanalysts) could co-operate with - and may co-operate within - PHC in the following five basic ways:

1. Giving support for personal development, work setting, professional training and group- or team- organisation for many of those who work in health centres: a *clinical-preventive and developmental contribution* to PHC.
2. Offering elements for the practical-theoretical and epistemological basis upon which to lay the fundamental principles of PHC: *a theoretical contribution.*
3. Offering psychotherapeutic elements, which can be used by primary health care professionals and mental health teams: *technical contribution.*
4. Offering a number of *pragmatic elements* both to PHC and mental health teams.
5. Offering elements of the previous four types for a renewed practice of *Community Mental Health Care* (the *Primary Mental Health Care* model: (Tizón, 1992, 2000).

2. PSYCHOANALYSIS AND PRIMARY MENTAL HEALTH CARE (PMHC)

We use the term *Primary Mental Health Care* to describe the application of the «patient centred care» model (Balint, 1968, 1973) or «care centred on the consultant» model (Tizón, 1981; Borrell, 1986; Epstein *et al.*, 1993; Stewart, 1995; Tizón, 1992, 1995, 2000) for the interdisciplinary work of mental health care in the community, supporting the primary health care team. This way of attending to (prevention and treatment in) health and

(mental) health will possess, in brief, a number of basic features which I have spent over twenty years promoting:

1. A theoretical link with the PHC model.
2. A practical link and strong connection with the actual PHC centres: this line of work implies that mental health problems, as well as prevention work in this field, must be the shared responsibility of both PHC staff (GPs and paediatricians) on one hand and by community mental health staff on the other.
3. Both types of staff should, moreover, be sufficiently interlinked with the rest of the professional care networks in their field: social services, psycho-pedagogical services, psychosocial services of legal and justice systems, community social welfare systems...
4. They will have to share the workload with the «lay» networks or non-professional social network: local groups belonging to the resident population; NGOs; sport or recreational groups *etc.*

Primary (Mental) Health Care would be, then, a way of providing community mental health care and psychiatric care with the support of PHC staff, in particular, and with the combined aims of: i) improving the capacity of PHC staff to deal with problems of «mental health» and ii) to encourage a progressive exchange of knowledge, techniques and skills between both types of staff.

3. THEORETICAL ISSUES

I shall continue, in this section, with the classic subdivision of the domains of all scientific disciplines: theoretical, technical and practical – to which should be added an epistemological view, though I cannot enter into this here. As I understand it, the basic theoretical applications of psychoanalysis to a not-strictly-psychoanalytical clinical practice tend to be based on the following features: a) several general meta-theoretical principles; b) an explanatory model of mental disorders and their origins (for example, the one exposed in Table 4); c) a model for the interaction of the biological, the psychological and the social (a certain conception of the bio-psychosocial model: Engel, 1977); and therefore d) a frame of reference to explain numerous phenomena associated with illness and with the experience of becoming ill (and seeking care).

At a theoretical level this implies that it would be difficult to speak of «Primary Care» in the case of health care which did *not* take into account, on the one hand the internal world, the world of mental representations (emotional, cognitive ...), and on the other the micro social group, the family, and their mental representations. And I believe that this care model

should take these elements into account with the explicit and deliberate purpose of preventing psychosocial conflicts from becoming chronic: the mental disorder, illness or disability... Here we find the role which psychoanalysis - as a frame of reference, and as «psychological theory» (or *meta-psychology*, in Freud's sense) – can play in Primary Health Care. It can represent one of the possible psychological frames of reference for understanding the internal world, its relationships with the external world and the role of both in the processes of generating psychological conflicts and of these becoming chronic conflict («chronification» is the basis of mental disorders).

Table 4. Paramount preventive notions in mental health

INNATE DISPOSITIONS
+
RISK FACTORS (Internal/external)
INITIAL RELATIONSHIPS and CONTINGENCIES
+
CONTAINING FACTORS And RESILIENCE Levels:

VULNERABILITY of
- social
- family
- individual
- and mental SYSTEMS

BIOLOGICAL, PSYCHOLOGICAL and SUBSEQUENT SOCIAL CONTINGENCIES

1. From the object internal world
2. Ego capacities
3. Body & "body self"
4. Family
5. "Lay" networks
6. Professionalised networks

⇩

WARNING SIGNALS
Biological
Psychological
Social

⇩

PSYCHOPATHOLOGY and/or MARGINATION
* in childhood
* afterwards

TERTIARY PREVENTION
Rehabilitation and reinsertion

SECONDARY PREVENTION
Early detection and treatment

PRIMARY PREVENTION
Avoid the appearance of the disorder

PROMOTION OF MENTAL HEALTH

With regard to models of interaction between the biological, psychological and sociological conditioning factors of mental disorders,

psychoanalysis will concentrate on the study of psychological conditioni factors and, even more, on the study of intra-psychic and relationsh factors. These include: the background of the first human relationships a personal risk factors – with special attention to emotions, mental sufferir and to how the patient lives with these: their motivation and perso standpoints – «programming» the basic guidelines for relating to oth (object relationships), *etc.* (Table 4). All this would not be exclusively way of experimental methods or retrospective searching, but rather by t study of transference and counter-transference, from the affecti movements perceived in the here-and-now of the consultation.

On a technical and pragmatic level, the above applications may specified, as we have seen, in the following situations or day-to-day areas work:

1. Area of observation and attention.
2. Area of diagnosis and intervention.
3. Area of teamwork and internal co-ordination.
4. Area of co-ordination with the exterior.
5. Area of training.
6. Area of research.

In this particular field of Primary Health Care, I believe th psychoanalysis provides, or could provide, at least the following elements:

1. Regarding the first area or the field of day-to-day work, psychoanaly can provide, as well as the theoretical aspects already mentioned, son indications about the essential care tool: the clinical interview, whi may not be overlooked. In reality, psychoanalysis and its vario applications provide, above all, elements for individual - family or gro interviews, which comprise the most often used technique in PHC (t only one necessary in one hundred per cent of consultations).
2. Adding this fact to the theoretical framework of PHC and contemporary health care, I believe that the main applications psychoanalysis in primary care approach implies something similar the bio-psychosocial model with psychoanalytical or «relational» ba (Tizón, 1988, 1992, 2000; Stewart, 1995). In this sense the applicatio and psychoanalytical supervisions would have to be orientated above towards helping to maintain the internal setting of professionals wi different backgrounds and training, as well as the team as a whol Especially, it should help them to maintain three indispensab perspectives: overall vision, ideological neutrality and emotion containment. *Overall vision*, in the sense of helping them to maintain overall, integrating and bio-psychosocial perspective of the patient, n forgetting the internal world of the health care seeker (his/her intern objects, affects, sentiments, cognitions...). *Ideological neutrality* a *emotional containment* in the sense of personal neutrality towards t

patient, much more important in primary care settings, where staff are constantly under pressure to be «flexible» regarding technical modifications or the use of various new techniques – a notion so easy to confuse with compliance and collusion.

3. Another set of contributions that psychoanalysis can offer PHC in this area regards the different ways and motivations of making a health-care consultation, and about the bio-psychosocial experience of becoming ill («the illness experience», Balint, 1968, 1973; Stewart, 1995). In the same sense, it can improve and broaden the capacity for observation and the observation techniques relevant to care. In particular, from a pathognomonic view of psychoanalysis: the observation of the relationship and counter-transference which this itself sets in motion (on PHC settings I have called this «to observe and to observe oneself observing»).
4. In the area of diagnosis, psychoanalysis provides considerable data concerning types of relationship, lifestyles, psychopathology, conditioning «psychosomatic» relationships as well as understanding mental disorders, conflicts, suffering and fundamental psychosocial transitions. But, in this field, to be able to work together with PHC, we psychoanalysts must be able to distance ourselves from our own mythologies and narcissism as a group, for example, in the «psychosomatic» field (Tizón, 2000).
5. At a diagnostic and therapeutic level we should not forget an outstanding fact regarding current health care practice: that more and more health care services tend towards the subdivision of the human individual, towards *a partial object care*. Psychiatry, too, more and more treats the human being as a set of «partial objects» (*i.e.* neurotransmitters) within that «production line of manufacture, reparation (and assembly)», in which every health worker applies his drug, his partial intervention, or puts another screw in place. At least as a model, PHC is the type of health service outlet most different from this dominant trend, made worse by economic interests and economicism. Therefore, more and more often, it is the family doctor or paediatrician who asks what is happening with the patient who has been taking «new generation» antidepressants for three, four or five years – how is his or her overall health; and, should another type of approach be tried? Or: what will happen to the child to whom somebody has recommended taking stimulants for the central nervous system over three, four or five years – since childhood! - because of a supposed «disorder of attention deficit with hyperactivity»?

4. TECHNICAL AND PRAGMATIC LEVELS

1. At the level of therapeutic techniques we should remember for instance the «flash» psychotherapies and «flash» techniques or techniques of sensitisation «to the psychological» (Balint, 1968; Tizón, 1997); the psychological aid available from PHC itself (for disorders of anxiety and depression for example); «orientation or counselling with a psychodynamic basis»; «promoting health and preventive rules of behaviour» from the psychodynamic perspective (in childhood and adulthood); «contention interviews»; interviews and processes for the management of grief; group therapies applicable within PHC, *etc.*
2. Furthermore, we should remember the actual availability of clinical guides for PHC services with a psychoanalytical basis such as: care for

Table 5. Group therapies carried out with PHC-PMHC shared working

(Direct) CARE GROUPS

- **Alcoholics**
- **Alcoholics** and relatives
- **Mutual Aid** and socialisation
- **Dysthymic** patients
- **Drugs**: Group of relatives of the **drug-dependent subjects**
- **Pregnant** and lactating women
- **Neurological**: Group of relatives of patients severely affected by neurological diseases
- **Severely ill**: Groups of relatives of severely ill or chronic patients
- **Family:** Family interviews
- **Migrations**: Group on **migration** and mental health
- **Middle-aged Women's Group**
- **Parallel**: (Parallel) group of relatives of **children** who attend groups (or periodic therapies)
- **Psychotic**: Group of relatives of psychotic patients
- **Relaxation**
- **Somatisers and heavy consumers of health care**

GROUPS INCLUDED AMONG PREVENTIVE PROGRAMMES

- **Psychological aid to maternity:** Pregnant and lactating groups
- **Parents**
- **Neuroleptic retard group**
- **Obesity – weight control**

GROUPS WITH CARE STAFF: Groups of:

- **Interconsultation**: (the interconsultation as a group)
- **Reflection with nursing staff** from the health centre
- **Reflection** on **health care and administrative problems** with staff from medical inspection and management
- **Reflection on psychological problems** for "non-medical" staff in health care
- Reflection on **parent-child relationships** with paediatric staff
- **Theoretical seminars** as with "working groups"
- **"Balint-type" groups** or groups of reflection on the relationship problems of health care practice
- **Functional Unit for Mental Health Care** of early infancy

agoraphobics; contention; withdrawal from psychopharmacologic products; psychodiagnostic elements for PHC; family interviews; interviews with accompanied patients; problems with a partner; use of psychopharmacologic drugs in relation to basic anxieties; relational relaxation; approaches to patients with somatomorphic complaints; follow-up of «open to flash», *etc.* (Tizón, San José, and Nadal, 1997, 2000). Also some group therapies, such as those shown in Table 5: these are techniques which we have already put into practice with some PHC teams, working together with PMHC staff – such as the care programs for children shown in Table 6.

Table 6. Health care programmes for primary mental health care in children

TRADITIONAL	ADAPTED
	Protocol type
Elementary group techniques	Problems with **meals** Functional **enuresis** in childhood
Scenotherapeutic techniques	**Language and speech** disorders in childhood and adolescence
Psychoanalytic help to families	**Day-to-day incompatibilities** between parents and children
Cognitive-behavioural help for families	**Follow-up** of children with **neurological** risk-factors
Interconsultation with paediatrician (Consulting liaison group)	**Follow-up** of children with high risk of mental disorder Childhood **sleep disorders**
"Balint-type" group with paediatric staff	
	Group programs
	Asthmatic: groups of parents of severely affected asthmatic children
	Self-expression and play for children of six years and above
	Parallel group for families of children who attend groups (or periodic therapies)
	Group of parents of enuretic children
	Reflection group on parent-child relationships with paediatric staff
	Others
	Relationship-based psychomotricity and logopedics
	Relationship-based re-education and psychopedagogy

1. In the areas of teamwork and co-ordination, psychoanalysis offers various techniques and ways of working in groups: supervision; discussion groups; groups for reflection; operative groups; «Balint-type» groups, *etc.* (Tizón, 1992, 1993, 1998). To date we have been running

«Balint-type» groups for over twenty years in particularly conflictiv and/or scientific-biased (scientificist) care settings. Some such grou are now at the stage of their 13th year stage.

2. In the area of training, there is a fundamental contribution fro psychoanalysis, which is that of supervision or tutorials in the ca setting, both individual and in groups. This method, with or without t psychoanalytical frame, has been acclaimed by all types of trainin experts. In Catalonia, with the experience we have accumulated, we ha even managed, with the help of our psychoanalytical perspective, define a minimum programme and a prioritised programme for t continuous training in mental health of members of PHC sta throughout Catalonia, paying special attention to prevention (Tables and 8). In general, in this field of training, the application psychoanalysis stresses the importance of «learning through experience and the value of shared emotions as a fundamental form of teaching f clinical practice, for (general) health or for mental health.

Table 7. The Generalitat of Catalonia's priority programme for continuous training in ment health for primary health care.

PHC PAEDIATRICS	FAMILY & COMMUNITY MEDICINE	NURSING	SOCIAL WORK
1. Course of clinical interview			
2. Basic training course in mental health for PHC			
3. Introduction to FAMILY care from PHC	3. Introduction to FAMILY care from PHC	3. Psychological aspects of NURSING CARE	3.Intervention of social work with specific groups of patients
4. PREVENTIVE PROGRAMMES for PHC paediatrics	4. Approach to BEREAVEMENT AND LOSS	4. Psychosocial intervention of nurse (level II).	4. Group techniques for PHC social work
5.(BALINT-type) reflection groups // or Seminars on basic anthropology	5. Early detection and treatment of DEPRESSION // or (BALINT-type) reflection groups	5. (BALINT-type) reflection groups	5. (BALINT-type) reflection groups

Adapted from the Advisory Council on Mental Health in Catalonia, 1996

3. As for research, the influence of psychoanalysis can be seen in th importance attached to clinical investigations, to careful attention to th clinical setting in investigations, to broad and contextualise

perspectives in such investigations, and to the emphasis on respect for the patient and the ethical norms of the research. Regarding specific information, in our unit we are currently undertaking research along the following lines: Mixed therapeutic systems (psychoanalytical-cognitive); the value for health care of a «psychologically based psychiatry» - at a time of uncontrolled biological bias (biologism) within the system; also about group techniques; preventive programmes in mental health; symptoms of mass hysteria or epidemic somatomorphic disorders; schizophrenia and its antecedents in childhood and in adolescence; warning signs of psychopathology in early infancy; preventive programmes during pregnancy and the puerperal period; the role of the father ...

Table 8. Mental health prevention programmes from PHC, the Programme for Preventive Activities and Health Promotion (PAPPS) of the SEMFYc*

PROGRAMME	**Promotion and prevention activities for mental health in children, including** (or incorporating) from other programmes
"HEALTHY CHILD" PROGRAMME (Paediatrics)	*Follow-up of psychomotor development (Haizea-Llevant). *Childhood and Adolescence Mental health protocol.
PROGRAMMES of P.H.C. for CHILDHOOD and ADOLESCENCE (Family Medicine)	*Ocular and sight-related abnormalities. *Hypoacusia. *Accidents in childhood. *Maltreatments and negligence on child.
MENTAL HEALTH PROGRAMME of P.A.P.P.S. (Family Medicine)	*Care in pregnancy and lactation. *Pregnancy in adolescence. *Children of single-parent families. *History of psychiatric pathology in parents. *Failure in school. *Disorders in the development of language. ***Activities in common with adults*****: *Prevention of suicide. *Secondary prevention of depressive disorders. *Secondary prevention of disorders due to excessive anxiety.

SEMFYC: Spanish Society of Family and Community Medicine.
PAPPS: Program for Preventive Activities and Health Promotion of the SEMFYC
***With a lesser degree of application in childhood and adolescence than the rest of the programs and sub-programs.

4. As for prevention and health promotion, the only immediate examples I can show are the outlooks summarised in Tables 8 and 9.

Table 9. Preventive programmes for primary mental health care in early childhood for a mental health unit linked to PHC

Belonging to PHC or shared work with MHU	Shared work PHC - MHU
	Coordinated by the Mental Health Teams (MHT)
*** Psychological and psychosocial assistance to maternity:** Groups of pregnant and puerperal women.	*** Psychological and psychosocial assistance to maternity (paternity).** *** Balint-type groups with paediatricians, nurses, management staff,** ***etc.*** *** FUNCTIONAL UNIT FOR MENTAL HEALTH CARE** IN EARLY CHILDHOOD.
* Preventive-teaching group and programme "Nurseries and observation of babies"	*** Nurseries and observation of babies.** *** Therapeutic observation in childhood.**
* Group of mothers and fathers.	*** Follow-up** of child with high risk for **mental disorders.** *** "Sickly" children.**
*** Follow-up** of children with **neurological** and/or sensorial **risks**	*** Reflection groups** on **parent-child relationships** with paediatric staff. *** "Theoretical" seminars** as far as working groups.
* Massage and relationship with baby	**MENTAL HEALTH PREVENTION PROGRAMMES OF THE SPANISH SOC. OF FAMILY DOCTORS (SEMFyC):** * Care of woman and baby in **pregnancy and lactation.** *** Pregnancy in adolescence.** *** Children of monoparental families.** * History of **psychiatric pathology in parents.** *** Failure in school.** *** Disorders in the development of language.**
*** Others	**PREVENTIVE PROGRAMMES LINKED WITH THE HEAD OFFICE FOR PUBLIC HEALTH** *** Risk** factors and warning signals in the various stages of childhood. *** Prevention in mental health in the "Healthy Child" Programme.**
	OTHERS *** Asthmatics:** Chronic asthmatic children. *** Asthmatics:** Groups of relatives of asthmatic children. *** Hospitalised and post- hospitalised children.**

5. Finally, I would like to say a few words about a preventive, clinical system for the earliest stages of infancy encompassed by PHC. This is also one of our fields of clinical research and one of the European Programs for Prevention in Mental Health in Early Infancy (European Commission, 52): Our *Functional Unit for (mental health) Attention in Early Infancy*, was set up on the basis of psychoanalytic techniques such as discussion and consultation groups and the psychoanalytic observation of babies – with the E. Bick system, adapted for PHC work by J.L. Tizón (Tizón *et al.*, 1997; Delgado *et al.*, 1999). The unit is now seven years old. It is composed of two working groups: the Interconsultation Group, partly closed, and the Seminary (or group) for Therapeutic Observation in Early Infancy, closed. Both are inter-professional groups, composed of paediatricians, paediatric nurses, psychiatrists and psychologists, infant care staff, social workers, kindergarten workers, and training staff from various disciplines, *etc.* In the Interconsultation Group (or liaison group) they discuss and follow-up interdisciplinary treatments in the cases of children and families with risk-factors or where there is a manifest psychopathology, especially in the first years of the child's life. Table 9 shows the types of help that, up to today, we have been able to set in motion for these children and families at risk. In the observation group, observations are carried out at the homes of some such babies; observations which are discussed in the fortnightly seminars. The observations are valid, above all, for the contention of the group observed and, besides this, for the training of the care staff.

5. A CLINICAL EXAMPLE

An exemplary case of the activity of the Unit was that of Viçens, an 18 month-old boy, sent by his paediatrician because of the frequent visits of his mother: she came every other day complaining that the boy «never stops, never. He doesn't sleep at all and only cries». The paediatrician had not been able to ascertain the reasons for the child's condition and presented the case to the [illegible] liaison (interconsultation) group. It was decided to carry out an observation of between 8 and 12 sessions at the home, to which the family consented.

From the very first observations, the observer was able to express her concern about the vulnerability of Viçens. He *not only slept*, and did not cry so much, but furthermore, it was observed that he could be left to sleep out in the corridor, alone, after hitting himself for minutes at a time against a wall or doorframe or practicing other auto-sensorial stimuli. The mother,

present at the house, seemed never to connect with the emotional suffering of the child, although she was able to carry out the «operational» aspects of his care. The father, present in some observations, seemed much more sensitive to and in contact with these emotional aspects. But in the house (and in the mind of the child) it seemed that there was a sinister or painful atmosphere, which was not easy to explain ... until the mother's sister, and later the mother herself, were able to do so. The father was off work, gravely ill and waiting for a cardiac transplant which never materialised. Neither the paediatricians, nor the family doctor, nor the health centre's nursing staff were aware of this fact. They were also not aware that the father had twice attempted to commit suicide and that all the family was overcome with death anxieties. Once again, the unrestrained crying of an infant, of Viçens, was able to explain a situation of intense anxiety about death, and depression, of an entire nuclear family, anxiety that until then had only become apparent through the indirect channel of the projective identification on the child. In this way, the work in the Unit, and with the family of Viçens, as with so much other psychoanalytically-informed work in PHC, is both an important and fundamental clinical aid and a channel for awareness, knowledge and prevention.

Knowledge of clinical work from another perspective, prevention and integrated clinical aid. Here again we have the fundamental contributions which, in my opinion, psychoanalysis can offer PHC in our time.

6. CONCLUSIONS

This chapter begins with a presentation of the model of Primary Health Care (PHC) and its relevance to health in the 21st Century. In particular it stresses the issues concerning its psychological and psychosocial repercussions.

Thereafter it develops some of the applications of psychoanalysis, both for PHC and, more specifically, in mental health care in PHC: the model of Primary Mental Health Care (PMHC).

Generally speaking, psychoanalysis is considered to contribute to PHC in five basic ways:

1. Giving support to many of those who work in health centres in terms of personal development, setting preservation, professional training and group organisation: Clinical-preventive and developmental contribution to PHC.
2. Offering elements for the practical-theoretical and epistemological basis upon which the fundamental principles of PHC can be laid out Theoretical contribution.

3. Offering psychotherapeutic elements, which can be used by primary health care professionals: Technical contribution.
4. Offering a number of pragmatic elements both to PHC and to Primary Mental Health Centres.
5. Offering elements of the previous four types for a renewed practice of Community Mental Health Care (the model of Primary Mental Health Care).

In short, psychoanalysis should contribute to PHC mainly with clinical perspectives, with theoretical knowledge which takes account of the internal world, and by supplying the basic frameworks for prevention and integrated clinical assistance.

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