

BEYOND MENTAL HEALTH: PSYCHOLOGY IN PRIMARY CARE

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This article begins by reviewing the role of Primary Care in the National Health System's Strategy for Mental Health, highlighting the inadequacy of the solutions proposed for dealing with common disorders (anxiety and depression), given their condition as problems of a psychological nature. The proposal set out is for the integration of Psychology in Primary Care on the basis of a contextual philosophy, different from that derived from the prevalent biomedical and bio-psycho-social model. This new philosophy includes a reappraisal of psychological problems in contextual terms, related to life, rather than in psychopathological terms, related to biology. In this same line, the figure of the psychological health consultant is introduced, defining the role of the psychologist in Primary Care. Finally, it is shown how the new role of Psychology in Primary Care is endorsed by efficacy, profitability and user preference.

Keywords: Psychological intervention. Primary care. Mental Health. Bio-psycho-social model. Contextual model.

Se empieza por revisar el papel de la Atención Primaria en la Estrategia del Sistema Nacional de Salud para la Salud Mental, señalando la inadecuación de las soluciones propuestas para abordar los trastornos comunes (ansiedad y depresión) con su naturaleza de problemas de tipo psicológico. Se propone la integración de la Psicología en Atención Primaria sobre la base de una filosofía contextual, distinta a la derivada del modelo biomédico y biopsicosocial al uso. Esta nueva filosofía incluye un replanteamiento de

los problemas psicológicos en términos contextuales, ligados a la vida, y no en términos psicopatológicos, ligados a la biología. En esta línea, se introduce la figura del consultor psicológico de salud, definiendo el papel del psicólogo en Atención Primaria. Se termina por mostrar que el nuevo papel de la psicología en Atención Primaria está avalado por la eficacia, la rentabilidad y la preferencia de los usuarios.

Palabras clave: Intervención psicológica. Atención primaria. Salud mental. Modelo bio-psycho-social. Modelo contextual.

In December 2006, the Spanish Ministry of Health published the Strategy for Mental Health in the National Health System (Ministerio de Sanidad y Consumo, 2006). This document was drawn up for the Ministry of Health's Quality Agency by a group of experts, with the cooperation of the Autonomous Regions, which are currently responsible for the management of healthcare in Spain, and of certain scientific associations from the mental health sector. In the words of the authors themselves, "the Strategy constitutes a support text for the nationwide coordination of the appropriate mental health promotion programmes, prevention programmes and diagnostic, therapeutic and rehabilitation resources for the administration of integrated and ongoing attention to persons with mental disorders. Also among the Strategy's goals are the promotion of research in mental health and the creation of tools that will permit the assessment of progress and the identification of shortcomings in the

development of this field" (p. 10). Bearing these goals in mind, the ideas, analyses, proposals and solutions outlined in the Strategy are key for understanding how the Health Administration views both the nature of mental health disorders and their prevention, treatment and rehabilitation.

The text consists of two separate sections. The purpose of the first section, called General Aspects, is to explain the need for the document, to contextualize its creation within the framework of certain principles and values that will guide the analyses and proposals, and to set out some epidemiological data on common and severe mental disorders in diverse populations (adults, children and adolescents, and the elderly), considering some of their potential consequences (suicide). There are no data, however, on the consumption of care, or on strategies of prevention, evaluation and treatment currently in use in mental health or Primary Care facilities, or on their efficacy, effectiveness or efficiency. In the second section the proposals are made, grouped by strategic lines, referring to the promotion of mental health and the

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prevention of mental illness, healthcare for mental disorders, coordination between the institutions involved, the training of health personnel, research in mental health, and assessment and information systems. There is no part of this latter section devoted to analysis of the nature of the disorders dealt with in Primary Care, nor to the way in which prevention, detection and treatment are approached in this healthcare field, despite frequent references throughout the document to this care sector in the field of mental health.

Leaving aside that part of the document dealing with the promotion of health and the prevention of mental illness, which makes scant reference to the role of Primary Care, and concentrating on the part devoted to healthcare for mental disorders, we find that it states the following: "The current reality is that the main point of contact with mental healthcare for the majority of patients is the general practitioner (GP), and that 80% of psychiatric patients receiving attention in the mental health system come from Primary Care. This is easy to understand if we consider the high prevalence of problems related to mental health at this level of care, which ranges from 18 to 39%, depending on the study, and that only 10% are referred. Recent studies indicate that in the everyday work of GPs, 15 to 18% of patients they see have some type of mental disorder or psychiatric pathology" (p. 90). These emphatic figures and considerations provoke no specific reaction in the text's authors other than proposing improvements to current procedures for detection and referral by GPs, despite the fact that "common mental disorders constitute a substantial volume of cases dealt with by GPs, who do not always receive adequate training for their diagnosis and treatment, nor have time for them, which means that many patients receive only pharmacological treatment, when in many cases they could benefit from multidisciplinary approaches with strategies and techniques of support and brief psychological advice" (p. 94). There is clearly a serious problem, since there appears to be considerable demand for care that fails to obtain an appropriate response, due to either lack of available resources or lack of expertise.

The consequences of this are twofold. On the one hand, in many cases patients are not obtaining the best treatment available. But on the other hand, public resources may be being wasted on inefficient care, not only in purely financial terms, but also with regard to professional's time – an extremely scarce resource in Primary Care.

The situation reflected in the text of the Strategy for Mental Health, whereby large numbers of patients with "common mental disorders" would be receiving ineffective and inefficient care from the health system, is not confined to the Spanish context. A recent report by a prestigious British institution (London School of Economics. The Centre for Economic Performance's Mental Health Policy Group, 2006) draws attention to the fact that, in the UK, just 1 in 4 persons suffering from chronic anxiety or depression is receiving some form of treatment, and of those who do, the vast majority are taking drugs prescribed by a GP, drugs they will eventually stop taking because of side-effects or because they want to regain control over their life. Very few have access to psychological therapy, despite recommendations from NICE (National Institute for Clinical Excellence) that this type of treatment should be available to those suffering from these kinds of disorders, unless they are very mild or recent. According to the authors of this report, this inefficacy of treatments generates considerable suffering and enormous financial costs, not only due to the pharmaceutical expenditure but also in view of the working hours lost as a result of such disorders.

According to Strosahl (2005), those researching in the health field have broadly accepted that, in the USA, Primary Care is the "de facto" mental health system. As shown by epidemiological data and service provision statistics, the vast majority of mental health services are dispensed by GPs. Moreover, and as the same author points out, specialist mental health services are inaccessible for the majority of citizens, due to problems of financing, inter-service communication, saturation, confusion with or rejection of referrals, and other factors. On the other hand, however, it is acknowledged that the limitations imposed by time constraints and lack of specialist expertise make it very difficult, if not impossible, for GPs to offer adequate treatment for patients' problems. Hence, it is clear that the great majority of mental health care provided in the United States can be considered scarcely effective. Such care, as would be expected, is based fundamentally on the prescription of psychotropic drugs, and the figures are striking, with 67% of all psychotropic medication prescribed by GPs.

There is a comparable situation in Australia (Vagholkar, Hare, Hasan, Zwar & Perkins, 2006), due to similar factors as those mentioned above, plus the peculiarities of the Australian context, with vast rural regions in which it

is very difficult to maintain a specialist mental health system, given the lack of professionals, in particular of psychiatrists. The need to provide support for Primary Care has led the Australian health service to launch a project that involves clinical psychologists at the Primary Care level, the initial results of which are starting to be published (Vagholkar et al., 2006).

Although the problems detected are almost always the same, this cannot be said of the quest for a solution. The UK, the USA and Australia favour integrated models that incorporate psychological attention into Primary Care; in Spain, on the other hand, though the problems are acknowledged, there is an insistence on maintaining the current model, hoping for an improvement in its functioning and results through the use of “buzzwords” such as “community care”, “inter-service coordination” or “bio-psycho-social model”, without much attention being paid to the objective conditions that determine the provision of service in this healthcare field.

THE NATURE OF THE MENTAL PROBLEMS DEALT WITH IN PRIMARY CARE

As already mentioned above, the Strategy for Mental Health states that Primary Care deals basically with the so-called common mental disorders (especially depression and anxiety), of which only 10% of cases are referred to specialists. The majority of the more serious disorders, which require or may require hospitalization, are also dealt with initially by GPs, but they are more easily referred to specialist attention.

These low referral figures, together with patients’ generally good opinion of healthcare, may lead to the illusion of high effectiveness of Primary Care services in the detection and treatment of common problems. However, there are some problems involved in accepting such a conclusion:

- 1) The costs of people’s incapacity for work and disability in general attributable to psychosocial factors (among them the common mental disorders) represent a large proportion of overall incapacity and disability costs. The therapeutic –and even diagnostic– measures in Primary Care would not appear to be sufficient for curbing the incapacitating effects of these mental disorders or problems.
- 2) The cost of drugs for the treatment of anxiety and depression has continued to increase, in spite of reports that question the effectiveness of this type of treatment, in relation to both its effectiveness and its

chronifying effects, especially in the way it tends to be used by non-specialist services.

- 3) Psychological treatments, more effective and efficient for dealing with these common disorders, are not available in Primary Care.

On considering the nature of the mental problems seen at the Primary Care level, it is tempting to argue that among the 90% of cases not transferred to specialists there are a substantial number of “non-cases”, that is, involving people not with any “real” depression or anxiety disorder, but rather with life problems, unduly medicalized, or even, indeed, psychologized. Figures revealing a high prevalence of anxiety and depression cases derive from the use of screening instruments, highly inadequate for capturing “the whole person immersed in the dynamic complexity of a life” (Summerfield/Veale, 2008, p. 326). The use of such instruments leads to an overestimation of cases of depression and anxiety disorder, since “if on average 1 in 4 or 6 of the people going about their ordinary business on the street, as I write, are diagnosable as mental illness cases, we need to re-examine our models before we examine the people” (Summerfield/Veale, 2008, p. 326). In line with this perspective, when we analyze the GP’s typical demand, very few cases (we do not know how many) would make the cut as illnesses or disorders. Consequently, the figures talked about for mental pathology in Primary Care are inflated, and the majority of cases are “life problems” that should not be “medicalized”, so as not to continue feeding the “mental health industry”. The status of depression and anxiety as psychological disorders is not explicitly denied. That label is reserved for cases correctly identified.

The basic problem with this type of reasoning is that it provides no procedure for “correctly” identifying cases. There is no proof that the cases seen in Primary Care are qualitatively different from those that are transferred to Specialist Care. The referral process is relatively complex, and the factors intervening are not solely those related to the characteristics of the patient’s pathology, but include also aspects such as accessibility and inter-service coordination, the doctor-patient relationship, different health policies, and so on.

Criticism of the hyper-medicalization of everyday life, the inadequacy of psychiatric nosology for explaining the problems of the person in their context, or the methodological inadequacies of screening tests is applicable to so-called psychiatric pathology as a whole,

and not only to the case of the common disorders. The logical consequence of this type of criticism is to increase the relevance of the individual's context in explaining his or her behaviour.

The key point is that the nature of the common disorders, such as anxiety and depression, is phenomenologically and etiologically psycho-social, without implying the exclusion of the biological component. The current care provision, however, is totally biomedical. The treatment offered in Primary Care is basically psychopharmacological, although, depending on the case, the skills of the doctor may create situations of counselling. These issues will be reconsidered later.

But we should also consider another important aspect with regard to the nature of the psychological problems dealt with at the Primary Care level. Although up to now we have referred to the common mental disorders, it must not be overlooked that many physical illnesses (see Box 1) have substantial psychological components that should be taken into account in both assessment and treatment. This is a kind of therapeutic "complication", basic to many chronic illnesses, that should be taken into account for the control and follow-up of this type of patient in Primary Care, since this is crucial to their recovery. Psychosomatic medicine, behavioural medicine and Health Psychology have long been aware of the importance of the psychological components associated with becoming ill, but their assessment and treatment are not confronted in a serious way due to lack of resources. Neither specialist medical services, nor specialist mental health care, and even less so the overloaded Primary Care system, pay attention to these aspects, which are in many cases covered to some extent by professionals working for patients' associations. The inclusion of clinical psychologists in Primary Care could help to cover this

demand, substantially improving the protocols of control and follow-up of the chronically ill.

INTEGRATING PSYCHOLOGY IN PRIMARY ATTENTION

The discrepancy between the nature of mental disorders and the model with which they are approached in Primary Care produces a chronic lack of fit between demand and treatment that generates a "revolving door" problem, resulting in demoralization among doctors and dissatisfaction among clients (Sobel, 1995), not to mention increasing costs due to ineffective and inefficient personal and pharmacological (financial) resources.

It may be thought the solution lies in increasing referral of suspected mental disorder cases from Primary Care to Specialist Care. But this solution involves a series of difficulties:

- a) Specialist services are totally saturated. The attention they provide is subject to lengthy waiting lists which, in many cases, adulterate the utility of health provision. Increasing the flow of patients would certainly not contribute to better functioning.
- b) Referral implies transferring the problem from one place to another without resolving it. This is the case because the specialist services, despite the fact that they usually involve psychologists, operate within a biological-medical model. A symptom of this problem is the growing demands, in the UK, for "talking time" in health services, or for more rapid access to psychotherapy. In Spain there are also problems of access to psychotherapy, and this is mentioned in passing in the Strategy for Mental Health when it sets as a future goal an increase in the percentage of patients with psychological disorders that receive this type of treatment. There is no reference to the way psychotherapy is applied in Spanish health centres, but anyone who is familiar with these services is aware that, in current conditions, it is very difficult for all those who need this kind of attention to be able to obtain it with minimum guarantees of quality.
- c) Community psycho-social care should be as close as possible to the social space in which demand occurs. It is in Primary Care that the demand is produced, and it is there that the solution should be found, so as to avoid unnecessary medicalization, along with undesirable effects such as labelling and the description of people as "mentally ill".
- d) Although one may think that the stigma of being referred to the mental health services has decreased

<p>BOX 1 SOME ILLNESSES FOR WHICH PSYCHOLOGICAL INTERVENTION IS RELEVANT</p>
<ul style="list-style-type: none"> ✓ Diabetes Mellitus ✓ Hypertension ✓ Cardiovascular illness ✓ Asthma ✓ Situations of acute and chronic pain ✓ Insomnia ✓ Obesity ✓ Gastrointestinal disorders ✓ Cancer ✓ AIDS

as a result of better social insertion and acceptability of those with mental health problems, it can still not be considered to have disappeared; indeed, some believe it may even have increased (see below). But it is reasonable to suggest that were mental health care services to be found in the same place as those of physical health, patients might prefer to be attended to in the Primary Care context.

- e) The forces that determine the status quo are not easy to change if there is no incentive for change. The biological reductionism that prevails in the treatment of psychological disorders or problems is firmly linked to medical training and to the working style required of doctors. Moreover, pharmacological prescription is strongly incentivized through powerful channels of commercialization, ranging from the training of prescribers to direct economic incentives. A change of direction in Primary Care can only come about if the new model of work succeeds in bringing tangible advantages for doctors and patients. Mere exhortations cannot have any effect for change while the conditions determining the current situation persist.

The alternative to referral consists in assuming the responsibility of treating common disorders in Primary Care. It is utopian to attempt to do so with the current models and resources. This assertion alludes not only to doctors' and nurses' lack of time, their insufficient training in psychotherapy, psychodiagnosis or psychopathology, their essentially bio-medical perspective or the conditioning factors associated with working in a health "industry". We must also bear in mind the difficulties inherent to a medicalized Clinical Psychology, which mimics the medical approach to through excessive "psychopathologization", psychotherapeutic techniques that fail to take account of the effectiveness and efficiency standards essential to public health provision, and psychologists' lack of grounding in the biological components and processes of illness, which severely hampers their incorporation into Primary Care, a service that addresses the population's health in general.

In spite of all these difficulties, the integration of Psychology in Primary Care services is being postulated by means of a model called Integrated Care (Byrd, O'Donohue & Cummings, 2005), which is defined as "the process and product of medical and mental health professionals working collaboratively and coherently toward optimizing patient health through biopsychosocial

modes of prevention and intervention" (p. 2) Although the current model of community care, as set out in the Strategy for Mental Health, stresses the need for coordination of services, the Integrated Care model goes further in seeking the collaboration of psychologists and Primary Care doctors in a close and immediate fashion, with rapid feedback on their interventions, the participation of the whole team at the health centre, and no watertight compartments between physical and mental health. The Integrated Care model does not necessarily require psychologists to be based at the Primary Care centres themselves, though its goals are clearly easier to achieve if everybody is working in the same space. Box 2 presents the goals of the Integrated Care model according to Byrd et al. (2005).

The achievement of these goals would permit both professionals and patients in the Primary Care context to obtain benefits from the change of model. Some of these benefits could be as follows:

- a) Reduction of the burden on healthcare personnel (doctors and nurses), their caseload of psychological problems being immediately referred to specialist resources.
- b) The development of screening and care protocols for patients with mental health or psychological problems, allowing a reduction in the use of psychoactive drugs and chronification, and improved social and employment reinsertion in the medium and long term.
- c) Improved satisfaction for patients, with better fit between demand and service provision.
- d) Active intervention in the preventive work of the Primary Care centre, in relation to both users themselves and the wider community. Of special significance here would be the development of campaigns in schools for the prevention of psychological or behavioural disorders/problems with high prevalence, such as addictions, eating disorders or sexual risk behaviours. Furthermore, there could be an emphasis on encouraging the capacity for recovery over a tendency for vulnerability (as discussed below).
- e) The development of protocols of coordination with specialized mental health centres to permit stricter follow-up and control of each patient.

As it can be seen, the new model would represent a significant improvement for the patient through increased effectiveness of treatments and a better fit between service

supply and demand; for current Primary Care health personnel through reductions in workload; for the health system thanks to reductions in pharmaceutical costs and in the prevalence of psychological disorders or problems; for the social welfare system because it would make possible the implementation of more effective monitoring and control of incapacity due to psychosocial factors; and for preventive programmes because the introduction of specialized personnel would permit the development of broader-based and more comprehensive actions, benefiting a wider population.

With these needs and possibilities in mind, we shall propose a philosophy and a model for Psychology in Primary Care, beginning by looking at how institutions think, and how it is possible to think in a different way.

HOW INSTITUTIONS THINK

What Primary Care needs is a new philosophy – a new way of thinking and acting in relation to psychological problems. This would involve a change in the way institutions, professionals and patients or users think. But indeed: how do they think? They think in terms of illnesses, as though psychological problems were illnesses like any other. Even if the term *illness* is not used and understood in a precise and formal way, it is used implicitly, shaping the way the problem is talked about and thought about. Such a situation is not surprising, given the context (health centre) and the history of medical practice. The way of thinking in question is basically that of the medical model. According to this model, some biological condition would

be at the basis of the problem, and would be the target of the medication. This model constitutes common sense, the natural, institutional way of attending to and understanding the problems (symptoms, illnesses) affecting people (users, patients).

Thus, institutions, in this case Primary Care centres, receive patients, who must be assessed (normally receiving a diagnosis) and treated (usually being prescribed a drug) or, where applicable, referred to a specialist. The point here is that the diagnosis –say, anxiety and/or depression– and the corresponding medication shape a general way (the biomedical way) of thinking, and obviously, of proceeding. Professionals, especially GPs, but also possibly psychiatrists or psychologists using the biomedical approach, are those who actually think that way, and in fact embody the institutional thinking. It is they who diagnose and prescribe medication. As mentioned above, the majority of psychoactive drugs today are prescribed by GPs, and constitute a large proportion of all the prescriptions they write (we should not overlook the fact that they are under the watchful eye of pharmaceutical marketing). For their part, patients also think biomedically, and hence go along with their symptoms, distress, troubles and complaints to doctors’ surgeries or health centres, receive a diagnosis and return home with a prescription. If their problem were not an illness, they would not be told that they “had”, for example, anxiety or depression; nor would they be given medication.

This is how institutions, professionals and patients think, in a context in which thinking does not so much mean representing as proceeding in conventional and now supposedly natural way, not only legitimate, of course, but also perfectly legitimized. This way of thinking becomes as characteristic and natural as night following day, or the growth of plants –this is how institutions think (Douglas, 1996). The institutions involved in this context think in this, as it were, *unthinking* way, but when they truly think about things, they understand and actually acknowledge the problems of this institutional way of doing things: the care-related, economic and political problems referred to above. The important thing is that it is possible to think about things in another way.

REASONS FOR THINKING IN ANOTHER WAY

We should begin by considering whether in fact psychological problems are illnesses like any others. The question has two dimensions: one fundamental,

<p>BOX 2 GOALS OF THE INTEGRATED MODEL OF PSYCHOLOGY IN PRIMARY CARE</p>
<ul style="list-style-type: none"> a) To improve recognition of mental health needs in medical facilities b) To improve collaboration in care and management of patients with psychosocial problems in Primary Care c) To increase availability of internal Primary Care resources for helping to attend to patients’ psychosocial or mental health problems and provide rapid feedback to the health professional, without referring patients to a specialist service. d) To improve the correspondence between patients’ demand for attention and the services provided in Primary Care e) To prevent the most serious physical and mental health problems through early detection and intervention f) To assess on behalf of the mental health professional when it is appropriate to refer a patient to specialist mental health services in order to receive more intensive treatment

ontological, about whether psychological problems can truly be classified as illnesses; and another pragmatic, prudential, about whether in any case such a consideration is appropriate because, for example, it is better for the “patients”.

As regards the fundamental, ontological question, what we would have to say is that psychological problems, far from being *natural entities or kinds* in the manner of diabetes or arthritis (with which they are sometimes compared), they would be *interactive entities or practical types*, according to the distinctions drawn in this context [the distinction between *natural* and *interactive* entities was introduced by Hacking (2001, chap. 4), and that made between *natural* and *practical* kinds can be found in Zachar (2000) and Haslam (2002). An in-depth ontological discussion appears in Pérez-Álvarez, Sass and García-Montes (in press).] Whilst natural entities are realities or conditions *indifferent* to our conceptions and interpretations of them (the diabetic condition does not vary according to what people believe or how they understand and explain it), interactive entities are realities or conditions *influenced* by people’s conceptions and interpretations of “them”. Thus, what would constitute “depression” is given by cultural practices related to emotional sensitivity, the experience of life situations, the way difficulties are lived through and, in general, the way people cope with life problems (loss, frustrations, etc.). But “they” are not entities that were “out there” as natural formations; rather, they are formed, and perhaps become something clinically relevant (e.g., “depression”), in relation to a given psychosocial and historical-cultural context, because it may also occur that “they”, these primary realities, the raw materials of which psychological problems are made (such as grief and sadness in relation to depression), do not become anything in particular, other than something that forms part of the vicissitudes of life.

The fact that psychological problems have become practically naturalized, institutionalized, as entities in the form of illnesses, and that there are thus so many disorders, is proof of their interactive nature, liable to typification according to how society treats these problems, in line with the thinking of the institutions charged with “treating” them. But again, far from being natural kinds, they are practical kinds, made to measure for being treated, as though they were illnesses to be treated with medication (González Pardo & Pérez Álvarez, 2007; Pérez-Álvarez & García Montes, 2007).

Note that we are not denying that psychological problems are *real* facts; what we are asking is how they become real *facts*. These primary realities that become full-blown psychological problems do not emerge from a void (nothing comes out of nothing, and something comes from something); rather, they emerge –and this is our thesis– from the problems of life: loss, frustration, disappointment, conflict, abuse, maltreatment, weakness, misery, unhappiness.

Paradoxically, the conceptualization of psychological problems as though they were “natural kinds”, like any other illness, is possible precisely by virtue of the fact that they are “practical kinds”, susceptible to being influenced and shaped by clinical practices –in this case, indeed, highly practical for biomedical professionals and, it goes without saying, for the pharmaceuticals industry. Given the apparent status of psychological problems, then, as interactive entities and practical kinds, the possibility arises of interacting with them in another way and of applying another type of clinical practice, perhaps more practical for the patients and institutions involved. However, first we shall consider the question of whether, for pragmatic reasons, it would be better for “patients” to continue to consider psychological problems in terms of illnesses like any other.

IS IT BETTER TO HAVE AN ILLNESS THAN A PSYCHOLOGICAL PROBLEM?

The consideration of psychological problems as illnesses has been introduced on the assumption that it has a positive effect in reducing moral judgements and discrimination in relation to sufferers. The assumption is that models of biological illness are de-stigmatizing, and lend seriousness to a disorder, compared to psychological models. The view that psychological problems have biological causes has been promoted within programmes aimed at reducing stigma, has been adopted by the influential National Institute of Mental Health in the USA (NIMH, <http://www.nimh.nih.gov/>), and is widely held among mental health professionals (not to mention the pharmaceutical marketing sector).

The truth is, as research shows, that the policy of “illness like any other”, far from reducing stigma, is itself stigmatizing, and in contrast, the psychological explanation is more positive than the biological one. When all’s said and done, it turns out that the psychological explanation is the correct one, both politically and scientifically.

Thus, we have seen how persons with supposed mental illnesses are treated distantly and considered as unpredictable and somewhat unreliable, even by their own family and clinicians themselves (Read, Haslam, Sayce & Davies, 2006; Van Dorn, Swanson, Elbogen & Swartz, 2005). Likewise, patients who are given to understand that the disorder has biological causes consider that the required treatment will take longer, are more pessimistic about improvement and adopt a more passive role to clinicians and to their own problem than if they are given to understand that it has psychological causes (Lam & Salkovskis, 2007; Lam, Salkovskis & Warnick, 2005). Psychological explanations of supposed mental illnesses are also effective in improving the images of people in the mental health context, beyond Primary Care. Rather than arguing that mental illness is like any medical illness, psychological explanations focus on environmental stressors and trauma as causal factors, including child abuse, poverty and work stress, in line with the idea of considering psychiatric symptoms as understandable reactions to life events (Corrigan & Watson, 2004). In the words of a patient, having a mental illness is not like having diabetes (Anonymous, 2007).

Moreover, persons with problems characterized in terms of illness are treated more harshly than if the problems are characterized in psychological terms, as has emerged in experimental studies following Milgram's paradigm. Participants went as far as applying what they supposed to be stronger shocks in a learning task to those 'learners' who, it had been suggested to them, had suffered a 'mental illness', than to those who had supposedly experienced 'psychological difficulties', or nothing in particular (Metha & Farina, 1997). This would suggest that the 'biological condition' generates the stigma of being different, giving rise to the well known form of mechanistic dehumanization, in which human beings are seen as automatons, inert, rigid and devoid of autonomy (Haslam, 2006).

As Lam et al. (2005), conclude, the data show that biological or genetic explanations of psychiatric/psychological conditions do not improve the negative view of mental health problems, and that people in general tend to react more favourably to the psychological explanation. It is therefore important in therapeutic work, continue these authors, for this "message of hope" to be transmitted to patients so that they are more proactive in working through their

psychological and stress-related problems, and so that therapists explore patients' psychosocial experiences over the course of their life, rather than attributing their problems to biological or genetic factors. The biological conceptualization of psychological problems of mental health, these authors state finally, does not appear here to be effective or useful in modifying stereotyped images (p. 463).

UNMASKING THE BIO-PSYCHO-SOCIAL MODEL

Given their interactive nature, then, we might consider another practical form of "processing" and solving psychological problems, another clinical practice of a non-biomedical nature. The point is not merely to change professionals, from the GP to the Primary Care psychiatrist or psychologist, since psycho-clinical professionals can also be wrapped up in the logic of the biomedical model, even though they might use psychological jargon. It is not a question of changing the horses, but rather of changing the carriage and the direction. It is supposed that the biomedical model has been overcome through the adoption of the bio-psycho-social model, as though its invocation and our compliance with it could release us from previous problems and situate us in a land where bio, psycho- and social would live in harmonious equality and each would make its due contribution without further ado. The truth is that the phrase "bio-psycho-social model" functions as a sort of talisman that supposedly magics away all the bad things and brings nothing but good.

The bio-psycho-social model is undoubtedly better than the *bio- bio- bio*-model, but it is a model that bears within it the conditions it pretends to overcome – assuming it is indeed attempting to supplant the biomedical model. It is a stratified model that assumes a bio condition as its basis, so that the psycho and social elements would be layers or filters through which the symptoms would pass on the way to their manifestation, and where they would acquire the psychological and social aspect (e.g., Berrios, 2000), leaving us back at square one. At the basis and origin of the symptoms there would be a *cerebral locus* which, to use a Freudian term, would pass through a series of psychosocial *vicissitudes* before becoming the symptom and set of symptoms that define the disorder. The point is that the bio-psycho-social model is the prisoner of body-mind dualism, and is thus pregnant (as stated above) with what it sets out to overcome – bio-centrism – if indeed it truly wants to overcome it. The



“cerebro-centrism” of neuroscience and of popular culture suggests that this “pregnancy” is desired, and it matters not that it offers no solution alternative to that of blaming others except to blame the brain for all the ills, or to see it as the depository of happiness to be conquered. In the meantime, psychological problems continue to grow unabated – perhaps because of this?

In a subtler way, this problematic (stratigraphic, dualist) aspect of the bio-psycho-social model is indeed present in other less linear representations, which are all the better for that, but are still not exempt from some degree of mechanism and composition, as opposed to integration *per se*. For the very structure of the word “bio-psycho-social” implies a stratigraphic and linear composition of supposed implicated parts that not only fails to guarantee their integration but indeed prefigures and structures a logical and chronological priority, in this case of bio- over psycho- and social, regardless of what its satisfied users choose to understand. Nor would any remedy lie in shuffling its components, saying, for example, “socio-psycho-biological”. It would still be a sham, juxtaposing components as though they existed separately and had now started interacting. The typical models with arrows going in all directions between the boxes representing, respectively, the bio-, the psycho- and the social, would be visions of this interaction, notwithstanding their heuristic value in a given context, to give them some credit.

The truth is that the bio-psycho-social model is at the basis of the separation of treatment from rehabilitation and of psychoactive drugs from psychotherapy, the consequences of which undoubtedly include the psychiatric career of many patients and the squandering of opportunities for authentic psychosocial rehabilitation, which is reduced to the status of “varnish” subsequent to the supposed “treatment”. And that is supposing that all the psychological effort is not geared to compliance with the medication and the application of the biomedical model in the name of the vulnerability mode, another bio-psycho-social variant.

THINKING IN TERMS OF A CONTEXTUAL PHILOSOPHY

Another way of thinking about psychological problems in clinical practice would be in terms of a contextual philosophy and model. We are talking here about a contextual model, not merely environmental, interpersonal or psychosocial, but rather phenomenological-behavioural, dealing with people’s

experience and behaviour in accordance with their biography and circumstances. This is a model conceived on an anthropological-philosophical basis, with four aspects that should be highlighted here.

One. *The constitutive articulation of the human being with the world.* The implication would be that all psychiatric and psychological study would have to take as its unit the indissociable couplet Man-World. The full and indissoluble equation is the human being and the world. As Ortega y Gasset says: “The world is the web of affairs or matters in which Man finds himself, like it or not, entangled, and Man is the being who, like it or not, is consigned to swim in this mass of affairs and inexorably obliged for it all to matter to him” (*El hombre y la gente; Man and People*). This being the case, it is difficult to understand and explain a psychological disorder isolated from the circumstances of being-in-the-world. A variant of this would be that the more we study a disorder by seeking its explanation within (be it in the brain or in the mind), the less we understand it. An implication of this is that we are always in some situation and in it in some way, i.e., in some mood state.

Two. *Moods as forms of being “in tune” with the world.* We are always in some situation (place, circumstances, affair) and in some way (feeling comfortable, uncomfortable, happy, sad, calm, uneasy). We refer to moods here not in a psychiatric sense, but rather in an existential one. A mood is a particular way in which we are “in tune” with the world in our activities (Guignon, 1999). We are always in one mood or another. Even the lack of mood on a grey day is a mood. When we control a mood we do so by means of an opposite one; we are never free of them. Anxiety and depression are above all moods, in an existential sense, which reveal our situation in the world. Whilst anxiety reveals a threatening situation in which the consistency and meaning of the world crumble (more than fear of nothing it would be fear of nothingness), depression reveals a stagnation of life and sealing off of the future (making one feel down and demoralized, with no way out, no prospects). Anxiety and depression are seismographs of the tremors and earthquakes that shake and batter our lives. Being, as they are, revealers of our situation and thus initial responses to it, it is not surprising that they are the commonest psychological problems in Primary Care.

Three. *Life as constituting a problem in itself.* This refers not to any “vale of tears”, nor to any philosophy of resignation, of suffering or life-for-death, but rather,



simply to life as a problem in Ortega's sense, which is from where the expression is taken. According to Ortega's *vital reason* philosophy, which is characterized by cheerfulness and sporting style (far removed from Heideggerian angst or the Unamunian tragic sense of life), life is a problem or challenge, something we have to get on with, taking in our stride both opportunities and obstacles, successes and failures. We are reluctant to state the obvious in this way, but such as things are in our society now, it cannot be avoided. As Derek Summerfield says in relation to today's massive expansion of psychological problems, seeking the cultural background to the matter, citizens are as strong as the culture in which they live expects them to be. In the last 40 years, the concept of person in Western society has stressed not the capacity for recovery, but rather vulnerability, with "emotionality" as everyday currency. This transcendental change has its roots, continues Summerfield, in the way the medico-therapeutic view has come to dominate everyday explanations of the vicissitudes of life and the vocabulary of stress (Summerfield/Veale, 2008, p. 327).

Four. *People are capable of taking charge of their lives.* We are not talking here about the typical humanist praise of Man as a prodigy replete with potentialities, nor about an exhortation to sacrifice and personal asceticism, but simply about responsibility as a person, in the dual sense of being capable of responding (ability) and of accepting the consequences of our actions and inaction (awareness of one's duties to oneself, to others and to the world in which one lives). It might seem superfluous to say this, but be it because of the decline of duties as they are eclipsed by rights, because of today's human being's self-conception as consumer (a degrading image, if we stop to think of it), because science and technology promise more than they can offer, because of the loss of common sense (to judge from our dependence on professionals and experts for every last thing), or for whatever reason, the truth is that people appear to have been expropriated of their own capacities. And perhaps they have, but capacities grow in parallel with needs, and according to what others assume us to have. As Goethe apparently said, if you treat a person as they are, they will remain as they are, but if you treat them as though they were what they should and could be, they will become what they should and could be.

The philosophy of this contextual model becomes strong in culture and in the construction of the human being and our forms of being-in-the-world, but it should not be

confused with a mere cultural anthropology or with typical postmodern constructivism. Culture is here for intrinsic reasons, constitutive of the human being. As Ortega would say, Man's nature is culture. For its part, construction refers to the historical character of the human being. To quote Ortega once more, Man has no nature, but history, not only as a child of his time, but also as constituted in time. In this regard, the human being is above all a *becoming* that incorporates other things and other people in itself ("Oneself as another," as Paul Ricoeur would put it).

The contextual model does not deny the biological factors that might be involved in psychological problems, but nor does it anticipate them or assume them as their basis (bio-psycho-social model). The model considers that biological factors are integrated and refounded in ways that are seized, more than learned, of perceiving and responding to them, and not that they represent a direct natural force or a basal irritation that comes to manifest itself via mental and social layers; it also considers that lived experience and the interpretation of and reaction to biological factors are determinant for the role they may play in psychological problems. The psychopathological problem is not in the fear, the anxiety, the grief, the sadness or even the hallucinatory voices, but rather in one's relationship with such events and experiences (Pérez-Álvarez et al., 2008). As Lipchik (2004) argues, "the feeling of sadness can be considered a problem if one believes it is an illness, or a solution if it means that a person who has been eluding affliction ends up accepting a loss" (p. 90). The real actors of a psychological drama would not be the biological factors. Biology would be refounded in biography. In sum, psychological problems would be not so much a biological condition as a human condition.

WHAT IS A PSYCHOLOGICAL PROBLEM?

What differentiates a psychological problem from a life problem? How is normal suffering different from suffering due to a psychological problem? These are undoubtedly complex questions, but which have a clear answer, if we are clear on what we are talking about; in our case, if we have a clear and distinct philosophy and contextual model. Briefly, a psychological problem would be a *counterproductive effort*.

It is understood that any psychological problem –anxiety or depression, for example– involves both a problem (the distress it brings) and a response to a problematic



situation (an attempt at a solution). This ambivalence and also functional ambiguity of a psychological problem is acknowledged in one way or another throughout the clinical tradition. Thus, it is in the ambivalence of the symptom, from Freud to Lacan, in Alfred Adler's "neurotic arrangement" (a magnificent expression), in transactional games with their dual social and psychological plane, in the problem presented as an attempted solution (Jay Haley), in the function of the problem of the functional analysis of behaviour, in "illness as a response" (Antonio Colodrón), in the adaptive function of the disorder from evolutionary (Darwinian) psychiatry; and indeed, it is also in the common clinical expression of "complaint" suggesting distress and suffering and at the same time discontentment and disagreement with something or someone. The affects involved in anxiety and depression are part of this functional ambivalence: on the one hand they are negative affects, bringing discomfort or distress – fear, anguish, grief, sadness–, and on the other, they produce positive effects as seismographs, as we said, of life's tectonics.

The recognition of this ambivalence situates the psychological problem in a perspective distinct from that which sees it as derived from a supposed internal dysfunction, deficit or breakdown, be it cerebral (locus, neurochemical imbalance) or mental (processing, underlying schemata). Anxiety and depression would be above all the response and effort in the face of myriad life situations –hence their prevalence when problems arise. But what makes anxiety and depression a psychological problem?: *the reiteration of a pattern in which what one does no longer extricates one from a problematic situation, but rather drags one ever further into a self-reflexive circuit.* This pattern, which might be called "neurotic", can consist in excessive rumination, in self-tormenting emotional reactions and in obstinate avoidance behaviour which, in the end, leaves one in the same situation; often, indeed, the neurotic pattern consists in an amalgam of all these aspects. In this conception, the ideas of circuit and situation are highly important.

The psychological problem can be defined as such when thoughts-feelings-actions constitute a self-reflexive *circuit*. Viktor E. Frankl's logotherapy offers the clearest model of this conception, formulated precisely in terms of self-reflexive circuit, but in some way or other this idea is found in the different clinical systems. Indeed, hyperreflexivity is probably a psychological process common to all disorders, and not as a mere concomitant

or consequent aspect but as a causal agent, as a result of which a life problem becomes a psychological problem (Pérez-Álvarez, 2008a). In this line, a psychological problem would be above all a *situation* in which one finds oneself, rather than something one has within oneself, in the head, in the brain or in the mind, and this is why it is as inappropriate to speak of brain illness as it is of mental disorder. Depression as a situation is formulated in behavioural activation therapy (Pérez-Álvarez, 2007), but the idea can also be found in other therapies (though perhaps not as clearly as in this one). Thus, for example, according to solution-centred therapy "problems are current life situations experienced as emotional dissatisfaction with oneself and in relation to others" (Lipchik, 2004, p. 46). From the point of view of treatment, the idea is to help the person get out of the situation, once it is established that keeping on doing the same is no longer any use.

And what distinguishes, finally, normal suffering from suffering due to a psychological problem? According to David Veale, a psychological problem emerges when normal suffering normal turns into a confrontation for the individual, so that the suffering gets worse and prevents the person from continuing in valued directions in his or her life (in Summerfield/Veale, 2008, p. 328). It is in this sense that, as we said earlier, a psychological problem is a counterproductive effort.

INTRODUCING THE FIGURE OF THE PSYCHOLOGICAL CONSULTANT

Thinking about the psychological problems presented by Primary Care users in terms of a contextual philosophy requires a new way of thinking in institutions, and among professionals and patients.

To begin with, institutions should include Psychology among the provisions of Primary Care, as a solution to the problems identified in the current state of things. The coherent solution would be the inclusion of psychological care. The form of implementing it is open to discussion. Whether, for example, the GP should have training in Psychology, an option that seems unviable, not only due to the training burden and workload it would imply, but also given the nature of psychological problems, which are distinct from medical problems, as we have stressed. Another possibility would be the extension of specialist care at mental health centres and hospital care units, but this solution has some disadvantages, as we have seen.

The most logical solution would appear to be the



inclusion of Psychology in Primary Care. As to the question of why Psychology and not Psychiatry, in line with our argumentation, the problems we are talking about are clearly not psychiatric problems, related to a medical specialization, but rather psychological problems that have to do with life problems which have become converted precisely into psychological problems, as we saw above. The potential contribution of the psychiatrist as a doctor would be covered by the GP him/herself, with no need for duplication of professionals. Also open to discussion is the question of whether the best access to the Psychology service would be through programmes coordinated with private clinics to which users were referred for psychological help over a set period (Vagholkar et al., 2006), or through the direct hiring of psychologists to form part of the Primary Care team. Here we consider the latter option: the inclusion of the psychologist in the Primary Care team. This would inevitably involve costs, and the magnitude of these would have to be seen, though a cost-benefit analysis would be the best way of assessing the benefits of these services with regard to improving people's healthcare.

It could also be discussed whether the Primary Care psychologist should be specialized in Clinical Psychology. Nothing would preclude this, but the profile of Primary Care psychologist would be not that of a clinical psychologist as specialist, oriented to mental health, but rather that of a health psychologist (Gatchel & Oordt, 2003). In any case, what is most important for now is to characterize the relatively new profile of Primary Care psychologist, an unsurprising figure in relation to the tradition of Clinical Psychology. The Primary Care psychologist could be characterized as *behavioural health consultant* (Rowan & Runyan, 2005) and his or her function as *behavioural consultancy* (Froján, 1998), though the best option would undoubtedly be *psychological health consultant*. Whatever the case, the crucial terms are "consultant" and "consultancy".

These terms, "consultant" and "consultancy", are situated within the great tradition of psychological advice and *counselling*, but go beyond counselling, as Costa and López (2006) stress in their "Handbook of psychological help. Giving the power to live. Beyond counselling" (*Manual de ayuda psicológica. Dar poder para vivir. Más allá del counseling*). Psychological consultancy certainly maintains from the tradition the well known empathic and collaborative therapeutic relationship of the motivational interview (Miller & Rollnick, 1999) for

helping people to resolve their psychological problems (crisis, life stagnation, etc.). But consultancy goes beyond mere advice. According to María Xesús Frojan, what characterizes behavioural consultancy in particular is brevity, compared to psychological therapies, and "the utilization of resources the client already has for solving their problem, optimizing them to the maximum so as to reduce as far as possible the learning of new skills that would undoubtedly prolong the intervention process" (Froján, 1999, p. 19). Box 3 presents the goals of behavioural consultancy.

Within this perspective, one of the most important goals is, in Frojan's words, an increase in the individual's self-efficacy, in the sense of feeling a responsibility for the changes, and feeling that it is he/she him/herself who possesses the resources. In a similar line, Costa and López (2006) stress that theirs is a model designed to *empower* people for living, and not just to "give advice". Both Froján's proposal and that of Costa and López are situated in the perspective of the functional analysis of behaviour, in which the problem presented is related to the antecedent and consequent circumstances (A-BC model), revealing to clients/consultees the fruitless of their efforts so far ("why do they self-immolate?", ask Costa and López) and attempting to re-channel this effort in a direction that is worthwhile for them. In particular, Costa and López's empowerment model covers four perspectives: biographical (it is not in your mind, nor in your heart, nor in your brain, nor in your genes: it is you); contextual or ecological; transactional (in reference to the help situation itself); and historical (the complete life history). This model emerges as an authentic contextual model, in the required sense.

The Primary Care psychologist has begun to be characterized as behavioural consultant, following Rowan and Runyan (2005), Froján (1998) and Costa and López (2006), but it should be acknowledged that the role can also be fulfilled in line with other clinical traditions, given the richness of Psychology and the highly interactive nature of psychological problems. Hence the more general denomination we propose, as *psychological consultant*, in a role which could draw, for example, on brief psychodynamic psychotherapy, whose very brevity and focus on specific problems could endorse this approach in Primary Care, the "client as active self-healing" model, one of the few alternatives to the "medical model" originating from the humanist tradition, logotherapy, mentioned above, the "new wave"

behavioural-contextual therapies, one of which (behavioural activation) will be discussed below, and “solution-centred therapy”, derived from family therapy.

If we consider some of the aspects of solution-centred therapy it is as indications of the Clinical Psychology required in Primary Care, without necessarily assuming the position of “false modesty” of therapists and their proclivity for moving from strategy to stratagem that tends to be found in this type of therapy, as we see it. What we would underline is that solution-centred therapy is more oriented precisely to solving the problem. Problems are problems insofar as they have some solution, and all have something in common: the desire for something to disappear (distress, conflicts, anxiety, depression, etc.). In other words, all problems require change: something that takes one out of the situation one is in. Box 4 shows some of the principles of solution-centred therapy.

Among the strategies available, we might mention in particular a continuous focus on the solution, consisting in the clarification of goals (“how will you know that the problem has been solved?”) and paying attention to exceptions to the problem and possible changes (“sometimes the problem doesn’t happen?” “what could you or someone else do so that it doesn’t happen?” “what’s happening that you would like to go on happening?”).

The idea of therapy focused on the solution more than on the problem, once the problem has been identified and assessed, also derives from the conception of the problem (see above) as a self-reflexive circuit. The general solution general for any problem, given that hyper-reflexivity is a common process, would consist in assisting a self-reflexive unravelling, and a re-orientation towards valued aspects of one’s life (Pérez Álvarez, 2008b). The point here is that this practical orientation to the solution should characterize the psychological consultant, bearing in mind, of course, that situating oneself before the problem in this way involves a prior evaluation of it (it is obviously not an indiscriminate attitude).

Consultant psychologists in Primary Care operate as part of a team, and although they would be consultants not only for the patient/consultee but also for the doctors themselves and other professionals at the health centre, they work on behalf of the doctor. In this regard, their self-presentation to the user is of the utmost importance. It would take approximately the following form, according to Rowan and Runyan (2005; Box 4).

An initial session with the patient/consultee might take

around 25-30 minutes, with the following missions: self-presentation according to the mentioned formula (1-2 minutes), moving from the problem indicated in the doctor’s referral to an assessment of the psychological aspects involved (5-10 minutes), assessment of the problem (10-15 minutes), moving toward intervention by providing a conceptualization of the problem focused on possible solutions (2-3 minutes), and intervention, providing as far as possible options for dealing with the problem (10-12 minutes). Subsequent meetings could last 5 to 25 minutes over several weeks, obviously depending on the case in question.

The basic skills of the psychological consultant would be as follows, in accordance with the views of various authors (Gatchel & Oordt, 2003; Robinson & James, 2005; Rowan & Runyan, 2005; Strosahl, 2005).

- 1) Procedures for the assessment of psychological problems or disorders must be rapid and focused on the current problem. The predominant model for explaining mental disorders in the health system is implicitly, and sometime explicitly, the psychiatric illness model. The basic assumption is that mental health disorders are distinct entities originating from imbalances of a biological nature. The natural consequence of this model, in the field of assessment, is that this type of activity is totally in consonance with the psychopathological diagnosis associated with a dominant nosology (CIE or DSM). From the perspective demanded here, it should be borne in mind that the most important predictors of psychological problems are not biological, but should rather be defined in contextual and psychological terms, as situations of stress or of grief, acquired habits, coping skills, false perception, thinking styles, and so on. Therefore, assessment should focus on the basic determinants of behaviour, according to an ABC model, which relates current behaviour to antecedents and consequences.
- 2) Intervention should be brief and based on the scientific evidence. The use of techniques focused on

BOX 3 GOALS OF BEHAVIOURAL CONSULTANCY
<ul style="list-style-type: none"> ✓ To promote the setting of reasonable goals ✓ To promote the ability to solve interpersonal problems ✓ To promote the ability for self-control ✓ To promote the development of coping strategies (Froján, 1999, p. 19)

solution of the problem should be favoured, with formats that reduce application time, such as group formats or homework exercises. With this in mind, it

**BOX 4
SOME PRINCIPLES OF
SOLUTION-CENTRED THERAPY**

Clients have strong points and intrinsic resources for helping themselves.
Nothing is totally negative.
You cannot change clients; only they can change themselves.
The solutions do not necessarily have to do with the problem.
(Lipchik, 2004, pp. 46-57)

**BOX 5
SELF-PRESENTATION OF THE PSYCHOLOGICAL CONSULTANT**

"Hello, my name is _____. Before we get going today, let me explain to you a bit about who I am and what I do here.

I'm a behavioural health consultant for the clinic and a psychologist by training. I work with the medical providers here in situations where good health care involves paying attention not only to physical health, but also to emotional and behavioural health, and how these things interact with each other. Whenever a provider is concerned about any of these things, they can call me in as a consultant. As a consultant, I help you and your provider better address things that are affecting your health or sense of wellbeing. To do this, I want to spend about 20 minutes with you to get a quick snap shot picture of what's going on in your life—what's working well and what's not working so well. Then, we'll take this information and come up with some recommendations that might help and that are doable for you.

The recommendations might be things you begin to do differently or they might include things we can do differently here at the clinic. Often they will involve some self-help materials. Additionally, we may decide it would help to have you come back to see me a couple of times if we think it would get some positive momentum going on specific skills. Sometimes, we decide that people might benefit from more intensive specialty services. If that were the case, I'd make that recommendation to your provider and help them arrange the referral.

After we're done today, I'll go over with your provider the recommendations we came up with so they can be incorporated in your overall health plan. Also, I'll write a note in your medical record so in case you see other providers they can follow up on the plan is going.

Finally, I want you to be aware that I have the same reporting requirements to ensure your and other's safety as other providers in this clinic.

Do you have any questions about this before we begin?" (Rowan & Runyan, 2005, p. 25).

- is not surprising that cognitive-behavioural techniques have some advantages for use in this context.
- 3) The psychological consultant must learn to make decisions based on extensive knowledge of risk and vulnerability factors associated with the patient/consultee's disorder or problem. As much individual data as possible should be obtained, always with the aim of maximum efficiency.
 - 4) Skills for bringing about motivation to change. Mastery of techniques such as those required in the motivational interview are especially necessary for dealing with patients whose main problem is a difficulty for changing certain behavioural habits (addictions such as smoking, alcohol or drugs; lack of physical exercise; inability to change diet; etc.).
 - 5) The consultant should be capable of working in the field of prevention. The principal goal of Primary Care is to increase the population's health level, and one way of achieving it is through prevention programmes, be they indicated, selective or general.
 - 6) A capacity for working as a member of a team and transmitting one's opinions and advice. Good communication with the rest of the Primary Care team is an essential condition for integration to function. Such communication should avoid psychological jargon and should be specific and clear. The complexity of the behaviour is no excuse for giving explanations or recommendations that are scarcely intelligible or impossible to follow. Consultants should be rapid and effective in their responses to demands, and avoid "going fishing" for psychological problems on their own initiative. It is not a case of creating a parallel psychological care service, but rather of assisting Primary Care in collaboration with doctors and other professionals.
 - 7) An adequate understanding of medical terminology, common illnesses and their treatments, and the effects of medication, is essential.

AVOIDING "PARKINSON'S LAW OF NEUROSIS"

The introduction of the psychological consultant implies a new role for the patient, as consultee, client and responsible agent, and less as a passive patient. The patient who sees a psychological consultant does so not under the assumption of having a mental disorder, but of needing psychological help to get out of a problem situation. This kind of help means that the patient/consultee must become actively involved in the

solution of the problem, as a so-called “active self-cleanser”. Costa and López’s empowerment model is clear in this sense, insofar as it involves giving people power to live; Frojan’s development of self-efficacy is on similar lines, while solution-centred therapy has as one of its principles that “only clients can change themselves”; and all insist on empowering patients/consultees through their own resources, re-orienting their efforts in a worthwhile direction.

The notion of responsibility is also implied here. It is a case of having the ability to respond to life’s challenges and problems, but also of taking charge of one’s life, in the sense of taking decisions and accepting consequences. Very often, psychological help –help of a highly valuable nature– may consist in simply clarifying the problems and resituating the consultee, no longer as a patient but as an agent. As in the motivational interview, the message could be as follows, *mutatis mutandis*:

“It depends on you what you want to do with this information. Nobody can decide for you, and nobody can change your way of drinking [and of living in general] if you don’t want to change. It depends on you, and if change happens, it will be you that makes it happen” (Miller & Rollnick, 1999, p. 58).

The fact that psychological help in Primary Care is necessarily brief may actually be a virtue, in the sense that people must learn that assistance has a limit, and once it has been given, that’s all there is. Otherwise, they may be being promised more than what is available, which may in turn increase both suffering and indolence. The interactive nature of psychological problems can be taken advantage of to interact with them throughout life, if the means are provided, so that a brief intervention can be both necessary and sufficient. If we agree with Goethe that the way people end up reflects the way we treat them, then the need due to limitations on resources can, as we say, become a virtue. Here once more, the available solution defines the problem.

This leads us on to another matter, which is the danger of excessive growth of psychological consultancy provision in Primary Care, leading sooner or later to collapse of the system, due not least to a kind of “Parkinson’s Law of Neurosis”, according to which neuroses would grow as the resources and availability for attending to them grow, a phenomenon which, indeed, is being capitalized upon by the pharmaceuticals industry. There is an open debate in this regard on proposals by the UK authorities for a “massive expansion” of

psychological therapy (Summerfield/Veale, 2008).

Avoiding the effects of such a law would mean a change in the role of patients to a more active and responsible one, as agents rather than patients; as consultees perhaps, but first and foremost as agents with the power to live. And this new role for patients need not be circumscribed to Primary Care (nor to Secondary Care); rather, it would extend beyond the clinic, with a cultural scope, in order to re-establish the concept of person on the basis of capacity for recovery, instead of on vulnerability, as has been the case over the last 40 years (Summerfield/Veale, 2008). This would also be a psychological task, not preventive in a medical sense, but rather educational in an anthropological sense.

THERE ARE COST-EFFECTIVE FORMS OF PSYCHOLOGICAL HELP WHICH PEOPLE PREFER

Although the role of psychological consultants in Primary Care includes, among other functions, consultancy for doctors and patients for the management of chronic conditions, somatization disorders and inexplicable medical symptoms, in addition to the promotion of healthy lifestyles, it is useful to continue highlighting their contribution in relation to anxiety and depression, as we have been doing up to now. In this regard, there are cost-effective procedures, which, moreover, are preferred by users.

There are a range of effective treatments for anxiety-related problems adapted or adaptable for application in Primary Care (Campbell, Grisham & Brown, 2005; Hakkaart-van Roijen et al., 2006). In general, these are brief procedures within the cognitive-behavioural tradition, consisting in an initial psycho-educational phase, where patients adopt a new way of thinking about their problems, and in a variety of activities, such as homework tasks (self-observation, writing about certain experiences), techniques for changing maladaptive thought and behaviour patterns or exposure to situations.

As regards depression, there are also a variety of effective psychological treatments appropriate for Primary Care (Wolf & Hopko, 2008). Indeed, it could be said that depression is one of the “favourites” for the use of psychological therapies. It is widely acknowledged that psychological therapy is the type most indicated for “mild” and “moderate” depressions, which make up the majority of them, and cover practically all those with which Primary Care is concerned. So-called “major depression” is that which would require medication as the

treatment of choice, according to the psychiatric handbooks, even though there are psychological treatments that are just as effective, even by the standards of medication, such as behavioural activation therapy (Pérez-Álvarez, 2007). Among the effective psychological interventions tried in Primary Care are brief forms of problem-solving therapy, interpersonal therapy and cognitive-behavioural therapy (Wolf & Hopko, 2008). It should be mentioned that this recent review by Wolf and Hopko from 2008, but submitted for publication in September 2006, makes no reference to a seminal work on behavioural activation therapy published at the end of 2006 (Pérez-Álvarez, 2007), in which it is shown that this therapy is as effective as medication (by the criteria of the latter) and even more effective than cognitive or cognitive-behavioural therapy, in patients with "major depression". The question is: what would this therapy not do with "mild" and "moderate" depressions in Primary Care? – bearing in mind that it is perfectly adaptable to brief applications.

Crucially, behavioural activation therapy embraces the logic of the therapies focused on solutions to problems with which Primary Care is concerned, on consisting basically in the self-reflexive unravelling characteristic of the depressive situation and in behavioural activation aimed at empowering people to use their own resources in a worthwhile direction for their life. Worthy of mention in this regard is the study by Sara González, Concepción Fernández et al. (2006), which shows precisely that empowerment, or the unlocking of personal resources, is as effective as cognitive-behavioural psychotherapy in the prevention of depression in Primary Care users; social support was in fact also effective at the end of the intervention, but not, like the other two factors, at the one-year follow-up. As these authors conclude, all the signs are that the promotion of coping strategies already available in people's repertoires would be the active component of cognitive-behavioural therapy. "That is," — say the authors— "the person would benefit from a therapeutic procedure in which they were stimulated to put into practice strategies already acquired but scarcely or poorly utilized, and in which they were shown how to use them in a more adaptive way in the appropriate contexts, where they would be maximally generalized and taken advantage of" (González, Fernández et al., 2006, p. 477). The importance of this study resides, in any case, in its showing that methodical empowerment (in relation to participants' own resources) over six 1-hour

sessions is effective in preventing depression in Primary Care users, who would otherwise be doomed to the customary medication and referral to the mental health sector (and who knows, perhaps condemned to an entire psychopathological career).

Mixed anxiety and depression disorder can also be treated with effective and efficient psychological procedures applicable in the Public Health System. A study by Enrique Echeburúa, Karmele Salaberría et al. (2000), in this case at a public mental health centre, shows that a cognitive-behavioural procedure is more effective than the customary pharmacological treatment, and that the combination of psychological procedure and medication is no better than the psychological procedure alone. The procedure was carried out in group format with 4-6 persons in 12 two-hour sessions once a week. The savings on medication involved and the group application format mean that this procedure is not only effective but also efficient, notwithstanding studies that show an even briefer version of its application. As the authors conclude: "Cognitive-behavioural therapy is the treatment of choice in this disorder" (Echeburúa et al., 2000, p. 532).

Different formats of the typical individual clinical applications are possible and welcome in Primary Care. These formats include relationships therapy (Leff et al., 2000), group therapy (Callaghan & Gregg, 2005; Echeburúa et al., 2000), therapy via other Primary Care professionals (Katon, Unutzer & Simon, 2004; Mynors-Wallis et al., 1997), telephone-assisted therapy (Tutty, Ludman & Simon, 2005), Internet-based treatments (de Graaf et al., 2008; McCrone et al., 2004; Warmerdan, van Straten & Cuijpers, 2007), self-therapy based on self-help manuals (Stan et al., 2008) and the organization of self-help groups (Bright, Beker & Neimeyer, 1999).

The provision of psychological help may appear more costly than medication, due above all to the greater amount of time it requires. Psychological aid can actually adjust to the time constraints of Primary Care, though there should not be an obsession with abbreviation: that which works takes time, and that which is worthwhile has its costs. Neither should we overlook the need to take advantage of the new culture that promotes Psychology in Primary Care in the sense of moving from a model of vulnerability (and of suffering and indolence) to one of capacity for recovery (of empowerment), with a view to people making more rational and reasonable use of services.

In any case, if we consider the direct cost of treatment (the professional's time plus medication or psychotherapy), the indirect cost of using other health service resources and the indirect cost to society (time off work, family breakdown, etc.), psychological help is not only no dearer, but is indeed more cost-effective. Thus, for example, the application of behavioural interventions reduces medical service use by as much as 62% over five years, and this reduction in costs is greater than the added costs of behavioural attention services (Byrd et al., 2005, p. 9). The calculation of the cost of a group psychological intervention for depression carried out in groups of 10 participants over 8 weeks with a total of 300 patients shows that it would cost in the region of 58 dollars per patient, whilst psychopharmacological treatment would cost 218 dollars, including, obviously, the cost of the professionals' visits in addition to the cost of the drugs themselves (Callaghan & Gregg, 2005). Relationships therapy emerged as significantly more effective in the long term in a study with two-year follow-up, as well as having a significantly lower drop-out rate (15%), in comparison to antidepressant medication, for which the drop-out rate was 56%, based on an equivalent cost for the two treatments (Leff et al., 2000). Problem-solving treatment carried out by nurses, despite initially incurring a higher cost than the standard treatment, succeeded in offsetting this thanks to the savings in time off work (Mynors-Wallis et al., 1997). Furthermore, an intervention consisting in self-applied cognitive therapy based on a manual and with professional supervision showed itself to be more effective and cost-effective than the standard treatment (Stant et al., 2008).

Although pharmacotherapy continues to be the treatment type of reference, as things are set up, the data support the claim that psychological interventions in Primary Care may constitute the most cost-effective alternative within the context of the new systems of health attention and care that are being proposed (Wolf & Hopko, 2008, p. 146). Users show a clear preference for psychological therapies, in accordance also with their psycho-social conceptions about the causes of the anxiety and depression from which they suffer (Prins, Verhaack, Bensing & van der Moer, 2008).

Given the availability of cost-effective and user-preferred psychological help, a health system worthy of the name should make the arrangements necessary to provide the Primary Care context with this option, as is indeed recommended by the clinical guidebooks of the

British and Dutch National Health Services. In particular, the National Institute of Health and Clinical Excellence (NICE), in its guidelines on anxiety and depression, recommends that patients be given the choice between psychological therapy, medication and bibliotherapeutic self-help based on cognitive-behavioural principles (NICE, 2007, Clinical Guideline 22; NICE, 2007, Clinical Guideline 23). Likewise, the Netherlands Institute of Mental Health and Addiction guidelines on anxiety and depression include the psychological options as the first line of intervention (Trimbos Instituut: <http://www.ggzrichtlijnen.nl/>).

In view of what we have seen here, it is clear that Psychology is both necessary and possible in Primary Care. It is unfortunate that this debate did not take place where it would have been most appropriate, which is during the drawing up of the Strategy for Mental Health in the National Health System. Let us hope that further opportunities arise in the future.

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