Retrieved from:
The European Journal of Psychoanalysis
Jun 24, 2024
https://www.journal-psychoanalysis.eu/articles/liaison-psychoanalysis-in-argentina/

Roberto P. Neuburger

Liaison-Psychoanalysis in Argentina

Summary:

The development of psychoanalytic Liaison “this side of the ocean” is presented. Two fundamental events set it in motion: the beginning of psychoanalytic practice in Argentina, and the creation of Psychopathology Departments at General Hospitals (the endeavor carried out by Mauricio Goldemberg). A description of the initial experience (by Juan J. Criscaut at the Policlínico Lanús follows, and, subsequently, that of Ferrari and Luchina at the Hospital Ferroviario)–together with a critical examination of the book issued by the latter. After the violent rupture and the decay of Public Hospitals as a result of the attack on Public Health carried out by the military coup, the ensuing developments are tracked reading through the published papers: on the one hand, the theoretic renewal that, by means of Lacan’s teaching, allows the development of a new psychoanalytic practice, and symptomatic oblivion of the former analytic work on the other. The difficult access to the texts does not contribute to a sound retrieval of analytic heritage, nor does it allow an extensive working through the Liaison field, which seems to start anew with each published article. New Journals gathering the experience at Public Hospitals may allow other expectations, becoming discussion forums with better stability perspectives.

I.

In Argentina, psychoanalysis had its beginnings within an essentially medical environment: the first Argentine psychoanalysts had all undergone medical training. Thus, it follows that “psychosomatic medicine”(1) would be not only a point of intersection, but also a way of making the new procedure known and justify its methods vis-à-vis the official Sciences. At the same time, it would also give rise to the temptation of assimilating its concepts to the Medical Order. Notwithstanding this state of affairs, as we look back to it, we may also find some unexpected features. The vicinity with a domain extraneous to the psychoanalytic institution allowed transcending the standardized rigidity of the IPA’s (International Psychoanalytic Association) current technique requirements. Indeed, most of the IPA membership associations were then subject to the same recommendations. But an extension of psychoanalysis, such as Liaison, always calls for unconventional moves, while the basic principles are kept.
In 1964, some well-known psychoanalysts of the Argentine Association lectured at the Society of Oncology, on Psychoanalysis and Cancer. A small book containing these lectures was issued. These pages are a good example of a tendency that would repeat itself across and along the volumes of the Argentine Journal of Psychoanalysis (Revista Argentina de Psicoanálisis). The introductory address by José Schavelzon is a tight accumulation of references displaying the incidence and weight of the psychological factor (i.e. psychogenesis) amidst the aetiology of cancer. José Bleger advances the integration of scientific levels (the mind, the body and the environment) aiming at an encyclopedic comprehensiveness. Isaac Luchina establishes a catalogue of the emotions at play within the doctor-patient relationship(2). But it’s the women analysts who were to play a different chord. Usually, a physician demands a Liaison-consultation when his knowledge is at stake. He is expected to be more acquainted with the margins of death, than we psychoanalysts are, as to us the Real does not usually manifest itself in such a crude way. Lily Bleger and

Marie Langer, the next lecturers in the booklet, are forced to proceed beyond their theoretical background, driven by the object they have to deal with(3).
Marie Langer finds her references in Ingmar Bergman's film Wild Strawberries. From the history of psychoanalysis, we know how much more effective it can be, at times, to explore the field of art, rather than to delve on theoretical excursions. The imaginary phantasmagoria encircling the figure of Death (as Langer says with her Kleinian language, infantile paranoid anxieties) can thus become mitigated by means of symbolic reference points. The same procedure is followed to track the family lineage and environmental network with the patients she mentions. Surprisingly, she is well able to keep a critical distance as to the possibilities of "psychologization"(4) and to consider singularity with care (the analyst must adapt himself to each particular case). And finally, she surprises us again with the full account of a case history, which closely resembles a liaison-consultation: a physician demands it, as his patient with cancer appears over-flooded by anxiety. But he stipulates one limiting condition for Marie Langer to work with: she shall not reveal the diagnosis. The analyst does not retreat, and overcomes these limitations with unconventional interventions, which certainly hit the goal. Thus, when she insists that her actions "aren't psychoanalysis" there's no reason to believe her…(5)

II.

The psychiatrist Mauricio Goldemberg was the first to establish a Department of Psychopathology within a General Hospital in Argentina (in the '50s). By now, this event has the overtones of a legend among us. There are, however, documents that tell us its scope and methodology. In these we find, indeed, references to past attempts or events. However, the segregation from the anachronistic madhouse–institution suffered by Goldemberg ("all's well that ends well")–was the origin of an actual break with the established order. And drives us to consider that the history of psychiatry in Argentina–if this "specialty" aims to have an ethical dimension–begins only with him.
Indeed, prior to his pioneering work we only find a pre-historic horror worthy of Foucault's History of Madness. In none of the "scientific papers" issued from madhouse personnel can we find positive references to Freud; any mention of psychoanalysis is only derogatory.
When Goldemberg says, The atmosphere of the old psychiatric hospitals continues to be desolate and pessimistic, even this seems euphemistic. And, in a frank contrast to anything written at that time, he resolutely mentions Freud's–and his followers'–genial discoveries. Even if time has duly shown the clefts of the "integrationist" conception, nobody can deny Goldemberg's foundational credit: having introduced and fostered psychoanalysis within the Public Hospital.
The paper Psychiatry in the General Hospital, by Valentín Barenblit, O. Fernández Mouján, V. Galli, H. Kesselman, A. Muller, A. Pérez, L. Ricón, C. Sluzki, G. Stein, describes the structure and operations of the different sections of the Department. Liaison-consultations are practiced from 1962 onwards, since demands from other, non-psychiatric Departments of the Hospital become an increasing concern. The general atmosphere of the paper remains traditionally medical–possibly, to keep up with the context of the Journal to which it was submitted–and only the formal conditions and proceedings are detailed, rather than the theoretical foundations. The latter must be read "between the lines".
The Consultation-function, by Valentín Barenblit (then Head of the Consultation Department), Juan J. Criscaut, L. Damigella, O. Davidovich, M. Fefer, S. Karol, I. McDonell, A. Schere and Fernando Ulloa, establishes a difference between

the psychological aspect as additional, or secondary to the medical condition that causes the patient to remain in the Hospital, from the so-called psychosomatic illness.

Likewise, the context of the environment that defines, produces or suffers the emotional impact of the illness is also considered. Subjectivity, as we see, is recognized in the margins of the only signs that the medical institution admits as valid, and that appear in connection with different signifiers, other than those pertaining to the psychosomatic phenomenon(6). The signifiers also appear to follow the guidelines of the institutional network on which transference is established.
As to the procedure, no demand of a liaison-consultation is privileged, regardless of its origin (we could call

this: an “ecumenical” perspective(7)):

…what level does the demand belong to? Anxieties may arise in the patient himself, or originate either in his relationship with the illness, or within the surrounding family, or even from the institution’s personnel

(As we see, the physician is not only mentioned indirectly: the reference appears at the end of the sentence).

In a lecture at the Faculty of Psychology (during the Seminar conducted by Fernando Ulloa), Juan J. Criscaut narrates the Liaison Department’s own “myth of its origins”(8). This includes characteristic nicknames, of anonymous genesis: “patrol”, the “police-domain” metaphor of a continually moving disposition; no fixed place within the Hospital, ever roaming; “external front” a term which indicates the presence of the domination drive, as the department members usually feel external to the medical Institution. And, finally, “the firemen of anxiety”, yet another metaphor of the expected soothing. An honest exposition of the Department proceedings cannot avoid the aesthetics of the Unbearable: suffering bodies, repulsive smells, moans, the infirmity of a collective ward, or the open, roofless corridors, anything far removed from the comfortable privacy of the traditional consultation-room.
In this paper, psychoanalysis as the founding frame of Liaison appears overtly for the first time, without any mixture with “other techniques”, even if these were quite common at the time. Correspondingly, the physician’s need to remain within his discursive position to be efficient is also presented. Indeed, the doctor must keep the body-mind dissociation if he desires to act as he is expected to; the lack of consistency of any “holistic” illusion becomes evident, regardless of its “good will”. Liaison is also described as an extension of the psychoanalytic frame or listening attitude: the consultant has no intention to “psychoanalyze” anybody, neither the patient nor his doctor. The demand of a consultation is “by procuration” (referring to a third party, i.e. the patient in his bed). In a few strictly selected cases, however, an exchange with the demanding physician may suffice to settle or solve the difficulty, and the consultant does not directly meet the patient. Balint is cited in the paper, whenever the “organizing” capacity of the doctor is mentioned regarding the patient’s illness; the signifier that the physician produces when he gives the illness a name. Thus, he also provides the patient with something to identify with. The elements of a Liaison-consultation are set within a network of mutual relationships, which Criscaut calls “consultative sequence”. A full description of the latter provides the structural framework on which the clinical experience will unfold. J.J.Criscaut follows it accurately, thus avoiding the usual post-Freudian pitfalls of the time his paper was written(9).

III.

The event of 1971 is undoubtedly the edition of the book by Héctor Ferrari, Isaac L. and Noemí Luchina, The psychological Liaison-Consultation in the Hospital, the first Argentinean volume entirely dedicated to the field of inquiry. The authors conducted their practice at the Hospital Ferroviario, Buenos Aires.
The Prologue by Mauricio Goldemberg, links this experience to the corresponding Department in the Lanús Hospital, carried out almost simultaneously. The text’s structure was to acquire a “classical” status, as a model for most papers issued afterwards, regardless of length or perspective: an Introduction (in the book, it stretches over the Prologue, the three following chapters and the conclusive Epilogue), and clinical vignettes (about 10 case histories are presented).
The stress is more on the “medical” domain, but this does not prevent psychoanalysis from finding a place. Likewise, “psychiatrization” is not attempted(10). The stress is not laid on psychoactive medicines; quite the opposite, their function as a hiding screen is put forward.
Setting the physician’s figure in the foreground allows the authors to elucidate the obstacles he must face. Besides, the institution is considered a substantial part of the description, as well as the doctor-patient relationship. The current psychoanalytic developments laid the stress on “technique”, often a “recipe”, with its corresponding do’s or don’ts. Likewise, the Kleinian “simultaneous translation” weighs sometimes on the negative side. Examples of this are the insistence of some expressions, e.g. the massive deposit of persecutory objects, possibly the expected finale of any “ballet” of object-relations, or the constant (ab)use–beyond any limit of significance–of the term psychotic. Or to pinpoint a surgical or diagnosis procedure as sadistic. As the authors say,

the organization of this field always follows some stereotyped guidelines, assuming more or less fixed resolution proceedings, these having their ground in the underlying ideologies;

however, this paragraph might stand for the whole text! (One understands, however, that the selected aspects describe extreme situations, i.e. the portrayal of dealing with some kind of excess).
A more Freudian procedure is the unveiling of identifications:

…the physician separates himself from the "other" he has established a determinate affective investment with. Thus, the "other" still remains as the "other". Else, he massively identifies with the "other", i.e. his affects mingle with the other's…

An interesting place is given to Arminda Aberastury's fertile concept of the illness-and-healing fantasy; this being, most probably, an adequate intuition of the fact that the subject offers, from the beginning, signifiers that show his, and the Other's, place in the transference at play with his physician, waiting for someone to recognize them.
Likewise, a description of two different discursive structures at play is also put forward, albeit rather intuitively:

Liaison-consultation, rather than establishing contact between two specialties, is a bridge between two disciplines, each of which has its own specific referential frame.

The temporal background is also different. But does attempting to make an auxiliary ego out of the Liaison-consultant not amount to filling the gap in the medical order with a Sufficiency?
The section devoted to the practice of Liaison-consultation (featuring ten full case histories) is, of course, the most vivid and exact. An account of Liaison in its intension and extension is given, showing how the authors have dealt with the interviewed physicians, with the institution, and with the patients.

Eight years later, the same group of authors added a further volume, Institutional Assistance, which can be considered a development of their practical sentence, to assist the assistants. The guidelines of the first book are dealt with more deeply, as are the aspects we do not share. The closeness to medical-psychiatric discourse continues to be a risk, and some self-sufficient psychologism also appears (e.g. when the authors seek to find a reparatory intention, or to put forward a vocational gratification). The beginnings of Lacanian studies in Argentina (that had already begun, possibly even before this second book was written) seems not to have been perceived (possibly on account of the well-known conflict within, and with the IPA(11)) except for a brief reference to a mirroring wish, which, even if elementary, proves to be quite an adequate explanation. Likewise, even if finding out the latent network of the demand is attempted, sometimes the accent is on the educational task to fulfill on the medical team, as if psychological knowledge could convert the Liaison-consultant into a Master, and the doctor were someone to "instruct"(12). Nevertheless, the thread is quickly found again, when an articulation point is unveiled in the transference, in order to produce the "necessary and small modification" described by Balint(13).
It might be discussed whether some chapters do belong to Liaison-psychoanalysis (e.g. a follow-up study of patients in a Psychopathology Department) or are better portrayed as its extensions (e.g. the section on supervision, which includes the presentation of a Liaison-consultant within a Rehabilitation Department).
The description of an "institutional typology" keeps its interest, with its references to communication theory and "anti-psychiatric" de-mystifying guidelines: "pseudo-mutual" and "mock-scientific" institutions are distinguished. The former stresses the accomplishment of normativeness over the patient's "needs", while the latter constitute an apotheosis of technology. That is to say, two variations of the Master discourse, two developments of the phantasm of total submission to the Signifier. Under the protection of the imaginary observation of behavior, the attempt of controlling all the situation's elements, in order to achieve a perfect, faultless functioning, which remains no less imaginary. Communication theory adds yet another, auxiliary ingredient: the possibility of an unhindered link between sender and receiver, devoid of any equivocal sense. The Imaginary Ideal knows neither impossibility nor impotence inherent to discourse, and the "integrationist" motto closes the point: a formulation that moulds and integrates different disciplines in a

unified convergence…
Some expressions of Argentinean Kleinism still await a critical revision that would allow their significance in analytic discourse. Thus, the insistence to reveal indiscriminate nuclei (an idea put forward by José Bleger) within institutional dysfunction could be understood as the submission to an omnipotent Other.
It is in the last chapter, however, that the clue reference clearly appears, as well as the main problem of whether the Argentine analytic heritage should be reinstated: the ideas of Enrique Pichon Rivière. In his situation analysis, this author attempts a dialectic bio-psycho-social integration. An assessment would exceed this paper's limits; it may suffice to say that the course of events and ideas would show a return to Freud as a firmer clinical orientation.

We may add some more examples of a similar approach, also issued almost at the same time by members of the "official" institution:

1) General aspects of Liaison-psychiatry, by Jorge Carpinacci, presents an attractive version of the original myth of an initial chaos, found by the consultant who begins his activity. He must avoid the temptation to settle the questions beforehand, with the veiling patchwork furnished by the psychiatric arsenal. Likewise, he should neither blindly run to tranquillize the excited, nor excite the depressed. He should rather work through this chaos with his conceptual tools.
For a time in which most of the papers looked for mimicry with "scientific language", the lyrical élan of this article is unfamiliar and original. The starting point of Liaison-proceedings is then described almost as the beginning of an initiatory journey:

…this is where Liaison work came to an end. The order in the ward had been reinstated: the previously excited dozed off, the depressed stilled his tears, the moribund did not deny the closeness of Death, but, shrouded in his loneliness, did not restrain from weaving timid plans for the future…
…During that period our objectives were obvious: everything, or almost, was clear as lightning. The brilliant, harboring radiance of the well known almost muffled our thought and senses…
…In order to avoid becoming blinded by the lights of routine, we artificially darkened the conventional categories of our professional knowledge; amidst the newly gained luminous obscurity, we began to perceive…

This optimism is quickly shattered by the intrusion of the institutional Monster, a new Hydra to besiege, an unequal, Herculean struggle. Lyricism is replaced by the monolithic, "ideological" source of the paper-dialectic logic-clearly representative of the current trends of the time. The romantic impulse overflows, the ideal is uttered, but the descriptive vicinity becomes blurred: the institutional places appear as positions within the struggle of the classes, and the enemy is, of course, rational bourgeois individualism, an ally of private property. Here the Liaison consultant must choose: either he becomes a supporter of the regime, or

…he acts as a member of the non-possessing class, as he lacks a stable place of his own, time or material to work on…

The humble practice of Liaison-consultation has thus acquired an unexpected, unsuspected, unheard-of social transcendence!

2) The Aspects of the Countertransference in Liaison-Psychiatry, by Pedro Boschan, draws a different picture, restricted with discipline to the psychoanalytic field. The language is Kleinian (the premium house specialty) but with full efficacy, as the scope is the Imaginary Register that acts as an obstacle to the consultant's actions. This is stated right at the beginning:

…A seldom-mentioned aspect is the effect elicited by the Liaison-consultation on the practitioners themselves, who are, after all, a part of the field of investigation…

In what follows, the identifications along with the resistances they produce, as well as the stereotypes, the isolation and even the dissolution of the consultant team are presented. A vivid clinical sense prevails, and extrapolations are avoided.

3) Liaison-consultation: between medicine and psychoanalysis, a possible mediation, by Mauricio Chevnik, is described by the author as an attempt to assess this frontier zone by means of Winnicott's concept of a transitional space. An interesting perspective, indeed; the article begins stating that Liaison-consultation

aims at constituting and sustaining a field of articulation and mediation between the patient and the environment in which the healing process should take place,

in order to accomplish this, the consultant should

…perform a supporting role, a kind of connective tissue… The constitution of this mediating apparatus amounts to establishing a frontier. It separates and unites at the same time; through its existence the territories keep their identity, while allowing exchange… This safeguards the transformation of any element that has not undergone symbolization and manifests itself in phenomena that hinder the healing process… The consultant's objectives are synthesis and integration…

The metaphor, however, is not developed. The attempt seems an idealized promise, rather than a fulfillment.(14)

"_____ _____ _____ &Mac185;_____, _____ ___ _____ ____ ___ &Mac185;_____ _____ _&Mac185;_ _____ &Mac185;_____ ____ ___ _____ _____ &Mac185;__ __ &Mac185;_____ __ __ &Mac185;_____ ___ _____"
_____, _____ 22 b-c
("you are eternal children, as you do not harbor any old concepts of ancient tradition, nor any teaching that ages as time goes by")
Plato, Timaios

IV.

After his exile, J.J.Criscaut returns to Argentina to continue his assessment of Liaison as A practice to think of from a psychoanalytic perspective. In his lecture at the Metropolitan Conference on Psychology, he describes again the successive stages of the procedure, examining the usual obstacles the practitioners met with, which frequently lead to desertions. At the end he proposes to establish a Liaison "nosography", and states that a single signifier sometimes condenses and summarizes a clinical situation. In A psychoanalytic practice within the medical field we find the reference to Lacan's writings as a new starting-point, a new articulation and assessment. A proposal of a Post-graduate Seminar on Liaison is written together with the new members of the Liaison Department of the Lanús Hospital, which in the meantime had been given new life.
In the papers describing this new team, a symptomatic "negative" feature cannot fail to strike our attention – and that was to be met with in many following Argentine articles: the cleft opened by the military coup of 1976. History seems to have been extracted, absorbed by an abyss, apparently without return. Even when Israelit, Amoedo, Demarchi, Fazzito, Polite, Guiñazú, Raiden start their Reflections on the practice of Liaison in the Hospital "Aráoz Alfaro" by naming the founders, the development of the Department until 1976 is never mentioned. Likewise, the severe blow that temporarily stopped its existence is omitted.
But the first clinical example in Liaison-psychoanalysis in the Institution that closely follows what the physician asks for (i.e. the manifest text), is an indication of the change in the type of questioning. New criteria to explore the institutional shortcomings display these in a clearer way. Bleger's concepts, regressive indiscrimination and syncretic deposit are re-examined; Maud Mannoni is also cited, with her idea of testing the power of words.
Furthermore, in The health professionals in the Hospital: from iatrogenic procedures to primary prevention

new phenomena appear, always present in the physicians' verbatim comments: the decline of the Public Hospital, the insufficiency of its resources, i.e. the effects of the anti-sanitary politics of the military government. This deterioration reaches a point unseen before.
Finally, two closely related papers by Israelit and Fazzito develop a classification of Types of institutional situations in the General Hospital, exploring unrecognized sectors that converge in the treatment of a patient, and sometimes create obstacles that become difficult to remove. Between adjustment and rejection is an attempt to localize subjectivity by means of two reference guidelines: Liaison-consultation as a misunderstanding inherent to medical discourse, and the possibility of working through the symptoms; a hasty or imprudent attitude may cause rejection from the physicians.

V.

In 1980 a spark is lit, followed by the publication of an ever-increasing series of papers on Liaison-consultation, parallel to the growing number of practicing psychoanalysts in the Psychopathology Departments. On the relationship between two discourses within the institutional environment, by Silvia Chiarvetti and Eduardo Gandolfo is a first Argentine consequence of Clavreul's analysis, which may be termed "paranoiac-critical"(15).
The difficulties, even the clashes with the institutional hierarchic-hegemonic milieu, require new elements for a working-through. At the same time, the assimilation of these to the medical, "de-subjectizing" encyclopedic knowledge should be avoided. The Balint group has also been submitted to conceptual revision, to judge after Raimbault's experience.
A follow-up of the ongoing flood of new articles becomes extremely difficult, disperse as they are. The following comments are thus necessarily anarchic:
In Psychoanalysis in the General Hospital – An analytic setting for Liaison-consultation, C. Schiavo, C. Braverman and C. Fantín, the clinical case history clearly shows how the analyst refuses to act as a "specialist". An in-patient is on the verge of being operated on account of her metrorrhagia, but has convulsions. These appear as a last resource to show the insufficiency of medical knowledge, which ignores desire while reducing it to a mere demand. Analytic working-through is required to reveal how neurotic sacrifice is a safeguard for jouissance:

…we understood that the physicians had supposed a demand in the patient (as she is supposed to be?) but obliterated her desire, when the body bleeds and convulses. They aimed at the patient's "well-being"…

Fortunately, the physicians admit their doubts, their own anxiety, and call for the analyst that is supposed to be able to recognize and handle it. The letter reaches its destination, and fulfils

…a constant re-setting of the roles' diagram, which produces new significations.

In psychoanalysis, language's equivocal is at the same time the focus of research and the research instrument. Thus, O. de la Motta, L. Prieto and M. Toyos, in The analyst's position in the General Hospital, describe the frequent passage from disposition–whenever the Hospital only admits the validity of the Master Discourse and the University Discourse–to (hysteric) in-disposition:

…institutional discontents: being excluded from the Hospital's great designs, to remain the garbage-can of the remainders, heaped in the corridor of the train of Medical Efficiency…

…as long as he doesn't toil his passage to the analytic position. Even if the credit the authors assign to Clavreul's ideas might be discussed (the equation Illness = patient – man is a conspicuous example) we could admit the successful interpretation of the demand as a result of a transference. The possibilities of subjectivity, when untimely recognized, are:

a) to be excluded;
b) it receives the status of a cause ("psychogenesis");

c) it becomes the object of moralistic rhetoric

The analytic alternative (in its distinctive otherness regarding the former) is to localize the phantasm, even in the reverse of the manifest contents: the patients go away can actually portray the physician's own "fading": the patients come, but sometimes we wish to leave!

R. Marín, C. Enghel, C. Virginillo and C. Pustilnik, in Liaison-consultation, or when the Master ceases to be identical to himself – discover that there is no such thing as Liaison-consultation–at least in the Spanish dictionary(16); to this negative finding, they add that there is neither a doctor-patient relationship, nor a relationship between Psychoanalysis and Medicine(17). Actually, if there is a place at all for an analyst in the (non) Liaison, it's the place of an inter-diction(18), a there is something unbearable in your body that does not belong to me, a statement that effects the physician and the analyst alike.
Closing our series, the paper by M. Colovini analyses this "a-topia" by means of modal categories: Between necessity and contingency, Liaison-consultation finds the appropriate words, when a physician says: I need you to see this patient… a demand that excludes any pre-conception or anticipatory preparation. Moreover, it requires a semblant de dupe(19), i.e. to appear as nothing else but a fool, overwhelmed by the impossible-unpredictable.

VI.

From its first number, which appeared in 1992, Psicoanálisis y el Hospital (Psychoanalysis and the Hospital) has granted a significant place to testimonies of Liaison-Psychoanalysis. The actuality of its practice and perspectives are thus easier to follow. With this event, the complex historic movement we have sketched finds its closing limit.

References:

Amoedo, S., Demarchi, G., Fazzito, A., Guiñazú, L., Izrailit, D. (1986) "Psicoanálisis en la institución desde la interconsulta", El Malentendido, 5, pp.15-18.

Barenblit, V., Criscaut, J.J., Damigella, L., Davidovich, O., Fefer, M., Karol, S., MacDonnell, I., Schere, A., Ulloa, F. (1966) "Integración de la Asistencia Psiquiátrica en los Servicios de un Hospital General: La función Consulta" (unpublished). X Conferencia de Salud Mental, FAP, Mar del Plata.

Boschan, P. (1981) "Aspectos contratransferenciales de la interconsulta psiquiátrica". Psicoanálisis (Revista de la Asociación Psicoanalítica de Buenos Aires), Vol. III, 1, pp. 253-265.

Carpinacci, J.A. (1975) "Consideraciones generales sobre la interconsulta psiquiátrica", Acta psiquiátrica y psicológica de América Latina, Vol. 21, pp. 64-70.

Chevnik, M. (1991) "La interconsulta médico-psicológica. Entre la medicina y el psicoanálisis, una mediación posible", in M. Béker (ed.) Lecturas de lo psicosomático (Buenos Aires, Editorial Lugar, p. 169-183).

Chiarvetti, S., Gandolfo, E. (1980) "Sobre la relación de dos discursos en un ámbito institucional". Revista Argentina de Psicología, Asociación de Psicólogos de Buenos Aires, Vol. X, 26, Marzo de 1980, pp. 115-124

Clavreul, J. (1978) L' ordre médical (Paris, Seuil)

Colovini, M. (1995) "Entre necesidad y contingencia: la interconsulta". II Congreso Rosarino de Psicología, Colegio de Psicólogos de la Pcia. de Santa Fe, Rosario.

Criscaut, J.J.:
– (1974) “Interconsulta Hospitalaria” (unpublished)
– 1983) “La Interconsulta: una práctica para seguir pensando desde el psicoanálisis”. II Congreso Metropolitano de Psicología, pp. 149-153
– (1985) “La Interconsulta” (unpublished)
– (1988) “La Interconsulta: una práctica psicoanalítica en el campo de la medicina” (unpublished)

de la Mota, O., Prieto, P., Toyos, M. (1994) “La posición del analista en el Hospital General: entre la disposición y la indisposición”, Tramas, Revista de Psicoanálisis, Año V, 6, pp. 14-23.

Ferrari, H., Luchina, I.L., Luchina, N.:
– (1971) La Interconsulta médico-psicológica en el marco hospitalario (Buenos Aires, Nueva Visión).
– (1979) Asistencia institucional. Nuevos desarrollos de la interconsulta médico-psicológica. (Buenos Aires, Nueva Visión).

Goldemberg, M. (1964) “La Psiquiatría en el Hospital General”, III Congreso Argentino de Psiquiatría, Embalse Río Tercero, Córdoba.

Goldemberg, M., Barenblit, V., Fernández Mouján, O., Galli, V., Kesselman, H.; Müller, A., Pérez, A., Ricón, L., Sluzki, C., Stein, G. (1966) “La Psiquiatría en el Hospital General”, La Semana Médica, Vol. LXXIII, 4015, 118, 1, pp. 80-102.

Izrailit, D. (1990) “Interconsulta a Salud Mental en la institución hospitalaria: entre la adaptación y el repudio” (unpublished).

Izrailit, D., Fazzito, A.:
– (1986) “Los profesionales de salud en el hospital: de la iatrogenia a la prevención primaria” (unpublished) APSA, Córdoba.
– (1988/9) “Hacia una tipificación de situaciones institucionales en un hospital general desde un Equipo de Interconsulta” (unpublished).

Marín, R., Enghel, C., Virginillo, C., Pustilnik, C. (1986) “La interconsulta a Psiquiatría o cuando el Amo deja de ser idéntico a sí mismo”, Reunión Lacanoamericana de Montevideo, pp. 167-171.
Polite, V., Amoedo, S., Demarchi, G., Fazzito, A., Guiñazú, L., Izraelit,

D., Raiden, S. (1985) “Algunas reflexiones acerca de la práctica de interconsulta en el Hospital ‘Aráoz Alfaro'” (unpublished) Jornadas “Psicoanálisis en la Institución Hospitalaria”, Hospital “Mi Pueblo”, Florencio Varela.

Schavelzon, J., Luchina, I., Bleger, J., Bleger, L., Langer, M. (1965) Psicología y Cáncer (Buenos Aires, Hormé).

Schiavo, C., Braverman, C., Fantín, J.C. (1992) “El psicoanálisis en el hospital general. Un dispositivo analítico para la interconsulta”, in “Neurosis, Psicosis, Perversión”, III Jornadas Municipales de Salud Mental, Hospital Dr. Teodoro Álvarez (Buenos Aires Lugar editorial), pp.152-158.

Uzorskis, B. (1980) “La asistencia clínica psicológica de pacientes internados en terapia intensiva”, Revista Argentina de Psicología, 28, pp.163-191.

Notes:

1) The “psychosomatic phenomenon” belongs to a particular field, which does not overlap strictly with that of Liaison-Psychoanalyis. Thus, we have not considered its description here. The outlook to interpret these initial psychoanalytic efforts finds its roots clearly in Groddeck’s writings. The “somatic manifestation” and the “psychic expression” are analogical aspects of a “demiurgic” Unconscious.

2) All these topics have been revised and criticized by the Lacanian School. As Lacanian psychoanalysis deals with synchronic structures rather than diachronic stages, the question of psychogenesis becomes meaningless. The stress laid on the lack, negativity, paradoxical and topologic models (including Gödel’s theorem), any proposed wholeness or completeness being synonymous with an Imaginary illusion. Finally, the post-Freudian accent on emotions is rejected, favoring the incidence of the signifier.

3) The theoretical outlook of the Argentine Psychoanalytic Association at that time was Kleinian; the local developments laid heavy stress on the handling of “countertransference”.

4) Almost a synonym for “psychogenesis”: to assume a psychological cause for a given fact or event.

5) Within the IPA (International Psychoanalytic Association) the formal conditions of an analysis were then (and, to a certain extent, still are) rigidly–or, let’s say, bureaucratically–established beforehand, independently of the particular situation or case (weekly rate and duration of sessions–or of the analysis itself). Anything else, not complying with these regulations, should not be termed psychoanalysis. Thus, we find excellent analytic work disavowed as analysis by the analysts themselves, such as Winnicott (Therapeutic Consultations in Child Psychiatry) and others, submitting to the Institution they belong to and its rules, rather than to analytic truth.
Needless to say, Lacan also criticized this outlook; he attempted to produce a very different formulization, the so called passe. This means that only retrospectively can it be established whether or not there have been any analytic effects.

6) Lacan has only fleetingly considered the “psychosomatic phenomenon” (PSP), but his followers have attempted to draw some conclusions from these scarce indications. The series where signifiers converge in a “holophrase” (which must be distinguished from the Freudian “condensation”) include psychoses, mental retardation and the PSP.

7) See Neuburger, R.(2002), On the Relation between Psychoanalysis and Medical Practice. Journal for the Psychoanalysis of Culture and Society, Vol. VII. 2, p. 344-351

8) Anyone familiar with the role of historic references in psychoanalysis, and of the merging of symbolic reference marks that punctuate the Imaginary development in a myth (both as attempts to set a limit to a determinate Real) can easily grasp the meaning of this expression.

9) Lacan has carefully criticised post-Freudian theories and their misconceptions regarding Freud’s discoveries. While the Lacanian outlook is certainly no absolute safety-certificate against any possible mistakes, a solid clinical perspective may also safeguard a post-Freudian approach, much more than his own theory would seem to allow.

10) The tendency to ascribe a specific biologic cause to any “disorder”, which is automatically followed by the assumption that a definite psychoactive drug shall revert this to a supposed previously harmonic “order”.

11) Lacan was expelled from the International Psychoanalytic Association; members of this institution–such as the authors of the book we are reviewing–avoided citing him or his followers (or even reading their writings…).

12) “Psychological knowledge”, like that which is taught or learned in a University, is of no use to the psychoanalyst, who should trust (and let himself be surprised by) the Unconscious and dispense with any established “truths”. As put forward before (Neuburger, 2002), the scope of psychoanalytical Liaison-

consultation is by no means to make a pupil out of the physician, to whom we have nothing whatsoever to “teach”.

13) Balint’s expression to describe the desired increase of the physician’s ability to listen to the patient, i.e. to develop sensitivity to his subjective position.

14) Perhaps this is a structural characteristic of Winnicottian descriptions, which sometimes do not go beyond an appraisal of motherhood. Melanie Klein noticed it, when she asked her loyal–and future Crown Princess–Hanna Segal, to review critically one of Winnicott’s books. Segal ends her comments complaining that, while the author speaks against sentimentalism and patronizing, she had found his text both sentimental and patronizing.

15) Read a year before at the APBA (Buenos Aires Association of Psychology) Conference, and issued by Revista Argentina de Psicología (Argentine Journal of Psychology). This Journal had already published another article on Liaison Psychoanalysis, by Luchina and Aragonés, in 1974. Furthermore, in No. 28 we find the paper by Benjamín Uzorskis, Clinical-Psychological Assistance of in-patients within an Intensive Care Unit

16) The usual Spanish expression for Liaison-consultation, Interconsulta, does not, in fact, appear in the Royal Spanish Academy’s Dictionary.

17) These negative statements are modeled after Lacan’s aphorism, il n’y a pas de rapport sexuel (there is no sexual relationship) and extensively commented in Clavreul (1979)

18) This word play, and many others, are usual in Lacan’s writings and Seminars.

19) “Semblance of a fool”. The expression is elucidated in Lacan’s Seminars Les non-dupes errent and Un discours qui ne serait pas du semblant.