DRUŽBENO ORGANIZIRANA ZDRAVSTVENA PSIHOLOGIJA: O VLOGI PSIHOLOGIJE V SKRBI ZA ZDRAVJE NA PRAGU 21. STOLETJA

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Eksplozivni tempo razvoja zadnjih 800 človeških generacij je dodobra izčrpal prilagoditvene potenciale človeka. Zato smo ljudje močno razvili stroke, ki imajo opraviti z zdravjem ali boleznijo - ne le medicino, ampak tudi druge stroke, med katerimi ima danes pomembno mesto psihologija. Psihologija je gotovo nastajala kot kulturno - adaptacijski odgovor človeka na vse bolj prisotne oblike neprilagojenosti. Kljub temu kaže, da - bolj se razmere zaostrujejo in hujše so (psiho)socialne krize, bolj psihologijo kot stroko mečejo v koš s tistimi, ki bodo šli med odpadke. Stroški skrbi za zdravje so vse višji. Viri financiranja so bolj ali manj omejeni, zato sredstva ožijo na območje (somatske) medicine, ne glede na to, da je tudi telesno obolenje signal neprilagojenosti in odgovor na stisko, zelo pogosto pa celo rezultat neprilagojenega vedenja. Naraščajoči interes za psihološka vprašanja ter vse večje mase tistih, ki hočejo vpisati študij psihologije, potrjujejo to stisko in protislovje.

Elias (1939) je na osnovi sociogenetične analize predvidel gibanje za zdravje, ki smo mu priča danes. To je seglo tudi v psihologijo in omogočilo razvoj "zdravstvene psihologije" (health psychology) kot to danes imenujemo. Ta stroka močno vpliva na zavedanje o telesnem in psihičnem zdravju in pozitivno vpliva na izbiro zravega načina življenja.

Skrb za zdravje na eni strani povzroča pritisk na zdravstvo, ki samo zase ne more dati rešitev za probleme, ki močno presegajo okvire medicine. Ljudje, ki skrbijo za ustreznost zdravstvenih programov zato bolj in bolj pritiskajo na sklade in proračunska sredstva. Krog neprilagojenih reakcij na neprilagojenost se tako zapira, strokovnjaki za mentalno zdravje pa, v boju za obstoj, tekmujejo med seboj in se fragmentirajo na posamezne stroke.

V razvitih deželah so zaznali zahtevo po novih oblikah kooperacije vseh disciplin, pomembnih za izvajanje programov mentalnega zdravja. Gradijo novi konsenz med plačniki - družbo, zavarovalniškimi sistemi, vladnimi institucijami ter različnimi

strokami, ne glede na to ali te funkcionirajo v družbenih zavodih ali so organizirane privatno.

Psihologija je bila dolgo preokupirana z boleznijo. Prvi korak naprej je naredila v preventivo, kar pa ne zadostuje več. Uveljavlja se model hkratne skrbi za stopnjo psihohigienskega varstva in pomoči, kakor tudi skrbi za kvaliteto življenja.

Mednarodna organizacija psihologov si prizadeva, da bi nacionalna profesionalna združenja uporabila strokovna znanja ter sodelovala pri oblikovanju nacionalnih programov in politike varovanja zdravja. Takšen pristop bo moral biti psihosocialen oziroma vedenjski (uporabiti "vedenjske znanosti" za promocijo kvalitete življenja).

Tudi pri na videz strogo telesnih obolenjih, še posebno kroničnih, kot diabetes, hipertenzija, obolenja srca in podobno, hitro opazimo, da so le-te tesno povezane z rizičnim, nezdravim vedenjem ter neustreznimi življenjskimi navadami. Ne le, da so te bolezni danes vodilne pri vzrokih smrti, ampak je tudi terapija močno odvisna od zmožnosti spremembe v vedenju. Na drugi strani pa alienacija in anomija pospešujeta negativne spremembe v vedenju in sprožata socialno patologijo, ki zastruplja cele sisteme - od družine do državnih tvorb in mednacionalnih odnosov.

Del zdravstvenih delavcev (medicina v ožjem pomenu besede) si prizadeva lajšati simptome, vplivati na zdravstveni status tako, da posameznikom pomaga z zdravili. Toda dogaja se da medikacija (in uporaba psihofarmakov) postaja družbeni problem, ne samo zaradi strmo naraščajočih stroškov ampak tudi zaradi brezkončnosti potrebe po zdravilih.

Avtor prispevka se zavzema za razvoj družbene skrbi za zdravstveno psihologijo kot znanost in kot strokovno disciplino znotraj osnovnega zdravstvenega varstva. Ta naj bi si kot osnovne cilje postavila:

1. Ozaveščanje o psihosocialnih aspektih zdravja in človeškega razvoja - v krogih, ki odločajo o vladni politiki, zdravstveni politiki in splošno med ljudmi;
2. Sodelovanje pri usposabljanju strokovnjakov s področja ocenjevanja dejavnikov ter intervencij glede psihosocialnih in vedenjskih faktorjev zdravja in bolezni;
3. argumenti naj bi podpirala odločitve o financiranju strokovnih institucij in programov na nivoju osnovnega zdravstva. Pri tem so uporabne tako imenovane "cost/benefit" analize, katerih rezultati so že na voljo, metodologija pa uporabna tudi na drugih področjih;
4. Potreben je tudi dober pretok informacij o novih preventivnih tehnologijah ter oblikah promocije zdravega življenja;
5. Potrebno je prodreti v nacionalne raziskovalne programe, ki odpirajo pogled na epidemiologijo in vodijo do nove tehnologije skrbi za zdravje.

V sloveniji smo relativno zgodaj odprli področje zdravstvene psihologije. Že leta 1969 smo pričeli odpirati "centre za psihohigieno" v zdravstvenih domovih in istega leta pričeli razvijati preventivne programe, ki so bili povsem primerljivi tistim v "razvitem svetu". Leta 1972 je potreba po psihohigienskih službah v zdravstvenih domovih bila celo uzakonjena.

Dandanes, ko je ekonomska situacija kritična, je to povzročilo razslojevanje tudi med strokami, ki skrbijo za mentalno zdravje pri nas. Smo na pragu odločitev ali bomo programe iz okvira zdravstvene psihologije sploh še financirali. Psiholog je že izgubil formalni status zdravstvenega delavca; zdravstvene organizacije se spreminjajo v zdravniške organizacije; Zdravstveni vestnik je postal Zdravniški vestnik... Psihologija kot stroka si - da bi preživela - utira pot z izgradnjo lastne zakonodaje o psihološki dejavnosti.

V teh prizadevanjih smo tudi povabili prof. dr. Ren_ja Diekstra, psihologa in visokega funkcionarja Svetovne zdravstvene organizacije. Temo, ki jo kot referat

predstavljamo v reviji Psihološka obzorja, je v predavanju, ki ga je Društvo psihologov Slovenije namenilo široki javnosti, predstavil konec marca 1993.

Naj opozorim na avtorjevo hkratno začudenje in razumevanje ob dejstvu, da nam ni uspelo privabiti politikov, tvorcev zdravstvene politike, pa tudi ne zagotoviti ustrezne odmevnosti medijev. Meni, da pač še ne zmoremo stopnje demokracije, ko bi se zaradi ignoriranja takšnih dogodkov pod vplivom javnosti zamajal tudi kakšen ministrski stolček. Na drugi strani pa politiki težijo k temu, da mislijo kratkoročno in rešujejo akutne probleme, namesto da bi načrtovali razvoj, ki bi večino problemov zaobšel.

Bolj je bil začuden nad medlim odzivom zavarovalniških sistemov. Ti so namreč po naravi življenjsko zainteresirani za smotrno investiranje v zdravje - če so res partnerji v prizadevanju za zdravje in ne le podaljšana zdravstvena (beri zdravniška) institucija.

Pri nas smo morda res še prisiljeni gasiti požare namesto da bi skrbeli za varnost. Bojim pa se, da bo pogumni gasilec v akciji medijsko vedno bolj privlačen kakor neopazni planer požarne varnosti.

PUBLIC HEALTH PSYCHOLOGY: ON THE ROLE OF PSYCHOLOGY IN HEALTH CARE IN THE 21ST CENTURY

René F. W. Diekstra

INTRODUCTION

If the last 50.000 years of man's existence were divided into lifetimes of approximately 62 years each, there have been about 800 such lifetimes. Of these 800, fully 650 were spent in caves. Only during the last 70 lifetimes it has been possible to communicate effectively from one lifetime to another - as writing made it possible to do. Only during the last six lifetimes did masses of men ever see a printed word. Only during the last four it has been possible to measure time with any precision. Only in the last two has anyone anywhere used on electric motor. Only in the last two lifetimes has anyone anywhere established behavioral sciences as an academic discipline and as an approach for social and individual action. And the overwhelming majority of all material goods, techniques and all behavioral knowledge and skills we use in daily life today have been developed within the present, the 800th, lifetime.

This 800th lifetime makes a sharp break with all past human experience bacause during this lifetime the scope and scale of change have extended enormously, but what is at least as important, we have radically altered its pace. We have in our time released a totally new social force - a stream of consciousness so accelerated that it influences our sense of time, revolutionizes the tempo of daily life and affects the very way we "feel" the world around us. We no longer "feel" life as men did in the past. And this is the ultimate difference, the distinction that separates the truly contemporary ties from all others. For this acceleration lies behind the impermanence - the transience - that penetrates and tinctures our consciousness, radically affecting the way we relate to other people, to things, to the entire universe of ideas, art and values. (Toffler, 1970, p. 14-17).

The astronomical acceleration of change in such a short period of time poses a serious challenge if not a threat, to the adaptive capacities of the homo sapiens. The human specics evolved under conditions which were very different from those which the great majority of people experience today. As Boyden (1987, p. 21) points out, there is one very important, if rather selfevident, consequence of the process of evolution that has special implications for human beings living in the 800th lifetime. Natural selection produces animal populations in which the majority of individuals are well suited in their genetic characteristics to the set of conditions prevailing in the ecological niche in which the evolutionary forces are acting.

Those forces are selecting for optimum performance in the given environment. It follows, therefore, that if the conditions of life suddenly deviate from those of the natural habitat, then it is likely that the individual will be less suited, in either psychological or behavioural characteristics, to the changed conditions. Consequently, signs of maladjustment, psychological, behavioural or emotional, may become evident.

It is my assumption that the emergence and booming development in the second half of the 799 and 800th lifetime of the disciplines and professions that deal with health and disease, psychology included, are cultural adaptive responses to contemporary forms of maladjustment.

A simple example of such a cultural adaptive response is provided by the sequence of events that followed the introduction of refined carbonbydrates, such as in bread, into the diet of human populations.

This change was culturally induced, being the consequence of technological developments and economic conditions. The formation of cavities in the teeth is perhaps the most widely accepted consequence of this dietary change and society has responded to this particular painful disorder by establishing a profession of men and women who are trained in the skill of filling these dental cavities. Of course there are also other cultural adaptive responses to this maladjustment such as brushing teeth, but those more simple, less hightech responses usually follow, not precede the establishment of a specialist discipline.

THE BOILING FROG PRINCIPLE

The fact that such cultural adaptive responses require that a state of maladjustment be recognized to exist, may seem so obvious as to be hardly, worth discussing. However, the full significance of this requirement is often not appreciated. If the onset of a relatively undramatic, chronic form of maladjustment is gradual during the course of an individual's lifetime, or if its increasing prevalence in a community oc-

curs slowly over several generations, the possibility exists that it might pass unnoticed, and that its manifestations might come to be regarded by the individual, or by society, as "normal" (which, of course, it would be under the new conditions) and that it might not be recognized as a departure from the optimal state.

We are dealing here with the socalled boiling frog principle, which may be of special importance in the case of behavioural and mental disorders. If a frog is placed in hot water, it will make frantic efforts to escape. It is said, however, that if the animal is placed into cold water, which is then slowly heated, it may after passing through various stages of maladjustment, be boiled to death without so much as a struggle.

Let me give two examples of how this principle applies to humans. For many years textbooks of medicine described progressively increasing blood pressure after the age of twenty to be a normal characteristic of human beings. We now know that under certain cultural conditions no such an increase in blood pressure with advancing age is found and that the relationship therefore is a consequence of highly industrialized, urbane contexts and the ways individuals behave in them.

Textbooks of psychiatry and psychology for decades described depressive disorders and suicidal tendencies as occuring very rarely in childhood and early and middle adolescence. We know now that severe depressive symptoms (point and year prevalence) are more frequently found in adolescents than in their parents, that suicidal ideation and parasuicide is frequently seen among adolescents and that both phenomena - depressive disturbances and suicidal tendencies - have steadily been rising over the last three decades in developed countries (Diekstra, 1989) and are now also rising in the urbanized areas of the developing world as well.

Many of the conditions or problems that psychology, as far as it is applied to the field of health and disease, is concerned with, obey the boiling frog principle. That is, these conditions or problems are often the outcome of or associated with slowly introduced environmental, social or cultural changes that produce changes in behaviour, in mood and in patterns of interpersonal ralationships in people and only become recognized as health problems once they affect the social and personal functioning of substantial or conspicuous parts of populations or communities.

As a consequence the role or contribution of psychology to health and health is predominantly a reactive or corrective one.

Already in 1939 Otto Rank in an essay entitled Psychology and Social Change pointed this out in his statement: "Every system of psychology is just as much an expression of the existing social order and the type representing it as it is an interpretation of the same" (1941, p. 27).

PSYCHOLOGY'S FAILURE TO MONITOR THE FUTURE

Psychology then is not much a visionary discipline, nor are psychologists generally visionaries or makers of the future who through the knowledge and skills or technologies they produce are shaping the future or at least a part of it.

In actual fact, one could say that they rather follow the future. It is therefore not easy, if not impossible, for psychology to state on its own behalf anything definite about its future roles in society. That would only be possible by drawing heavily on other sciences, such as demography, physics, biomedics, informatics, sociology, political sciences and the like. The complexity of such an undertaking has apparently frightened off most psychologists because there is next to nothing in the current literature nor in academia that can be considered as a serious scientific effort to project

the future of psychology both as a science as well as a practice or as a social phenomenon and a social function. Quite a few universities in the United States and Europe teach courses in the history of psychology or even have chairs dedicated specially to this topic. Traveling around the globe quite in recent years in my work for the World Health Organization within the framework of its programme on Psychosocial and Behavioral Aspects of Health and development, I however nowhere came across courses, let alone chairs that deal with The Future of Psychology.

This lack of effort to monitor and shape the future might well explain the paradoxical phenomenon that at the same time as psychology is producing more and more important knowledge and skills for society and its members, the threats towards psychology and psychologists in many countries are increasing. For example, reimbursement for psychological services in several countries has become more difficult than ever, research budgets are under severe pressure and in the battles with other health professions, especially psychiatry, psychologists presently seem to be on the losing side. And all the while public interest in psychological knowledge and skills is growing and masses of students keep coming to colleges and universities to graduate in psychology.

With public support and interest on the rise and support at the political and policy level declining many psychologists ask themselves what they are doing wrong?

The number and variety of coping responses they show is stunning and produces chaos.

Some say it's high time to shift away from psychotherapy to psychodiagnostics, other state that short-term treatment is the magic bullet, again others claim that primary health care psychology is the "find", while there are also psychologists who believe that the most promising future for psychology lies within the industrial world and therefore develop such new expertises like employee assistance programmes, human recourses management or outplacement. This diaspora takes place while the field is still internally divided up in different and often opposing schools. The lack of order and direction is so conspicuous that of course most politicians and public administrators would not want to make long-term formal arrangements or "deals" with this milling crowd. Some policy makers even believe that the best solution is a sort of deportation. An example of that is Turkey where there are a great many psychologists unemployed and the Directorate of Mental Health of the Ministery of Health is thinking of "sending" them to remote rural areas of the country to set up or work in primary health care centers. An excellent idea if not for the fact that almost none of these psychologists is adequately trained and prepared and perhaps even motivated for such work. Turkey, however, is no exception in this respect because in other countries where psychologists have digged themselves the trench of primary health care psychology, training programmes vailured towards this kind of work usually do not exist, neither in Universities nor outside.

When I come to think of the ways, the often absurd or irresponsible ways, in which many psychologists deal with their present plight, I am reminded of the absurd response by one of two young villagers who decided one day to go on hunting wild ducks. They tried from early in the morning till late in the afternoon with catching any game however. Disencouraged they sat down on the stump of a tree. Then the one quite philosophically said to his partner: "John, I think there is something we are not doing right", to which John replied: "I think you are right, may be we should throw the dog higher up". What is wrong in our field, in my opinion, is that we have neglected all too long to monitor the future of our science and profession. The time has come for an international initiative on monitoring the future of psychology and

psychologists way up into the 21st century, using the best data and insights available and supported by all the relevant international and national associations. Like the Organization for Economic Cooperation and Development (OECD) this initiative, taking the form of a forum or institute should every one or two years issue both diagnostic and prognostic reports on member countries regarding their state and prospects of psychological development to be used by the associations for reference and guidance in their policies and activities.

In the remainder of my presentation I will describe the main aspects of what is my personal and of course very incomplete blueprint for psychology and for the role of psychologists in the 21st century.

DETERMINATS OF PSYCHOLOGY'S FUTURE

But before doing that let me first go back one lifetime, to the end of the 799th, to the year 1939 to be exact, in which a now renowned sociologist Norbert Elias on the base of a very careful (sociogenetic) analysis predicted the wave of "healthism" that we are now witnessing and that has also profoundly touched upon contemporary psychology, such as in the emergence of what we now call "health psychology".

In that year Elias published a monumental work under the title the Process of Civilization. In it he explains among other things the intimate relationship between societal structure on the one hand and the sorts of anxieties people suffer from on the other hand.

When societies in which as a result of a strong increase in standard of living and greater protection against physical harm by outside forces, such as by war with other nations and groups, people will and do not have to worry any longer about external threats to their physical well-being or integrity, their anxieties will begin to focus around internal threats to their physical well-being. Consequently, people will become increasingly body - or health - conscious and a general cultural attitude that could be termed "healthism" would rapidly develop. If Elias, writing this 60 years ago, would have foreseen the "peace sweep" that presently goes all over the world, he would as far as psychology is concerned certainly have foresaid the development of a "health psychology", first to appear in that part of the world that seems the most secure, the Northern-American continent and then gradually affecting other parts of the world to the degree that they become secure, such as Western Europe.

Whether one agrees with Elias' predictive analysis or not, it is hard to disagree with the bottomline of his approach that in order to be able to make guesses about the shape of the future of a discipline such as psychology, it is essential to hypothesize about 1) the shape of societies to come and related to that about 2) the nature and trends in the development of problems with which psychology and psychologists have to deal. In the context of psychology's role in the health area we should add a third aspect yet, that is 3) changes in agents that will implement health programmes.

I will not dwell long upon the first determinant of the future of psychology, that is the shape of societies to come this having been addressed by many more competent authors in recent years (e.g. Toffler, 1970, Boyden, 1987), but limit myself just to mention a few changes that are likely to have major consequences for psychological development, functioning and disorder, such as the changing position of women, the growing number of disabled people in communities and the continuing trend of postponing adulthood, which is observable in more and more countries.

THE NATURE OF THE PROBLEMS TO BE TACKLED

The second determinant of the shape that psychology and psychologists in the next century will take is the nature of the problems that must be tackled, and here we are talking about the mental, psychosocial and neurological disorders of the future and the factors influencing their development such as the low or decreasing value given to mental life and functioning; the dehumanization of medicine/health care and overall development.

Let me elaborate on this somewhat more. If health care improves, 2certain disorders such as mental retardation and epilepsy will decrease in numbers and as a problem with which mental health agencies have to deal. Stroke and its neuropsychological consequences will diminish in importance if the current promise of hypertension control programs holds. Neuroses are likely to become less visible, drowned in vague somatoform complaints managed by the general practitioner (or the patient himself) or demedicalized.

Shizophrenia has already changed its picture. To an extent this change may be due to treatment or to social and economic change, yet a true change in the nature of the disorder cannot be excluded either. Depressive disorders remain a puzzle: although there are good reasons to predict an increase in their numbers, it is also likely that heir treatment will be further simplified and improved so that the duration of the disease - and thus the prevalence and public health concern - will decrease. Whether this will also be true for the young waits to be seen (Diekstra, 1989).

Furthermore, there are various forms of psychological problems related to, caused by, or associated with physical ailments, chronic disease, prolonged pain, and impairment. The successes of medicine increase the numbers of people who survive with such diseases or conditions for a long time and who require intensive and prolonged psychological support.

Although dealing with mental, psychosocial, and neurological problems looms large as a task, other tasks are incomparable more formidable. Mental health and functioning are held in low esteem by most people in most countries of the world. Pleasure, esteem by others, beautiful bodies, and earthly possessions are all given a higher value. In comparison with these and many other values, ranging from patriotism to sexual potency, mental life occupies an abominably low rank.

As a consequence, programs and plans made by individuals, communities, and whole societies provide too little for either developing or maintaining the capacity to think, feel and be social.

Unless mental health surges upward in the hierarchy of values, most of the efforts of mental health professions will be ephemeral. Mental health professionals cannot act alone in this area; but they must seek the help of others. Teachers, media, political bodies, and many more must be converted and mobilized. The value attached to mental life must become the moving spirit, the force to move programs forward, the energy which, at present, mental activities have to borrow from other sources such as the wish to attain acceptability in society, to succeed in school, to be admitted into civil service, or to obtain a driver's license.

THE HUMANIZATION OF HEALTH CARE

In spite of the high and constantly growing cost of medical care, the population's satisfaction with treatment and services received is decreasing. Nor are personnel in

health services satisfied with their roles and professional work. There is a continuous escape of doctors, and others from clinical work toward laboratories, lucrative "office" forms of medicine, jobs in education, and part-time occupations.

The complaints of staff usually center on the fragmentation of their role in relation to the patient; other reported reasons for dissatisfaction invoke conditions of work but probably reflect the basic lack of the feeling of purpose, of being useful.

Dehumanization of medicine has a pernicious counterpart in the medicalization of life problems. Issues that should be approached by broad social measures are declared medical and dumped onto the overstrained health service system. The health care sector cannot and does not do anything about them because the origin of such problems and their solutions lie outside health care, but neither does anyone else tackle the job. Occasionally, people with such problems are shunted into the treatment or examination services, not infrequently leading to true, iatrogenic health problems.

Thinking about people who matter in implementing (mental) health programs is somewhat depressing. Trends today seem to augur for programs of tomorrow. Community leaders and politicians are still by and large prejudiced against mental or psychological problems. They are often unaware of the size of the problem, of possibilities for prevention and treatment, and of the gain that the community could derive from strong mental health programs. They are firemen fighting the embarrassing fires of juvenile delinquency, heroin dependence among children of the best endowed and most powerful members of the community, alcohol-related traffic accidents, and street violence. A more comprehensive approach that could have multiple effects is still unacceptable and rejected in spite of the fact that its cost would not be higher than the paroxysmal efforts of dealing with a particular problem by financial and technical overkill.

Nor is the general population becoming more caring, friendlier, and less prejudiced toward mental health programs. Stigma is expressed less frequently in words but just as often as before in deeds. The disintegration of the family and reliance on communal services does not help this situation either; it makes the continuing prejudice against mental health problems a challenge worthy of priority attention.

In the mental health proffessions, there are equally ominous trends. Governmental mental health experts have little connection with the academic groups; psychiatrists fight psychologists who are making a major entry into the treatment territory; nursing professions are in competition with psychiatrists, psychologists, and social workers; psychiatric social workers claim their right to make program decisions.

The list of interprofessional tensions in the field of health is long and the battle fierce, without sign that it will abate soon.

THE SEARCH FOR SOLUTIONS

What cures for the ailments described are available and how desirable are they? Sartorius (1987) lists a number of "thought-shapers" for future developments in the mental health field such as the necessity for a true multisectorial approach to health and disease. Indeed, coordinating mechanisms bringing together social welfare, health education, judiciary, and other allied sectors are already coming into existance in a number of countries and lend new credibility to programs; not only do they have to come into existence at national, but also at provincial and district levels. But there are still strong resistances and territorial squabbles that prevent their

establishment; there are also traditions in psychology still isolating it from public life and medicine; there are feelings of incompetence by psychologists faced with public health issues, often compensated for by a striving for domination in groups convened to draft outlines of future programs. The redefinition of the scope for mental health programs and multisectorial action in their implementation is, however, inevitable for economic as well as ideological reasons. If psychologists refuse to accept a leadership role in bringing about this change, they will end up in an even less enviable position than they are today in many countries. Such a leadership role means the establishment of strategies to promote the increase of value attached to mental health and functioning; it means an intensive input of psychological knowledge and skills into general health care and development programs; it implies an advocacy of rehumanization of both medicine and economic growth; it comprises a better and continuing translation of knowledge into a form that can be offered for broad application to different social sectors; finally it requires a standing offer to bring together and cooperate with the different disciplines relevant to mental health programs.

New consensus among the main contributors to the cost of such programs has to emerge between communities, insurance, industry, government, and private sources. The arrangements will be different from country to country; what is uniform at present across countries is that there is much dissatisfaction with current arrangements and little collaboration in efforts to improve them.

Sartorius (1987) also stresses the importance of replacing the description of roles of members of professions by the definition of mental health tasks, regardless of who will do them, has already had revolutionary effects on service organizations, in the best programs of third-world countries. The present castelike system in which each profession may do some and not other tasks is wasteful and often harmful: it results in the continuous generation of new disciplines born out of desperation over tasks at the limit of disciplines. It emphasizes the lonely existence of mental health professions and the isolation of the mentally ill.

Furthermore, a major overhaul of training on topics related to mental health is needed now, with regular revision in the years to come. There are new themes that have emerged and make such change urgent. They include the need to harmonize training of various social agents -- doctors, teachers, lawyers, administrators, and others -- in matters concerning mental health; the need to ensure that the training of health personnel in general fosters positive attitudes to mental or psychological problems; the need to ensure that the humane requierements of health care remain foremost in the minds of future graduates; and the need to contribute, through training, efforts to maintain (or place) human well-being in the center of overall development efforts.

There are many issues of burning urgency concerning the care for those who are ill and the rehabilitation of those impaired. A number of models have been put forward recently, for example, by developments in Italy, the United States, Japan, China, and two elements common to those models and to debates about them seem to have the power to extend into the next century.

The first element concerns the need to reallocate much of the responsibility for health to the people themselves.

Psychology has for too long had an ill-concealed craving to take on the total responsibility for prevention and treatment of mental problems. This craving can be satisfied, but the results for the patient are less than satisfactory. People can and should participate maintaining their health, in surviving their disease, and in living with their own and other people's impairments.

The second element concerns the ideal model of care. It is now clear that the development of such a model, valid for all settings, is impossible at our current stage of knowledge. Instead, consensus has emerged on principles that may be helpful in living with the possible. There should be equal emphasis on quality of care and quality of life of those who are being treated: diversity, in congruence with cultural and socioeconomic norms; flexibility and responsiveness to new opportunities; and precedence of humanism and common sense over rigid ordering of steps in service development and overadherence to theory.

TOWARD PUBLIC HEALTH PSYCHOLOGY

Righting the psychology of the twentieth century is the best remedy for a better twenty-first century psychology.

One thing that should be rightedd is the relative lack of leadership and initiatives provided by psychologists in the development and implementation of international and national programmes aiming at the promotion of the application of behavioural science knowledge and skills in health care and health promotion and the treatment and prevention of disease and disability. It is my personal conviction that national associations of psychologists should develop national policies directed towards this aim with linkages to relevant national programmes or policies in other disciplines and sectors of their societies. International organization of psychologists should see it as one of their most important tasks to provide encouragement to national associations in this endeavour that should result in psychology becoming firmly rooted in the public health field both as a science, a practice and proliferator of knowledge and approaches for public health policy making at all levels. But, one may ask is the rationale for a Public Health Psychology?

THE NEED FOR A PUBLIC HEALTH PSYCHOLOGY

There are millions of people around the world who seek medical care for complaints or disorders that are caused or aggravated by their own behaviour or the behaviour of others. There are millions more whose behaviour interferes with or is tragically untouched by the care they receive. There may be germs or viruses involved, and lesions, fevers and pathogenic tissue changes. But one of the most important causes of their problems is nothing that a pathologist could see under a microscope and nothing that a doctor could change with a pill. In order to see it, to understand it and to influence it another approach is called for. That approach is the psychosocial or the behavioural one.

Studies in industrialized countries indicate that 30 - 50% of all patients who consult health care agents exhibit no ascertainable organ pathology, or complain of discomfort and dysfunctioning disproportionate to their physical problems. In developing countries such patients make up between 15 - 30% of those coming to the attention of health care personnel, therewith constituting the largest single complaint category in primary health care.

Individuals who are suffering from chronic diseases such as diabetes, respiratory diseases, hypertension, ischaemic heart disease, cancer and sexually-transmitted diseases often have contracted such illnesses as a result of careless, dangerous or unhealthy behaviour. Bad eating habits, abuse of alcohol and tobacco, refusal to ad-

here to hygiene and safety prescriptions and lack of skills in coping with life stresses are among the most salient of such behaviours. It has also been found that such individuals have stress-related problems and emotional difficulties arising from their diseases and impaired functioning. These in return may keep them from following doctor's orders or health advice from other sources.

Behaviour-related chronic and disabling diseases are now the leading causes of death in the industrialized world, and they are rapidly gaining significance in the developing world, especially in the urbanized areas. But there is also a growing recognition of the role that behaviour plays the spread and control of parasitic and infectious diseases, that for centuries have been and still are the most frequent cause of death and disability in most developing countries.

Schistosomiasis, for example, represents a constant threat to as many as 600 million people. It has been established that modification of the behaviour of people urinating and defeacating in water that is also used for swimming, fishing, farming, washing and bathing, is crucial for the control or elimination of the disease.

It is not only through its causative role in the development, course and outcome of diseases, that behaviour rakes its toll. It is often a direct cause of physical and mental disability and malfunctioning. Each year an estimated 400 million persons are injured by accidents (often involving the use of alcohol or other psychoactive substances) or by intentional violent behaviour by themselves or others, even from their own families, serious enough to require medical attention. Recent data show that road traffic accidents are becoming as important a cause of death in developing countries as they are already in developed countries. The same appears to be the case with selfinflicted or suicidal deaths. In contrast to the past the highest suicide rates are nowadays found not in countries in the developed, but in the developing world.

Such changes in patterns of morbidity and mortality are related to the fact that in many countries in the developing world people are subject to rapid social changes, resulting from economic development, industrialization and urbanization. Because of the effect these developments have on structure of communities and family functioning, they can often no longer cope by using their traditional ways of behaving and of solving problems. Erosion of traditional support systems and loss of social cohesion, often aggravated by migration and uprooting, throw many adults into a state of alienation and anomie. They become vulnerable to the lure of alcoholism and drug abuse, or may develop such adverse emotional states as brutalization, apathy, depression or other mental health problems. There is a concomitant increase in developmental and behavioural problems in children and adolescents as well as in loneliness and accompanying emotional and health problems in the elderly.

In addition to such pervasive social forces and problems, there are many other adverse situations of life events in which individual or small group behaviour can strongly influence the risk of loss of well-being and of mental and physical disorders. Family breakdown, among other things evident in increasing rates of divorce and separation in both more and less developed countries, can lead to a weakening of ties between generations and interferes with the upbringing and well-being of children.

The negative effects do not stop at children: adult morbidity and mortality from all kinds of causes is sharply increased following separation, divorce or bereavement. There is ample evidence that the effect of such conditions on health and well-being to a considerable part depends on coping reactions, social network and the ability to elicit support from that network by the persons involved.

Health workers through their behaviour in several ways also can have a profound influence on the health status of the people. First, inability to recognize and deal appropriately with symptoms that are the expressions of psychosocial distress or health-risking behaviour patterns, often lead to overuse of psychotropic and other drugs, to unnecessary and sometimes harmful medical-diagnostic examinations and treatments including unnecessary surgery and therewith to iatrogenic disorders and disability. The resulting burden of human suffering and economic costs is considerable.

Next, the functioning of health care services is related to the health status, in particular the mental health status, of health care workers themselves. Many of them, especially on the primary elevel and in isolated rural areas, work in settings that are associated with high levels of stress, an overload of work and limited resources. If they themselves are not adequately trained in human relationships, helper-patient communication skills and stress management skills, after a longer or shorter period of time, they may exhibit symptoms of emotional exhaustion, the end of which might be the "burn-out" syndrome. Burn-out describes a range of responses to increased emotional demands, such as emotional detachment, cynicism, an unwillingness to admit having emotional needs, fatigue and feelings of helplessness. It is presumably one of the most important factors of the high turnover rate among health care workers on the primary level and so a continuous threat to quality of care.

As WHO's Director-General stated in his address to the United Nations General Assembly on October 27, 1988, many of the world's major health problems and premature deaths are preventable through changes in human behaviour and at low costs. Although much more workd has to be done, the available body of know-how and technology is impressive, but it has to be transformed into effective action at the individual, family and community level.

PUBLIC HEALTH PSYCHOLOGY: GENERAL AIMS

Against this background, Public Health Psychology both as a science and a professional discipline should seek:

Increased awareness of psychosocial aspects and behavioural aspects of health and human development by regional and local governments, health policy makers, health care workers and the general public.

Establishment of training recommendations for health care workers on assessment and interventions with regard to psychosocial and behavioural factors of ill-health and disease.

Establishment of recommendations for legislation/regulation and financing of psychosocial and behavioural intervention services and programmes on the primary health care level based on adequate cost/benefit analysis methodology for assessing the quality of care and economic implications of such efforts.

Collection and dissemination of up-to-date information on effective psychosocial and behavioural technology for prevention of disease and disability and the promotion of health and development.

Establishment and coordination of national research programms on psychosocial and behavioural technology for intervention and prevention programmes on health and development.

Review of assessment methods for quality of life and development of interantional guidelines for appropriate use of such methods in health policy and health care, particularly with regard to the chronically ill, the elderly and displaced persons.

PUBLIC HEALTH PSYCHOLOGY: COURSES OF ACTION

In order for a Public Health Psychology to develop and contribute optimally to health and health care, it will be necessary to identify those issues or areas where it can play its role par excellence, both by using and applying available behavioural science knowledge and techniques/skills and by further developing and evaluating such techniques and by disseminating them. Against the background of what has been said above, five central areas or courses of action present themselves.

1. THE PROBLEM: The behavioural origins of ill health and disease

At least one fourth to possibly one half of all patients seen at the primary health care level are presenting complaints for which no organic pathology can be ascertained or which are in excess to the underlying physical disorder. Primary health care services are designed and run by professionals who have inadequate training or even no training at all in psychosocial and behavioural diagnostic methods and treatment approaches. As a result, the primary health care system is increasingly criticized for its lack of relevance to patients' needs, its use of unnecessary and often harmful biomedical procedures and the concomitant burden it puts on local, regional and national health budgets.

By ignoring the psychosocial and behavioural factors of many physical complaints and disorders, primary health care workers fail to inform and educate patients, their families and communities about the role they themselves can play in regaining and maintaining health.

Course of action will therefore be to:

* Form national task forces of social and behavioural scientists and practitioners, to identity and field test psychosocial and behavioural methods suitable for: (a) diagnosis and treatmentby primary care professionals of behaviour-related health problems; and (b) self-diagnosis and self-treatment by patients and their families.
* Publish guidelines for training primary health care workers in psychosocial and behavioural diagnostic and treatment methods.
* Establish multicentre network of research projects concerning the effects of psychosocial and behavioural technology on quality of care, patient participation and cost-benefit at the primary health care level.
* Collect, evaluate and disseminate behavioural and social science knowledge and skills related to health care and health promotion, to governments, health policy makers, health care workers and the population at large.

2. THE PROBLEM: The relationship between health care and quality of life

The overall goal of all public health and medical care programmes is to improve the quality of life of people. Sometimes improved quality of life is reflected at the community level by reducting prventable mortality, sometimes by reducing the occurrence of disease or injury, and sometimes by minimizing discomfort and maximizing effective daily functioning, despite the presence of diseases that are not curable or disabilities that cannot be completely removed. In all cases, the goal of health services is not the abstract reduction of "statistics", but tangible improvement in the quality with which people in the community live their lives.

The quality of life and the level of well-being in chronically ill and disabled persons should be judged by three categories of criteria, sometimes referred to as the three F's:

* Feelings or symptoms- the person's own appraisal of freedom from symptoms of physical pain or emotional and interpersonal distress, and the presence of positive self-regard and sense of well-being;
* Functions or abilities- the observable capacity to do things "normally", such as physical movement, self-care activities, interpersonal interactions, cognitive function, and fullfillment of social roles appropriate to one's age and circumstances, such as having a job;
* Future or prognosis- an acceptable probability that good feelings and good functions will continue for a reasonable future period.

Patients suffering from chronic illnesses have available to them a number of medical and surgical treatments, that may be effective with regard to control of pathogenic tissue changes or of pathological functioning of organs and metabolism, but not necessarily contribute to the quality of their lives. Some may not even enhance survival, while at the same time deteriorating quality of life in general.

Failure to take quality of life considerations into account in medical health care, causes many people to show impaired physical, social and personal functioning that is disproportionate to the severity of their physical illness or disability.

Decisions that health care policy makers and health care workers make with regard to the availability and the use of biomedical therapies should therefore be based on data relating to overall patient satisfaction and should account for the optimal psychosocial conditions under which such therapies be used.

Specifically, the course of action will be to:

* Establish guidelines for the use of existing quality of life assessment instruments.
* Develop new measures of quality of life for use by local health care workers.
* Produce publications for health care policy makers, health care workers and the public on the importance of quality of life considerations in health care decisions.
* Identify and review existing programmes for enhancing quality of life and stimulate the development of new programmes, especially for those most at risk.
* Review social and health policies with regard to whether they facilitate the emergence and functioning of community self-help organizations in this area and estanblish recommendations for the government to adapt policies wherever indicated.

3. THE PROBLEM: Early acquisition of health-sustaining behaviours

Health problems and diseases can often only be effectively treated, prevented or controlled if related behaviour patterns are unlearned and replaced by other, health-sustaining behaviours. This proves to be a costly, time-consuming process, usually with limited success, particularly in the case of longstanding behavioural habits. Research shows that health risk behaviours manifested early tend to persist into later life. Conversely, longitudinal studies have shown that early health-sustaining behaviour is a strong predictor of later healthful behaviour. Altogether, interventions focusing on the prevention of any form of health risk behaviour at an early stage of development, such as childhood and (early) adolescence, are most desirable. Even the tragic burden to many societies of substance abuse, delinquency, aggressive acts and suicide already visible in many young people, can be effectively tackled by large scale community participative preventive intervention programmes.

The course of action therefore will be to:

* Identify successful methods for community-based preventive intervention with regard to an array health risk or self damaging behaviour and make the information available to the country.

* Establish a network of research projects in community based programmes on early acquisition of health-sustaining behaviours.
* Establish national recommendations for legislation and policy in health and social services in order to promote community based health promotion programmes for the young.

4. THE PROBLEM: Psychosocial and Mental Health Consequences of Emergency and Disaster situations

It has been common in the health field to focus primarily on the physical health consequences of emergency situations, such as refugee movements resulting from war or famine, or disasters such as earth quakes, floods and nuclear plant fall outs. The psychosocial and mental stresses and strains on individuals, families and communities in such situations are often so severe that breakdowns in adaptive functions occur resulting in emotional and behavioural problems and mental illness. They may contribute directly to the development or deterioration of physical illness or may have an indirect effect by altering relevant behaviour patterns, including exposure to infection, nutrition and rest.

Psychosocial and mental health problems often outlive the length of the emergency or disaster situations and can for many years interfere with the well-functioning of individuals and communities. Post-traumatic stress disorders are a poignant example of a mental health consequence of such situations, that might disrupt health and well-being of individuals and whole communities for one generation or more, if not timely recognized and adequately dealt with.

International and national emergency preparedness and relief organizations presently are insufficient aware and inadequately equipped to deal with the psychosocial and mental health aftermath of emergency and disaster situations. The same holds true for health care services of countries of temporary stay, resettlement or repatriation of refugees.

The course of action therefore will be to:

* Assemble, review and disseminate information on psychosocial and mental health aspects of emergency and disaster situation.
* Produce guidelines for identification, management and prevention of psychosocial and mental health problems in refugees and victims of disaster.
* Develop and evaluate training material for health care workers and community workers on psychosocial and mental health aspects of emergency and disaster situations.
* Establish recommendations for government polices in order to promote coordination of general health, mental health and social services in the event of emergency and disaster ituations.
* Encourage a network of centres and organizations for coordination of research and standardization of training of relief workers wih regard to psychosocial and mental health aspects.

5. THE PROBLEM: The Health of Health Care Workers

Job-related stress can have serious consequences for both individuals, the organizations in which they work as well as the people they serve. Chronic stress and burn-out plays a major role in the poor delivery of health services to people in need of them. They wait longer to receive less Attention and less care. Besides contributing to absenteeism and high job turnover, burn-out also correlates with other damaging indexes of human stress, such as substance abuse, marital conflict, mental disorder and suicide.

Assessment and management of job stress in the healt care system should be aimed at the prevention of debilitating stress conditions and should not only be targeted at the individual health care worker. It should also involve training of health administrators and team leaders in human skills and awareness of factors contributing to job satisfaction, individual initiative and the prevention of emotional, interpersonal and mental health problems in health care workers.

The course of action specifically will be to:

* Develop and evaluate methods for the assessment and management of job stress in the various categories of health care workersin all the regions.
* Disseminate up to date information on successful training programmes on the management or prevention of health profession related job stress.
* Establish national recommendations for policy in health and social services in order to promote the use of adequate stress management training.
* Establish a network of research and service projects in stress management comprising all categories of health care professions.

DISCUSSION

Although the programme outline provided for a Public Health Psychology is simply a tentative one and might well take on a different format and context depending on national and regional characteristics and needs, it heavily draw upon the programme for Health for All by the year 2000 of the World Health Organization as endorsed by its 166 member states.

Therefore, it presumably reflect, though in varying degree, priority areas as they exist in the public health field in many countries.

Colleagues are welcome to translate and adapt the text of the programme to their national situation. The author would highly appreciate to receive copies of such adaptations in order to be able in due time to publish a review of existing national programmes that might further international exchange and cooperation.

REFERENCES

Boyden, S. Western Civilation in Biological Perspective. Oxford: Clarendon Press, 1987.

Diekstra, R. F. W. Suicide and attempted suicide: an international perspective. Acta Psychiat. Scand., 1989.

Elias, N. Das Prozess der Civilization. (Ned. vertaling) Spectrum, Utrecht, 1978.

Rank, N. Beyond Psychology. New York: Dover Publications, 1958.

Sartorius, N. Mental Health Policies and Programs for the Twenty-first Century: a personal view. Integr. Psychiatry, 1987, 5, 151-158.

Toffler, A. Future Shock, Bantam Books, 1970.