European Journal of Mental Health, Volume 1 (2006) 1–2, 1–21
DOI: 10.1556/EJMH.1.2006.1–2.1

INTRODUCTION

Human services professionals make great efforts in their own fields to preserve or restore the individual's mental health. Their endeavours, however, often remain isolated, for the elements that would connect the individual to the social level are missing. As a result, the psychologist's therapeutic work or the teacher's educational activities frequently function only in isolation; clinical assistance is confined to the patient or, worse, to the sick part of the body, while the spiritual counsellor is concerned with nothing but the salvation of the individual's soul. All of this does not merge into common activity; it does not form a social environment in which different approaches could mutually enrich each other, reduce harmful factors and promote mental health. Self-destructively, society often defies influences that could improve mental health. Sometimes it resists changes; sometimes it sacrifices human values in the name of competitiveness or under pressure from the *zeitgeist*.

We advocate a social model of mental health and are convinced that mental health promotion must not be limited to the protection and improvement of the individual's mental health, but must be extended to include the community, and through the cooperation of all human services it must contribute to the emergence of a mentally healthy society. We therefore interpret mental health promotion to include every effort and all manner of individual and communal endeavour to realise principles and ideals of mental health at a social level. This means approach and attitude, praxis and theory, fields of activity and institutional systems alike.

Experts generally agree that the concept of mental health includes more than an absence of mental illness. The latter, limited and limiting, notion may be called negative mental health. It refers to the extent to which mental problems are present in the form of symptoms and disturbances in the individual's life and is often used as a syno-

1788-4934 / $ 20.00

nym for mental ill-health. It is an equilibrium maintained by the interaction of numerous biological, psychological, cultural and spiritual factors, but social conditions and structures also influence it. Positive mental health, by contrast, can be viewed as an independent value or resource that includes coping elements as well as efforts to prevent somatic and psychic illnesses and disorders when one is facing mentally harmful experiences. Positive mental health is therefore not simply a state but a goal and aspiration which is primarily directed at furthering prosocial values, improving the quality of life, and encouraging life affirming behaviour whereby it fosters moral values and reduces harmful, self-destructive and asocial manifestations and patterns, and consequently lowers indicators of negative mental health. We thus take positive and negative mental health not to be the opposite poles of a single continuum but two different analytical dimensions in the interpretation of healthy personality.

Dictatorships rightly perceive both autonomous individuals and free associations of such individuals as their natural enemies. They suppress all activities that might cultivate independent and community-oriented character. That is why the decades after World War II were inimical to psychotherapy, self-awareness and religious expression in East Central Europe but favoured, instead, a 'pedagogical mass production' of uniform and docile personalities. In a sustained attempt to extend control over all spheres of life, the state stifled the self-organising mechanisms of civil society. Team work and group activities were most strongly discriminated against: youth groups, personality development groups and communities were powerfully discouraged outside a narrowly sanctioned circle.

Citizens of state socialist systems shared similar situations. They were hindered in forming organised groups within their own countries, and they were even less able to establish free contacts with colleagues from other nations for the purposes of professional exchange across political borders. Since printing was strictly controlled by the state, even modest experiences could not be freely shared. When the Soviet system collapsed in 1989, the most deeply felt need was the first to surface, and isolation from the West had to be addressed first. It is understandable, yet regrettable, that questions of cooperation between East Central European countries again receded into the background, and little is yet known of the treasures that have emerged in that region during the post-Communist period.

East Central Europeans must therefore strive to find each other and come closer together, but certainly not at the price of the hard-won contacts between the two halves of an all too long divided continent. On the one hand, our common history, the many similarities in our past pave the way for cooperation both rationally and emotionally; on the other, we all share a vision of a truly common European future, hopes and goals that unite us. Between past and future, our situation, our problems and experiences are similar but not identical. They can mutually complement and enrich each other and contribute to the achievement of our common goals, the reduction of harmful factors and the promotion of mental health. For mutual and deep understanding, however, we must develop a common language in which we can share our experiences and reflect

on them together. This journal seeks to contribute to that effort in order to serve, through the emergent dialogue, a colourful and many-faceted reality which consists not so much of education, social work, health care, religion, mass media, political activity and legislation as of individuals, families, communities and societies.

Budapest, 1 July 2006

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