

TEODÓRA TOMCSÁNYI, ROGER CSÁKY-PALLAVICINI, GÁBOR ITTZÉS,
GÁBOR SEMSEY* & PÉTER TÖRÖK

HEALTH PROMOTION STRATEGY AND PRIMARY PREVENTION PROGRAM AT SEMMELWEIS UNIVERSITY

(Received: 31 July 2006; accepted: 2 October 2006)

In contemporary societies, health is widely recognised as the most valuable personal asset. It has undergone significant reconceptualisation in recent decades, of which the *Ottawa Charter for Health Promotion* (1986) is a major document, advocating empowerment and community mental health thinking. Such concepts have fallen on fertile ground in East Central Europe, where a veritable community mental health promotion movement has sprung up, soon developing institutional means of disseminating the novel views. A discussion of the East Central European scene is introduced by an overview of the emergence and key elements of community mental health thinking and of the possible levels of corresponding intervention. An examination is offered of the deforming effects of dictatorship on community mental health, using the related notions of salutogenesis and Sense of Coherence to deepen the analysis. An exemplary graduate program was developed and established in Hungary even before the *Ottawa Charter* stated its directive on training. It is designed not so much to convey specialised knowledge as to impart a set of skills and competencies through which helping professionals are better equipped to practice their primary vocation and promote the mental health of the wider community. The program's goals, contents, structure and specific features are described in detail, emphasising knowledge of self and society, multidisciplinary, a holistic approach and society building.

Keywords: added knowledge, community mental health promotion, East Central Europe, graduate training program, Hungary, mental hygiene movement, multidisciplinary, primary prevention, salutogenesis, Sense of Coherence (SOC)

* Corresponding author: Gábor Semsey, Institute of Mental Health, Semmelweis University, Üllői út 22, H-1085 Budapest, Hungary; semsey@mental.usn.hu.

Strategien der Gesundheitsförderung und der Primärprävention an der Semmelweis-Universität: In modernen Gesellschaften gilt Gesundheit vielfach als das wertvollste persönliche Kapital. In den vergangenen Jahrzehnten kam es diesbezüglich wiederholt zum grundsätzlichen Umdenken. Das wichtigste Dokument dieses Prozesses ist die Ottawa Charta zur Gesundheitsförderung (1986), die „ein höheres Maß an Selbstbestimmung über die Gesundheit“ von größeren oder kleineren Gemeinschaften (*empowerment*) befürwortet und die Bedeutung des Schutzes der umfassenden seelischen Gesundheit (*mental health*) von Gemeinschaften betont. In Mittel- und Osteuropa, wo eine regelrechte Bewegung für eine Förderung der umfassenden seelischen Gesundheit der Gesellschaft ihren Ursprung hatte, die die neue Denkweise bald auch mit Hilfe von Institutionen verbreitete, fielen solche Konzepte auf fruchtbaren Boden. Die Diskussion über die mittel- und osteuropäische Szene wird mit einer Übersichtsarbeit eröffnet, die die Entstehung und die wichtigsten Elemente der umfassenden seelischen Gesundheit (*mental health*) einer Gemeinschaft sowie die möglichen Ebenen einer wechselseitigen Interaktion beschreibt. Eine Untersuchung über die deformierenden Auswirkungen der Diktatur auf die seelische Gesundheit von Gemeinschaften wird analysiert, dabei werden zum besseren Verständnis die entsprechenden Konzepte der Gesundheitsentstehung (*Salutogenese*) und des Kohärenzgefühls verwendet. Ein Modell-Studiengang wurde in Ungarn bereits vor der diesbezüglichen Empfehlung der Ottawa Charta entwickelt und eingeführt. Dieses Aufbaustudium dient weniger der Vermittlung von speziellen Wissensinhalten als vielmehr der Vermittlung von Fertigkeiten und Kompetenzen, mit deren Hilfe Mitarbeiter in ihren ursprünglichen helfenden Berufen der umfassenden Gesundheitsförderung, also der Mentalhygiene, einer breiten Zielgruppe dienen können. Die Ziele der Ausbildung – Selbstkenntnis wie auch Kenntnis der Gesellschaft, Multidisziplinarität, eine ganzheitliche Sichtweise und die Förderung der Gesellschaft –, die Studieninhalte, der Aufbau und spezifische Aspekte werden detailliert beschrieben.

Schlüsselbegriffe: Aufbaustudium, Gesundheitsförderung der Gesellschaft, Kohärenzgefühl, Mentalhygiene-Bewegung, Mittel- und Osteuropa, Multidisziplinarität, Primärprävention, Salutogenese, Ungarn, Wissenszuwachs

1. The importance of health and mental health. Paradigm shift in health care away from a biomedical perspective

Health is considered the most valuable personal asset in contemporary society. That is evidenced, for example, by surveys in Austria that have found that health takes precedence over joy, family, leisure time, and even affluence (ZULEHNER 1991, 22). That is so because health is regarded not only as the decisive aspect of personal well-being, but also as a precondition for a number of further important goals and aspirations. Many feel today that without health they would become unfit for work and achievement, for love (by losing attractiveness) and also for self-realisation by being unable to develop optimally.¹ The preponderance of health over other values is further

¹ Empirical studies indeed suggest a correlation between health problems (e.g. headaches and musculoskeletal pain) and depression (RÉTHELYI et al. 2004).

strengthened by the individualistic nature of contemporary values in that an ever greater emphasis on individual achievement results in an ever greater demand on health as well.

The notion of health had been narrowly limited to the field of biomedicine for long generations. It was not until new problems, such as the recognition that even persons living in good physical condition and without disease cannot always become creative members of society, prompted a reconceptualisation that resulted in personality factors, lifestyle, social integration and spiritual resources being given a place among conditions of health.² Besides contributing to well-being, those components will play an even more spectacular role when the individual has to cope with grave difficulties or come to terms with personal crises.

The *Ottawa Charter for Health Promotion* of 1986 interprets health as a resource rather than a goal. 'To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment' (p.1). Health promotion is not limited to the health sector, but goes beyond healthy life-styles to full well-being. The definition indicates that a new way of thinking is gaining ground that considers medical science an important but certainly not exclusive means of health preservation. A healthy society strives to provide its members with appropriate norms and patterns. It tries to prevent the emergence of large disparities in the accessibility not only of material but also of social and intangible resources.³ It is aware that ontological dis-orientation and loss of tradition have become widespread phenomena, that traditional values have greatly diminished in power to orient lives, and that normative patterns and guiding principles have become considerably weaker. The 1999–2004 World Values Survey, to cite but one example, found that only forty per cent of respondents believed that reliable, unambiguous guidelines were available in deciding between moral good and bad; the majority tended towards an ethical relativism. The latter represented a particularly high proportion (over eighty per cent) in Scandinavian countries (European Values Study Group and World Values Survey Association 2006; see also ZULEHNER & DENZ 1993, esp. 1:127).

² Research by R.L. PIEDMONT (1998) confirms the necessity of supplementing the well-known five-factor model of personality assessment with a sixth factor, spirituality. Scales so augmented will substantially improve in explanation of variances over the five-factor model.

³ On the harmful effects of large social inequalities and on a strong middle class recommended as a good solution in general, see ARISTOTLE's *Politics*, esp. Book IV, and, in an American context, Alexis de TOCQUEVILLE's *Democracy in America* (1969) which has established itself as a classic in the field since its first publication in 1860. It is difficult to empirically establish the necessity or positive effects of a strong middle class, but Roland INGLEHART's book (1997) has provided some strong supportive evidence. Though this book examines the strength of democracy rather than the middle classes per se, it suggests that democracy is strongest in societies with economically and culturally strong and active middle classes. In another book that critically analyses the role of religion and religiousness, he and his co-author claim that '[c]onditions of socioeconomic inequality are critical for widespread conditions of human security' (NORRIS & INGLEHART 2004, 16). Extreme differences within a society are particularly dangerous because, so NORRIS & INGLEHART, 'growth [then] only enriches the affluent elite and the governing classes, a common pattern in many mineral and oil-rich nations' (p.16).

According to the *Ottawa Charter* (1986) fundamental conditions and resources for health include peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. That is reflected, for example, in the rapid dissemination of the concept of empowerment, which seeks to enhance communities' 'ownership and control of their own endeavours and destinies' (p.3). In a learning process they may recognise that psychosocial well-being is a function of the presence and accessibility of social resources, that is, support systems and social networks. It is therefore a primary objective that individuals as well as communities do everything in their power to improve their life conditions and to counteract the scarcity of their resources in order to enhance social coexistence (STARK 1996). That means that the individual will extend control over an ever larger part of her life and activity while also seeking cooperation with people in comparable situations in order to increase personal development and the synergic effect of working together.

Another important twentieth-century concept connecting mental health and societal operation is community mental health promotion. A concept of American origin, the term denotes endeavours to protect and improve mental health at social levels. Having gained impulses from European health policies and grown strong, the concept found fertile ground in the East Central European region, in Hungary under Socialist dictatorship.⁴ This is a region where, on the one hand, otherness-induced conflicts had been traditionally strong but, on the other, the ideal of mental health had yet been preserved as a common goal to be achieved. Community mental health at the time must be considered a movement since it mobilised broad social forces.⁵ The socio-political changes around 1989 did not break it, nor has it lost vitality ever since, for cultural discontinuity induced by accelerating social transformation has become a growing problem, and institutions of socialisation as well as individuals looking for a new fit find it ever more difficult to adapt.⁶

The idea of community mental health promotion is spreading, and a corresponding perspective is beginning to permeate political action, religious practice, social and health care, education, law and legislation, mass media as well as the activity of natural and artificial groups. It helps various branches of learning better understand other 'neighbouring' disciplines and contributes to a fruitful discussion between them by encouraging dialogue about conflicts.⁷ Accordingly, we take the task of community

⁴ The period of Socialist dictatorship extended from 1948 to 1989.

⁵ If *movement* is understood in the sociological sense of the term, i.e. as a usually loose and not yet institutionalised association of people fighting together for certain goals within society or a larger group, then we have to underline the incredible swiftness and success of the Hungarian community mental health promotion movement because it was able to institutionalise very soon. On the definition of the term 'movement' in the sociological sense see, for example, BOTTOMORE (1993) or RENON (1994).

⁶ The crisis of cultural transmission fundamentally concerns religiousness and values. Religious institutions are in a particularly difficult situation because religion is maintained by the continuity of memory, and memory seems to be losing its structuring role in modern societies (HERVIEU-LÉGER 1998).

⁷ According to the *CompLex Intranet Jogtár* legal archives, the Hungarian equivalent of 'community mental health promotion' occurs in a total of twenty-four laws, decrees, etc. in the country (cf. JABLONSKY 2006).

mental health promotion to be ‘the restitution, restoration in theory and practice, of the humanistic complete image of the human, on a social level and through the co-operation of all human disciplines’ (TOMCSÁNYI 1994, 31, *trans. ours*).⁸ The basis of its working mechanism is an *added knowledge of community mental health* whose constituent parts exert their influence combined, as if in an amalgam, with the skills of the primary field of expertise. The constituent parts in and of themselves cannot be rightly called community mental health promotion. The pillars of added knowledge of community mental health promotion include:

- an approach and a corresponding motivation which, from a focus of mental health, strive to see and understand phenomena holistic-ecologically;
- interdisciplinary theoretical knowledge concerning mental health;
- action orientation which not only recognises processes but seeks, in cooperation, to effectively sustain (or counteract) them in order to promote healthy ways of functioning;
- skills and competencies which enable the practical implementation of action orientation (TOMCSÁNYI 2002).

A great opportunity to further disseminate and transmit a community mental health perspective and the added knowledge outlined above has been a multidisciplinary *training program* in community mental health developed twenty years ago. By the time the *Ottawa Charter* (1986) stated its directive on training,⁹ our program had already been fully developed. Given the participants’ diverse backgrounds, the contents and design of the program, our graduate level training launched in 1987, serves multiple objectives: not only does it enhance community mental health thinking and communication, but it also fosters society building by encouraging democratic mentality. It broadens participants’ understanding of the world, society and human beings while reconfirming their original expertise and professional identity.

2. The notion of community mental health and East Central Europe

2.1. Development of the concept of community mental health promotion

Encyclopædia Britannica offers a twofold definition of ‘mental hygiene’ as ‘the science of maintaining mental health and preventing the development of psychosis, neurosis, or other mental disorders’ (2002, 21). Mental hygiene thus includes a system of knowledge and activities to acquire and preserve mental health. Such theory

⁸ ‘[F]eladata a humanisztikus egész emberkép restitúciója, helyreállítása elméletben és gyakorlatban, társadalmi méretekben, minden humán diszciplína együttműködésével.’

⁹ ‘Reorienting health services also requires stronger attention to health research as well as changes in professional education and training’ (p.3).

and praxis may be gained from several disciplines and integrated into a professional's original field of expertise.

The roots of mental hygiene as communal, social mental health care are to be traced back to the nineteenth-century United States. The phrase 'mental hygiene' was coined by W. SWEETSER in 1843, but it only gained wider currency as a result of Clifford BEERS' unfailing efforts, whose autobiography (1981, first published 1908), based on his experiences at various mental wards, was tremendously influential in securing broad support for a reform of the treatment of psychiatric patients. The mental hygiene movement was brought to life by his extraordinary energy, organisational talent and commitment. His goal was to ensure a more humane treatment of the mentally ill, and the way he accomplished it, looking beyond the domain of health care to a wider context, moved out of the narrow confines of psychiatry. When the Connecticut Society for Mental Hygiene was founded at Yale University on 6 May 1908, the mental hygiene movement created an interdisciplinary cooperation, which has remained its hallmark ever since, of church, school, college, hospital and social institutions whereby narrow intradisciplinary isolation was overcome right at the outset. Soon after an initial phase of support from individuals and foundations, the conditions of institutionalisation also emerged in the United States, and after the Mental Health Act of 1946, which stipulated federal coordination and a cooperation of all human disciplines, community mental health had become a responsibility of the federal government (FATKE 1980). Wartime problems lacking adequate solutions within the traditional institutional framework also contributed significantly to an acceleration of the development of the mental health movement. Such problems included war neuroses as well as severe mental disorders induced by environmental effects in previously healthy persons. These phenomena drew increasing attention to the inadequacy of earlier approaches to prevention, treatment and the preservation of mental health.

The institutional development went hand in hand with a conceptual development of community mental health. *Promotion of mental health became a science and organised practice*. It includes both knowledge of acquiring and maintaining mental health and a corresponding system of organised interventions which are always integrated into and become effective through the mental health expert's primary professional field. Mental hygiene thus integrates an interdisciplinary body of knowledge originating from a variety of sciences (including psychiatry, sociology, social work, social psychiatry, psychology, psychotherapy, education, theology, ecology, systems theory, etc.) and is far from being reducible to psychiatry which was only its starting point. It is enriched by methods borrowed from human helping professions and many other fields that fit well into a community mental health approach: accumulated knowledge and experience from self-help groups or ways of indirect help (e.g. substituting for parents' inadequate psychosocial behaviour through influences of educational institutions).

2.2. Cornerstones of community mental health thinking

- a) Community mental health *is not some new theoretical science, but an action-oriented perspective, approach and praxis motivated by knowledge that fosters mental health. It involves several branches of learning.* Its field of operation includes, but is not limited to, the health sector. It reaches beyond that to cover education, the social sphere and sports, and even entertainment, church and other broad aspects of culture.
- b) A community mental health perspective is developed within the expert's own original professional discipline by supplementing her primary expertise with *biological, psychological, social, educational, ethical, spiritual, etc. factors, and forming a complex unified relational system* which promotes internal equilibrium and mental health.
- c) This perspective carries a positive mental health concept: a source of joy, creativity and a capacity for adequate responsibility taking which can be preserved even in a state of somatic disease.
- d) A community mental health perspective sees the individual not in and of herself but in her social connectedness, taking into account reciprocal effects, e.g. that a symptom that appears negative for the individual may have a positive overall impact on the family.
- e) Consequently, its endeavours go beyond the individual level, and it operates on a community or social level since a healthy operation of the individual is best fostered by a healthy environment.
- f) In addition to professional resources, it also mobilises the resources of lay helpers, self-help groups and NGOs.
- g) It emphasises the importance of the most effective point of intervention, that is why it advocates primary prevention and elevates to the first line of defence the education and training, whose mobilising factors emphatically include the strengthening of values and discovery of resources, of human professionals (multipliers). Education and training which count as forms of primary prevention, however, also impact secondary and tertiary prevention in that their target group also includes physicians, social workers and clergy who, in part, care for ill people.

2.3. Levels of mental health intervention

- a) *Individual level* mental health intervention is provided by human services professionals when they do their everyday work informed by a mental health perspective, e.g. when they teach, offer pastoral counselling, or give legal advice. Further activities at this level include individual mental health counselling, various forms of supportive relationship, case-work or individual therapy.

- b) *Group level* intervention can be provided in many different ways such as by creating homogeneous groups (e.g. students, pastoral care clients, youth communities, therapeutic, problem-solving or training groups) or by steering the activity of natural groups (e.g. group consultation, group work informed by a community mental health perspective). In these cases the community mental health expert provides assistance, upon the request of a particular group, to foster operation, development or change.
- c) Intervention at the *organisational level* is directed at influencing the operation of an organisation so that it better approaches the community mental health ideal which is achieved by changing both the mutual relationships between the groups involved and the participants' perspectives. This type of intervention exhibits numerous methodological similarities with organisational consultation, but, depending on her primary expertise, the intervening professional may also integrate appropriate contents and techniques from her own field.
- d) *Community level* mental health promotion intends to apply different levels of mental health intervention in a complex and integrated way in a given regional unit or geographically defined community. Its goal is to increase the given community's own health promotion potential and to create an environment conducive to mental health. In addition to the previous three levels of intervention, community level mental health promotion includes effective intervention in local decision-making processes that impact the well-being of the community as a whole (i.e. all inhabitants in the region). In ideal cases, social decision-makers and executives take community mental health aspects into consideration; they ask for and make use of the advice of community mental health experts.
- e) The highest degree of organisation is required by intervention at the *societal level*, which is possible through appropriately influencing large-scale political (economic, legal, social policy, public health, educational, cultural, etc.) decisions. In case of unavoidable political decisions which may involve potentially harmful consequences, community mental health experts may help find and develop corrective strategies and compensatory measures.
- f) A possibility of *worldwide mental health interventions* (on the level of nations, regions, communities) is emerging today. International and world organisations as well as legislative mechanisms of ever more closely cooperating countries are now bringing it within reach that a community mental health perspective may be brought to bear at the very outset.

2.4. Historical situation and community mental health promotion in East Central Europe (Hungary)

In Hungary, the community mental health movement was launched by those professionals who were the first to declare the inefficiency of state Socialist health protection in the 1960s (HÁRDI 1982; PANETH 1969, 1972). Disappointment was most deeply felt by those who had initially believed firmly in the success of a total role

taking by the state. Trust had also been undermined by political and ideological overstatements such as the slogan 'mental disorder is a capitalist disease which will cease by itself in Socialism.' Furthermore, the individual had no freedom to make choices and find the alternative that best harmonised with her personality and values and, considering her options, integrate that with her own traditions, objectives and conscience. Such an attitude stood in strong conflict with the stated goals and strivings of the four decades of state Socialism.

The Hungarian Socialist Workers' Party, working from a Marxist base and systematically extending its power, claimed absolute rights for its ideology which confronted everyone who believed in anything else, relegating them to a status of 'the enemy within'. The Party took measures against all manner of convictions, be they democratic, liberal or conservative, and wanted to root out all manifestations of religious commitment (Marx had, after all, called religion the opium of the people) declaring an atheistic 'scientific Socialism', so called, to be the only possible, legitimate and modern way. Consequently, all organisational forms of civil society including religious associations and cultural clubs, artistic circles and youth groups were branded enemies and their destruction had become a prime objective of Socialist dictatorship. The disappearance of these groups and organisations caused immeasurable damage to the social fabric. Those institutions bore the brunt of persecution that had, and could have, been active in fostering independent thinking and in producing autonomous individuals. The ideal of the state power was, however, the faceless, helpless, easy-to-manipulate 'yes-man' in limitless numbers. An autonomous personality with her own social network could be a dangerous element in a dictatorship; coercion was therefore used against any community activity in the era. Even when dictatorship had begun to soften up, those who disregarded warnings and continued to be engaged in youth work of any kind outside the state sanctioned limits, were severely punished.¹⁰ That retributive practice was particularly harmful from the point of view of community mental health.

Those at the pinnacle of dictatorship attached great importance to the education (read, indoctrination) of young people; that is why the pioneer movement, under Communist auspices, and, for teenagers and young adults, the 'KISZ' (League of Young Communists) remained the only legally recognised youth organisations after 1948. The political campaign against ecclesiastical schools quickly accelerated, and, despite wide social resistance, the churches' whole colourful, efficient and well-organised educational system was effectively abolished (only ten schools were allowed to continue under religious oversight after 1950 up to the political changes of 1989). From that time on, Marxist ideology permeated the curriculum; political commitment and trustworthiness became the primary admissions criteria to institutions of higher learning. From a community mental health perspective, that was harmful because, on the one hand, the result of systemically and systematically applied selection criteria in the humanities was that the education of people with a particular, nonreligious orientation

¹⁰ The last such processes where several priests and their secular colleagues were sentenced were held in 1973 (TÖRÖK 2003, 81).

was sanctioned and unduly privileged for long decades. On the other hand, while the campaign against traditional and religion-based values was successful and quickly resulted in their decline, the corresponding attempts to make an effective Socialist value system widely accepted failed, producing a vacuum of social standards which, combined with the effects of persecutions, contributed to a deepening anomy and alienation crisis (ANDORKA 1996).¹¹

Ethnic tensions also added to the list of conflicts to be resolved. That is a relatively new issue because it could not exist before the development of nation states; later on it was 'solved' by dictatorial, or at least by authoritarian, measures in the East Central European countries. Even this short overview of social fissures indicates clearly how important the emergence and development of a community mental health movement was in the region, with its emphasis on mentally healthy functioning at all levels.

2.5. Salutogenesis

The concept of *salutogenesis* was introduced by Aaron ANTONOVSKY in 1979. It analyses resources rather than losses, and its central question is how one can be healthy in spite of all kinds of harmful effects. How is one able to mobilise enough resources to regard oneself more or less healthy in spite of so much unproductivity, contradiction, and stress? The starting point of salutogenesis is thus a positive change of attitude that views social processes as an individual strives to actualise her positive opportunities, including her coping mechanisms. It involves a mobilisation and orientation of resources toward action. The success of this effort depends on a subjective competence that Antonovsky called a Sense of Coherence (SOC) whose essence is that one's life is not a mere plaything of blind fate¹² but has a meaning, that its components are not accidentally heaped upon each other by odd chance but are deeply and meaningfully interconnected. Coherence is a sense of internal relatedness which, like a compass, helps one orient oneself in all fields of life. That capacity is based on a deep trust that guarantees a continued orientation in life as a whole on the one hand, and a dynamic adjustability to an ever-changing world on the other. Antonovsky's dialectical concept of SOC, then, involves a sense of confidence that

- it makes sense to meet the challenges of life (meaningfulness),
- one can understand and explain the nature of those challenges, and even count on and prepare for their occurrence (comprehensibility), and

¹¹ On the failure of the education of a Socialist 'New Man', i.e. of the development and transmission of a Socialist value system, see MEDYESY (1980). Furthermore, TOMKA (1991) even speaks of the 'genesis of anomy', not only with respect to Hungary but to the whole of East Central Europe (esp. p.96).

¹² A large proportion of the Hungarian population, 46 per cent of men and 55 per cent of women, is characterised by an 'external control attitude', i.e. an orientation that may easily lead to depression and that suggests that one has no or minimal control over one's life (KOPP & SKRABSKI 1997).

- one is in possession of the resources that enable one to cope with the emerging challenges (manageability) (ANTONOVSKY 1987, 19 and 1990).

That perspective and sense have been eroded at several points by experiences in contemporary society. On the one hand, a great number of people are unable to develop or nurture the positive feelings of reasonableness, understanding or coping; on the other hand, the cognitive background of those values is often endangered because our times create new challenges at a faster pace than one is able to find adequate answers.

Has the need for SOC been superseded then? From time to time, we see developments that seem to suggest so. We again bring examples of social psychological phenomena from a period of East Central European societies which called itself Socialism but which in fact produced different degrees of dictatorship. In this form of existence, opportunities for individual self-actualisation tapered off, and while the powers that always advocated freedom and a multioptional way of life at a propagandistic level, ordinary people came up against walls at every turn.¹³ Many found the battle hopeless, and their pessimistic philosophy led to a SOC which was able to provide them with a kind of internal equilibrium even in a world without chances. That SOC was a somewhat distorted or, at least, simplified formation which contributed to mental survival by second-best means. The latter included a bogeyman which was able to hold together large groups. Most Socialist dictatorships consciously employed as a problem-solving method the fact that masses can blame any social tension on the existence and subversive acts of a perceived enemy. A characteristic example of the primitive schematics of such bogeyman tactics is that, at the height of the Cold War, the ludicrous claim of the propaganda machine that American imperialists spread the eggs of fall webworm or Colorado potato beetle from airplanes, and that this was the reason for the proliferation of parasites, and, consequently, for the shortage of food-stuff in the country, was widely accepted.

Somewhat more hidden processes played a role in the Balkan crisis. In the former Yugoslavia, various nationalities had lived in apparent peace for long decades, their conflicts settled by a policy of strong hand and authority. Problems were swept under the carpet. As the conflicts had deepened, however, various groups saw their out-groups in an ever more evil light while gradually developing an unrealistically positive self-image. As social psychology would predict (SMITH & MACKIE 1995, 561–62), there was an ever-growing conviction that the in-group could only do good things and the out-group bad things, and that the in-group would be stronger if it came to open conflict. For a while, eruption was prevented by the belief that existence and

¹³ VARGA (1995) makes a distinction between totalitarian and authoritative stages in the state Socialist era in Hungary. While in the totalitarian regime the power of the state extended to all spheres of political, cultural and economic life, in the authoritative stage it had the political sphere under full control, the cultural sphere under partial control, and the economic sphere had some relative, though limited, autonomy. In Hungary, the transition from the totalitarian to the authoritative stage took place in 1968 when what was called the 'New Economic Mechanism' was introduced.

independence could only be maintained through permanent rope dancing: now the West, now the Soviet Union appeared the greater enemy. However, improving economic relations with the West gradually tamed the image of one fiend, and the dissolution of the Soviet Union robbed them, almost overnight, of the other enemy, too. Consequently, a new enemy, crucial for maintaining the equilibrium, had to be sought and found within the country's borders. That was when, from one day to the other, neighbours who might have been friends until then began to perceive each other as murderous enemies, perhaps in ways not fully comprehensible to themselves either. A bogeyman strategy to problem solving thus led, by necessity, to tunnel vision in large numbers of people, resulting in the exclusion of disturbing (i.e. ideologically unacceptable) facts from the field of vision and producing a behaviour that selectively reduced the total experience of the world to a mere fragment of it. That mode of vision, in turn, effectively justified one's narrow pattern of selection and, finally, led to a peculiarly limited interpretation of the world.

The false track outlined above need not raise doubt about the necessity of SOC. It is true that, due to the accelerating pace of change in the world, we need tools that offer new opportunities for the understanding and solution of new problems. We may therefore leave behind such versions of SOC that could guarantee, by their mere existence and a narrative of closed meaning, our internal unity and harmony. We can, instead, propose to achieve equilibrium through a reinterpretation of whose more open structure offers a place for various possibilities and apparently contradictory details with the open-ended potentiality of their future interconnection.¹⁴ The individual has to develop an effective pattern of such interconnections in order for coherence to function properly so that it can support her efficiently in finding an adequate place in the psychosocial world and gaining recognition in interpersonal relationships as well.

The goal of this new type of SOC is not to discover prefabricated and stable answers but to develop a behaviour that is able to provide novel answers to the questions posed by an ever-changing environment. That requires new competencies whose main features include plurality and internal variegation, and which constitute a precondition for the development of a flexible and open pattern of identity. That, in turn, means that individualised modes of formation must come to the fore, that is, different personality parts must be connected from within; they must be integrated into the personality. That presupposes an undisturbed transmission of tradition, for it is unimaginable that ready-made products of the mass media could be integrated and internalised by the individual without communal filters or cultural transmission. Without that, their integration cannot occur at all or can only take place in a harmful (i.e. unintegrated) way.

¹⁴ Perhaps it is the sense in which R.J. LIFTON (2003) speaks about the 'Prothean man', and also the 'enlightened man' imagined by Anthony DE MELLO (1988, 208) may be like this.

2.6. Community mental health and salutogenesis

Community mental health promotion (TOMCSÁNYI 2003), which has been discussed in detail, and salutogenesis, whose core insights we have briefly outlined, both harmonise with, and mutually supplement, each other. The definition and the resulting attitudes of both offer help to approach risk factors of individual and social problems optimistically. A social scale was inherent in community mental health promotion right at the outset. A salutogenic approach also considers the individual in her social context. They differ, however, in that the central concept of salutogenesis is a Sense of Coherence (SOC), it focuses on the individual's mental health, and its praxis involves people from fields in direct connection to medicine, mobilising physicians, psychologists and sociologists active in the health system. That is also mirrored in the authors of the first handbook in the field (SCHÜFFEL 1998).

The central concept of community mental health promotion is the added knowledge of community mental health promotion that foregrounds ways of primary prevention, consists of (multidisciplinary) knowledge of human disciplines that impacts mental health, and, as a result both of this knowledge and of an approach of primary prevention, focuses on a healthily functioning society. Consequently, it seeks to mobilise not only those involved in the healing practice but other representatives of human services disciplines as well, including teachers, theologians, social workers, public educators, lawyers, politicians) and thereby also seeks to reach institutionalised or non-institutionalised groups and communities.

3. Training in community mental health promotion

Our multidisciplinary training in community mental health promotion (TOMCSÁNYI 2000; TOMCSÁNYI et al. 2001) was launched in 1987 at the Institute of Mental Health, Semmelweis University (or, more precisely, at its predecessor in title, the Hungarian University of Physical Education). On the basis of that curriculum, community mental health education is now being offered at three institutions of higher learning in Hungary. The number of degree holders is almost two thousand. An important step toward the wider recognition of the program was that, after several years of cumulative experience, an effectivity study had been completed (TOMCSÁNYI 1994; TOMCSÁNYI et al. 2001, 2002) which confirmed a positive change of perspective in participating helping professionals. They include school and kindergarten teachers, educators, physicians, clergy, politicians, societal decision makers, social counsellors, advisers to minority and self-help groups, crisis intervention workers, managers and many others, and their training takes place in a purposefully designed environment of adult education.

3.1. The program's goal

The goal of the training is not specialisation in a particular discipline but an extension of the helping professionals' primary skills and expertise through the acquisition of a community mental health perspective. The aim is to provide students with a capacity to approach the contents of their own profession from a new perspective, with increased cultural and psychosocial competence.

3.1.1. Phases of implementation

1. Developing the professional personality: through an integrated development of *professional and personal competencies*.
2. Developing everyday activity: integrating mental health related *interdisciplinary knowledge* into everyday activity in order to increase its health promoting potential.
3. Encouraging community mental health action: *increasing capacity for action* through the extension of external and internal possibilities (also by interdisciplinary cooperation).

3.2. Program content and structure

The content of the curriculum is made up of mental health related multidisciplinary theoretical knowledge, including knowledge of self and society, and the development of skills and expertise, which enhance healthy modes of action. By the time students reach graduation, they will have acquired a special perspective which we may call 'added knowledge of community mental health promotion'.¹⁵ The concrete content of this added knowledge is determined for each individual by her primary profession and the actual requirements of her personality development. However, she has to be a professional, an expert in a particular field in order to 'select' an appropriate body of knowledge. She must have anchor points from which she can process new theoretical and experiential information and into which she can incorporate her new knowledge that can only have adequate impact through her primary professional activity. That is also a reason for the choice of graduate training as the form of education.

3.2.1. Theoretical knowledge

The theoretical component of the curriculum comprises a multidisciplinary body of knowledge which is indispensable for the development of a complex perspective required in the helping relationship. It includes:

¹⁵ A methodology is being developed to empirically measure components of the added knowledge (ITTZÉS et al. 2004).

- basic concepts of mental health (positive mental health, community mental health, history of concepts of prevention, features of prosocial behaviour, helping movements);
- the system of human services and how they promote community mental health;
- community mental health promotion, ecological mental health;
- aspects of community mental health in the family;
- community mental health related macrosocial and cultural phenomena (deviances, minorities, prejudices, radicalism);
- mental health in different ages of life;
- mental disorders;
- the helping relationship (self-help, network);
- ethical dilemmas in community mental health promotion;
- mental health of leadership.

3.2.2. Knowledge of self and society

Experts and groups of experts must be equipped to maintain their own mental health as well as that of their narrower and broader environment, and to monitor potentially harmful influences. That requires a heightened awareness of possible causes, a critical evaluation of prejudices, and an openness to reconsider hypotheses and preferences, at the same time avoiding disturbances caused by the presence of a multiplicity of options or an exclusive preference for any given option. Furthermore, the competencies and boundaries of the students' own professions as well as the articulation of their deficiencies must be made more conscious by the acquisition of a common language. A better understanding of how different kinds of cultures (body, social, communal, psychological and religious cultures) interrelate as well as of the reintegration of the individual or the group into social contexts must be fostered.

3.2.3. Helping relationship promoting community mental health: specific and non-specific methods

The aim of this training segment is to deepen cooperation needs and skills, to equip participants to consider and weigh different perspectives and needs (WELSCH 1988, 44–49), to adequately use both directive and non-directive forms of accompanying, to develop the ability to change perspectives, to increase cooperation and team aptitude through the development of project building skills.

3.2.4. Attitude formation, communication, and network development

A primary tool of attitude formation is the impact of heterogeneous small groups bringing together professionals from different fields of humanities, from various intel-

lectual, political, social and religious backgrounds. New issues emerging from the differences are treated in the intimacy of group work. Such an environment is conducive to a better understanding of each other's thinking, difficulties and opportunities, and encourages participants to rethink their own intellectual paths.¹⁶

Important objectives of the curriculum include, through work and experience in professionally and ideologically inhomogeneous small groups, to challenge fundamental value orientations, to foster encounter with otherness inherent in heterogeneity, and to encourage communication that offers opportunities to assume individual responsibility and to practice tolerance.

3.3. Specific features of the program

3.3.1. Curricular multidisciplinary

First, the curriculum is multidisciplinary: it is selected from the fields of sociology, psychology, pastoral counselling, law, education and other humanities. Elements of community mental health knowledge are not arbitrarily or randomly chosen but assigned to representative phenomena under strict principles of selection; and they work as guiding principles and points of reference. On the other hand, the program does not seek to eliminate contradictory statements because that would result in reductionism. Theoretical differences between disciplines are clearly outlined; the training is thus multiperspectival in nature. Finally, the curriculum is neutral in its approach in the sense that it is not dependent upon historical periods, disciplines or trends. Instead of professional imperialism, it teaches to think in various change management strategies which it brings into dialogue.

3.3.2. Multidisciplinary created by participants

Reflections of educational, theological, philosophical and social political professionals participating in the program mutually strengthen each other and provide formal and substantial contours. In developing the community mental health curriculum, we endeavour not to assign universal validity, either consciously or unconsciously, to any fundamental concept or any paradigm. We must avoid the pitfalls both of getting lost in a variety of options and of exclusively privileging any one of them (WELSCH 1996, 948; see also 1988, 66–67).

¹⁶ We have conducted research projects (TOMCSÁNYI et al. 2002) to explore how our students' views and beliefs changed during the training about professions that had been in a particularly difficult situation during the era of dictatorship (teachers, theologians).

3.3.3. Continuing education in a university context

The context of higher education demands controlled standards through which community mental health thinking and perspective can be learned and taught. Being a graduate level program, the curriculum employs methods and approaches appropriate to adult education. An important feature of the training is that it strengthens motivation and counts on the mature student's sense of responsibility. Students take an active part in selecting program contents and designing methods of engaging the material. Through continuous reflection and feedback, students themselves are the most important factor in shaping the program: they come from a variety of disciplines, and they are co-authors in the training process and in the continual renewal of the curriculum. Graduating students can better articulate their own professional preferences, which means that the training also has a reinforcing effect on identity.

3.3.4. Holistic / ecological approach and society building function

The program is a well-coordinated system whose central goal is a better understanding, better coordination and better management of interactions between individual and social changes, and whose organising principles are to place phenomena in context and to conceive of the human being as a whole. Starting from professional relationships, the training seeks to understand the process of self-understanding in its social context. The program's mission, its actual society building function in a Hungary after forty years of dictatorship was and is principally connected to attitude formation and communication development which we have discussed above.

The basic principles of community mental health promotion and this training in community mental health promotion are no new discoveries. Skills required for the preservation and promotion of mental health have always been present spontaneously in human relationships, in the work of institutions as well as in a 'born' teacher or priest. Nevertheless, spontaneous helping and care guided by human values have been stunted in East Central Europe through the transformation of traditions, relational systems and civilisation patterns, and the emergence of other viewpoints, interests and reflexes. The resulting lack called for a new approach, and the gap has been filled, through the joint effort of several disciplines, by a new emphasis on community mental health promotion. That, in turn, has led to the development of a system of transmission, the training in community mental health promotion, for what had earlier lived in people and in professional roles *naturally* must now be, in a sense, *re-learned and re-taught*.

References

- ANDORKA, R. (1996) *Merre tart a magyar társadalom?* (Lakitelek: Antológia).
- ANTONOVSKY, A. (1979) *Health, Stress, and Coping: New Perspectives on Mental and Physical Well-Being* (San Francisco: Jossey-Bass).
- ANTONOVSKY, A. (1987) *Unraveling the Mystery of Health: How People Manage Stress and Stay Well* (San Francisco: Jossey-Bass).
- ANTONOVSKY, A. (1990) 'Studying Health vs. Studying Disease: Lecture at the Congress for Clinical Psychology and Psychotherapy, Berlin, 19 February 1990', retrieved 10 Jun 2006 from Salutogenesis Project, Sense of Coherence website (old), <http://www.angelfire.com/ok/soc/aberlim.html>.
- BEERS, C.W. (1981) *A Mind that Found Itself: An Autobiography* (repr. of 5th ed.; Pittsburgh: U of Pennsylvania P).
- BOTTOMORE, T. (1993) *Political Sociology* (2nd ed.; Minneapolis: U of Minnesota P).
- DE MELLO, A. (1988) *One Minute Wisdom* (New York: Doubleday).
- European Values Study Group & World Values Survey Association (2006) *European and World Values Surveys Four-Wave Integrated Data File, 1981–2004*, v.20060423 (Madrid: Análisis Sociológicos Económicos y Políticos & JD Systems; Tilburg: Tilburg University; Cologne: Zentralarchiv für Empirische Sozialforschung) retrieved 15 May 2006 from <http://www.worldvaluessurvey.org>.
- FATKE, R. (1980) 'Psychohygiene und Pädagogik' in W. SPIEL, ed., *Konsequenzen für die Pädagogik* (2), vol. 12 of H. BALMER, ed., *Die Psychologie des 20. Jahrhunderts* (Zürich: Kindler) 729–53.
- HÁRDI, I. (1982) *Lelki élet, lelki bajok* (9th, rev. ed.; Budapest: Medicina & Franklin).
- HERVIEU-LÉGER, D. (1998) 'The Transmission and Formation of Socioreligious Identities in Modernity', *International Sociology* 13, 213–28.
- INGLEHART, R. (1997) *Modernization and Postmodernization* (Princeton: Princeton UP).
- ITTZÉS, A., B. EHMANN & T. SZABÓ (2004) 'A tartalomelemzés alkalmazási lehetőségei a mentálhigiénés szemlélet összetevőinek feltárásában', *Mentálhigiéné és Pszichoszomatika* 5, 227–43.
- JABLONSKY, L., ed. (2006) *CompLex Intranet Jegtár*, v.2006.4 (Budapest: CompLex) retrieved 21 Jun 2006 on Semmelweis University Intranet at <http://pluto.sote.hu:81/jr/sf/initnp.html>.
- KOPP, M. & Á. SKRABSKI (1997) 'Magyar lelkiállapot – 1997', *Távlatok* 34, 157–67.
- LIFTON, R.J. (2003) 'Foreword' to M.T. Singer, *Cults in Our Midst* (2nd, rev. ed.; San Francisco: Jossey-Bass) xi–xiii.
- MEDYESY, L.M. (1980) *Evolution of the Socialist 'New Man' in Hungary: A Study of Political Socialization (1956–1975)* (Vienna: UKI).
- 'Mental Hygiene' (2002) in D.H. HOIBERG & T. PAPPAS, eds., *Encyclopædia Britannica*, 32 vols. (15th ed.; Chicago etc.: Encyclopædia Britannica) 8:21–22.
- NORRIS, P. & R. INGLEHART (2004) *Sacred and Secular: Religion and Politics Worldwide* (Cambridge: Cambridge UP).
- Ottawa Charter for Health Promotion* (1986) First International Conference on Health Promotion, Ottawa, 21 November 1986 – WHO/HPR/HEP/95.1, retrieved 5 May 2006 from the World Health Organization website, http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf.

- PANETH, G. (1969) 'A mentális hygiéné (lelki egészségvédelem) szervezésének néhány kérdéséről', *Ideggyógyászati Szemle* 22, 345–50.
- PANETH, G. (1972) 'A mentálhygiéniai gyakorlat néhány újabb tapasztalatáról', *Ideggyógyászati Szemle* 25, 161–72.
- PIEDMONT, R.L. (1998) *The Revised NEO Personality Inventory: Clinical and Research Applications* (New York: Kluwer Academic/Plenum).
- RENON, K. (1994) 'Social Movement' in W. OUTHWAITE, T. BOTTOMORE, E. GELLNER, R. NISBET & A. TOURAINÉ, eds., *The Blackwell Dictionary of Twentieth-Century Social Thought* (2nd ed.; Oxford, England & Cambridge, Mass.: Blackwell) 597–600.
- RÉTHELYI, J.M., R. BERGHAMMER, A. ITTZÉS, I. SZUMSKA, Gy. PUREBL & Cs. CSOBOTH (2004) 'Comorbidity of Pain Problems and Depressive Symptoms in Young Women: Results from a Cross-Sectional Survey among Women Aged 14-24 in Hungary', *European Journal of Pain* 8, 63–69.
- SCHÜFFEL, W., ed. (1998) *Handbuch der Salutogenese: Konzept und Praxis* (Wiesbaden: Ullstein Medical).
- SMITH, E.R. & D.M. MACKIE (1995) *Social Psychology* (New York: Worth).
- STARK, W. (1996) *Empowerment: Neue Handlungskompetenzen in der psychosozialen Praxis* (Freiburg i.Br.: Lambertus).
- SWEETSER, W. (1843) *Mental Hygiene: Or, An Examination of the Intellect and Passions, Designed to Illustrate Their Influence on Health and the Duration of Life* (New York: Langley).
- TOCQUEVILLE, A. de (1969) *Democracy in America* (Garden City: Doubleday).
- TOMCSÁNYI, T. (1994) *Mentálhygiéné és pasztorálpszichológia* (PhD diss., Magyar Tudományos Akadémia, Budapest).
- TOMCSÁNYI, T. (2000) 'Mental Health Promotion through the Dialogue of Different Philosophies and Professions: An Interdisciplinary Training Program in Mental Health', *Mental Health, Religion & Culture* 3, 143–55.
- TOMCSÁNYI, T. (2002) 'Az interdisziplináris mentálhygiénés szakképzés' in T. TOMCSÁNYI, *Mentálhygiénés képzés a Semmelweis Egyetemen: Egy sokoldalú, tudományos program elmélete, gyakorlata és eredményessége* (Budapest: Animula) 49–75.
- TOMCSÁNYI, T. (2003) *Gesellschaft und seelische Gesundheit: Mentalhygiene in Theorie, Forschung, Praxis und Ausbildung* (Freiburg i.Br.: Lambertus).
- TOMCSÁNYI, T., R. CSÁKY-PALLAVICINI, M. BUCHOLCZNÉ SZOMBATHY & A. MESTERHÁZY (2001) 'Interdisziplinäre Ausbildung zum Schutz der seelischen Gesundheit (Mentalhygiene) im „postkommunistischen“ Ungarn', *Archiv für Wissenschaft und Praxis der Sozialen Arbeit* 32:1, 105–22; abr. vers. repr. in TOMCSÁNYI (2003) 95–114.
- TOMCSÁNYI, T., A. ITTZÉS, B. EHMANN, R. CSÁKY-PALLAVICINI, T. SZABÓ & Sz. TÖRÖK (2002) 'A tevékenységkísérő stúdium működési elvei és hatékonyságvizsgálata' in T. TOMCSÁNYI, *Mentálhygiénés képzés a Semmelweis Egyetemen: Egy sokoldalú, tudományos program elmélete, gyakorlata és eredményessége* (Budapest: Animula) 101–16; German trans. 'Die Prinzipien des berufsbegleitenden Seminars und die empirische Untersuchung seiner Effektivität' in TOMCSÁNYI (2003) 115–33.
- TOMKA, M. (1991) 'Secularization or Anomy? Interpreting Religious Change in Communist Societies', *Social Compass* 38, 93–102.
- TÖRÖK, P. (2003) *Hungarian Church-State Relationships: A Socio-Historical Analysis* (Budapest: Magyar Egyházszociológiai Intézet).

- VARGA, I. (1995) 'Modernity or Pseudo-Modernity? Secularization or Pseudo-Secularization?' in R.H. ROBERTS, ed., *Religion and the Transformations of Capitalism* (London & New York: Routledge) 231–47.
- WELSCH, W. (1988) *Postmoderne: Pluralität als ethischer und politischer Wert* (Köln: Bachem).
- WELSCH, W. (1996) *Vernunft: Die zeitgenössische Vernunftkritik und das Konzept der transversalen Vernunft* (Frankfurt a.M.: Suhrkamp).
- ZULEHNER, P.M. (1991) *Vom Untertan zum Freiheitskünstler: Eine Kulturdiagnose anhand der Untersuchungen „Religion im Leben der Österreicher 1970 bis 1990“, „Europäische Wertestudie – Österreichteil 1990“* (Freiburg i.Br.: Herder).
- ZULEHNER, P.M. & H. DENZ (1993) *Wie Europa lebt und glaubt: Europäische Wertestudie*, 2 vols. (Düsseldorf: Patmos).