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EHPS Newsletter

Newsletter Of The European Health Psychology Society

Contents

Editor's Foreword

This issue presents the Articles and Standing Orders of the Society that were accepted in Oxford and that will be put to a final check in Lausanne.

As a European Society, we are particularly interested in international comparisons. We therefore wellcome the discussion by Gerda Methorst, Mary Janssen, and Ad Kerkhof of the results of their survey on training and professional status of health psychologists in Europe, North America, Australia, and New Zealand.

Also we continue our series on health psychology in Europe with the presentation of health psychology in Poland and Finland.

Health psychology is part of a rapidly changing field. On page 12 Ad Kaptein draws our attention to one aspect of this evolution: the relation between health psychology and behavioural medicine.

Jan Vinck, co-editor

Health Psychology in Europe, North America, Australia, and New Zealand

*A survey on prevalence, training, and professional status**

INTRODUCTION

In our efforts to develop a health psychology training program we found that most formalized training programs exist in the United States, whereas only a few have emerged in Western Europe. Since it is questionable that the American standard of Ph.D. training should or could be applied to settings in other countries (Maes and Kittel, 1990) an international survey was designed to elicit information about the availability and content of training in Health Psychology.

METHOD

Because of a lack of worldwide standardization of academic training and insufficient knowledge of the specific training situations in different countries a semi-structured questionnaire was designed using a combination of American and European academic standards. Training at beginning and at intermediate university level was differentiated from training at advanced university level. All training programs taking place before graduation in psychology were labeled graduate training programs. All training programs taking place after graduation and leading to a doctoral degree for which a scientific dissertation is needed were called doctoral training programs. All training programs taking place after graduation and leading to a professional identification for which no scientific dissertation is needed were called professional training programs.

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* This article is a revision of "Training in Health Psychology: An International Look", *Psychology and Health*, 1990, 4, 19 - 30.

EHPS Conferences

• ***Lausanne, 28-30 August 1991*** • ***Psychology and Promotion of Health***
The Fifth EHPS Conference and Congress of the Swiss Society of Psychology is held at the University of Lausanne. See page 13 for information on the scientific program. For further information contact Mrs. Elena Martinez, Department of Psychology, University of Lausanne, BFSH 2-Dorigny, CH-1015 Lausanne.

• ***Leipzig, 25-28 August 1992*** • ***Health Psychology in a Changing Europe***
The Sixth EHPS Conference will take place at the University of Leipzig. Information and abstract forms can be obtained from: Prof. H. Schröder, Universität Leipzig, Fachbereich Psychologie "W. Wundt", Tieckstraße 2, D-O-7030 Leipzig.

Health Psychology in Europe, North America, Australia, and New Zealand

(continued from page 1)

Countries included in the survey were selected on the basis that their cultural backgrounds and foundations of psychology were comparable. Thus, Asian, Latin American, and African countries were excluded. Participants were chosen either because of their membership of the EHPS, because they had published on health psychology subjects, or because they had been referred to by other experts in the field.* Questionnaires were sent to the USA, Canada, Australia, New Zealand, Norway, Sweden, Finland, Denmark, Poland, German Democratic Republic, Czechoslovakia, Bulgaria, Hungary, Federal Republic of Germany, Austria, Italy, Switzerland, Spain, France, Belgium, the Netherlands, Great Britain and Northern Ireland.

RESULTS

Questionnaires were returned by all except those in Denmark, Poland, Bulgaria, and France**. The data from Northern Ireland and Great Britain were combined to provide a summary picture of the United Kingdom.

Several comments on the questionnaires revealed that the differences are very great. Because of these differences adequate responding to the questionnaire was often considered to be impossible and more than half of the respondents provided additional information on the organisation of psychological training in general and Clinical and Health Psychology in particular.

Prevalence of Clinical and Health Psychology within the national health care systems

The *estimated ratios* to total populations of clinical and health psychologists combined reveal that the prevalence of Clinical and Health Psychology varies considerably between countries. *High ratios* (up to 1:5.000) were reported for the Netherlands, Canada, USA, Norway, Australia, Finland, Federal Republic of Germany, and Belgium. *Intermediate ratios* (up to 1:10.000) were reported for Switzerland and Spain. *Low ratios* (over 1:10.000) were reported for Hungary, German Democratic Republic, United Kingdom, Czechoslovakia, and Austria. For Italy only the ratio of psychologists in general to the total population could be given (1:8.800), and for New Zealand no figures were reported.

Compared to the numbers of clinical psychologists the numbers of health psychologists, if existent or known, are much smaller. Estimations range from 4 in Austria (i.e. 0.4% of all psychologists and 1.2% of all clinical psychologists) to 10.000 in the USA (10% of all psychologists and 14% of all clinical psychologists).

Specialized training programs in Health Psychology

True specialized training programs in Health Psychology seem to exist only in the United States and Canada. In the US health psychology training is confined to the Ph.D.-level, in Canada it is also included in graduate programs. In Europe health psychology training at graduate level is mostly part of clinical psychology training if differentiation within the general psychology program exists. Differentiation in graduate training programs seems especially lacking in Eastern Europe. In the South Pacific no special training programs in Health Psychology exist but are comprised within the clinical psychology programs. In New Zealand Health Psychology is also taught in teacher's training, community psychology, and medical psychology.

In most countries the *graduate program* takes 4 to 5 years. In the first 2-3 years general topics including methodology and research statistics are taught and in the remaining 2-3 years students choose one or two application areas in which specific courses and skills labs are taken, an internship is completed, a research study is carried out and a thesis is written. The international comparison of health psychology training programs is complicated by the fact that graduate training in (Health) Psychology varies between universities within one country.

Doctoral and professional training in Europe and the South Pacific is hardly comparable to the North American Ph.D. training. As far as data were reported*** the percentages of Ph.D.'s in Health Psychology were compared with the percentages of Ph.D.'s in Clinical Psychology. In most West European countries higher percentages of Ph.D.'s were found for health psychologists. In the USA and Canada doctoral training comprises both research and practice aspects, and is required to be registered as a clinical psychologist. In most other countries doctoral training focuses primarily on research and is mainly done by completing a lengthy dissertation on a subject of one's choice. Formalized programs that combine practical and scientific training rarely exist. Professional training is frequently provided by health care institutions

*Data were collected from May through December 1988. At that time Germany still consisted of the German Democratic Republic and the Federal Republic of Germany. Therefore these names are also used in this article. Because of the short time span between the invitation to report the results in the Newsletter and the time of publication most recent developments have not been retrieved.

**We express our gratitudes to Gertrud Bonneberg, Ruth Burckhardt, Kerry Chamberlain, Rocio Fernandez-Ballesteros, Arne Holte, Michael Murray, Pierre L.-J. Ritchie, Hans-Dieter Rosler, Lothar R. Schmidt, Lucio Sibilia, Jaroslav Sturma, Bako Tihamer, Maila Upanne, Jan Vinck, John Weinman, Beate Wimmer-Puchinger and Helen R. Winefield for their cooperation. Special thanks are directed toward John Weinman and Stan Maes for suggesting names of prominent health psychologists.

***No data were reported for Finland, United Kingdom, Spain, Italy, Hungary, German Democratic Republic, Czechoslovakia, Australia and New Zealand.

and/or private or specialized psychotherapeutic associations. If specialized and time limited programs are mentioned they are of recent origin or in the process of planning. In general, this kind of specialization takes another 5 years. The overlap between Clinical and Health Psychology seems especially true for the East European countries and for Finland. However, developments have been reported which indicate that psychologists in these countries are increasingly consulted in cases where somatic conditions exist and where illness prevention and health promotion are desired. In the South Pacific no special doctoral training in Health Psychology exists. In New Zealand all psychology departments provide a clinical psychology Ph.D. program. In Australia Master's and Doctoral degrees are offered by so-called tertiary institutions and comprise a mixture of research-only and research-plus-coursework arrangements. There are seven Ph.D. programs in clinical and one in clinical neuropsychology. These programs presumably include health psychology topics since graduates find work in health settings in addition to the more traditional psychiatric settings.

The overlap between Health and Clinical Psychology is evident from the *content of the various programs.* All subjects that were considered relevant for either specialized clinical or health psychology training programs are covered by health psychology programs as well as by clinical psychology programs. Health psychology programs pay relatively more attention to risk behaviours, primary prevention, relapse prevention, rehabilitation, and public health. In Canada and the USA these subjects are most often provided in doctoral health psychology training programs and less frequently in doctoral clinical psychology training programs, although an overview of these topics may be included in many clinical psychology programs. Also in the U.S. and Canada there is frequently a blurring of specialties due to prevailing market forces which make it advantageous for a program to offer coursework in a given area.

Professional status of psychologists in health care

With the exception of Italy, the German Democratic Republic, and New Zealand all participants reported the existence of a *National Psychological Association* (NPA) with a section or division for Clinical Psychology. Most NPA's, except the ones in Austria, Belgium, the Federal Republic of Germany, Switzerland, and Czechoslovakia, have also a section/division for Health Psychology.

Almost all countries have *accreditation processes for training programs* in general psychology; none of the countries has an accreditation process for health psychology training programs. *Licensing and registration procedures* for clinical psychologists are available in less than half of the countries. Procedures for health psychologists exclusively have not been reported. Licensing and registration procedures are lacking in Belgium, Italy, and Czechoslovakia; plans are in progress in the Federal Republic of Germany, the United Kingdom and Austria. No data were available for Hungary, the German Democratic Republic, New Zealand, and Australia. If a clinical psychologist is registered or licensed, he/she can practice independently as far as the western countries are concerned. In Eastern Europe independent practice is unknown in the health care system. The allowance for independent practice does not imply direct reimbursement from the government and/or private health insurance companies. Reimbursement from private insurance companies is only reported for Canada, the Federal Republic of Germany, Norway, Spain, and the US. In Australia and Holland it depends on the company's policies.

Compared to medical doctors psychologists have less legal responsibilities, receive lower salaries, and are considered less powerful and/or professional by the general public. Despite these differences, psychologists and psychiatrists seem to collaborate well on a personal level; competition for patients was considered a relatively minor problem especially in Europe, Australia, and New Zealand. The reason for this is less fortunate than one might think since medical doctors are protected by a closed medical system and long established rules on financial and insurance procedures and psychologists are not powerful enough to change these long standing traditional boundaries. Recently, some national psychological associations are beginning to address this issue; especially in the U.S. where court case have established psychologists' right to independent practice and third party reimbursement.

DISCUSSION

Because of the large international differences it was impossible to validate the questionnaire for all participating countries. This, together with the fact that completion of the questionnaire proved to be difficult for many respondents, throws serious doubts on the accuracy of the data. However, since most respondents spontaneously provided additional information, the qualitative material together with the data from the questionnaire gave sufficient information to delineate major trends in the development of Health Psychology in general and health psychology training in particular.

In general it can be stated that Health Psychology in Europe, Australia, and New Zealand is still in its infancy. International collaboration in setting up appropriate training programs that represent international standards of qualification will provide substantial support for the development of this new branch in psychology.

Present day health psychologists were originally trained as clinical or as research psychologists. In Europe they more frequently have a doctoral degree than practising clinical psychologists. In order to maintain the scientific and practical base for Health Psychology as an independent discipline within psychology, it is advocated that future training programs encompass research training as well as practical professional training. For many components the overlap found

between health psychology training programs and clinical psychology programs is justifiable and should be continued. True health psychological areas such as primary and secondary prevention, psychological applications in somatic conditions, and psycho-education should, however, be better emphasized and specified whereas specific psychotherapeutic approaches could be deleted. More specific guidelines are provided by Swan et al. (1980), Stone (1983a; 1983b), Russo (1985), Singer (1987), and Stokes et al. (1987). Since these guidelines are primarily based on US training traditions the elaboration on the advantages and disadvantages of US and other training systems by Maes and Kittel (1990) is highly recommended.

The finding that health psychologists are poorly represented at the professional level stresses the need for an adequate organisation to promote and protect the occupational interests of health psychologists. It is therefore suggested that health psychologists organise themselves on national levels either by creating a division for Health Psychology within a national psychological association or by creating a national health psychological association itself. These national associations should exchange information, support, and knowledge through the already established international health psychology societies.

*Gerda J. Methorst, Mary A. Jansen, and Ad J.F.M. Kerkhof**

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Articles and Standing Orders

of the European Health Psychology Society

The Articles and Standing Orders of the European Health Psychology Society were, in principle, accepted at the last members' meeting in Oxford. However, as we will be legalizing these in the autumn of this year, we thought it wise to publish them in the newsletter for a final check at the members' meeting at the Lausanne conference.

Stan Maes, president of the EHPS

Articles

I. NAME AND PLACE OF RESIDENCE OF THE SOCIETY

Article 1. The Society is named : "European Health Psychology Society" and is domiciled in Leiden. The Society is governed by the law of the Netherlands.

Article 2. The Society year coincides with the calendar year and the financial year of the Society runs from January 1 until December 31 as well.

II. PURPOSE AND MEANS OF THE SOCIETY

Article 3. The purpose and objects of the Society are the promotion and development within Europe of empirical and theoretical research in and applications of health psychology and the interchange of information relating to this subject between the European members and other associations throughout the world towards an international achievement of these objects and purposes.

Article 4. The Society strives to reach the goals paraphrased in Art. 3 by :
a) the organization of conferences;
b) the publication of a newsletter;
c) the promotion of mutual scientific communication, co-operation between members and the organization of a network of correspondents.

III. THE MEMBERS OF THE SOCIETY

Article 5. Membership of the Society is confined to those who may be expected to make a contribution to the research and/or applications in Health Psychology.
The Executive Committee decides on the admission of members.

Article 6. The procedure for admission to membership is established by the Standing Orders.

Article 7. Membership expires with :
a) the member's death;
b) resignation by the member;
c) removal from membership. This can only take place when a member acts contrary to the Articles, Standing Orders or decisions of the Society, or damages the Society in an unreasonable manner.

Article 8. Removal from membership will be executed by the Executive Committee.

Article 9. The person concerned has the right to appeal to the Members' Meeting within one month after receipt of notice of removal from membership by the Society.

IV. CONTRIBUTIONS OF THE MEMBERS.

Article 10. Members must pay an annual contribution, which is determined by the Executive Committee. Members who do not pay their

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HEALTH PSYCHOLOGY IN EUROPE (3)

Two countries are presented in this issue: Poland and Finland. The description of Poland is, with the exception of Belgium, the last description that was prepared with the original set. The implication is that recent developments in this country are not yet reflected in the present description. Upon our request, our polish colleagues did not express a wish to update their description before publication.

The description of Finland is the first that is made recently for publication in the Newsletter. As we already indicated, we will continue our efforts to collect data from other countries so that our european picture can be completed.

Lothar Schmidt announced that a description of health psychology in Germany will have to wait some two or three years in view of the important political changes that take place in that country. We will hear more about this in Leipzig.

Poland

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1. Psychology in Poland

The population of Poland is 38.000.000 people; number of psychologists : 65.000; number of psychologists in fields which have relevance to health : 2500, mostly their basic professional identity is clinical psychology. They are employed in the National Health Services - about 1200 in psychiatric services, 500 in child guidance clinics and counseling centers, about 300 in neurological department or neurological rehabilitation centers and 500 in various units treating somatic disorders.

2. Training

Basic training includes five years of full-time psychological study at one of the 10 universities. The first two and half years cover mainly the basic courses in psychology which are taken by all students. Alongside with the basic courses in psychology there are supplementary courses in related disciplines. After this uniform stage, specialisation begins in three domains of applied psychology (clinical, educational and work psychology). There are some divisions within each specialisation, e.g. clinical psychology is divided into adult clinical psychology, child clinical psychology, forensic and neuropsychology. The specialisation courses are organised partially outside the Faculty of Psychology : in clinics, factories or in schools. Furthermore the students are also required to write a Master's thesis, during the last two years of the curriculum. After presenting a degree examination, students are awarded the degree of Master in psychology and the specialisation is also specified in the Master's diploma. Then they have right to be hired in health care institutions as a psychologist.

A uniform system of post-graduate specialisation in clinical psychology was created in Poland in 1984. The specialisation has two degrees and included four fields of specialisation :
- clinical psychology of mental disorders,
- clinical psychology of children and adolescents,
- medical psychology,
- clinical neuropsychology.

Specialisation in clinical psychology of the first degree may be started after a one year employment in units of health care centers and includes :
- at least 2 years professional experience together with training under the supervision of a specialisation supervisor;
- four branch training two-month periods (in psychiatry, neurology, internal diseases, pediatrics);
- systematic self-training;
- participation in specialisation post-graduate courses;
- preparing a case-study and presentation of the paper;
- command of at least one foreign language;
- final examination.

There are established general requirements which refer to knowledge, practical skills and personal qualities.

Second degree specialisation may be continued in a chosen field of clinical psychology after completing the first degree training in clinical psychology. Specialisation curriculum

includes among others :
• at least 3 years of professional practice
• part-time internship in one of the four following fields: clinical psychology of children and teenagers, neuropsychology, somatic illness and mental disorders;
• participation in post-graduate courses as indicated by specialisation supervisor;
• systematic self-training and publishing or presenting two papers;
• passing of a commission examination which includes theoretical and practical tests.

There is no health psychology specialisation separate from clinical psychology.

3. Organisation of health psychology

Treatment and rehabilitation are performed most frequently in the National Health Service units which provide free of charge services. Some group physicians have private practice or work in doctors cooperatives, covering about 25% of outpatients services in Poland (patients have to pay the full fees without any compensation from insurance). More clinical psychologists work in hospitals than in outpatient units. As a base for legal status of the clinical psychology profession there is a Ministry of Health and Social Welfare (M.H.S.W.) regulation statement; "..profession of permanent applicability in the health services". Moreover clinical psychology is recognised by M.H.S.W. as one of 33 medical subspecialities. Clinical psychologists are members of the Polish Psychological Association and the Polish Psychiatric Association (especially Psychotherapy Section), Polish Association of Mental Hygiene. A Committee for Supervision in Clinical Psychology in Poland has been appointed in 1981 by the M.H.S.W. The Committee is responsible for curricula and organisation of postgraduate training of clinical psychologists as well as for certification examinations. Clinical psychologists closely cooperate with psychiatrists, cardiologists, pediatricians and other medical staff. They are members of medical scientific societies, participate in medical conferences and in research projects carried out jointly with medical colleagues.

The following journals publish materials on clinical psychology : Psychotherapy, Psychological News, Polish Psychiatry, Polish Neurology, Psychological Review, Polish Psychological Bulletin (published in English), Polish Medical Journal, Polish Cardiology. A new journal "Clinical Psychology" is under preparation by the Polish Psychological Association.

Health Psychology is not a separate branch of psychology and some tasks in this area are performed by clinical and educational psychologists.

4. Areas of activity of health psychologists

We do not separate health psychology from clinical psychology and there is a common opinion that this separation is not necessary in Poland now. Some part of the activity in this wide field is more within the scope of a narrow definition of the health psychology domain. Apart from psychological activity in mental disorders and neurological treatment and rehabilitation we would mention the following domains of action :
• psychological education of medical staff as a means for innovations in medical institutions (especially teaching of the psychological skills for G.P. and nurses in the primary health care);
• psychological education of teachers and educators as a means for mental health prevention for children
• new psychological technologies treatment and rehabilitation of alcoholics, in treatment of families and psychosomatic illness;
• cooperation with self-help groups and education of non-professional helpers.

5. Research

The majority of research projects are carried out at the universities, medical academies and Polish Academy of Sciences. The projects are supported by state grants. The main research topic of the projects relevant to clinical and health psychology are:
• stress, social support and illness,
• Type A behavior pattern,
• processes and outcome of psychotherapy,
• psychological technologies for treatment and rehabilitation of people with alcohol problems,
• theory of change process of destructive personal habits,
• methods and outcomes of psychological rehabilitation in cardiology,
• psychological determinants of etiology, course and treatment of somatic disease (esp. cardiological and oncological);
• personality development and psychosocial factors of drug addiction,
• medical staff attitudes, burn-out in helping professions and patient-therapist interaction;
• preparation for surgery,
• bio-feedback.

6. Further comments

6.1. Health of population

There are many signs that the health status of the Polish society is not good. Especially alarming phenomena are, among others :
• considerable increase in number of persons with alcohol and drug problems (a dynamic growth tendency in women and youth),
• increase in number of persons with diseases of heart, lung cancer, hypertension, with neuroses and mental illness;
• still high infant mortality rate and some decline in life expectancy for males in cities.

The mortality rate for men in Poland is the highest in Europe - mostly due to cardiovascular diseases and neoplasms. About 7.1% of the general population in 1978 were diagnosed as suffering from various forms of disability. In 20% of polish families at least one family member is disabled which leads to various family crisis situations. In 1980 out of the total number of deaths under age 65, accidents accounted for one third of the

cases, heart diseases for one-fourth. Mental disorders are found in 3% of the general population and in 25% of patients of primary care units.

There is a very negative social evaluation of the quality of health services, because of shortage of staff, medicines, beds in hospitals and means of hygiene. 'Health' is not a very highly evaluated personal value in the Polish society. Research showed that such values as happiness, love, friendship, freedom, autonomy or justice are estimated much higher. Health is appreciated high only when someone is losing it. Learning to disregard health in an early period of life is a typical phenomenon in our society. For many persons the building of their own personal autonomy and 'adult' identity through rejecting and contempt of health recommendations of their parents became an important part of maturation. In this way lack of internal motivation and even a negative attitude toward a healthy conduct is recorded in personality structure. Health hazard became an important element of the 'male' conduct pattern and is imitated by young women more and more often.

This is a dangerous source of neutralisation of most health education which should promote healthy behavior. It reduces the outcome of many treatment influences which are based on compliance with the physician's recommendations. There is a strong tendency to reject personal responsibility for one's own health status. A state of illness is experienced by many in the first place as an excuse to withdraw from duties and personal tasks. Specific research data to support this description are not available, but the above picture may refer to the state of attitudes among health professionals.

6.2. Opportunities for health promotion and disease prevention

Measures planned by M.H.S.W. up to the year 2000 (Last Report of Ministry of Health) :

• "... to provide the necesssary legal, administrative and economic mechanisms aiding and promoting a healthy way of life".

The role of psychologists : consultation of programmes for promotion of healthy behavior and attitudes; elaboration of psychological technologies for teaching the skills of stress coping and of taking up responsibility for one's own health.

• "... to strenghten the role of the family and self-help groups in order to promote health-promoting ways of life".

The role of psychologists : family counseling, providing the knowledge about the psychology of healthy life (educational programmes on mass media, books, popular psychology journal), stimulation and consultation for self-help groups.

• "... reorganisation of the primary health care".

The role of psychologists : practical participation in primary health services by means of consultations for physicians, counseling and psychotherapy for patients with mental disorders, providing of psychological counseling for families with small children and for mothers during pregnancy.

6.3. Image of psychology

The popularity and social expectation from psychology are still growing. The popular image of psychology is connected with the expectation that psychologists are able to explain difficult and intimate emotional events and to help people in solving their personal problems. There is a increasing amount of employment opportunities for psychologists in health services, mostly in carrying services for individuals - but participation of psychologists in consultation, planning and evaluation of health services and facilities is not expected by the health authorities. ■

Finland

Ritva NUPPONEN & Maila UPANNE

Introduction

In Finland, psychologists work primarily in organizations maintained by the society. There is one professional psychologist per 2000 inhabitants. One in two psychologists works in a health care organization or some sector of the social services closely connected with coordinated health promotion activities. Most psychologists are members of the Union of Finnish Psychologists that was founded in 1957 to look after the professional interests of psychologists. The Finnish Psychological Society, founded a few years earlier, is a scientific body.

The status of psychologists in health care is equal to that of all other Finnish psychologists in terms of training, professional autonomy and terms of employment. The major fields of professional activity of health psychologists are described in Chapter 3.2.

Psychologists have made major contributions to the development of Finnish health care services. They have anticipated social policies that now form part of the WHO Health Promotion concept. Their activities have ranged from participation in drafting laws to the education and training of health care personnel and the further development of health care units. Psychologists are, of course,

concerned with the treatment of illness, but they also help to promote the health of individuals and of the population as a whole, even outside the public health sector (Nupponen 1890).

1. Number and distribution of psychologists

At the beginning of 1989 the population of Finland stood at five million. The population density is 15 per square kilometer. The population is concentrated in the south and southwest of the country, which are also the main industrial areas. The northern and north-eastern parts of Finland are sparsely populated. They are important areas of primary production for the wood-processing industry. The considerable size of the country affects the provision of services. The traditional aim of Finnish social policy has been to ensure that public health, and social educational services are available to all citizens,irrespective of their place of residence, wealth etc. (see Facts about... 1989, Health for... 1989).

There are at present 2500 professional psychologists in Finland. They are fairly evenly distributed in relation to the population throughout the country because they work in public service organizations. Some 90% of psychologists are paid from public funds, mainly as monthly salaried employees of the State or municipalities. The number of psychologists working in industry and commerce on marketing, research and human resources development is fairly small (Nupponen 1980). Recently, however, private enterprises have been employing increasing numbers of psychologists.

Over 1300 psychologists work for municipalities in public health care, and 300 are engaged in primary health care. There is usually one psychologist in each local health care center. About 400 work in psychiatric outpatient care, that is mental health centres. Health psychologists also include psychologists working in hospitals and rehabilitation centres as well as in occupational health care.

In Finland, psychologists working in the social services, particularly in centres for child guidance and family counselling, and in organizations providing services and care for retarded persons and disabled, are responsible for therapy, guidance and counselling which, in some other countries, are the responsibility of the health care services. These social services are evenly distributed throughout the country. and employ some 400 psychologists. National employment services, in particular vocational guidance and career counselling, also employ psychologists in all parts of the country. The system of school psychologists is still incomplete and is concentrated in the largest towns and cities.

State-funded expert institutions such as the Institute of Occupational Health, The Rehabilitation Research Centre of the Social Insurance Institution, and the Rehabilitation Foundation play an important role in health care and also employ psychologists.

Roughly one hundred psychologists are in private practice as psychotherapists or neuropsychologists, mainly in the large cities. The number of private medical institutions in the Finnish health care system is small (see Health care... 1987, Services... 1989).

In addition to their full-time work, many psychologists (600) undertake, at least occasionally, private counselling, teaching, etc.

2. Training of psychologists

All Finnish psychologists are trained to MA level. At present, a psychologist can be trained at one of six universities. It is also possible to take postgraduate degrees in psychology (Lic.Psych. and D.Psych.) at these universities. Doctoral theses must be published and must demonstrate a higher level of theoretical and methodological knowledge than is required in a licenciate's dissertation. Ten percent of psychologists hold the degree of licenciate or doctor but these qualifications have no relevance to the right to practice their profession, to salaries, etc...

The training of psychologists is governed by a decree. The structure and content of training is fairly similar at all universities. The degree of Master of Psychology is required for tenure of a public post. It does not include specialization in any specific area or task. In a country like Finland with a small population it is important to ensure that the labour force, including psychologists, are proficient and able to undertake various tasks in their own professional sphere.

The degree (M.Psych.) includes theoretical and methodological studies in psychology, with social sciences and pedagogics as minor subjects. It also includes courses in statistics, physiology and medicine. In the final stages, the content of the studies can be modified to reflect the student's particular interests and the special strengths of each university. The degree requirements include submission of a graduate thesis and training in professional skills (psychodiagnosticis, interviewing, counselling, consultation, basic skills in psychotherapy, etc...). Towards the end of the studies, the student undergoes an internship supervised by a senior psychologists in either one or two areas of professional activity. The minimum duration of the internship is 20 working weeks.

The degree course usually takes six years. Because of voluntary additional studies and extended internship, it is not uncommon for studies to take more than six years.

Most university postgraduate studies have, until recently, been geared to a higher scientific degree. Professional further training has been the responsibility of the Union of Finnish Psychologists and some other bodies.

Psychologists have been very active in organizing and participating in such training. Currently, many postgraduate courses in psychology are undertaken at universities at the expense of the psychologists themselves, or their employers. Finland has no official specialist training, or any corresponding system of specialist psychologists. However, specialist training is currently being planned.

Since 1957, The Union of Finnish Psychologists has had a qualification system for new psychologists starting their careers. Most psychologists have completed the relevant course, which consist of consultation with and counselling by a senior psychologist over a three-year period to promote individual professional development and skills. The qualification system also involves 180 hours of theoretical and professional further training in the form of courses approved by the Union of Finnish Psychologists.

Another important branch of professional further education is structured training in psychotherapy. The National Board of Health approves training programmes leading to official qualification as a psychotherapist (specialized level, a minimum of 2.5 years, highly specialized level, 5 to 6 years of training). One psychologist in three has undergone at least three years of theoretical and practical postgraduate training in psychotherapy. Sixty per cent of officially qualified psychotherapists are psychologists. Most other psychologists have undergone shorter training in counselling, and various forms of individual and group therapy and family therapy, as well as health psychology.

As in psychotherapy, two and three-year postgraduate training courses have recently been organized for psychologists specializing in supervising and peer counselling, and in neuropsychology.

The National Board of Social Welfare is responsible for the coordination of the nine-month in-service training required of new workers, including psychologists, in child guidance and family counselling centres, partly in conjunction with the universities. The Ministry of Labour organizes training leading to qualifications in vocational guidance and career counselling for psychologists. The National Board of Vocational Education organizes similar training for psychologists working in vocational adult education and re-training.

3. Psychologists and the health care system

3.1 Organization of health care

In Finland health is considered the right of all citizens, and society is seen to be responsible for ensuring health, for example through maintenance of adequate services.

Historically, the Finnish health service has largely been the responsibility of the local authorities. In Finland local government is based on autonomous municipalities, which have elected councils with power to levy taxes. Municipalities can cooperate through federations of municipalities to ensure adequate levels of services (Facts about... 1989, Health Care... 1987, Health for... 1989).

Major public health organizations include municipal health care centres, occupational health care systems organized by health centres and private organizations, and a labour protection system under the Ministry of Labour. Health care centres provide a wide range of preventive and curative services: outpatient medical and laboratory services, health education and counselling, services provided by a psychologist, a social worker and a speech therapist, physiotherapy and, to a limited extent, inpatient care. Maternity and child health care, guidance for the elderly, and health education are mainly organized on a neighbourhood basis. Health centres are also responsible for school health care.

Specialist medical care is provided by hospitals maintained by federations of municipalities. Some are university hospitals and participate in the specialist training of doctors. Hospitals supplement the services provided by health centres with outpatient services, radiological and laboratory services and constellations. Psychiatric health care is the responsibility of psychiatric hospitals and, in particular, local mental health centres. The latter provide outpatient services, psychotherapy and counselling for psychiatric outpatients and their families, emergency services, and community mental health services, the latter often in conjunction with municipal social services, health centres and non-governmental organizations.

Outpatient care is becoming an increasingly important part of health care, particularly in psychiatric care and rehabilitation. This will continue to be the general trend in the future. The National Board of Health, working under the Ministry of Social Affairs and Health, is the authority responsible for the related guidance and development at the national level.

Nearly all services provided by health centres and all services in mental health centres are free. In other health care units, counselling and health education, and most psychological services are free.

Outpatient visits to a hospital and hospital treatment are subject to a charge. The costs, together with the costs of visits to a private practitioner, private laboratory or physical therapy, etc. are reimbursed through the sickness insurance scheme. The social insurance scheme pays a maternity allowance and reimburses part of travel expenses and rehabilitation costs arising from illness.

In Finland the private sector accounts for only about 20% of all visits to doctors. The services concerned consist mainly of examinations and outpatient treatment by specialists. However, private physiotherapy and rehabilitation are important adjuncts to the public health service. A growing rate of psychologists is working in private practice, nowadays, too.

3.2 Status of psychologists

A great part of health psychologists are employed by public health and social services. They are paid by the State or the municipalities and are subject to the ordinary laws, decrees and principles guiding professional practice. A few psychologists work in private organizations supported by the State or municipalities. These follow the same policies as those in the public health care sector.

In health care, the legal and professional status of psychologists is similar to that of psychologists in other

public services. There are no significant differences in status between psychologists working in private health care institutions and those working in public health care.

There is no special law in Finland protecting the use of the title of psychologist or defining the right to practise as a psychologist. This has not led to any major problems within the health care service. However, legislation has been under consideration for a long time. The Finnish Psychological Association considers such legislation necessary because, at present, no control or qualification requirements apply to private services relating to training, selection of personnel and therapy not financially supported by the State or municipalities.

In Finland, practice as a dentist, veterinarian or optician is subject to legislation. The Act relating to the practice of nursing makes provisions relating to the control of health care professions entry to which is based on college or school-level training. There is no law covering the practice of psychology but legislation has been in preparation for 25 years. Since the professional title of psychologist and the right to practice as a psychologist are unprotected by law, psychological services may be provided by totally unqualified persons.

The possibilities open to the authorities for monitoring of the activities of psychologists in the health care sector are limited. The legal protection afforded to clients is inadequate because there is no official means of appeal in relation to psychologists or psychological services. To solve these problems, the Finnish Psychological Association believes legislation relating to the practice of psychology in Finland requires enactment.

Psychologists are subject to the same laws and official regulations as other health care personnel. The qualification requirements and other terms of employment of psychologists in public health care are uniform. The private sector also adheres to them. The same authorities scrutinize the work of psychologists and other health care personnel at both local and national levels. Criticism of appeals to and complaints about health care personnel, including psychologists, are seen as directed against the service organization as a whole, i.e. the psychologist's activities are considered to be a part of a more comprehensive service.

The terms of employment such as hours of work and salaries of health care personnel, including psychologists, are fixed nationally through collective bargaining between trade unions and employers' associations. There are no significant differences between the different organizations or between public and private services. However, the salaries of health care personnel, as of nearly all personnel in the public sector, are markedly lower than those in industry and business. In health care, psychologists are paid much less than doctors but more than social workers and speech therapists with master's degrees.

Psychologists, doctors, nurses, social workers and others employed in public health care receive a monthly salary that does not include any special fees. However, a qualified psychologist registered by the Social Insurance Institution can carry out privately psychological examinations on patients referred by a doctor. Patients receive reimbursement for the fee from the sickness insurance fund. A qualified psychologist on the Social Insurance Institution register can offer psychotherapy and neuropsychological rehabilitation privately. Patients are reimbursed from the social insurance rehabilitation funds or from the funds of the local health centre or inter-municipal federation for psychiatric health care according to a separate services purchasing system.

3.3 Task and responsibilities

In Finland, psychologists are members of a small but respected professional body. The role of psychologists as providers of care is more firmly fixed in the minds of the public than would be expected on the basis of their distribution in various fields. Work undertaken by psychologist in child guidance and family counseling, in counselling and health education at health centres, and in vocational guidance have fostered the notion that the work of psychologists is related to the everyday life of individuals, not merely to mental disorders.

The number of psychologists in health care units is less than sufficient in relation to the amount of work they have to cope with and the tasks considered to be within their area of expertise. In general, psychologists perform the same kind of duties in all health and social services. Priorities are determined by the responsibilities of the organization or unit, by the numbers of personnel or psychologists in the unit, and even by the versatility and availability of local social and health services.

In health care organizations, psychologists work as independent experts and internal consultants responsible directly to the head of the organization or some larger unit. Psychologists themselves do not usually have managerial responsibilities within the organization. Professional management, however, falls within the responsibility of leading psychologists. In larger organization, the variety of tasks of psychologists can be modified through internal distribution of work so that some psychologists may concentrate on, say, therapy, others on community mental health activities. In small organization, the tasks are likely to be more varied. Psychologists themselves determine whether or not particular tasks should be undertaken by a psychologist. No serious problems relating to distribution of work or competition over tasks with doctors have occurred.

In almost all health care organizations psychologists participate in planning as specialists in psychology and the social sciences. They also work as part of teams appointed to deal with special tasks or health education projects.

Psychologists usually also participate in investigations and studies connected with psychology or the social sciences. They also liaise with

social service units, work places, etc...

Contracts between psychologist and patients, clients and families vary, depending on the primary tasks of the health care units concerned. Diagnosis and related consultation can sometimes account for 50% of working time but, particulary in health centres, the percentage can be considerably less. In health centres, counselling and guidance account for a substantial proportion of the total workload, which also includes psychological supervision of public health nurses and inpatient ward personnel. In hospitals, there is less guidance and counselling for patients, and the proportion of psychotherapeutic work is higher. In mental health centres, some psychologists may concentrate almost entirely on psychotherapy, others on counselling for families of psychiatric patients and day hospital personnel, etc. They often participate in community mental health projects. In health centres and hospitals, health education, or guidance relating to nutrition, physical exercise, smoking, etc., tends to be provided by nurses, nutritionists and physiotherapists. Psychologists undertake health counselling when clients or patients have specific problems or when problems are related to child upbringing and personal relations. They participate in the planning and organization of health counselling and on-the-job training of personnel.

4. Research

Health care research and studies of the health service are financed mainly from public funds. The number of private sponsors, foundations etc. is fairly small, except in pharmaceutical research and drug trials. Most psychological research takes place in university departments of psychology. Health care research is primarily carried out in medical faculties. The Academy of Finland makes major financial contributions to such research. The Ministry of Social Affairs and Health and the National Board of Health finance health care research at universities and individual research centres.

About two-thirds of research psychologist works as university teachers, or in fixed-term university research projects, some studying for their licenciate or doctor's degree at the same time. For financial reasons, the numbers of staff other than teaching staff vary considerably. The number of psychologists working in universities is roughly 150. Only about 30 senior researchers, including professors, have permanent university posts.

Researchers in psychology or social sciences usually hold fixed-term contracts of 1 of 5 years in duration. Their responsibilities can also include activities other than research.

There have been few long-term research projects in psychology, and none relating primarily to health psychology. Most studies have been carried out by individual psychologists or by groups of a few psychologists. They have covered extensive fields, ranging from the psychological aspects of health and illness to problems of treatment and treatment organizations as well as theoretical problems relating to the science of psychology (Peer review 1985).

Some hundred psychologists work in research institutions partly or totally dependent on State support. Some 70 of them participate in research relating to health or occupational safety. Their work often involves professional tasks, too. Research into occupational health and rehabilitation is a theme of many of studies. The methods used in psychodiagnostics, the treatment and prevention of illness, and psychological decision-making have also been studied.

Hospitals and health centres undertake research on a relatively small scale. Questions arising from the everyday operation of the organization or unit constitute the main topic. Action research approach has been favored during the past few years. Small research and development projects at work places have increased in number. Psychologists play active and prominent roles in such research, because of their position in the organizational structure and their training in research methodology and theory.

Medical research is carried out mainly in large hospitals, particularly university hospitals. Psychologists are in demand as members of research teams, but the outline of topics and the implementation and leadership of the studies are nearly always medical. Extensive epidemiological projects and evaluations of health care policy and health care systems are undertaken in medical faculties or research institutes working under the Ministry of Social Affairs and Health, namely the Research Institute for Social Security and the National Public Health Institute.

The role of research into health psychology has been considerably less prominent and its status has been more vague than the role status of professional psychologists.

Studies carried out by psychologists, although of a high standard, have been few in number. Basic theoretical approaches extend from psychoanalytical and psychogenetic trends to theories of learning and social or developmental psychology. Most of the research reports are published in Finnish or Swedish, but some have also been published in other languages, e.g. as monographs in scientific publications. Finnish health psychologists have more often reported their studies in medical journals or journals relating to research on work or occupational safety than in international psychological journals.

Tradition, settings and sources of financial support have meant that psychological research has focused mainly on clinical topics, that is on patients, illnesses and rehabilitation. Most research has concentrated on mental health, the prevention and treatment of psychiatric disorders, psychotherapy and the phenomena relating to social systems in health care. There have been fewer psychological studies relating to health. In Finland research into ways of life and life-styles and even health education has been carried out mainly by institutions controlled by physicians. Extensive preventive programmes and current population studies on the social aetiology of cardiovascular diseases, for example, have been undertaken

with almost no contribution from psychologists. However, psychologists play an important role in the ongoing national project for the prevention of suicide. Health research has seldom offered psychologists long-term jobs or opportunities for independent research.

Accordingly, there are few experienced research psychologists in the field of health psychology. It remains to be seen whether or not the future will provide opportunities for high-level psychological research relating to health. ■

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Behavioural Medicine

versus

or

and / or

Health Psychology

It's a funny world - hundreds of psychologists have developed a body of knowledge regarding health, illness and psychology and already they have succeeded in labelling their activities under different headings : health psychology and behavioural medicine. If there are two labels, surely there must be differences in their work, their visions on where to go in the next decades, their theoretical notions, their methods, the problems they want to study and solve?

I have edited two books with Behavioural Medicine in the title and I am European editor of Psychology & Health - have I become schizophrenic in the process ? No, I don't believe so. What then are the differences and similarities between health psychology and behavioural medicine - if any?

A critical analysis of the definitions of the two fields will not be repeated here. Definitions of what constitutes a scientific discipline are useful and necessary. However, in this editorial I merely want to give my thoughts on some of the more or less subtle differences between behavioural medicine and health psychology. How many of us are offended by the characteristics of the two fields in this figure?

Behavioural Medicine	***Health Psycholgy***
treatment, rehabilitation	prevention
cooperation with physicians	psychologists only
disease/illnesses	health/complaints
medical faculty	psychology faculty
clinical	research

If these contrasts reflect the emphases in the two fields correctly, how good or bad is this for psychologists who are involved in research, teaching, and patient care - all aimed at preventing people becoming ill, or helping those who are ill to cope - and many other topics?

Those colleagues who insist on being called health psychologist emphasize, in my experience, the importance of strengthening the position and power of psychology vis a vis medicine and physicians. Sometimes, I discern a tendency to feel superior over "the boys in white" by those health psychologists. I myself think that physicians, governments, health insurance organisations, and the public at large increasingly recognize the importance and relevance of behavioural factors in the development and maintenance of illness. In my opinion, therefore, there is less need to be defensive or antagonistic towards medical colleagues. Good theories, relevant empirical work and good cooperation with relevant health professionals is what it's all about. I myself feel it is not so important then, to quarrel about whether we work in the field of Behavioural Medicine or Health Psychology?

Looking forward to your dissenting opinions,

Adrian A. Kaptein, co-editor Newsletter EHPS

Fifth European Health Psychology Society Conference - Congress of the Swiss Society of Psychology

Lausanne: Scientific Program

Psychology and the Promotion of Health

Form	*Titles*	*Chairman and speakers*
28 August PM		
	OPENING ADDRESS	DAUWALDER J. P. (CH)
LECTURE	The role of psychologists for health promotion	SARTORIUS N. (WHO)
PANEL	How to promote Health Psychology in Eastern Europe?	MELLIBRUDA J.P. (P)
SYMPOSIUM 1	Psychophysiology	OEHMAN A. (S), Benton S. (UK), Dixon C. (UK), Gaillard F. (CH), Hauert C. et al. (CH), Pruneti C. et al. (I)
SYMPOSIUM 2.A	Coping with HIV	PERREZ M. (CH), Guillaume M. (CH), Halttunen A. et al. (FIN), Hedge B. (GB), Hedge B. (GB) & Sherr L. (GB)
SYMPOSIUM 3	Work-site intervention	NOACK H. (CH), Kittel F. et al. (NL), Oldenburg B. et al. (AUS), Werner M. (CH), Reulecke W. et al. (D)
	PUBLIC CONFERENCE	LABORIT H. (F)
29 August AM		
SYMPOSIUM 4	Emotion and Cognition	SCHWENKMEZGER P. (D), Gerhard U. et al. (CH), Kreegipuu M. (EST), Schwenkmezger P. et al. (D), Uutel A.A. & Sormunen P. (FIN), Weber H. (D)
SYMPOSIUM 5	Children and chronic disease	BIONDI G. (I), Sturma J. (CS), Ruta T. (SF), Bode U. (D), Rossi A. (I), Serrano I. (B)
SYMPOSIUM 2.B	Coping with HIV	PERREZ M. (CH), Maguire B. (USA), Gerbert H. (USA), Sherr L. (GB), Sieber M. (CH), Skutle A. (NOR)
SYMPOSIUM 6	Primary care	DIEKSTRA R. (NL), Gruyters T. & Priebe S. (D), Oldenburg B. et al. (AUS), Probstova V. (CS) & Schroeder H. (D), Upanne M. et al. (FIN)
SYMPOSIUM 7	Occupational stress	SEMMER N. (CH), Jones F. & Fletcher B. (GB), Matthiesen S. et al. (NOR), Semmer N. & Baillod J. (CH), Semmer N. et al. (CH), Udris I. et al. (CH)
LECTURE	Promotion of health for the elderly	LEVENTHAL H. (USA)
29 August PM		
PANEL	Which "identities" for professionals in Health Psychology?	JOHNSTON, M. (GB)
SYMPOSIUM 8	Life-style	HORNUNG R. (CH), Versteegen U. (CH), Frey D. (D), Julkunen J. (FIN), Schwenkmezger P. & Hank P. (D), Hornung R. (CH)
SYMPOSIUM 9	Community health	SCHOBERBERGER R. (A), Rieder A. et al. (A), Wimmer-Puchinger B. (A), Servais E. (B), Schoberberger R.(A)
SYMPOSIUM 10	Coping with cancer in the long term	HEIM E. (CH), Buddeberg C. (CH), Bernhard J. et al. (CH), Augustiny K. (CH), HEIM E. (CH), Guex P. (CH)
SYMPOSIUM 11	Issues of health and ageing	VISSER A. (NL), Holte A. (NOR), Oldenhave A. (NL), Pooken I. (D)
LECTURE	Religious beliefs and health	STONE G. (USA)
30 August AM		
SYMPOSIUM 12	Quality of life	KAPTEIN A. (NL), Baker G. & Owen R. (GB), Hoernquist J. (S), Kaiser F. & Fuhrer U. (CH), Lauer G. (D), Mc Gee H. et al. (IRL), O'Boyle et al. (IRL)
SYMPOSIUM 13	Health screenings	N.N., Boer H. et al. (NL), Conner M. & Norman P. (GB), Glynn R. & Frasad R. (GB), Halttunen A. et al. (FIN), Sutton S. & Bickler G. (GB)
SYMPOSIUM 14	Health behavior in Europe	WARDLE J. (GB), Wardle J. & Steptoe A. (GB), Skrarski A. & Kopp M. (HUN), Reelick N. et al. (NL), Rutter D. (GB), Mendoza R. (E)
SYMPOSIUM 15	Ecological risks	DAUWALDER J. (CH), Borgo S. et al. (I), Chatrou M. et al. (NL), Hand I. (D), Stark M. & Andresen B. (D), Dauwalder J. (CH)
SYMPOSIUM 16	Health psychology and suicide prevention	KERKHOF A. (NL), Schmitke A. & Schaller S. (D), Sonneck g. (A), Kerkhof A. &Visser A. (NL), Egmond M. & Kerkhof A. (NL)
LECTURE	Promotion of health in- and outside the hospital	THEORELL T. (S)
30 August PM		
PANEL	Which standards for training in Health Psychology (Europe '92)?	MAES S. (NL)
SYMPOSIUM 12.B	Quality of life	KAPTEIN A. (NL), De Haes H. (NL), Muthny S. (D), Maille R. (NL), Moum T. (NOR), Wright S. (GB)
SYMPOSIUM 17	Attitudes and knowledge	N.N., Adamson B. (AUS), Bennet P. et al. (GB), Decruyenaere et al. (B), Paulhan I. et al. (F), Udris I. et al. (CH)
SYMPOSIUM 18	Health education	N.N., Breemhaar B. (NL), Parbri D. & Munari A. (CH), Galama P. (NL), Schlosser M. &, Maes S. (NL), Seydel E. et al. (NL)
SYMPOSIUM 19	Social support	N.N., Bizinni L. & Bizzini V. (CH), Colland V. (CH), Knox S. (USA), Pennings L. (NL), Schumacher J. (D)
LECTURE	Perspectives for promotion of health	TAYLOR S. (USA)
PANEL	La situation en Suisse et dans le Canton de Vaud	GILLIAND F. (CH), Kleiber C. (CH), Buehler B. (CH), Schoeni G. (CH), Ponce L. (CH)

Articles and Standing Orders

(continued from page 4)

annual contribution two years in a row, will be suspended on January 1 of the third year until the next Members' Meeting, at which their membership will be terminated.

V. STRUCTURE AND FUNCTIONING OF THE SOCIETY

Article 11. The Society has a Members' Meeting and an Executive Committee.

A. The Members' Meeting.

Article 12. All members are admitted to the Members' Meeting. Guests may be invited by the Executive Committee.
The Members' Meetings are convened by the Executive Committee. Notice will take place in writing to all members. The term of notice will be at least 20 days, notwithstanding Article 39 hereof.

Article 13. Each member of the Society has one vote.

Article 14. Normally, the Members' Meeting convenes once in two years. At the request of 10 per cent (10 %) of the members an extraordinary Members' Meeting can be held.

Article 15. On the agenda of the Members' Meeting will always appear the following matters of business :
a) the reports of the Executive Committee on the activities of the Society;
b) the accounts of the Society;
c) the advice of the accountant on the accounts of the Treasurer;
d) the estimate for the forthcoming years;
e) the organization of the next Members' Meeting; and
f) the election of new members of the Executive Committee.

Article 16. So far as not stipulated otherwise in these Articles, all decisions in the Members' Meeting are taken by a majority of the recorded valid votes.

Article 17. The Standing Orders regulate the order of the Members' Meeting.

B. The Executive Committee

Article 18. The Executive Committee will be in charge of governing the Society and will submit issues for the decision of the Members' Meeting; the Executive Committee will carry out the decisions of the Members' Meeting and will look after the interests of the Society in the periods between Members' Meetings.
The Executive Committee, provided that the Members' Meeting has approved so, will be competent to enter agreements, to buy, transfer or encumber immovable property, to enter agreements in which the Society stands surety or is several co-debtor, makes out a case for a third party or stands security for a third party's debt.
Third parties can appeal and can be appealed against if this approval is lacking.

Article 19. The Executive Committee, which consists of eight members, is elected by the members. This may take place both during an ordinary or extraordinary Members' Meeting and direct elections outside of the Members' Meeting, or through a combination of both. The eight members of the Executive Committee must be as representative as possible of the following five regions of Europe :
a) United Kingdom, Ireland;
b) Benelux, Scandinavia;
c) Federal Republic of Germany, Switzerland, Austria;
d) France, Spain, Portugal, Italy, Greece;
e) Eastern Block.

Article 20. Only members who have been a member of the Society for two years can be elected as members of the Executive Committee.

Article 21. The procedure of the election and the duration of Executive Committee's offices are regulated by the Standing Orders.

Article 22. The President-Elect (also named Vice-President) just as the other members of the committee, will be elected by the members during an ordinary or extraordinary Members' Meeting or during direct elections outside of the Members' Meeting, or through a combination of both.

Article 23. The Society will be represented in all business matters by either :
a) the Executive Committee;
b) the President;
c) the Vice-President;
d) other members of the Committee nominated by the Executive Committee.

Article 24. The Executive Committee may, from time to time, be assisted or advised by experts from outside the Society or by other committees on affairs relating to the field of Health Psychology.

Article 25. It will be the duty of the President to preside at all meetings and to perform such other duties as are incident to his or her office, or as may properly be required by vote of the Executive Committee.
The Secretary will keep records of all meetings of the Society. It shall be the responsibility of the Secretary to bring to the attention of the Executive Committee and of the Society such matters as deemed necessary; to conduct the official correspondence of the Society; to issue official call and notices of meetings; to notify new members of their election directly.
It will be the responsibility of the Treasurer to sign such cheques or other drafts upon the funds of the Society as may be necessary; to execute, seal and deliver any contracts, deeds, instruments or other documents which shall be required on behalf of the Society by the Articles or by vote of the Society; to have custody of all funds and securities and to deposit same in the name of the Society in such bank or banks as the Society may direct; to have custody of all other property of the Society not otherwise expressly provided for by these Articles and to hold them subject to the order and direction of the Society; to collect dues and other debts to the Society by any persons whatsoever. The treasurer will, at any reasonable time, exhibit the books and accounts to any member of the Society, and in general will perform all such duties as may be incident to the office or as properly may be required by vote of the members of the Executive Committee at any duly constituted meetings.

Article 26. In the case of the death, incapacity or resignation of the President, the office shall be filled by the Vice-President until the vacancy is filled by the Members' Meeting.

Article 27. In the case of the death, incapacity or resignation of the Secretary, a stand-in will be appointed by the President. During its next meeting the Executive Committee will appoint a new Secretary from its members.

Article 28. In the case of the death, incapacity or resignation of the Treasurer, a stand-in will be appointed by the President. During its next meeting the Executive Committee will appoint a new Treasurer from its members.

Article 29. Any member of the Executive Committee, even if appointed for a certain period of time, can be removed from office by the Members' Meeting.

Article 30. Meetings of the Executive Committee may be held at any time on the call of the President or the Treasurer. A quorum at any meeting will consist of four or more members of the Executive Committee. Decisions will be taken by a simple majority of the members of the Executive Committee present at a meeting.

Article 31. The Executive Committee may delegate all preliminary organizational work for scientific meetings, conferences, congresses, symposia and seminars, in whole or in part (and whether that committee acts alone or in co-operation with others) to one or more ad hoc committees, (notwithstanding Art. 23 hereof) duly established for such purposes.

Article 32. The Executive Committee may, for the promotion of co-operation with other associations in the field, appoint members to represent the Society in national or international committees of contact, deliberation or co-operation and invest these members with special powers, but subject always to the provision contained in Art. 23 hereof.

Article 33. The Executive Committee may delegate its duties (either wholly of partially) to one or more committees of members, notwithstanding Art. 23 hereof. The functioning of these committees is regulated by the Standing Orders.

Article 34. The Members' Meeting may itself appoint other committees in addition to those mentioned in Arts. 31, 32 and 33.

VII. THE FINANCES

Article 35. The pecuniary resources of the Society consist of :
1) contributions of the members;
2) contributions of supporting institutions;
3) donations and legacies;
4) the proceedings of publications;

5) subventions;
6) interest; and
7) other profits.

Article 36. The administration of the pecuniary resources will be checked and reviewed by an independent accountant appointed by the Executive Committee, and the accounts will be reported at each Members' Meeting.

VIII. ARTICLES AND STANDING ORDERS

Article 37. Articles will be approved by the Members' Meeting.

Article 38. Modifications in these Articles may be proposed by the Executive Committee or by at least 25 members present at the Members' Meeting.

Article 39. A proposal for modification by the Executive Committee is to be notified by the Executive Committee in writing to the members, at least 20 days before the Members' Meeting. They who propose modifications of the Articles to the Members' Meeting, will put a copy of the proposal, in which the proposed modification is presented in its exact wording, in such a place that members can read it, from at least 24 hours before the Members' Meeting until the end of the day on which the Members' Meeting is held.
Furthermore, a copy as defined above, will be sent to all members.

Article 40. Every decision to modify the Articles must be taken by a majority of at least two thirds of the recorded valid votes, subject to the provision that a modification will be null and void if less than 20 voting members vote for it. A modification of the Articles will not be valid, until a notarial act has been drawn up. Every member of the Executive Committee is capable of having the act drawn up.

Article 41. For the regulation of matters not determined by the Articles, and for other matters concerning the administration of the Society, the Standing Orders must be consulted.

Article 42. The Standing Orders will not contain regulations which run contrary to these Articles.

Article 43. The Standing Orders must be approved by the Members' Meeting.

Article 44. Modifications in the Standing Orders may be proposed by the Executive Committee or by at least 25 per cent of the voting members.

Article 45. Every decision to modify the Standing Orders must be taken by a majority of at least 60 per cent of the recorded valid votes, subject to the provision that a modification will be null and void if less than 20 voting members vote for it.

Article 46. The Executive Committee may act in any situation which is not provided for in the Articles and Standing Orders.

IX. DISSOLUTION OF THE SOCIETY

Article 47. The Society may be dissolved by a decision of the Members' Meeting.

Article 48. A decision to dissolve the Society must be taken by a majority of at least two thirds of the recorded valid votes, subject to the provision that no more than 20 voting members vote against the dissolution.

Article 49. The credit balance after balancing falls to those who are members at the time of the decision to dissolve the Society. They all receive an equal share. In the decision to dissolve, however, another allocation of the credit balance can be given.

Standing Orders

1. DOMAIN OF RESEARCH

EHPS covers research in and applications of the study of behaviour, health, illness and health care.

2. NATIONAL REPRESENTATIVES

National representatives can be installed by the Executive Committee to function as a central contact for EHPS in the various countries.

3. PROCEDURE FOR THE ADMISSION OF NEW MEMBERS

a) Only individual persons can become members of the Society.
b) Persons interested in joining the Society should apply to the Secretary of the Executive Committee, providing information concerning their academic and professional history. The Secretary will refer such applications to the Executive Committee, or to a subcommittee appointed by the Executive Committee, for the purpose of deciding upon the admission of new members. If the Executive Committee or its subcommittee considers that a candidate satisfies the requirements for membership, his/her name will be notified to all members.

4. NON-EUROPEAN AFFILIATES AND STUDENT MEMBERS.

a) Persons who do not have a European nationality, but who meet the requirements of Article 5 of the Articles, may apply for membership as a Non-European Affiliate.
b) The procedure for the admission of Non-European Affiliates is the same as for regular members.
c) Students may apply for membership by sending in a request, accompanied by a recommendation of at least two EHPS members. Otherwise, the procedure for admission is the same as for regular members.
d) According to the financial paragraph (6) of the Standing Orders, the Executive Committee can reduce dues and assessments for Non-European Affiliates and Student Members.

5. PROCEDURE FOR ELECTION OF MEMBERS OF THE EXECUTIVE COMMITTEE

a) At least four months before the Members' Meeting, the Executive Committee will ask the members for nominations for vacancies, Vice-President, Secretary, Treasurer, Newsletter Editor(s) and Ordinary Members. Nominations must be signed by the nominee him/herself, and must be sent to the Secretary, not later than three months before the Members' Meeting. If insufficient nominations are sent in, the Executive Committee will add its own nominations.
b) Members will receive a ballot form by mail, not later than one month before the Members' Meeting. Members who are not able to attend the Members' Meeting, may return their ballot form to the Secretary in a sealed envelope, not later than one week before the beginning of the Members' Meeting.
During the election, the Secretary will hand over the absent members' sealed envelopes to the scruntineers.
c) Voting will be by secret ballot and candidates who receive the largest number of votes will be declared elected, subject to the restriction that not more than two candidates from one country can serve on the Executive Committee and depending on the representativeness as defined in Article 19 of the Articles. That is to say, the scruntineers are obliged to judge the representativeness of the Executive Committee elected and they have the right to propose to the Members' Meeting to appoint members with less votes than other candidates to improve thereby the representativeness of the Executive Committee. The members present at the Members' Meeting decide whether to accept or to reject this proposal.
d) In the case of ties, a second ballot confined to the Members' Meeting will be conducted.
e) The period of office of the members of the Executive Committee is defined in terms of intervals, which refer to periods between two Members' Meetings.
f) No member of the Executive Committee can serve for more than 3 consecutive intervals, except when President or Vice-President. An Ordinary Member of the Executive Committee can serve for no more than two consecutive intervals.

6. FINANCES

Annual dues and assessments will be established by the Executive Committee. The Executive Committee may reduce dues or assessments for students or for members of other groups.

7. HONORARY FELLOWS

Members may nominate deserving persons to become Honorary Fellows of the Society. To become an Honorary Fellow, the person must have an unusual and outstanding contribution to the field of Health Psychology.
Decisions on Honorary Fellowships will be made by the Executive Committee.

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Conference Agenda

1991

Lausanne, 28-30 August
Psychology and Promotion of Health, Fifth European Health Psychology Society Conference
@ Prof. J.W. Dauwalder, Institut de Psychologie, Université de Lausanne, CH-1015 Lausanne, Switzerland.

Cologne, 10-15 September
European Congress of Sport Psychology
@ Congress Secratariat 1991, c/o Deutsche Sporthochschule Köln, Carl Diem-Weg 6, D 5000 Köln 41, Germany.

Munich, 16-20 September
Advances in Applied Psychophysiology
@ AAPB, Dr Rainer Schandry, Psychology Institute Clinical Division, Leopoldstraße 13, D 8000 München 19, Germany.

Nottingham, 20-21 September
BPS Health Psychology Section Annual Conference
@ Paul Kennedy, Department of Clinical Psychology, National Spinal Injury Centre, Stoke Manderville Hospital, Aylesbury, Bucks, United Kingdom.

Amsterdam, 22-25 September
Biopsychosocial Aspects of HIV infection
@ QLT/Congrex, Keizergracht 782, 1017 EC Amsterdam, The Netherlands.

London, 23-25 September
Psychophysiology Society & Psychobiology Section of the BPS - Joint Meeting
@ Marjan Jahanshahi MRC Human Movement and Balance Unit, National Hospital for Neurology & Neurosurgery, Queen Square, London WC1N 3BG, United Kingdom.

New York, 10-12 October
Current Concepts in Psycho-oncology IV
@ Memorial Sloan-Kettering Cancer Center, 1275 York Avenue, New York, NY 10021, United States of America.

Berne, 15-18 October
Annual Meeting of the European Society of Social Paediatrics
@ Professor J-C Vuille, City Health Department, Montbijoustraße 11. CH-3011 Bern, Switzerland.

Jerusalem, 27 Oct - 1 Nov 1991
Third International Congress of Neuroimmunology
@ Haim Ovadia, Department of Neurology, PO Box 5, 0006, Tel Aviv 61500, Israel.

1992

New York, 24-28 March
Annual Conference of the American Psychosomatic Society
@ American Psychosomatic Society, 6728 Old McLean Village Drive, McLean, BA 22101, United States of America.

Hamburg, 15-18 July
Second International Congress of Behavioural Medicine
@ Dr Irmela Florin, Department of Psychology, University of Marburg, Gütenbergstraße 18, D 3550 Marburg/Lahn, Germany.

Brussels, 19-24 July
International Congress of Psychology.
@ Brussels International Conference Centre, Tentoonstellingspark, Belgiëplein, B1020 Brussel, Belgium.

St Andrews, 17-20 September
BPS Health Psychology Annual Conference
@ Dr M. Johnston, Psychological Laboratory, University of St. Andrews, St. Andrews KY16 9JV, Fife, Scotland.

Recent Books on Health Psychology

From Harwood Academic Publishers we received documentation about the following books on health psychology. A reduced rate is available to members of the EHPS.

• Lothar Schmidt, Peter Schwenkmezger, John Weinman, and Stan Maes (Eds.), ***Theoretical and Applied Aspects of Health Psychology.*** New York: Harwood Academic Publishers, 1991, 443pp - ISBN: 3-7186-5053-3. Price for EHPS members is $65.00/£33.00.

• Paul Bennett, John Weinman, and Peter Spurgeon (Eds.), ***Current Developments in Health Psychology.*** New York: Harwood Academic Publishers, 1991, 358pp - ISBN: 3-7186-5064-9. Price for EHPS members is £26.00.

Orders may be sent to:
Harwood Academic Publishers
c/o STBS
Order Department

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Reading RG1 8JL
United Kingdom
or
P.O. Box 786 Cooper Station
New York
NY 10276
United States of America