



Social Psychology and health: assuming complexity *Psicología social y salud: asumir la complejidad*

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Resumen

Este artículo es una declaración de posición basada en una larga trayectoria de investigación e intervención en el contexto brasileño. El argumento que se presenta es que las experiencias sanitarias son complejas y que la práctica profesional debe basarse tanto en la experiencia técnica como en la erudición. La complejidad no tiene que ver con los distintos puntos de vista: el de la gente saludable, los pacientes, los doctores, los profesionales sanitarios, los administradores y la ciencia, claro está. Tiene que ver con la concomitancia de varias versiones, de las realidades fractales que representan de distintas maneras los muchos actantes sociales y materiales presentes en esta red heterogénea. Este argumento está estructurado en dos partes. La primera de ellas simplemente reafirma la multiplicidad desde la perspectiva de la Psicología como una profesión sanitaria. La segunda propone que la acción en un escenario complejo requiere una amplia base de información basada más en la erudición que en la experiencia técnica: es la familiarización con aquellos temas culturales e históricos relacionados directa o indirectamente con la organización actual de la prestación de asistencia sanitaria la que presentará las prácticas diarias políticas y éticas

Palabras clave: Psicología social; Profesiones sanitarias; Servicios de asistencia sanitaria; Complejidad.

Abstract

This paper is a position statement based on a long trajectory of research and intervention in the Brazilian context. The argument put forward is that health experiences are complex, and professional practice must be based on both technical expertise and scholarship. Complexity is not about different points of view: that of healthy people, patients, doctors, health professionals, health administrators and science, of course. It is about the concomitance of multiple versions; about fractal realities that are performed in different manners by the many social and material actants that are present in this heterogeneous network. This argument is structured in two parts. The first one merely restates multiplicity from the perspective of Psychology as a health profession. The second, proposes that action in a complex setting requires a broad base of information based on scholarship rather than technical expertise: it is the familiarity with issues that are cultural and historical and directly or indirectly related to present-day organization of care delivery that will anchor political and ethical everyday practices..

Keywords: Social Psychology; Health Professions; Health Care Services; Complexity.

In tune with the re-launching of a scientific journal that inevitably, like the god Janus, looks back and forwards, the ensuing article is a very personal statement. It is, in many ways, a position paper: it reflects on a long trajectory of research and intervention in the health arena and a continued commitment to a critical view on how psychologists, specially of the social kind, perform health through their practices. It does not propose ways of bettering technical aspects of practice; much the contrary, it proposes that practice is made better by traditional scholarship, as in Mike Billig's (Billig, 1988) insightful discussion of this approach.

Experience is local and historical. As a teacher and researcher, I have been concerned with health issues for a long time. My doctoral thesis, way back in the 1980's, focused on the experiences of first pregnancies in a particular moment in the organization of Brazilian Health Services when pre-natal services, in São Paulo, became available and normative. Since then I worked for a short time as a researcher in a Public Administration agency (FUNDAP) and then as a lecturer at the Pontifical Catholic University in São Paulo (where I am at present a Professor at the Department of Social Psychology) and in both settings health was (and is) the focus of my activities. It is on the basis of this experience that I was invited to write about my personal views on the relationship between Psychology (especially of the Social kind) and the health arena. Inevitably, my point of reference is the manner in which health services are organized in Brazil and, therefore, considering that this journal and its potential audience is inserted in a different social context, I will have to explain some peculiarities of the milieu in which I have derived my experience.

The argument I will put forward is that health experiences -the activities of our day-to-day as well as actual or potential health problems and the long and tortuous ways of keeping healthy or being cared for in ill-health - are complex, and professional practice must be based on both technical expertise and scholarship. Complexity is not about different points of view: that of healthy people, patients, doctors, health professionals, health administrators and science, of course. Complexity is about the concomitance of multiple

versions (Law and Mol, 2002); about fractal realities that are performed in different manners by the many social and material actants that are present in this heterogeneous network.

For clarity's sake, this paper is structured in two parts. The first one merely restates multiplicity from the perspective of Psychology as a health profession. The second, proposes that action in a complex setting requires a broad base of information based on scholarship rather than technical expertise: it is the familiarity with issues that are cultural and historical and directly or indirectly related to present-day organization of care delivery that will anchor political and ethical everyday practices.

Is there such a thing as Health (Social) Psychology? Multiplicity in a historical and theoretical perspective

It is impossible to imprison questions and answers based on theory and practice within strictly defined boundaries; knowledge is fluid and overflows artificially defined borders. Struggling with dichotomies such as mind-body, or individual-social, it is no wonder that Psychology is so often described as multifaceted, an archipelago of lonely paradigms as Serge Moscovici once described it, referring one of its fields, that of Social Psychology (Moscovici, 1988).

The same metaphor was used by contemporary Brazilian social psychology authors, in dialog with Actor Network Theory. Alexandra Tsallis and colleagues (Tsallis, Ferreira, Moraes & Arendt, 2006) suggest that:

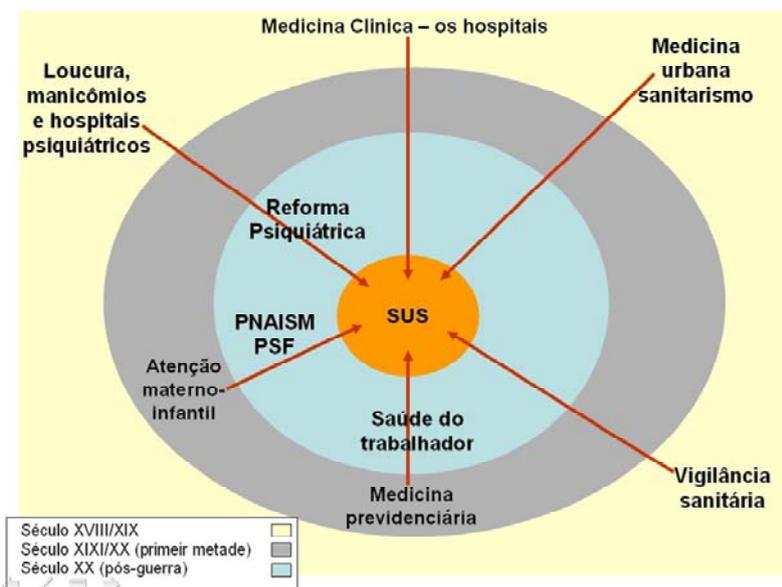
We are nearer to the cartography of an archipelago, to a confederation without a center of systems, schools, small theories and disperse practices than the geopolitical map of a continental nation unified by a common project. What sustains this psychological dispersion under a same name? We are not referring to minor theoretical and methodological divergences within a same project (as in Physic's discussion about the nature of light, if wave or particle), but to the very definition of what is Psychology, of cohabitation of antagonist projects within the same rubric. Going back to the geopolitical metaphor, it is as if, within a federation, each state could adopt its own representation of a nation, disrespecting whatever central political control, and in open tension with the other states (p.75).

However, unlike the authors, it is not the reason behind this curious configuration of the discipline of Psychology that is at stake in this paper. What is of interest here is that this multiplicity inevitably leads to very different insertion of psychological practices within the health arena. A possible starting point is, obviously, to do some "history of the present", in the Foucaultian tradition, as in Nikolas Rose's work on the professionalization of Psychology as a biopolitical strategy (Rose, 1998). Diversity of theory and practice responds to the miscellany of tasks that Psychology is called to perform in the context of the strengthening of Governmental responsibility to the wellbeing of the population (Foucault, 2004).

This multiplicity of points of entry, and hence of delimitation of professional practice within the health arena is depicted in Figure 1. Points of entry, for this purpose, have been

organized in chronological layers, considering the differential rate of institutionalization of health care. The outer layer encompasses the long period between the 18th and 19th centuries that sees the progressive organization of public health surveillance systems, urban health apparatus, Clinical Medicine, Hospital Care and psychiatric institutions for the care of the those that were considered to be mad (Foucault, 1977, 1978, 1982; Rosen, 1963). In the next layer, encompassing the latter half of the 19th century and first half of the 20th century, there is a progressive organization of Social Medicine, Maternal-Child Care and welfare systems geared for the poor and the working population. But this is not yet a task for Psychology, at least not as an organized profession and specially not in Brazil where psychological know how was initially confined to the educational field in the hygienist mode of biopolitics (Antunes, 2003).

Fig. 1: Historical associations between Psychology and health



It is in the next period, in the latter half of the 20th century, that Psychology finds a place in the health arena as a curative style of Medicine gives way to emphasis on primary care. Many movements in Brazil contributed for this opening of professional opportunities

for health professions other than the traditional medical and nursing practices. With the reversal to democracy after the long period of military dictatorship, systems were created for providing care for the working population (Sato, Lacaz & Bernardo, 2004) and for the

reorganization of mental health. Mental health workers and Occupational Health personnel joined forces with critical health professionals in the fight for the organization of a universal health care system that led to the creation of the Sistema Unico de Saúde, SUS. (Faleiros et al, 2006),

As a result, from the 1980's, but more strongly in the 1990's, health care systems opened up posts for psychologists, with an increasing participation of the profession in care provision. But numbers also give visibility to multiplicity. In 2005, as a result of a cooperation agreement between the Brazilian Association for the Teaching of Psychology (ABEP), the Ministry of Health and the Pan-American Health Organization, a study was carried out to map the presence and practices of psychologists in public health services with the aim of providing subsidies for implementing changes in the graduate courses of Psychology so as to better prepare students for work in the health arena (Spink, 2007a)¹.

This study encompassed two strategies. The first consisted of an analysis of the Ministry of Health data base on health establishments (Cadastro Nacional de Estabelecimentos de Saúde - CNES) in tandem with other data bases specific to professional Psychology organized by the Sistema Conselhos de Psicologia (Conselho Federal de Psicologia e Conselhos Regionais de Psicologia). The second strategy consisted of telephone interviews with a sample of 250 psychologists carried out by a telemarketing agency based on questions set up by the research team.

At the time this research was carried out, there were 14.407 psychologists registered in the Ministry of Health database, a number that has been increasing with the expansion of the SUS system. However, this number is far from being impressive when considering the total number of professionals registered in the Conselhos. The percentage of professionals with ties to the SUS, on average, represented only 10% of the total number with professional registers in the Conselhos. And this number varied from 8% in the Northern

regions to 15% in the Northeast - the region with the highest number of psychologists acting in the SUS.

However, it is not the presence of Psychology in the health services that is at stake here, although it does fortify the argument that professionals have to be better prepared for practice in this setting. More astounding than numbers was the variety of modes of practice and theoretical backgrounds reported in the interviews. Table 1 provides some information on this diversity from the perspective of the theoretical anchorage of practice².

We are, therefore, back to the metaphor of the archipelago and faced with the dilemma of working doubly with complexity: that derived from Psychology as multiplicity of theories and manners of practice, and that concerned with health as an arena of complexity, where culture, politics and historical practices mingle. Can we work with complexity? Can we turn away from the lure of simplification?

Simplification is about domestication of diversity by means of definitions and versions of histories that aim at arguing for the specificity of Psychology in relation to the many fields of knowledge that have sociability as their focus. It is about the ordering of knowledge in compartments within the many contemporary institutions that act as gatekeepers of legitimate knowledge. A brief incursion into the literature on the organization of knowledge suggests that the quest for order emerges in two very different contexts. Initially, it is associated with the explosion of information that was set in motion by new technologies, such as the press, and by the voyages of "discovery" in the transition to Modernity. Peter Burke (2003) proposes that, at this time, the ordering task was based on three strategies: university curricula, libraries and encyclopedias, even though none can be taken as a reflex of the ideas on ordering that were then in circulation; they were subjected to the vicissitudes of each area of knowledge and there were overlays, at least concerning the very need for classification. However, "where the three systems overlap, the fundamental categories are likely to express the assumptions of the university population if

¹ There is, at present, a process of curricula reform that has opened up space for discussion on health, especially public health at in undergraduate Psychology courses as well as other experiences of integration of in health services such as the PROSAUDE.

² Data obtained in answer to the question: "What are the theoretical and methodological basis of your work?"

not of the population in general, or, as the French historian Lucien Febvre used to say, their ‘intellectual equipment’ (outillage mental)” (Burke, 2003, p. 86).

Table 1: Theoretical basis for the practice of psychologists in the SUS

Theoretical basis (multiple responses)	N	%
Psychoanalytic (Freud, Winnicott, Lacan, Melanie Klein, Bion)	82	32,8
Behavioural/Experimental/Cognitive/Motivational	37	14,8
Psychoanalytic and Gestalt/ Humanistic/Psychosocial/Other	17	6,8
Brief/Focal Psychotherapy	15	6,0
Psychoanalytic and Behavioural (Cognitiv/Behaviorist)	13	5,2
Psychosocial/Community/Institutional/Psychodramatic	13	5,2
Various (excluding Psychoanalysis)	9	3,6
Systemic Theory	8	3,2
Developmental theories, Piaget	8	3,2
Phenomenological, Existential, Humanist (Rogers)	7	2,8
Organizational, Work and Hospital Psychology/Human Relation Theories.	6	2,4
Psychodynamics/Psychopathology/ Personality Theories/Diagnostic Techniques	5	2,0
Analitic/Junguian	4	1,6
Gestalt	4	1,6
Doesn't know/ did not inform	2	0,8
Outras*	20	8,0
Total	250	100,0

*“Others” included a myriad of responses, such as Theory of Character Formation; Psycho-oncology; Psychosomatic Theories.

Later, the emergency of new disciplines, as in the case of the human sciences, led to the abandonment of the ideal of *mathesis universalis* - the universal science modeled on Mathematics visualized by Descartes and Leibniz - in favour of specialization, installing the double differentiation between fields of knowledge and their classification in terms of degrees of formalization.

In the Classical period, the field of knowledge, from the project of an analysis of representations to the theme of the mathesis universalis, was perfectly homogeneous: all knowledge, of whatever kind, proceeded to the ordering of its material by the establishment of differences and defined those differences by an establishment of an order (...). But, from the nineteenth century, the epistemological field became fragmented, or rather exploded in different directions. It is difficult to escape the pre-eminence of linear

classifications and hierarchies in the manner of Comte (...) (Foucault, 1966/1970, p. 346).

However, these rational modes of classification reduce complexity by means of ordering, dividing, simplifying and excluding. They eliminate the nuances between black and white. The effect of ordering is not only about expulsing anomaly to the margins; whilst insisting in domesticating chaos, they provide the illusion that all relations can thus be explained. But other ways of dealing with diversity can be found. John Law and Annemarie Mol (2002), joining the ranks of those that have revolted against the tendency to simplify reality, ask: what is complexity and how can we deal with it in our practices of knowledge production?

Thus, whilst agreeing that it is important to denounce the violence perpetrated by simplifying schemas, they propose that mere denouncing is problematic: it is too agreeable and simple! It is not enough to denounce; we need to create manners of dealing with complexity so that it can be accepted, produced and performed. When instead of "order" one discovers that there is a diversity of orders (ways of ordering, styles, logics, repertoires, discourses), the dichotomy between simple and complex begins to dissolve. Order gives way to performances, to effects.

Obviously, it is not merely a question of dealing with diversity as a plurality of points of view. This exercise in deconstruction implies understanding the difference between plurality and multiplicity (Mol, 1999), or, more precisely, it requires acceptance that reality itself is multiple, hence the need to refer to "ontologies" in the plural. If diversity is interpreted as plurality, one falls in the trap of a same reality seen from multiple perspectives. Thus, the many theoretical anchorage points portrayed in Table 1 become vantage points that compete among themselves for hegemony (as well as competing with the lay theories, perspectives brought to the scene by the users of health care services).

To refer to reality as something that is multiple requires a different set of metaphors. No longer perspectives or construction, but intervention and performances. Multiplicity suggests that reality is done and enacted by many tools in the course of a diversity of practices and not merely being observed from many different vantage points. It is about co-existence of versions of reality and we must learn how to deal with this in our texts and practices. These different ways of thinking and acting about health issue perform practices that interfere one with another; that reveal partial connections. Therefore, one can conceive multiplicity as the point of encounter of many simplifying forms of ordering.

So, how can we deal with diversity in the mode of complexity? The argument that I want to put forwards is that technical expertise and theories are not sufficient. That we must encourage another mode of dealing with diversity that takes scholarship seriously.

More than techniques: the need for scholarship as a basis for action

In the introduction to this text, following Mike Billig, I suggested that, in order to work with complexity, there is a need for "traditional scholarship". Billig, was in fact referring to scholarship as an anti-methodological stance. However, his comments do apply to the anti-technical (or theoretical) stance proposed in this paper:

It was taken for granted by the traditional scholar that one should read as widely as possible, and in as many languages as possible. Through wide reading, breadth and depth of knowledge would be gained, as well as the ability to make connections between seemingly disparate phenomena. (Billig, 1988, p. 200)

Practice in the health context goes beyond mere application of techniques based on theoretical views. Although necessary, techniques must be adaptative and flexible to be able to work with the multidimensionality of health issues. Personal research experience along these many years has led to the conclusion that scholarship, in this case, spans literature derived from Anthropology, Sociology, Politics, Administration and Medicine as well as specific psychological bibliography. Familiarity is needed regarding at least three domains of policy inspiring practices: cultural (and historical) specific views on health and illness; health care and provisions as governmentality strategies and the tensions concerning the resignification of health as both a right and a duty.

A first task in the quest for scholarship: understanding diversity of health and illness processes

Florencia Tola, in her study of the Qom, in the Argentinean Chaco region, introduces the concept of "corporized person" and "corporal extensions" in order to analyze how body and personhood are present in the day-to-day practices of people who do not limit personhood to humans and for whom personhood does not end at the physical limits imposed by the body. The concept of "corporized person" allows for understanding the relationship between personhood and the collective processes that constitute corporality. "The corporatized person thus becomes because of other people who launch beings and their transfor-

mations into a body" (Tola, 2007, p. 502). Furthermore, some of the components of the person are thought of as extensions of the body, even if they are beyond its limits. Some, like the body fluids, eg. the sperm, are extensions that come from other bodies; other, like the Iqui'i and one's own name, are made up of elements that are not bound by the body and, like the body's fluids, are open to capture by enemies.

The analysis of the Iqui'i is particularly fascinating and reminds one of the work of Carlo Ginsburg on witchcraft and agrarian cults in the sixteenth and seventeenth centuries (Ginsburg, 1992). Two aspects of Tola's analysis are particularly intriguing. First, people exist in potential and virtual manners. Their Iqui'i live in heaven before descending into their mother's womb and starting its complex transformation into a human body. Second, the Iqui'i is not bound to a human body. For example, habitually it leaves the body during sleep to visit other people, living or dead. That is why the Qom wait for a few moments before getting up so as to give the Iqui'i time to find their bodies.

I can quite imagine an unscholarly psychologist working in the Pantanal region - the Brazilian equivalent of the Chaco -- coming in touch with a client of the health service who relates his problems with a wandering Iqui'i. Most probably the mental health track would be activated.

The literature, both historical and local, of health/illness beliefs is vast and counts with wonderful records. But why should a health psychologist, other than those that have a literate taste, be familiar with these tales of otherness? My answer has always been: because health practices are about communication and this demands common understanding of repertoires used to give meaning to health/illness related issues. This is about action in local and usually face-to-face settings. Therefore, it is about discursive practices.

Repertoires, following Jonathan Potter et al (1990) are the terms, concepts, common-places and figures of language that are used in our discursive practices. But, when we work with repertoires we immediately face the fact they are also part of the long history of culture and, in our professional practice we

do not deal only with repertoires acquired through socialization in psychological literature. We enter and leave various positions throughout the day and use repertoires that have resonances in the long time of history, albeit this is history made present through discourse. In our approach (Spink, 1999) we have dealt with this paradox through a three tier version of time: the long time of history; the lived-in time of our experiences and the here-and-now time of interaction. The long time of history is made present through the circulation of these repertoires by means of the various medias that we encounter in our day-to-day: iconography, literature, documents. Although products of specific contingencies, they remain present and able to convey meanings in a variety of cultural artifacts. Lived-in time is basically the filter constituted by our socialization processes: primary, secondary and post-secondary. It is akin to Pierre Bourdieu's concept of habitus (Bourdieu, 1994), with a flavor, also, of Ludwig Fleck's concept of the thought collective (Fleck, 1979). A filter, but not an imposition; an opening, perhaps, to multiplicity. Finally, the time of here-and-now interactions; the process of communication and negotiation of meanings that is the articulation of repertoires in a negotiated order.

If familiarity with historical and culturally contingent repertoires is a must, scholarship is surely a route for the acquisition of communicative skills in encounters between health providers and clients. This assumption was put into practice in a variety of research projects conducted by the members of the research group under my leadership at the Pontifical Catholic University of São Paulo. One of the projects emerged from the preoccupation with the uncritical use of repertoires related to risk discourses in biomedical settings. As a result, from 1998 through to 2005, a series of studies were carried out concerning a variety of aspects of risk discourses: its circulation in the media, the experiences of risk in daily life as well as the role of media in legitimizing risk-adventure³. On the basis of these cumulative studies, repertoires associated with risk were categorized according to three traditions: risk as danger (which antecedes the introduction of the word risk in

³ For information about publications, consult <http://lattes.cnpq.br/9915632947357389>

Western vocabularies), risk as probability and risk as adventure.

The last study in this research programme ("Risk and Uncertainty in contemporary society") concerned the incorporation of risk as adventure as socially legitimate practices. More specifically, its aim was to understand how images of risk-adventure that circulated in the media became metaphors for the legitimation of person positions that were open to experiences related to boldness, challenges and adrenaline related emotions. This specific study encompassed two strategies: a diachronic analysis of a sample of 210 issues of a popular magazine, VEJA, covering the period from 1968 to 2003; and a synchronic analysis of a sample of 101 thematic magazines. All magazines were scrutinized for presence of risk repertoires, textual and imagetic, related to the three traditions of risk discourses. In a synchronic perspective, the analysis of the thematic magazines provided valuable information about how risk messages are geared to specific public. The diachronic analysis was particularly helpful in understanding the progressive incorporation of risk-adventure as a legitimate lifestyle, a process that seems to have occurred through two complementary movements: one related to the professionalization of radical sports, the other associated with the offer of adventure for tourism purposes. The diachronic analysis of images used in advertisements allowed for a better understanding of the use of the risk-adventure imaginary as an invitation to join a particular consumer community.

The analysis of repertoires associated with the three traditions of risk discourses provided opportunities for theoretical and methodological advances that fed back to a more critical analysis of promotional health and a better understanding of harm reduction strategies for those who opt for more risky lifestyles.

Understanding the context of practice in the health scenario: health care as a governmentality strategy.

Health care provision is historically situated and, in a linear mode of ordering, the time line of health care institutions is easily traced. Following Michel Foucault (1982), a first reversion happens as Feudal society gives

rise to Nation-States and the sovereign's right to kill or let live is transcendent into the duty to protect the peoples of a nation. Health becomes a governmentality strategy and, in the rizomatic manner that Foucault conceives power, the duty to protect is spread out into a myriad of institutions that have biopolitics as their aim. In a Foucaultian time line the State intervention into health takes place through the institutionalization of Social Medicine, a process that has different and yet related forms in different contexts.

In the beginning of the 18th century, in Germany, a system was established on the basis of two strategies: the detailed observation of population morbidity and mortality, and the normalization of medical practice. Somewhat later, in the same century, France organized a series of sanitation measures with three related objectives: analyze all that, in the urban space, could be a cause of disease; control circulation of people and elements, such as air and water, and organize sequences of distributions, of water and sewage, for example. And, by the end of the 19th century, the English model prevailed - a form of health care that, being closely associated with the Industrial Revolution, had the human work force at its center. Developed concomitantly in many countries in the Western Hemisphere, this model was exported to developing countries recently liberated from colonial bondage. Its triple mission was firmly associated with growth and development in a western model: control vaccination; organize registers of epidemics and infectious diseases; locate and eliminate focus of insalubrities. This model, strongly associated with the rise of the Welfare State, was based in three modes of attention to health issues portrayed in Figure 1: medical attention to the poor through free access to health care; control of the work force and public-health surveillance.

But, for many countries in South America, the model did not come ready-to-wear. In Brazil, the road to a unified health service - the SUS - was long and tortuous. For many years, if not centuries, health care for those who had no access to private medical facilities was relegated to the "Santas Casas" - institutions linked to religious groups, specially the Catholic Church. The first State-based organization of health services was established in 1923 (Lei Eloy Chaves) through the "Caixas",

a governmental strategy to minimize potential conflicts with the working classes. The main aim of the "Caixas" was to provide social security through pension schemes, not unlike what happened in many European countries (Ewald, 1986). Health care was only a secondary objective and, in any case, it was a very restricted model of care, based on those work groups that had achieved considerable internal organization through cooperatives and syndicates. For many years, there were various attempts at unification and reorganization of the Caixas: a vertical model by sector of production (Institutos de Aposentadoria e Pensão) and later, in 1966, a first unification of medical care through the creation of the Instituto Nacional de Previdência e Saúde, INPS.

This quest for unification became stronger in the 1970's. According to Sonia Fleury Teixeira (1989)⁴, the necessary reorganization contemplated various measures including the extension of health care to all urban population and part of the rural population and the reorientation of individual medical care to preventive and collective measures. But it also introduced a bias towards buying services from private providers, that propitiated the mercantilization of health care, and the expansion of the technological based network of services, with use of expensive exams and use of medicaments.

By the end of the seventies the inadequacy of this model had become all too obvious. With the weakening of the military regime and the first signals of the depletion of the economic model that had prevailed until then, social movements started to be organized in earnest; among them the Sanitary Movement - a broad based rizomatic wave of discussions and proposals that involved health professionals, central administration personnel, university teachers and researches and local based social organizations.

The sanitary movement made itself present at the various forums that were preparing the way to the new Constitution, approved in 1988. In this declaration of principles, health is recognized as a right of the people and a duty of the State, establishing the basic prin-

ciples of universality and gratuity. The Constitutional text also establishes the basic structure for health provision, based on decentralization of administration, thus reversing the tendency towards centralization in Federal Government so as to cater for local needs, and on social control as the basis of democratic participation in all instances of government and care provision.

The SUS was created by law in 1990 (Lei 8080). It has as its basic principles the universality of access to health care, equity in health provision and integrality of care. Its organization is based on integral care, decentralized administration and social control.

But, why should the familiarity with this history be considered as "scholarship"? The SUS is still in its infancy; there is still a lot to do in order to make it work according to its basic principles and this task is a responsibility of all of us. It is the continuous questioning of the obstacles to its full implementation that will create the scenario for effective action. In this perspective, health professionals carry the responsibility for political action and political participation does not come out of the blue. For many of us that work or research aspects of health care, it is always a wonder that students at undergraduate level are so unaware of the proposal on which the SUS is anchored. And yet, the SUS, as shown in the beginning of this paper, provides a viable and in many cases the only alternative for a career in Psychology.

Furthermore, new modalities of care provision in the SUS have turned to multi-professional action in order to cope with the very difficult proposal of integral care. Experiments in "matriciamento", within the managerial umbrella of "Saúde Paidéia" (Campos, 2003), for example, have required reflexivity about what is common to all health profession and what belongs to specific domains.

"Matriciamento" is a type of health care participative management organization based on a matrix structure in which a diversity of professionals are involved. It operates through the creation of relational spaces for exchanges between professional of the various services that care for the health of clients. The objective of this type of structure is to guarantee that health professional teams are aware of the trajectory of health service us-

⁴ Sonia Fleury Teixeira is one of the few Brazilian psychologists dedicated to the analysis of public health policy.

ers so as to guarantee integral care at all the levels of health care.

In many ways, this proposal is innovative. However, there have been experiences, albeit on vertical programs, where integrality and matrix-style management have prevailed. This is the case with the Brazilian AIDS Programme. Initiated in the 1980's, the AIDS Programme has won many international awards and has been instrumental in helping implement similar care systems in other third world countries. I became involved with AIDS research and policy as from 1993 as principal investigator for social behavioral aspects of a feasibility study of AIDS Vaccines. Later, between 1994 and 2003, I was a member of the National AIDS Committee (Comissão Nacional de AIDS, CNAIDS). This involvement certainly fueled my views regarding the need for psychologists to become familiar with policy issues in the health arena.

Created in 1986, the CNAIDS went through many reformulations regarding its role and membership as a result both, of the institutionalization of the AIDS Programme and the need to comply with the directives of the newly formed SUS. By 2002, there was an urgent need to review its objectives. Because of the familiarity with AIDS and the long standing role as a member of the Committee I was asked to carry out an evaluation exercise, a request that was reinterpreted as a research project with four objectives: understand its historical contribution in the formulation of policies for dealing with AIDS in Brazil; review its role in view of the proliferation of specific committees created to deal with technical aspects of AIDS control; and understand its role as a space for dialogue with organized social movements.

In order to accomplish this task, we (a) analyzed a variety of official documents related to public presentation of the CNAIDS, to internal norms of conduct and to the register of the themes and proceedings of the 63 meetings held since 1986 (b) interviewed the Head of the AIDS Programme, the Executive Secretary of the committee and some of its long standing members and (c) collected statements about the committee by all its members.

The results (Spink, Galindo e Garcia, 2003) were initially presented to all the commit-

tee's members in order that corrections and suggestions could be incorporated into the analysis. In a second round, the report was presented by the Head of the Programme and by one of the long standing members in a meeting specially called for this purpose. This, in turn, led to a proposal for restructuration of the committee.

This is an example of an intervention research in the arena of health policy that illustrates the manifold forms of practice that are opened to psychologists (and other health professions) other than strictly defined technical expertise.

Old demands and new tensions: health as a right, or health as a duty?

Many contemporary authors have discussed changes that are occurring in biopolitics as a result of the increasing emphasis on promotional health as from the second half of the 20th century. On one hand, there has been an undoing of the links that connected individual health - specially reproduction -- and the quality of the race or Nation, based on a type of biopolitics associated with eugenics. On the other hand, it is longevity, and no longer morbidity, that defines the health of the population. Longevity is associated with the better conditions of life as well as the advances in medical technology and, as such it is mostly a problem in developed countries. However, it is also a problem for countries like Brazil where poverty related diseases are still not under control.

Although promotional health still has as its focus the "health of the Nation", it is no longer a question of the consequences of ill health for territorial defense of conquests. Consequences are now expressed in economic terms related to the costs of ill health, of lost days at work, the cost of health insurance or, even, in moral terms, i.e. the need to reduce inequalities in health status (Rose, 2007, p. 63).

These new approaches are still concerned with the government of life. However, this form of government of life is no longer concerned with external control of the undesirable from a perspective of the vitality of population or race. Contemporary modes of biopolitics function on the basis of risk ad-

ministration (Castel, 1987; Rose, 2007; Spink, 2001): a set of "ways of thinking and acting that involve calculations about probable futures in the present followed by interventions into the present to control that potential future" (Rose, 2007, p. 70).

This strategy is still based on security principles, but no longer on mere distribution of the costs of adverse events, such as accidents, illness and death. In promotional health, there is an expectation of elimination of risks through anticipatory measures, such as increasingly sophisticated clinical exams or the adoption of life styles that promote health. Such expectation requires an exacerbation of the individualization processes, inherited from Christianity, that Foucault has called "pastoral power".

The pastoral metaphor is useful for understanding a type of power that can articulate discipline and biopower; hence, is concomitantly collectivist (aimed at the flock as a whole) and individualized (aimed at each individual sheep). A form of power that is no longer controlled solely by the complex network of laws, governmental agencies, research institutions and regulation committees; that is administered by each of us in our relations with the specialists of the soma: doctors, health professionals (including psychologists) and personal assistants of various kinds.

In this new sense, health demands intense personal participation. Each of us must take responsibility for our well-being. This argument is based on two separate strands of our relation to health care systems, one related to the advances in the arena of rights; the other concerned with the recent transformations in medical technologies.

Historically, health has only recently become a right. For a long time, curative Medicine excluded great part of the population: for the rich, the most advanced diagnostic and care technologies; for the poor, the *Santas Casas*, charity or nothing. It was as part and parcel of the social movements derived from the precarious conditions of work in industrial capitalism that health services for all were organized. Access to health services can thus be seen as a conquest of popular movements and a response to more contemporary sensibilities with regards to inequalities. A right

that, as we have seen, was only achieved recently in Brazil with the creation of the SUS in 1990.

However, as life conditions improved, and with better control of the infectious diseases that killed so many in poorer countries, other ills became epidemiologically relevant. As life span increased, so did the prevalence of chronic diseases: heart disease, diabetes, cerebral vascular accidents (strokes) and the many degenerative problems that ail the elderly. To face this changing scenario, prevention strategies became of fundamental importance. True, prevention in many ways, has always been present in popular and specialized practices. For example, it was central to the system proposed by Leavell and Clarke in 1965 of a three tier classification: primary, secondary and tertiary prevention. But it is with regards to primary prevention that we have seen a reconfiguration of the sanitary discourse since the 1970's.

This is a narrative that has long threads, dating back to the Report of Canada's Minister of Health, Lalonde, published in 1974, and to the famous Alma Ata Conference in 1978. At present, the emphasis on promotion is well established and has incorporated modern conceptions of administration and social control. According to Marcia Westphal (2006), this modern view on promotion is based on five principles: (1) a holistic concept of health that is based on the multicausality of the health/illness process; (2) equity as a form of dealing with the structural inequalities that lead to differential distribution of the health determinants; (3) intersectoriality as a way of dealing with the complexity of the health/illness process; (4) social participation in the definition of policies, social control and evaluation of practices and services, and (5) sustainability in order to ensure continuity.

It is a politically correct posture, no doubt. However, it is not impermeable to criticism: for being too prescriptive as to styles of life deemed positive for health, and for reinforcing individual responsibility for health, emptying somewhat the role of the State. Over and above possible criticism, promotional health does seem to inaugurate a modality of biopolitics that no longer has in view the population as a whole. Health, at present, is reconfigured in economic terms (cost of lost working days; cost of social security support) or

moral terms (the contemporary imperative of reduction of iniquities in the health arena). In this new modality, the State maintains the traditional tasks concerning the population as a whole: the distribution of water, sanitation, control over medicaments and food, etc. But the responsibility to sustain each individual member of the population, acquired in the "welfare state" modality, is often transferred. In this new scenario, typical of neoliberal economies, each individual becomes responsible for his/her health. Rights become duties: the duty to be healthy.

Furthermore, the transference of the responsibility for health to each of us individually, fomented by moral and economic repertoires, creates a spiral that amplifies the very meaning of health (Spink, 2007b). A spiral that is fed by the selective presentation of information inspired by the present-day ethos of communication. This amplification can best be understood from the perspective of the new desires fomented by novel medical technologies - those that many contemporary authors refer to as "technologies of life": for example, modern biotechnology and its arsenal of diagnostic technologies that reconfigure vital processes and, therefore, our views about our relation to our bodies.

There are two important dimensions in this reconfiguration: individual susceptibility and enhancement. Susceptibility, following Nikolas Rose (2007), concerns the identification and treatment of problems on the basis of the probability of future occurrences. It no longer concerns recognition of risk factors on the basis of correlations, but identification of precise genetic variations that might lead to certain diseases. It concerns bringing probable futures into the present. Enhancement is equally future-oriented: any capacity of body or soul is amenable to improvement by means of technological interventions. Think of the sport records broken with the aid of chemical substances and/or use of special clothes. And these interventions are no longer aimed at "patients"; they target "consumers" that make choices based on desires that might seem trivial or irrelevant, that are formatted no longer by medical counseling but by the market and the consumer culture.

Health must now be thought of from the standpoint of ethopolitics. The ideal of health, in mid 19th century, was bound by governamen-

tality issues: a healthy population was part of the wealth of the state. This ethic has been reconfigured by the proliferation of rights as well as by the new desires for health fomented by the biomedical market. They are desires that stem from personal needs but also configure new biosocialities (Rabinow, 1996) as in the activism in the AIDS scenario or the many advocacy groups that fight for the rights of patients.

This is an ethic in which the maximization of healthy life styles and quality of life have become obligatory. Life style, incidentally, is not circumscribed to the health arena. According to Luiz Castiel e Carlos Diaz (2007) the notion has been in use in Sociology for a long time; it can be traced to Max Weber and, more recently, to the theorization of Pierre Bourdieu on habitus. In Sociology, however, the notion refers to ways of life that are typical of certain groups within a population. They are collective categories that, in late modernity, following Anthony Giddens (1991), have come to be applied to individuals desterritorialized by globalization processes. Life styles, for Giddens, can be defined as "a more or less integrated set of practices which an individual embraces, not only because such practices fulfil utilitarian needs, but because they give material form to a particular narrative of self-identity" (Giddens, 1991, p. 81).

Obviously, from an individualistic standpoint, life styles concern choices - when choices are possible; there are cases where, because of economic deprivation and social exclusion, there is no choice available. In these situations one cannot hold people responsible for their life styles. But when there are no extreme necessities, moralist connotations and judgments come to play and the "most acceptable pattern is that of the rational agent that evaluates, weights and decides his actions in terms that are theoretically objectifiable within the umbrella of cost-benefit calculations" (Castiel; Diaz, 2007, p. 85).

It is in this individualistic framework that the notion of life style was imported into the health arena and became ressignified as the ability we all have to make rational decisions about what we eat and drink, the exercise we do or not take, and the toxic substances we consume. And those that do not adhere, that do not take a prudent stand with regards to the future, are distrusted or penalized.

Research, in this context, can help to understand this other side of promotional health. This has been the case with a recent study of mine in the context of present-day measures to curb the use of tobacco so as to explore the meanings that people who smoke attribute to smoking and the manner in which pressure for cessation of smoking are experienced. Based on 50 interviews carried out with different segments of the community of a university in São Paulo (teachers, office workers, outsourced employees, under graduate and graduate students), the analysis focused three aspects: why people smoke, the ambivalence between pleasure and risks associated with tobacco, and smokers experiences. It concludes that in a public health perspective it is imperative to inform the public about risks associated with tobacco, confront ill effects with the seduction of cigarette marketing by the industry and offer means for tobacco cessation. However, it is also necessary to understand the smokers point of view for whom tobacco is still a legal drug that provides many positive effects but causes physical and psychological dependency; as such, those who wish to stop smoking face many difficulties. This scenario of manifold difficulties raises the question of whether smoking can be classed as a risky life style for which approaches of harm reduction might be pertinent,

Concluding remarks: what does (Social) Psychology have to do with all this?

This new awareness about how we should conduct our relation with ourselves and postulate our responsibility towards the future, this new configuration of ethics as ethopolitics, brings forth new forms of authorities that are no longer confined to the medical arena - the specialists of the soma: therapists, counselors, information providers (specially the media) and personal-everything. As psychologists, we are part of these new authorities of the soma. As social psychologists affiliated to the critical strands of the discipline, we have the responsibility of understanding how these new biomedical modalities of care affect people. Faced with the capitalization of Medicine, it would be an illusion to think that we can reverse the situation: after all, we all want longevity with quality. But we do have tools to follow these

new developments and empower those that have less access to these new technologies.

As a discourse analyst, attentive to the discursive practices that circulate in the day-to-day, I encourage the participants of the research group on Discursive Practices to pay attention to what is happening to health policies and to the repertoires these policies circulate. But much more is at stake. The emphasis on primary health care and on forms of organization based on cross-disciplinary team-work have opened up new spaces for psychologists that, since the 1980's, have become part of the health services at primary care units and specialized services (such as mental health units). This has prompted changes in teaching at undergraduate level with the aim of reverting some of the traditional characteristics of Psychology courses in Brazil: over valuation of specialization to the detriment of primary care; focus on individual care; lack of experience on team work care delivery; emphasis on theory with very little information on public policy; resistance in thinking administration from a participatory perspective. In order to revert this situation, there is a need for action in various fronts especially with regards to at least four important issues: (a) creating spaces for ethopolitical discussions regarding contemporary person positions; (b) instilling a multidisciplinary perspective that might deconstruct knowledge boundaries and promote team work; (c) reinstating client needs as central focus of practices, breaking the hegemony of technical specialization; (d) re-thinking health promotion to make space for risk-reduction strategies for those who choose risky life styles..

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