

Sixth Edition
Key Concepts in
Mental Health

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Mental Health Promotion

DEFINITION

Like mental health, mental health promotion has been defined in a variety of ways. Common or recurring strands include the promotion of happiness, the right to freedom and productivity, the absence of mental illness and the fulfilment of an individual's emotional, intellectual and spiritual potential.

KEY POINTS

- The relationship between mental health promotion and the primary prevention of mental illness is considered.
- The range of factors which are implicated in both of these closely related concepts is outlined.

The promotion of mental health is closely linked to the primary prevention of mental health problems. The subtle distinction is that in the former case, positive mental health has to be defined as one or more desired outcomes. In the latter case, there needs to be a demonstration that the probability of diagnosed mental illness is reduced. A danger of conflating mental health promotion with the primary prevention of mental illness is that it may maintain a restricted focus on a limited clinical population and not address the population's needs as a whole (Tudor, 1996).

The WHO (World Health Organization, 1986) has offered a view of mental health promotion – the ability of individuals to 'have the basic opportunity to develop and use their health potential to live socially and economically productive lives'. In 1986, WHO launched a campaign to implement a charter for action to achieve health for all by 2000. Later, it emphasised that 'the concept of health potential encompasses both physical and mental health and must be viewed in the context of personal development throughout the life span' (World Health Organization, 1991: 3).

The primary prevention of mental illness can be distinguished from secondary and tertiary prevention. Secondary prevention refers to 'nipping mental health problems in the bud' following early detection. Tertiary prevention refers to lowering the probability of relapse in those with chronic mental health problems.

The distinction, but also the relationship between promotion and primary prevention, was also made clear by Albee (1993), who used two versions of an equation using similar factors (see Figure 1.5).

$$\begin{aligned} 1 \text{ Incidence of mental illness} &= \frac{\text{stress} + \text{exploitation} + \text{organic factors}}{\text{support} + \text{self-esteem building} + \text{coping skills}} \\ 2 \text{ Promotion of mental health} &= \frac{\text{coping skills} + \text{environment} + \text{self-esteem}}{\text{stress} + \text{exploitation} + \text{organic factors}} \end{aligned}$$

Figure 1.5 Preventing mental illness and promoting mental health

The factors in the two equations can be addressed one by one:

- *Stress* In the entry on social class, it is noted that stress accounts for some of the differences in diagnosis between poorer and richer people. While both groups have adverse and positive experiences, the ratio between the two is different, with the richer group having more buffering positive experiences.

Those exposed to lower levels of personal and environmental stress are more likely to be mentally healthy. Conversely, the higher the level of stress, be it acute and severe (trauma) or chronic and low-level, the higher the probability of a person developing a mental health problem.

- *Exploitation* The exploitation of individuals, whether financial or related to physical, sexual or emotional abuse, increases the risk of mental health problems. Conversely, a person not exposed to these versions of exploitation is more likely to maintain their mental health. The discourse of exploitation is not common in the psychiatric and psychological literature (Sartorius and Henderson, 1992). This may reflect the tendency of the two disciplines to avoid the language of politics, which might bring accusations of unscientific bias and risk undermining professional credibility. However, a problem for the human sciences is that they are intrinsically about human relationships. Exploitation and other expressions of power differentials are part of the landscape, in some form or other, at all levels of all human societies. Another reason that professionals do not typically address the question of exploitation is that it is beyond their immediate control. The scope of their interventions is limited to the micro level. This refers to the coping strategies of individuals (as in the use of social skills training or cognitive-behavioural therapy), family interventions (Dwivedi, 1997) and, at its most extensive, local community psychology initiatives (Rappaport et al., 1984). By contrast, political factors, which manifestly affect the possibility of developing mental health for all, in line with the WHO's expectation noted earlier, are outwith the direct and privileged control of professionals. These include measures to prevent starvation and warfare and to ensure that all citizens are well housed and educated and protected from the prejudicial actions of others (Sartorius, 2001).
- *Organic factors* These refer to environmental toxins and stressors and to biological susceptibility (see the entry on Causes and Consequences of Mental Health Problems, which discusses the latter). The former refers to poisons (such as lead and petrochemicals) that damage the nervous system. It also refers to behavioural stressors, which are then mediated by physiological mechanisms to produce brain damage. The most common example of this is in relation to raised blood pressure increasing the risk of stroke and dementia. The stressors here include insecure work conditions, noisy and dangerous living environments and lifestyle habits such as quality of diet and exercise levels.
- *Social support* This is a crucial buffer against mental health problems. Chronic personal isolation increases the risk of both depression and psychosis. Both are reduced in probability in those people who are part of a supportive social network or primary group (be it close friends or family).
- *Self-esteem building* This refers to early family life and its capacity for developing confidence in the growing child. It also refers to the presence of benign and affirming current relationships – linking back to the above points about exploitation and social support.
- *Coping skills* The ingenuity in coping with adversity varies from person to person and probably links back to personal styles learned in the family and

at school. Much of the work of cognitive therapists is devoted to enabling patients lacking these coping skills to learn new ones. Conversely, those studying positive psychology have identified those of us who excel at being positive across a range of social contexts.

These factors demonstrate that positive mental health and the primary prevention of mental illness implicate a wide range of factors – political, social, psychological and biological (Herrman, 2011). Strategically, mental health promotion requires changes in both public policies (plural) and public education (Tones and Tilford, 1994). For example, a number of apparently separate policies can affect mental health related to, among other things, environmental pollution, child protection, employment, leisure, street cleaning, traffic levels, parenting, schooling, diet and exercise.

The approach taken to mental health promotion and primary prevention reflects the constructs used by those intervening (be they politicians or health and welfare professionals). The public policy implications for mental health, noted in the list above, reflect a social model of mental health. Those who emphasise psychological determinism would limit their interest to individual and family life. Those who emphasise biodeterminism would highlight biological interventions (such as genetic counselling and early intervention for psychosis). At its most extreme, this might culminate in a eugenic policy to prevent mental illness.

See also: *causes and consequences of mental health problems; eugenics; mental health; physical health; warfare; wellbeing.*

FURTHER READING

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