

KEY KNOWLEDGE

- mental health as a continuum (mentally healthy, mental health problems, mental disorders) influenced by internal and external factors that can fluctuate over time
- the typical characteristics of a mentally healthy person, including high levels of functioning, social and emotional wellbeing and resilience to life's stressors
- ethical implications in the study of, and research into, mental health, including informed consent and use of placebo treatments.

Mental health as a continuum 00

Mental health as a product of internal and external factors 00

Typical characteristics of a mentally healthy person 00

Ethical implications in mental health study and research 00



There are many definitions of mental health, and they typically refer to a state of wellbeing, often emphasising emotional and social wellbeing. The most commonly used definitions in psychology are variations of the World Health Organization (2016) definition which views **mental health** as 'a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community'.

According to this definition, good mental health is a positive and productive state. The individual has a sense of wellbeing, confidence in their abilities and therefore good self-esteem. It enables them to fully enjoy and appreciate other people, day-to-day life and their environment in general.

A person in good mental health can:

- make the most of their potential
- cope with the challenges of everyday life
- play a full part in their family, school, workplace, and community and when among friends.

The WHO definition also reflects a shift from viewing mental health in terms of the presence or absence of symptoms of a mental illness or disorder to an emphasis on what it means to be in good mental health and what we can each do as individuals to foster our own mental wellbeing.

Psychologists view mental health as just as important as physical health, and a vital part of overall health and wellbeing. It is also recognised that our mental health doesn't always stay the same. It can vary over time as circumstances change and as we move through different stages of our life.

In this chapter we examine what it means to be mentally healthy, factors that influence our mental wellbeing and ethical issues of particular relevance to the study of, and research into, mental health.



FIGURE 11.1 Good mental health is a positive and productive state of wellbeing.

MENTAL HEALTH AS A CONTINUUM

Mentally healthy means being in a generally positive state of mental wellbeing, having the ability to cope with and manage life's challenges, working productively, striving to fulfil one's goals and potential, and having a sense of connection to others and the community in general. It is a desirable quality in its own right and is more than the absence of mental ill-health (WHO, 2016).

Good mental health is reflected in how well we deal with the positive and negative emotions associated with the various stressors and other events in our lives. For example, a mentally healthy student who is preparing to do an end-of-year exam may feel anxious and be grumpy or short-tempered. However, they will probably still be able to eat, study, sleep, remember what to take to the exam, hold a conversation with friends and laugh when something funny happens.

Mental health is not considered in an arbitrary way as something we either have or do not have. Instead, we may be more or less mentally healthy (or not healthy). Therefore, mental health is often represented as a continuum of mental wellbeing. As shown in the example in figure 11.2, the continuum may range from *mentally healthy*, when we are feeling positive and functioning well in everyday life, through to a *mental health problem* that interferes with functioning but is relatively moderate in severity and tends to be temporary, to a diagnosable *mental disorder* that tends to be more serious, longer-lasting and may require treatment. Although degree of severity is shown to increase from left to right, there are no absolute or clear-cut dividing lines between different points along the continuum. Similarly, mental health and mental disorder are represented at different ends of the continuum, but this does not mean that they are entirely separate or can be compartmentalised.

The location of an individual's mental health on the continuum is also unstable. This means that it is not fixed because it may vary or fluctuate over time depending on circumstances. An interplay of several internal and external factors combine to influence our mental health at different points in time. For example, the mapping of an individual's mental health on the continuum may shift from the left to right side following exposure to a stressor, then back to the left side when the stressor passes or following intervention such as use of a coping strategy. In addition, an individual's mental health may have many different possible values on a continuum if its different elements were mapped separately.



FIGURE 11.2 Mental health may be represented as a continuum of mental wellbeing.

A **mental health problem** adversely affects the way a person thinks, feels and/or behaves, but typically to a lesser extent and of a shorter duration than a mental disorder. Experiencing a mental health problem is sometimes referred to as a 'rough patch', a 'low point' or 'the blues'. This does not necessarily mean that the problem is trivial or that it doesn't cause distress or impair functioning to some degree. Examples of mental health problems include the sadness and despair associated with grief and loss, and symptoms associated with stress.

As shown in table 11.1, mental health problems can cause a range of personal difficulties such as worry, irritability, inability to concentrate for as long as usual, reduced motivation, social withdrawal, and changes in appetite and sleep pattern. Over the course of a person's lifetime, every individual will most likely experience mental health problems like these at some time. Usually, they are normal, short-term reactions that occur in response to difficult situations such as school- or work-related stressors, conflict in relationships, loss of a significant relationship, a change in living arrangements and so on. However, symptoms will typically resolve with time or when the source of the problem changes or passes. We can get over them or learn to live with them. However, if a mental health problem persists or increases in severity it may develop into a mental disorder (Hunter Institute of Mental Health, 2014).

A **mental disorder**, also called *mental illness*, is a mental health state that involves a combination of thoughts, feelings and/or behaviours which are usually associated with significant personal distress and impair the ability to function effectively in everyday life. The term is most commonly used in relation to a clinically diagnosable disorder involving mental health, such as schizophrenia, major depressive disorder (commonly called depression) or an anxiety disorder (APA, 2013; Mental Health Foundation of Australia (Victoria), 2016; WHO, 2015).

There is a wide range of mental disorders, each with its own set of symptoms. As shown in table 11.1, they are typically organised in categories such as mood disorders, psychotic disorders and personality

disorders based on common experiences by people with the disorder. Each disorder is diagnosed according to standardised criteria that have been derived through research.

The essential characteristics of a mental disorder are:

- the disorder occurs within the individual and results from dysfunction within the individual
- there is clinically diagnosable dysfunction in thoughts, feelings and/or behaviour e.g. low levels of functioning, social and emotional wellbeing
- causes significant personal distress or disability in functioning in everyday life
- actions and reactions are atypical ('not typical') of the person and inappropriate within their culture
- the disorder is not a result of a personal conflict with society (APA, 2013).

Each of these characteristics captures a part of what a mental disorder is. All must be evident for a mental disorder to be diagnosed, but diagnosis of a disorder does not necessarily mean that there is a need for treatment. To the mental health professional, the need for treatment is an issue that is separate from diagnosis and takes into consideration a range of other factors such as the severity of the symptoms, the level of distress experienced by the individual, resilience to life stressors, social and emotional wellbeing, the types and levels of impairment to daily functioning, the risk of self-harm, and the risks and benefits of possible treatments (APA, 2013). Overall, however, a mental disorder usually lasts longer than a mental health problem and causes more distress and disruption to a person's life.

As with mental health problems, mental disorders differ in severity and involve variable amounts of impairment and distress to the individual. It is also possible for a person to feel 'mentally ill' even though a doctor or mental health professional cannot find evidence of any known disorder.

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Animation on 'mental health wellness' continuum 2m 17s

TABLE 11.1 Characteristics of being mentally healthy, having a mental health problem or a mental disorder

Mentally healthy	Mental health problem	Mental disorder
<p>People who are mentally healthy can:</p> <ul style="list-style-type: none"> function at a higher level than people who have a mental health problem or disorder use their abilities to reach their potential cope with and manage life's challenges, including change, uncertainty and challenges that are stressors (e.g. a good level of resilience) work productively at school and work contribute constructively to their community form and maintain good relationships with other people (good social wellbeing) feel, express and manage a range of positive and negative emotions (good emotional wellbeing) learn from their experiences think logically and clearly enjoy and appreciate other people, day-to-day life and their environment. 	<p>People with a mental health problem may:</p> <ul style="list-style-type: none"> feel worried, tense, low, irritable, quiet, confused, angry (often in response to a stressor) feel sadness or despair associated with grief or loss have difficulties concentrating, making decisions and thinking clearly become forgetful experience changes in sleep and appetite experience a loss of energy and motivation feel that things are somehow 'different' socially withdraw develop negative feelings or attitudes to themselves, school or work, and life in general. 	<p>People are diagnosed with a specific type of mental disorder such as:</p> <ul style="list-style-type: none"> anxiety disorder; e.g. phobias, panic disorder, separation anxiety disorder obsessive compulsive disorders mood disorder e.g. depression, bipolar disorder psychotic disorder e.g. schizophrenia, delusional disorder personality disorder e.g. antisocial personality disorder, narcissistic personality disorder neurodevelopmental disorder e.g. intellectual disabilities, autism spectrum disorder, feeding and eating disorders substance-related and addictive disorders.

TABLE 11.2 Examples of mental disorders

Category	Description
Anxiety disorders	Include <i>phobias, panic attack, panic disorder, separation anxiety disorder</i> and <i>substance/medication-induced anxiety disorder</i> .
Neurodevelopmental disorders	These disorders often emerge before starting school. They include <i>autism, Attention-Deficit/Hyperactivity Disorder, intellectual disability</i> (with onset early in development) and various learning and motor disorders that first present early in the lifespan.
Neurocognitive disorders	Include disorders involving major or minor impairment to cognitive functioning, such as those due to <i>Alzheimer's disease, Parkinson's disease, Korsakoff's syndrome, traumatic brain injury</i> and <i>delirium</i> .
Substance-related and addictive disorders	Include <i>alcohol-related disorders, cannabis-related disorders, hallucinogen-related disorders, stimulant-related disorders</i> and <i>gambling disorder</i> .
Schizophrenia spectrum and other psychotic disorders	Common symptoms include delusions, hallucinations and disorganised thinking.
Depressive disorders	Characterised by severe lowering of mood for an extended period of time. Include <i>major depressive disorder</i> and <i>premenstrual dysphoric disorder</i> .
Bipolar and related disorders	Characterised by severe disturbances of mood involving alternating episodes of mania (e.g. elation, high energy and activity) and depression (e.g. sadness, low energy and activity).
Obsessive-compulsive and related disorders	Characterised by recurring thoughts and/or impulses that are difficult to control. Include <i>obsessive-compulsive disorder, hoarding disorder, trichotillomania (hair-pulling disorder)</i> and <i>excoriation (skin-picking) disorder</i> .
Feeding and eating disorders	Include avoidant and restrictive food intake of infancy and early childhood, and serious eating disorders more common in adolescence such as <i>anorexia nervosa, bulimia nervosa</i> and <i>binge-eating disorder</i> .
Sleep-wake disorders	Characterised by persistent sleep related disturbances. Include <i>insomnia, narcolepsy, substance/medication-induced sleep disorder</i> and breathing related sleep disorders such as <i>sleep apnoea</i> .
Disruptive, impulse-control and conduct disorders	Characterised by problems in behavioural and emotional self-control. Include <i>kleptomania, pyromania</i> and <i>intermittent explosive disorder</i> (i.e. aggressive outbursts).
Personality disorders	Include <i>general personality disorder, narcissistic personality disorder, antisocial personality disorder</i> and <i>dependent personality disorder</i> .

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, Virginia: Author.

MENTAL HEALTH AS A PRODUCT OF INTERNAL AND EXTERNAL FACTORS

Our mental health is influenced by a wide variety of internal and external factors throughout our lifespan that can fluctuate over time.

Internal factors are influences that originate inside or within a person. These can be organised as biological and psychological factors. *Biological factors* involve physiologically based or determined influences, often not under our control, such as the genes we inherit, whether we are male or female, balances or imbalances in specific neurotransmitters, substance use, physiological response to medication, brain and nervous system functioning, hormonal activities and fight–flight–freeze and other bodily responses to stress. *Psychological factors* involve all those influences associated with mental processes such as our thoughts, ways of thinking, beliefs, attitudes, our skills in interacting with others, prior learning, perceptions of ourselves, others and our external environment, how we learn, make decisions, solve problems, understand and experience emotions, respond to and manage stress, and reconstruct memories.

External factors are factors that originate outside a person. These can include school- and work-related

factors, the range and quality of our interpersonal relationships, the amount and type of support available from others when needed, exposure to stressors, level of education, employment history, level of income, housing, risks of violence, access to health care and other community resources, exposure to social stigma, and specific cultural influences such as our values and traditions.

Internal and external factors *affect* and are *affected* by one another. For example, internal factors may combine with other internal factors as well as external factors to influence a person's mental health. This complex interaction of multiple factors helps account for individual differences in mental health, as well as the onset or experience of mental health problems and disorders. For example, depression could be explained by the combined effects of genes and brain chemistry (biological), negative ways of thinking and prior learning experiences (psychological) and the death of a marital partner (social). However, it is recognised that specific factors may have more or less influence on an individual's mental health at a given time and put the individual at more or less risk of having good mental health or developing a mental disorder. For example, being rejected by a boyfriend or girlfriend on its own may not cause depression, but if it occurs at a time when the person has also been made redundant from their job, the combination of these two factors at that point in that person's life may be enough to precipitate the onset of depression.

In contemporary psychology, internal and external factors tend to be organised within a framework called the biopsychosocial model. As seen in figure 11.3, the *biopsychosocial model* is a way of describing and explaining how biological, psychological and social factors combine and interact to influence a person's mental health. The model is based on the idea that mental health is best understood by considering specific factors from within each domain (areas) and how these factors may combine and interact to influence our wellbeing (WHO, 2014).

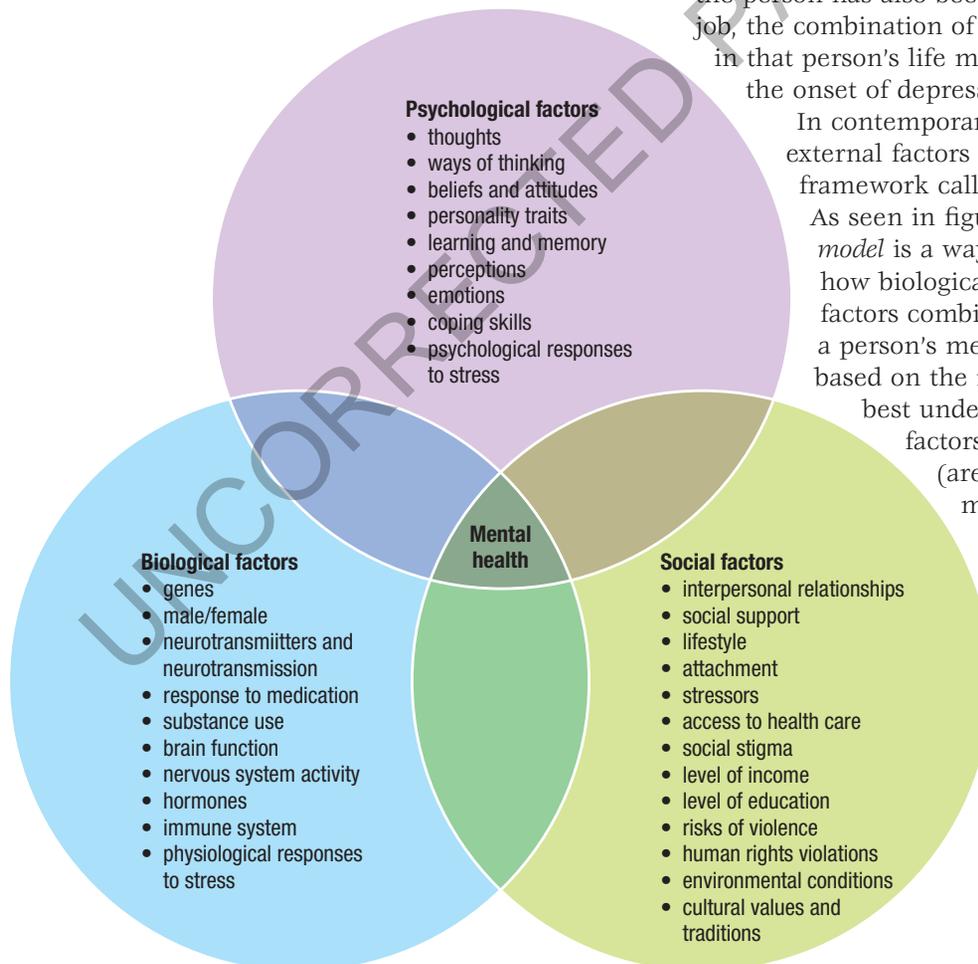


FIGURE 11.3 Biological, psychological and social factors interact to influence mental health.

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Biopsychosocial analysis of a mental disorder

The biopsychosocial model reflects a *holistic* view of mental health – the individual is considered as a ‘whole person’ functioning in their unique environment. The focus is not just on the individual’s mental condition (‘within the individual’), but also on their wider social setting and circumstances (‘outside the individual’).

In addition, focusing on the influence of factors from one or two domains, rather than all three, is likely to give an incomplete and therefore inaccurate picture of a person’s mental health. This also applies to a mental health problem or mental disorder an individual may have and the treatment that may be required.

LEARNING ACTIVITY 11.1

Review questions

- 1 (a) What is a mental health continuum?
 (b) List three considerations when mapping or interpreting the location of an individual’s mental health on a continuum.
- 2 Complete the following table to distinguish between mentally healthy, mental health problem and mental disorder.

Mental health state	Definition	Examples of characteristics associated with the state	Distinguishing characteristics when compared with other states
mentally healthy			
mental health problem			
mental disorder			

- 3 For each of the following four cases, identify whether the person is mentally healthy, has a mental health problem or a mental disorder and give a reason for your answer.

(a) Samina is 29 years old. She has been working as a salesperson in a toy shop but has found this increasingly difficult to manage due to feelings of extreme lethargy and tearfulness. Samina used to really enjoy working at the toy shop but it now doesn’t bring her any enjoyment at all. Last week, it all got too much and Samina quit her job. Since then, she hasn’t left the house where she now spends most of her time crying, watching TV and sleeping. She hasn’t eaten much either.

(b) Harriet is 21 years old and completing her first year of a law degree at university. Recently, she has been experiencing a loss of energy and motivation and has been going out less with her friends than usual. Harriet is also feeling confused and questioning whether she wants to continue to study law at all or whether it was a mistake and she should have chosen something less demanding. She has decided to continue to go to her classes while she makes her decision.

(c) Xavier is 17 years old and just finishing year 11. He has two more exams to go. He’s quite irritable, but he’s able to concentrate well, do his revision, he’s still sleeping and eating well and catching up with his friends and girlfriend.

(d) Simon is 46 years old. He’s in charge of a major project at work at the moment and is feeling very worried and stressed about meeting the deadlines. He’s having difficulties concentrating, making decisions and thinking clearly. This morning he left his laptop on the train coming in to work. Simon is also feeling really tired right now, but despite feeling so tired he still finds it hard to get to sleep at night.

4 (a) What is the essential difference between internal and external factors that can influence mental health?

(b) Give two examples of internal factors that can influence mental health.

(c) Give two examples of external factors that can influence mental health.

5 (a) What is the biopsychosocial model?

(b) Name and describe the three domains in the biopsychosocial model with reference to relevant examples

(c) For each domain, give two additional examples of factors not referred to in the text.

(d) Briefly describe three key characteristics of the biopsychosocial model's explanation of mental health.

(e) Write a series of questions a psychologist who has adopted the biopsychosocial model may ask a patient or client presenting with symptoms of a mental disorder.

6 Read the case of Michael below and identify the biological, psychological and social factors contributing to his mental disorder.

Michael is a 26-year-old male who has been diagnosed as having schizophrenia. He finished year 10 at school before completing a bakery apprenticeship in the regional town where he grew up. At age 20 he moved to Melbourne to get work but struggled to establish friendships and was not happy despite enjoying his work. He was diagnosed with a psychotic episode at 21, when he was experiencing auditory hallucinations and delusional beliefs. He has a first cousin who was diagnosed with schizophrenia, and his grandfather committed suicide in his mid-twenties. Michael has had difficulties coping with stress and used cannabis in his later teens to avoid dealing with issues and to 'chill out'. His family connected him to a mental health support service after his manager noticed odd behaviours and deterioration in his previously good work habits.

Michael has had to be hospitalised three times due to his symptoms but has not been to hospital for two years. He generally experiences few symptoms, and takes antipsychotic medication regularly. He currently works as a baker but reports recent trouble with his boss. He broke up with his girlfriend last month. Michael has had increased auditory hallucinations and hasn't slept for two nights.

Source: Mental Illness Fellowship of Australia (2015), http://www.mhpod.gov.au/assets/sample_topics/combined/Biopsychosocial_factors/biopsychosocial_objective1/biopsychosocial_obj1_activity1/index.html

LEARNING ACTIVITY 11.2

Reflection

Comment on whether a continuum is an appropriate way of representing mental health and whether there may be an alternative, more appropriate way.

TYPICAL CHARACTERISTICS OF A MENTALLY HEALTHY PERSON

Multiple biological, psychological and social factors determine the level of mental health of a person at any point of time (WHO, 2014). There are, however, some characteristics that mentally healthy people tend to have in common. These include high levels of functioning, social and emotional wellbeing and resilience to life stressors.

High level of functioning

In relation to mental health, the term **functioning** generally refers to how well an individual independently performs or operates in their environment. It is most evident in observable behaviour when meeting the ordinary demands of everyday life. This includes underlying cognitions and emotions as they are considered critical to daily functioning (WHO, 2001; 2010b).

A person's functioning may vary in a number of ways. It is commonly described as varying in level and represented on a continuum like mental health. As shown in figure 11.4, functioning may range from a high level (e.g. superior functioning, functioning competently or very well) at one extreme through a moderate level of function to a low level (e.g. poor or impaired functioning) at the other extreme.

Level of functioning tends to correspond with how well or adaptively a person is meeting the challenges of living across a range of domains or areas such as the following:

- *interpersonal relationships* e.g. ability to interact with and get along with other people (family, friends, peers/colleagues, online contacts, neighbours, unknown people in the community)
- *school and work/occupational settings* e.g. productive and achieving goals
- *leisure/recreational activities* e.g. participation in extracurricular activities at school, hobbies/interests/structured or unstructured activities in 'free' time outside school/work, engage in sports or community activities
- *daily living skills* e.g. participation in self-care and independent living activities such as personal hygiene, dressing, eating, remembering to take any prescribed medications, fulfilling household responsibilities, management of personal resources, ability to access private and public transportation and travel/commute safely

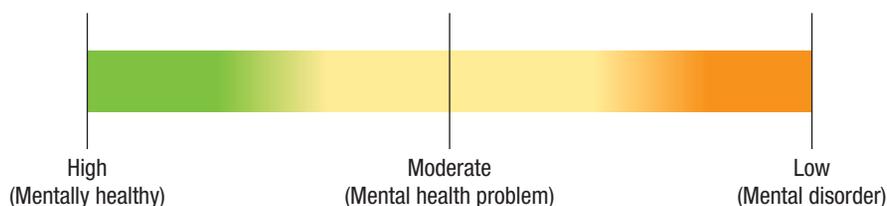
- *cognitive skills* e.g. learning and applying knowledge, understanding and communicating, logical and clear thinking, planning and decision-making
- *emotions* e.g. self-regulation of a range of emotions, dealing with positive and negative emotions, keeping daily worries, hassles and other stressors under control.

Mentally healthy people typically have a high level of functioning in most of the above domains. They are able to cope effectively with living independently in everyday life and in meeting the challenges of living. They tend to actively engage and cooperate with others, develop and maintain warm and trusting relationships, get involved in a range of activities inside and outside of the home, have a balance of work, rest and recreation in their life, a desire for activity and are positive, flexible and productive in how they approach challenges and what they do. They are emotionally stable and tend to deal with transient (temporary) difficulties and everyday worries effectively. They also tend to see themselves as developing into better people, have a direction in life, feel they belong to and are accepted by their communities, seek to develop, belong and contribute to society in meaningful ways, and have a degree of self-determination (WHO, 2010b; Keyes, 2002).

The behaviour of someone with a high level of functioning is primarily adaptive. *Adaptive behaviour* involves actions that enable a person to effectively carry out their usual everyday tasks, such as in the domains described above. Basically, the individual is able to 'adapt' to the demands of daily living and do so relatively independently. In contrast, *maladaptive behaviour* interferes with the person's ability to carry out their usual activities in an effective way. Maladaptive behaviour is sometimes called *dysfunctional* behaviour because it disrupts or impairs everyday functioning. There is a reduced ability to do the things one normally does each day.

Maladaptive behaviour is commonly associated with a low level of functioning. Similarly, mental disorders typically involve a significant impairment in one or more areas of everyday functioning and are therefore associated with a low level of functioning in one or more areas. For example, schizophrenia and depression often significantly impact on a person's ability in each of the domains described above, such as socially connecting with others, attending to self-care and daily living tasks, and engaging in school, work and leisure activities (Roeling, 2010).

FIGURE 11.4 Mentally healthy people tend to have a high level of functioning.



BOX 11.1

World Health Organization Disability Assessment Schedule

The *World Health Organization Disability Assessment Schedule* (WHODAS 2) is a 36-item questionnaire designed to measure level of functioning in adults aged 18 and older. Level of functioning is assessed in relation to the following six domains:

- Self-care e.g. ability to attend to personal hygiene, dressing and eating, and to live alone
- Getting along e.g. ability to interact with other people
- Life activities e.g. household responsibilities, leisure, school and work
- Participation in society e.g. engaging in community activities
- Cognition e.g. understanding and communicating
- Mobility e.g. ability to get around.

Individuals are asked to answer a number of questions in each domain, rating how much difficulty they had doing various activities using a 5-point scale. For example:

In the past 30 days, how much difficulty did you have in:					
Maintaining a friendship?	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Extreme/ Cannot do</i>
Getting out of your home?	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Extreme/ Cannot do</i>
How much of a problem did you have in joining in community activities (e.g. church) in the same way as anyone else can?	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Extreme/ Cannot do</i>
Starting and maintaining a conversation?	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Extreme/ Cannot do</i>
Getting all the household work done that you needed to do?	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Extreme/ Cannot do</i>
Getting dressed?	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Severe</i>	<i>Extreme/ Cannot do</i>

The individual's answer for each question is converted to a rating score, with a score of 1 assigned to 'None' and a score of 5 to 'Extreme/Cannot do'. The scores are then totalled and mapped on a continuum ranging from 0–100, with 0 = high level of functioning; 100 = extremely poor level of functioning/disability.

Summary scores for each domain can also be calculated and high scores in a particular domain may indicate functional impairments requiring further assessment or intervention.

Source: World Health Organization (2010). *Manual for WHO Disability Assessment Schedule: WHODAS 2.0*. Geneva: Publisher.

High levels of social and emotional wellbeing

Wellbeing refers to our sense of 'wellness' or how well we feel about ourselves and our lives. The term may be used globally in relation to our overall mental and/or physical state or in relation to a specific domain or area of functioning.

The Australian Psychological Society (2015b) has described six different but inter-related 'wellness' domains, each of which contributes to a person's overall sense of wellbeing. These are shown in figure 11.5. Social and emotional wellbeing are two of the domains. A mentally health person tends to have a high level of both social and emotional wellbeing.

Social wellbeing is based on the ability to have satisfying relationships and interactions with others (APS, 2015b). It essentially involves 'getting along' with other people and includes the ability to establish and maintain positive relationships with family, friends,

peers, colleagues and acquaintances, as well as the ability to socially interact in appropriate ways with people in the community (including known and unknown people). It also encompasses abilities such as good communication skills (including use and interpretation of body language), understanding of other people's motives and problems, giving and receiving social support, and appreciating the differences in people.

For example, a person with a high level of social wellbeing is likely to be willing and able to:

- develop and maintain healthy relationships with family and friends
- socially interact with others in appropriate ways
- respect and understand other individuals
- respect the cultural identities of others
- competently resolve conflicts with others
- effectively manage unhealthy relationships
- spend time with loved ones
- feel self-confident alone or with others (AIHW, 2012; NIHCE, 2009).



- Intellectual well-being — the ability to learn, grow from experience and utilise intellectual capabilities
- Physical well-being — the ability to carry out daily tasks with vigour (enthusiasm)
- Emotional well-being — the ability to control emotions and express them appropriately and comfortably
- Spiritual well-being — finding meaning, purpose and value in life
- Social well-being — the ability to have satisfying relationships and interactions with others
- Vocational well-being — having interests, employment, volunteer work or other activities that provide personal satisfaction and enrichment in daily life

FIGURE 11.5 Six wellness domains that contribute to a person's overall sense of wellbeing

Source: Australian Psychological Society (2014). *Stress and wellbeing in Australia survey 2014*. Retrieved from <http://www.psychology.org.au/Assets/Files/2014-APS-NPW-Survey-WEB-reduced.pdf>

Emotional wellbeing is based on the ability to control emotions and express them appropriately and comfortably (APS, 2015b). It encompasses the abilities to understand, share and regulate our emotions, to acknowledge and appropriately share both positive and negative emotions with others in socially or culturally appropriate ways and to enjoy life despite its occasional set-backs, disappointments and frustrations.

For example, a person with a high level of emotional wellbeing is likely to be willing and able to:

- develop awareness and understanding of their own emotions
- regulate their emotions and exercise control when appropriate
- express a range of emotions in a suitable manner
- identify emotions in others and empathise
- have a positive attitude about emotions, their experience and expression

- consider thoughts and behaviour as well as feelings when making personal choices and decisions
- accept mistakes or setbacks and learn from them
- make decisions with a minimum of worry, stress or anxiety
- manage their stress reactions using appropriate coping skills
- live and work independently while realising the importance of seeking and appreciating the support and assistance of others
- take on challenges, take risks and recognise conflict as being potentially healthy
- take responsibility for their actions (AIHW, 2012; University of California, 2014).

Resilience to life stressors

Having good mental health does not mean we do not go through bad times or fail to experience disappointment, sadness, anger, fear, anxiety or other unsettling reactions to daily hassles, major stressors and other disturbing events. Instead, mental health is linked to our resistance to adversity and how well we cope with life stressors. This involves resilience.

Resilience is the ability to cope with and adapt well to life stressors and restore positive functioning. It means 'bouncing back' from adversity or difficult experiences that are stressors — such as family and relationship problems, school or workplace stressors, rejections, failures, threats or even tragedy—and restoring positive functioning. Adaption through resilience may involve either adjusting to or overcoming the stressor (APA, 2016c).

Some people have more or less resilience than others. In particular, people who are mentally healthy are commonly described as 'resilient' because they tend to have a high level of resilience, whereas people who are



FIGURE 11.6 People who are mentally healthy have high levels of social and emotional wellbeing. Even though this couple are having a discussion about a serious matter, they are respecting each other, listening to each other's viewpoints and regulating their emotions.

mentally unwell tend to have a low level of resilience and may therefore be described as 'not resilient'.

Resilience is one reason why people perceive and respond or adapt differently to life stressors. For example, a mentally healthy person tends to be 'resilient' and therefore more likely to perceive a life stressor as an opportunity to excel because they have the resources to cope, whereas a mentally unwell person tends to be 'not resilient' and therefore more likely to feel significantly challenged or even overwhelmed, possibly to the point of breakdown.

Research studies have found that resilience is not an unusual or extraordinary characteristic. People commonly demonstrate resilience when faced with significant adversity. For example, resilience is apparent in the numerous Australians who rebuild their lives and bounce back after devastating natural disasters such as floods and bushfires. Our resilience is the product of a range of personal skills and is significantly influenced by external factors, particularly our social connections and access to social support.

Psychologists have studied resilience in adolescents and adults dealing with life stressors. They have identified a number of characteristics that enable someone to 'bounce back' and get back on track when faced with adversity. These characteristics include a strong belief in their abilities to accomplish tasks and succeed (i.e. high self-efficacy); high self-esteem; approaching adversity and stress with a sense of optimism, opportunity and hope; being adaptable and flexible; being organised; having problem-solving skills; and having the ability to make realistic plans and carry them out. Resilient people also tend to have good social support systems, or know other people they can talk to or get help from in difficult times. In particular, they tend to have caring and supportive relationships within and outside the

family. Relationships that create love and trust, provide appropriate role models for problem solving, and offer encouragement and reassurance, help bolster a person's resilience (APA, 2016b). We consider characteristics associated with resilience in more detail in chapter 14 when examining maintenance of mental health.

Having a lot of resilience does not mean that a person never experiences difficulty or distress or is always untroubled or endlessly happy. Every single person experiences adversity and other challenges to varying degrees in their lives. Through resilience, we interpret, respond and either overcome or adapt to that adversity. Importantly, resilience is not a 'fixed' ability that cannot be developed or enhanced. It is possible to learn knowledge and skills that can promote or build resilience (APA, 2016b; Mind Matters, 2016a).



FIGURE 11.7 Asylum seekers and refugees tend to have a high level of resilience which helps them to adapt and recover from the adversity they experience in seeking a new life in a new country.

LEARNING ACTIVITY 11.3

Review questions

- 1 (a) Explain the meaning of functioning in relation to mental health.
(b) List three characteristics that may be attributed to a person with a low level of functioning.
(c) Explain how having a mental disorder may impact on a person's functioning with reference to three characteristics that may change.
(d) Write four or five questions a psychologist assessing level of functioning may ask a client for the purposes of the assessment.
- 2 (a) Explain the meaning of social wellbeing and emotional wellbeing with reference to examples of characteristics associated with high and low levels of functioning in each of these domains.
(b) Explain whether having low levels of social and emotional wellbeing is the same as having a mental health problem or disorder.
- 3 (a) What is resilience?
(b) Describe the relationship between resilience and mental health, ensuring you refer to life stressors.
(c) List three personal characteristics you would reasonably expect to observe in someone described as resilient.
(d) In what way does having a good social support system contribute to resilience?
(e) Explain whether a high level of resilience is possible without having a good social support system.

ETHICAL IMPLICATIONS IN MENTAL HEALTH STUDY AND RESEARCH

Stan is an elderly man who was diagnosed with depression in his early twenties. He has tried numerous anti-depressant medications over the years and continues to use them despite his belief that 'they have not cured me'. Stan has been asked to participate in research on a new drug for depression that has been trialled with animals and since been approved for human trials. The study involves hospitalisation for a 4-week period during which Stan must not take any medication at all. Volunteer participants will then be assigned to either an experimental group (who will be given the new drug) or a control group (who will be given a placebo treatment). Stan agrees to participate in the study, commenting that, 'I don't care anymore. I don't care if I get the medicine or the placebo. What difference does it make anyway?' However, he has previously made it clear when he had a 'pretty good day' that he continues to hold some hope for 'a magical cure'.

Despite Stan's apparent ambivalent attitude, many participants before him have played vital roles in mental health, advancing knowledge about neural mechanisms and processes involved in mental disorders and enabling the discovery of new and better drug treatments to complement psychotherapy and other interventions. Similarly, many animals have suffered from drug testing to ensure suitability for use with humans. As a result, millions of people throughout the world with disorders such as depression, bipolar disorder, schizophrenia and various anxiety disorders are able to lead more productive and fulfilling lives.

Much of the human research requires the cooperation of participants like Stan who suffer from the mental disorder under investigation. However, many people with a mental disorder are particularly vulnerable as research participants. For example, Stan's hopelessness and desperation may have impaired his ability to properly consider the possible effects on his mental health of being un-medicated for a considerable period of time. This may occur despite being 'fully informed' by the researchers, including the opportunity to ask questions.

Consequently, the welfare and rights of such participants are in need of protection that is especially suited and targeted to their specific vulnerabilities. Safeguards in the form of ethical standards and guidelines help provide this protection.

For example, as described in chapter 1, when conducting any research with human participants, the researcher must be aware that there is a need to ensure that all risks of discomfort or harm to participants are balanced by the likely benefit to be gained. As well as ensuring that no psychological or

physical harm is caused to research participants, a researcher must also respect and ensure the security of participants' human rights.

The *National Statement on Ethical Conduct in Human Research 2007* has a specific section that outlines considerations that must be adhered to when conducting research with people with mental disorders (and other 'mental impairments').

People with mental disorders are entitled to participate in research. However, some may be vulnerable in relation to research and this must be taken into account. Although the National Statement refers to vulnerability, it is not defined, nor is the vulnerability of people with a mental disorder clarified. Vulnerability is relevant to a researcher's need to take account of the fact that some people who are mentally unwell may have one or more cognitive impairments that diminish (reduce) their capacity for decision-making and judgments about their participation in research, including susceptibility to harm in the particular circumstances of the research.

Two issues that pose particular ethical challenges for researchers studying and conducting research with vulnerable participants who have a mental disorder are informed consent and use of placebo treatments.



FIGURE 11.8 People with a mental disorder have the right to participate in research. However, they may be vulnerable in some circumstances in relation to research and this must be taken into account.

Informed consent

A core component of ethical research is informed consent – the process by which a researcher discloses appropriate information to a potential research participant so that the person may make a voluntary and informed choice about whether or not to participate.

As described in chapter 1 (p. 00), participant consent should be voluntary and based on sufficient information and adequate understanding of both the proposed research and the consequences of

participation in it. In order for this to be achieved, information should be given on such aspects as the nature and purpose of the research, the procedures to be used, possible risks or adverse effects of the procedures, the demands and possible disadvantages of participating, the right to decline to participate or to withdraw at any time, and possible benefits or other outcomes of the research. All relevant information about the research and participation should also be documented in plain, comprehensible language on a 'consent form'.

An important issue is therefore that potential participants must be able to understand the proposed research, the nature of their involvement and the associated risks. A participant's informed consent cannot be considered as having met ethical requirements unless they have received all the information required for consent, understood it and voluntarily agreed to participate. Voluntary consent means the decision to participate is free of coercion and pressure from the researcher (or any other person).

A participant for mental health research (and any other type of human research) should have the competence to give informed consent. This means that they should have the ability to understand the information relevant to making an informed decision to participate. A wide variety of symptoms, diseases, injuries and other conditions can affect a person's ability to understand such information, to weigh the advantages and disadvantages of their participation, and to subsequently reach a truly informed decision about whether to agree to participate.

In particular, a wide range of mental disorders are associated with one or more impairments that can adversely affect the ability to provide informed consent; for example, impairments to attention, concentration, reasoning, judgment, short-term working memory, long-term memory, decision-making and other relevant cognitive functions. The presence of a mental disorder can therefore interfere with a person's capacity to give genuine consent as it may prevent them from fully understanding some or all of the details of what it is that are actually consenting to (Amer, 2013).

Like mental health, the capacity to provide informed consent is considered to be on a continuum and depends in part on the complexity of the decision required of the participant. Generally, the more complex a research study and the information provided, the harder it will be to understand all the relevant consent issues. Understanding is even more difficult when a mental disorder impairs cognitive functioning (National Institute of Health, 1999).

Competency is not overlooked in the National Statement. One of its requirements is that researchers should outline to an ethics committee (HREC) how they will determine the capacity of a person with a mental disorder to give informed consent.

The National Statement also advises that if a person's mental disorder is temporary or episodic, an attempt should be made to obtain consent at a time when their symptoms do not interfere with their capacity to give informed consent. Finally, it is also recognised that a person's mental health may deteriorate during the course of a study or research. Consequently, they may initially give informed consent, but then their capacity to continue to participate in the research may vary or be lost altogether. The researcher is therefore required to have a discussion with the participant about this possibility before the research commences to find out the participant's preference if deterioration occurs.

Of course, having a mental disorder does not necessarily mean that an individual is incapable of giving informed consent, or, if incapable, the person will always be incapable. For example, although people with schizophrenia tend to have impaired reasoning and decision-making skills, they may still be able to competently give informed consent if provided with appropriate support to do so. Even people with severe schizophrenia may be able to give informed consent following 'educational interventions'; for example, by providing information about the research in more comprehensible or accessible ways, such as by using prompts to assist them to understand key points, and by providing the information on more than one occasion, or in alternative formats at different times (Carpenter, et al., 2000).

In the event that a potential participant is unable to give informed consent, this can be obtained from their legal guardian or any person or organisation authorised by law to do so on the participant's behalf. If informed consent has been given by someone other than the participant, the researcher is still required to explain to the participant, as far as possible, what the research is about and what participation involves. In addition, if the participant recovers the capacity to give consent at some time after the research commences, the researcher should offer them the opportunity to continue their participation or to withdraw.

Despite ethical safeguards in the National Statement (and the APS Code of Ethics), it is still possible to include a person in mental health research without their consent. This includes research testing a medical procedure such as the use of a new medication, equipment or treatment. (commonly called a 'clinical trial'). This type of research can and does occur with patients in the public mental health system who have not given informed consent. Moreover, it is legally permissible under the *Victorian Mental Health Act 2014* and can include patients who have been involuntarily hospitalised under the Act. For example, research requiring participants as 'part of a clinical trial' or 'for the administration of medication' may be carried out 'on a patient who cannot themselves provide consent' if approval is

obtained by a human research ethics committee. The committee 'may be based at the hospital where the patient is being treated or it may be at another hospital, a university or other institution' (Office of the Public Advocate, 2016).



FIGURE 11.9 (a) Participants in research usually give informed consent and the presence of a mental disorder raises special considerations about the ethical requirements for consent. (b) However, it is legally permissible in Victoria under certain conditions to conduct medical research with patients in the mental health system who have not given informed consent.

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Weblinks

- Mental Health Act 2014
- Office of the Public Advocate: medical research for patients who cannot consent fact sheet

Use of placebo treatments

Placebo treatments are commonly used in research studies (or 'clinical trials') to determine the *efficacy* ('effectiveness') of a new or improved medication or other treatment such as psychotherapy, physical therapy, exercise, a special diet or even surgery. For example, a placebo treatment may be used in research

to test whether a new version of a medication alleviates symptoms of a particular mental disorder.

The placebo is the substance or treatment that appears real and resembles the actual substance or treatment, but is actually inert — it is neutral or has no known effect. Exposure to a placebo can result in a placebo effect involving a change or improvement in wellbeing that may be short-term or lasting. The placebo effect is triggered by a person's belief in the treatment and their expectation of relief or feeling better, rather than the specific form the placebo takes. Although many theories have been proposed to explain the placebo effect, mechanisms and processes that can actually produce physiological change due to a placebo treatment remain unclear.

Experiments and other studies that are conducted to test the efficacy of new medication typically use a placebo treatment. In a simple experiment, there may be two groups — an experimental group (who receive the drug treatment) and a control group (who receive the placebo treatment). None of the participants know whether they are taking the active or inactive drug. Often, not even the researchers know because the double blind procedure is commonly used. After a suitable period of time to allow for the drug to exert its effects, comparisons are made between participants in both groups on relevant measures of the DV. It is assumed that any participant change or response due to merely taking what is believed to be an active drug would have occurred in both groups. In many studies, multiple groups are used. For example, there could be three experimental groups, each of which receives a different dose of the drug, and one control group who receive the placebo treatment. Generally, the placebo-controlled double-blind experiment with random assignment to groups is widely considered to be the 'gold standard' for a clinical trial or other research that tests the efficacy of a treatment.



FIGURE 11.10 Use of a placebo treatment in studies on treatments for mental disorders raises specific ethical issues.

The placebo effect observed in studies on medications and other treatments is not unusual. Furthermore, symptoms of a disorder can actually be relieved by taking an inert substance or undergoing a fake placebo procedure. Many people demonstrate symptom relief or reduction after taking a placebo. The placebo effect is often significant and long-lasting. For example, one team of researchers who analysed the results of 75 studies that used a placebo found that 29.7% of participants with a diagnosed depression disorder improved after they received a placebo treatment which they believed was an antidepressant medication (Walsh, et al., 2002). Placebos can also cause unwanted side-effects. For example, nausea, drowsiness and allergic reactions, such as skin rashes, have been observed as placebo effects (Davis, et al, 2011; Khin, et al, 2012).

According to the National Statement, use of a placebo treatment is ethically acceptable when all relevant ethical requirements have been addressed. For example, it is essential that the research is justifiable and potential harm to participants is negligible. When it is ethically justifiable to conduct such a study, then it is also vital that all treatment conditions in the research study pose a low and acceptable risk of harm to the participants and that all participants are fully informed about and understand such risks. These conditions also apply to studies for which informed consent is not obtained.

Some psychologists, however, hold ethical concerns about the use of placebo treatments, especially when testing medications with people who have a mental disorder. One concern is that researchers intentionally withhold an effective treatment from people who genuinely need the treatment and are therefore allowed to remain unwell and may also suffer as a consequence. For example, in many experiments (or clinical trials), placebo control group participants are denied their usual 'real' treatment for the duration of the study. If they are not permitted to take their prescribed medication(s), then there is the possibility of symptoms that are under control re-appearing or worsening. This can cause severe discomfort, distress or some other unwanted psychological or physical problems that can inhibit or prolong recovery. An associated ethical concern is that the researcher would be aware of this possibility but has nonetheless decided to administer a treatment that they know will be ineffective at best. Notethat placebo group participants are also not given the medication being tested. This raises the ethical issue of their having been knowingly and intentionally denied access to a treatment that they most likely need and from which they could possibly benefit.

In addition, experiments to test drugs are often conducted over a prolonged period which increases the probability of participant attrition. This tends to be more likely in studies using participants with certain

mental disorders because of the very nature of their disorder. For example, many people with depression experience difficulties maintaining motivation which can reduce their commitment to a study after it starts. Consequently, a participant may withdraw mid-way during active treatment as a member of the experimental group taking a new, not fully tested drug, or, as a member of placebo treatment group not taking prescribed medication and with a belief that they have been taking an appropriate alternative. In such cases, follow-up by the researchers is vital but not always possible when participants do not formally withdraw and simply discontinue their involvement without contacting researchers.

The National Statement recognises the need to protect participants from exposure to research that poses a significant risk to their wellbeing and therefore specifies that it is ethically unacceptable to conduct a research study for which there is 'a known risk of significant harm in the absence of treatment'. Nonetheless, such studies are still possible under the Mental Health Act 2014.

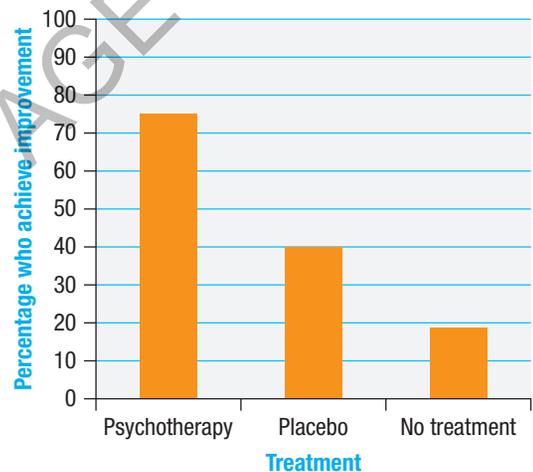


FIGURE 11.11 An analysis of the results of more than 300 studies found that about 75% of people who access psychotherapy (e.g. CBT) achieve at least some improvement, compared with a placebo and no treatment. These results also show that about 25% of people do not benefit from psychotherapy. It has also been found that an estimated 5%–10% of adult clients leave treatment worse off than they began treatment.

Source: based on Lambert and Ogles (2004).

Ethical concerns have also been expressed about the use of deception. For example, participants in the placebo treatment group must be deceived by being led to believe that they are taking an active drug that may reduce or inhibit their symptoms. Although deception is ethically permissible for placebos, critics of placebo treatments maintain that deception is wrong, regardless of whether the deceived participant experiences improvement or even an end to their symptoms. For

example, it is argued that deception involves wilfully misleading participants and is a violation of trust and a person's informed consent. Furthermore, many believe it is inappropriate in studies of mental disorders because vulnerable people are likely to be manipulated. In many cases, a well-tested drug treatment may

already exist so it is suggested that people already taking this active drug should be used as a control group. An active-treatment control group may not raise ethical concerns, but it can be more difficult to demonstrate a difference between different types of active treatments.

BOX 11.2

Research using a placebo to test a new drug for the treatment of schizophrenia

American psychiatrist Christoph Correll and his colleagues (2015) conducted a study to investigate the efficacy, safety and tolerability of a new anti-psychotic drug called brexpiprazole. This drug was designed for the treatment of schizophrenia. The study was part of the procedure required for drug approval by the US Food and Drug Administration authority.

Volunteers for the study consisted of 636 adults diagnosed with acute schizophrenia who were hospitalised as part of their treatment. Participants were randomly assigned to either of three groups to receive one of three doses of the drug (0.25 mg, 2 mg or 4 mg) or to a placebo treatment group for a 6-week period. Both the researchers and participants did not know which groups received which treatment.

The PANSS test which assesses symptoms was completed by all participants at the start (baseline) and end of the study.

The mean changes in PANSS total scores from baseline until study end were:

- 0.25 mg: -14.90
- 2 mg: -20.73
- 4 mg: -19.65.

For the placebo group, the figure was -12.01.

The most common side-effect reported for the drug was restlessness (2 mg: 4.4%; 4 mg: 7.2%; placebo: 2.2%). Weight gain with drug use was moderate (1.45 and 1.28 kg for 2 and 4 mg, respectively, versus 0.42 kg for placebo at week 6).

On the basis of the results, the researchers concluded that at week 6, compared with the placebo treatment, participants who used brexpiprazole at dosages of 2 and 4 mg/day demonstrated greater reductions in psychotic symptoms and good tolerability of the drug.

The researchers also reported that 59.2% of participants in the placebo group were able to complete the 6-week study. The remaining 40.8% had to withdraw at various points due to an intolerable worsening of their psychotic symptoms. In addition, only 62.2% of the participants in the 0.25 mg group completed the study.

LEARNING ACTIVITY 11.4

Review questions

- (a) Explain the meaning of informed consent for research.

(b) In what way might someone with a mental disorder be vulnerable to giving informed consent without fully comprehending what that means or may involve?

(c) What is an ethical standard or guideline that helps protect research participants who may be vulnerable?

(d) What is a procedure that can be used by a researcher to help ensure a potentially vulnerable adult gives consent that is truly informed?

(e) Explain whether research involving people with a mental disorder can be undertaken without their informed consent and outline relevant ethical issues that may be raised.

(f) Kian has bipolar disorder and agreed to participate in a 4-week research study comparing the effectiveness of two types of psychotherapies. Kian is in a group that is exposed to the new therapy but is not required to discontinue his medication. During the second week of the study, Kian develops mania. He becomes grandiose, his thoughts are racing and incoherent, he is extremely distractible, he is getting little sleep and is spending most nights gambling at the casino.

Does the researcher have any ethical obligations with regard to Kian? If so, what should be done?
- (a) Explain the meaning of placebo treatment.

(b) Give two reasons to explain why a placebo may be used.

(c) What is the difference between a placebo and placebo effect?

(d) Give an example of a placebo that could be used in a study testing the efficacy of a new psychotherapy for a mental disorder.

(e) Comment on whether the deception required for research using a placebo treatment exploits vulnerable people.

(f) Outline three ethical concerns or issues, other than deception, that may be raised in relation to the use of a placebo treatment.

LEARNING ACTIVITY 11.5

Analysis of research by Correll and colleagues (2015)

Read the research study conducted by Correll and his colleagues (2015) described in box 11.2 and answer the following questions.

- 1 What was the aim of the research?
- 2 Who were the participants in the research?
- 3 Identify the operationalised independent and dependent variables.
- 4 Identify the experimental and control groups.
- 5 Formulate a research hypothesis that would be supported by the results.
- 6 Explain whether a single- or double-blind procedure was used and why it was used.
- 7 (a) Describe the results obtained with reference to each group of participants.
(b) Explain whether the conclusions are consistent with the results obtained.
(c) What is a possible explanation of the improvement in psychotic symptoms by the placebo group?
(d) What is a possible limitation of the research and its findings?
- 8 Describe three ethical issues of relevance to this particular study.

LEARNING ACTIVITY 11.6

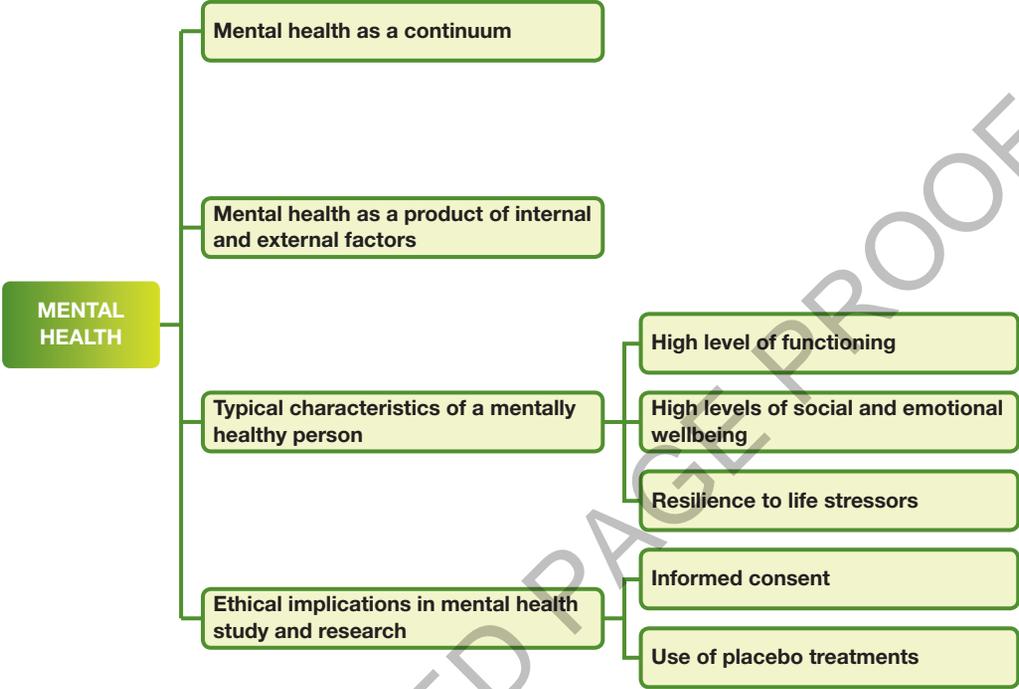
Reflection

What is your view on the ethical behaviour of the researcher who intentionally allows some people to remain unwell for a period of time in the interests of testing a potentially effective treatment that could ultimately benefit millions of others throughout the world?

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CHAPTER 11 REVIEW

CHAPTER SUMMARY



study on

Unit 3 > Area of study 2 > Topic 4

Summary screen and practice questions

KEY TERMS

emotional wellbeing p. 00

external factors p. 00

functioning p. 00

internal factors p. 00

mental disorder p. 00

mental health p. 00

mental health problem p. 00

mentally healthy p. 00

resilience p. 00

social wellbeing p. 00

wellbeing p. 00

LEARNING CHECKLIST

Complete the self-assessment checklist below, using ticks and crosses to indicate your understanding of this chapter's key knowledge (a) before and (b) after you attempt the chapter test. Use the 'Comments' column to add notes about your understanding.

Key knowledge I need to know about mental health	Self-assessment of key knowledge I understand <i>before</i> chapter test	Self-assessment of key knowledge I need to revisit <i>after</i> chapter test	Comments
Mental health as a continuum			
Mental health as a product of internal and external factors			
Typical characteristics of a mentally healthy person			
Ethical implications in mental health study and research			

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CHAPTER TEST

SECTION A — Multiple-choice questions

Choose the response that is **correct** or that **best answers** the question.

A correct answer scores 1, an incorrect answer scores 0.

Marks will **not** be deducted for incorrect answers.

No marks will be given if more than one answer is completed for any question.

Question 1

A mental disorder is best described as

- A. maladaptive or dysfunctional behaviour.
- B. a mild and temporary change in the way a person thinks, feels and behaves.
- C. a mental condition that will usually resolve itself without treatment.
- D. a diagnosable psychological condition that significantly disrupts how a person usually thinks, feels and behaves.

Question 2

Which of the following individuals is most likely experiencing a significant mental health problem?

- A. Adnan, who has been experiencing changes in appetite, motivation and mood but is still managing to get to work each day and be quite productive.
- B. Rumana, who became annoyed when someone crashed into her car, but got over it quickly.
- C. Danielle, who is a manager at a local fast food outlet and has a good group of friends.
- D. David, whose anxiety about coming into contact with other people is causing a lot of distress and preventing him from leaving his house.

Question 3

Which of the following is a psychological factor that could contribute to the development of a mental disorder?

- A. gender
- B. not having enough money for the basic essentials of everyday life
- C. being bullied by someone at school
- D. how we perceive our internal and external environments

Question 4

Which of the following is not a biological factor that could contribute to the development of a mental disorder?

- A. social stress
- B. poor nutrition
- C. low birth weight
- D. prenatal brain damage from exposure to drug use

Question 5

A mentally healthy person with a high level of functioning is likely to

- A. be socially disconnected from others.
- B. participate fully in school and leisure activities.
- C. avoid extracurricular activities at school.
- D. have negative feelings about themselves and life in general.

Question 6

The biopsychosocial model would account for mental health or the development of a mental health problem or disorder by explaining

- A. the relative contribution of biological, psychological and social factors.
- B. the interaction of biological, psychological and social factors.
- C. how biological factors influence psychological factors, which in turn influence social factors.
- D. the impact of underlying biological factors on psychological and social factors.

Question 7

Before any psychological research with human participants can be conducted, the researcher must

- A. be a registered psychologist.
- B. obtain informed consent from their peers or colleagues.
- C. obtain written approval from their employer.
- D. obtain written approval from their ethics committee.

Question 8

A mental health continuum can be used to show

- A. internal and external factors influencing mental health.
- B. biopsychosocial factors influencing mental health.
- C. the variability of mental health.
- D. impairments in the ability to function effectively in everyday life.

Question 9

Olivia has developed satisfying interpersonal relationships with a diverse range of people, which makes her feel good about herself. It is likely that Olivia has a _____ level of _____ wellbeing.

- A. low; social
- B. high; emotional
- C. low; emotional
- D. high; social

Question 10

Which of the following reasons best explains why a placebo treatment is likely to be of ethical concern when used in an experiment to test a new drug for a mental disorder?

- A. The treatment typically causes a placebo effect.
- B. The treatment may interfere with a person's capacity to give informed consent.
- C. Participants in the control group may be exposed to harm in the absence of treatment.
- D. Participants in the experimental group may be exposed to harm when the placebo treatment is introduced.

SECTION B — Short-answer questions

Answer all questions in the spaces provided. Write using blue or black pen.

Question 1 (4 marks)

(a) Define 'mentally healthy'. 1 mark

(b) Give three examples of characteristics typical of a mentally healthy person. 3 marks

Question 2 (2 marks)

What two criteria could be used to distinguish a mental health problem from a mental disorder?

Question 3 (4 marks)

Explain the difference between internal and external factors that can influence a person's mental health, with reference to an example of each type of factor.

Question 4 (3 marks)

Give three examples of criteria that could be used to locate someone's mental health status on a continuum.

Question 5 (2 marks)

What two features of a treatment plan for a mental health problem or disorder would reflect use of a biopsychosocial approach?

Question 6 (3 marks)

List three characteristics typical of someone with a high level of emotional wellbeing.

Question 7 (3 marks)

Explain the meaning of resilience with reference to a characteristic that distinguishes someone with low resilience.

Question 8 (4 marks)

Give two examples of ethical issues associated with each of the following in the study of, or research into, mental health.

(a) informed consent 2 marks

(b) use of a placebo treatment. 2 marks

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Return to the checklist on page xxx and complete your self-assessment of areas of key knowledge where you need to do more work to improve your understanding.

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The answers to the multiple-choice questions are in the answer section at the end of this book and in eBookPLUS.

The answers to the short-answer questions are in eBookPLUS.

Note that you can also complete Section A of the chapter test online through eBookPLUS and get automatic feedback. **int-0000**