Mental Health and Health Promotion

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Contents

Pēpeha

Tēnā koutou, tēnā koutou, tēnā tātou katoa. | Greetings to you all, greetings to us all.
Ko Helvellyn te maunga. | My mountain is Helvellyn.
Ko Don te awa. | My river is the Don.
Ko Waka Oranga te waka. | My canoe is Waka Oranga.[1]
Ko Werehi te iwi. | I have Welsh ancestry.
He tangata Tiriti ahau. | I am a person of the Treaty.
Ko Tudor te hapū. | My family name is Tudor.
Ko Ngā Wai o Horotiu te marae. | My marae is Ngā Wai o Horotiu.
Ko John Tudor te tangata. | My ancestor is John Tudor.
Nō Sheffield ki Ingārangi ahau. | I am from Sheffield, England.
Kei Titirangi, kei Waitakere ahau e noho ana. | I live in Titirangi, in the Waitakere.
Ko Louise taku hoa rangatira. | My wife is Louise.
Ko Saul raua ko Esther taku tamariki. | My children are Saul and Esther.
Ko Keith Tudor taku ingoa. | My name is Keith Tudor.
Tēnā koutou, tēnā koutou, tēnā tātou katoa. | Greetings to all.

Introduction

The relationship between mental health and health promotion requires an understanding of the two respective fields that these terms represent. Moreover, mental health is a particular aspect of the broader concept of health. This paper addresses mental health promotion by discussing both health and positive mental health or wellbeing, before describing what is understood by mental health promotion. Finally, it addresses the basis of promoting mental health in Aotearoa New Zealand.

Health

The English word "health" has its roots in words that mean "whole" and "heal". Thus, health refers to a state or process that is indivisible. Graham (1992), who has explored the etymology of health, has argued that "health is to be whole or holy, which clearly embraces both spiritual and physical features rather than merely the latter" (p. 53). Despite the World Health Organisation's (WHO) (1948) acknowledgement that health is "not merely the absence of disease or infirmity", its definition that "Health is a state of complete physical, mental and social wellbeing" is:

a) partial – in that it refers only to the physical, mental, and social aspects of health;
b) problematic – in that it appears to propose a fixed "state" of health, and ignores other ideas about health as a resource, potential, a relationship or process, a value, a belief, particular behaviours and practices, as not ill-health, dis-ease or illness, a status, or indicator (see Tudor, 1996);
c) outdated – as it has not been amended since 1948; and
d) limited – in that it was signed by representatives of only 61 States (there are currently 195 recognised countries in the world).

Health or wellbeing in te reo Māori is commonly translated as "ora" but, as Durie (2001) has observed: "when paired with mauri, the meaning is expanded to suggest a force that generates and sustains life, vitality, and health." (p. x) Thus, the phrase mauri ora not only "accentuates

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[1] Waka Oranga is a group of Māori and non-Māori psychotherapists, counsellors and health providers.

the interactive environment within which health is contrived" (ibid., p. x), it also embodies a genuinely holistic understanding of health.

One of the barriers to such an holistic understanding of health is the Western medical model of "health" (which usually stands for - or means - "illness"), about which there are a number of criticisms. Writing about the *Political Economy of Health*, Doyal and Pennell (1979) identified three problematic assumptions on which (Western) medicine and its view of health rest:

1. That the determinants of health and illness are predominantly biological.
2. That medicine is assumed to be a science.
3. That scientific medicine "provides the only viable means for mediating between people and disease" (p.12) – and, for that matter, health.

In a publication on mental health promotion (Tudor, 2004), I examined the implications of these assumptions for mental health, and added two more assumptions that I identified as problematic, i.e:

4. The dualistic split between mind and body.
5. The defining of health in terms of illness.

An alternative to the Western model of health and its assumptions may be found in the following quotation from *The Geneva Declaration on the Health and Survival of Indigenous Peoples*:

> Indigenous Peoples' concept of health and survival is both a collective and individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These four dimensions are the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present and future co-exist simultaneously. (United Nations Economic and Social Council, 2002)

Mental Health

Ideally, then, as an holistic concept health should encompass the mental dimension, aspect or sphere. Neumann, Schroeder and Voss (1989) argued that, as the agent of all health-relevant interactions, our mind or psyche is at the centre of all dimensions of mental health and thereby criterial to health. Similarly, the WHO (2014) has stated that: "Mental health is an integral part of health … there is no health without mental health", and, indeed, there are clear links between mental and physical health status. Thus the imperative of recognising, supporting and promoting mental health is, in part, grounded in these links (see Stewart-Brown, 1998; Stephens, Dulberg, & Joubert, 2000; Raphael, Schmilke, & Wooding, 2005). This is supported by epidemiological evidencethat links elements of mental health with physical disease e.g., the increased risk of coronary heart disease to low control in the work environment (Bosma, Marmot, Hemingway, Nicholson, Brunner, & Stansfield, 1997), and the relationship between mental health and public health, social capital, and human rights (see Herrman, Saxena, & Moodie, 2005).

Nevertheless, when people and policies refer to health, they tend not to include or encompass mental health. In order to put positive mental health or wellbeing on the map, therefore, we need to name it as such. However, when doing so, people run into another problem, which is
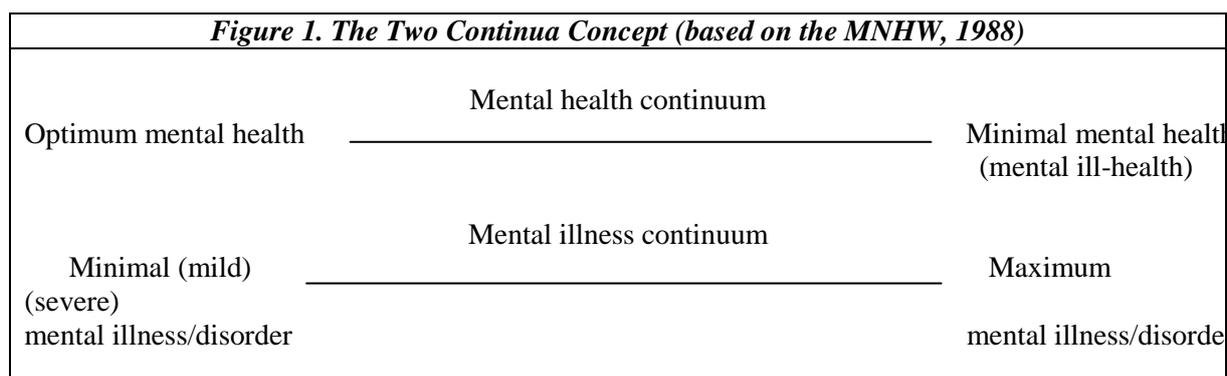
that there is considerable confusion in the field about the term "mental health" as, predominantly, it is a term used to refer to mental illness or mental ill-health (see Table 1).

Table 1. "Mental Health": Terms and Conditions
Mental health   1. Is used to refer to positive wellbeing, sometimes in the general sense, sometimes with specific reference to "mental" wellbeing which is often taken to refer only to the intellectual or emotional sphere of human experience   2. Is also used, confusingly, to refer to mental illness(es) and disorder(s)
Mental health problems   A euphemistic and confusing term, used synonymously with and to encompass mental illnesses and disorders. Although some argue that, as a term, it is kinder than "mental illness" there is no evidence that its use reduces the stigma of mental illness/disorder or personality disorder
Mental health status   1. Refers to the overall mental health experience of a population ascertained through research   2. Is, again, predominantly used to refer to mental illness and its incidence
Mental wellbeing   A term used synonymously with "mental health" to clarify that the user is referring to health as in wellbeing, rather than 'health' as in illness
Positive mental health   Is used similarly to mental wellbeing (above)

In this context, the use of the terms "mental health", "positive mental health" or "mental wellbeing" is a medium-term strategic issue. Health promoters (and others working in health) need to consider the implications of these terms when using them, and consider providing clarification of their meaning, until such a time that "health" is understood as a positive, holistic and multi-dimensional concept and practice.

Mental Health and Mental Illness

In order to distinguish between mental health and mental illness, a number of authors have found it useful to draw on what is known as "the two continua concept". Originally published by the Canadian Minister of National Health and Welfare (MNHW) in 1988, and popularised in my own book on *Mental Health Promotion* (Tudor, 1996), and subsequent training programmes based on the book, this concept acknowledges that people can have different degrees of mental health or wellbeing, separate from whether or not they are mentally ill – or, more accurately, have a diagnosed mental illness (see Figure 1).

Figure 1. The Two Continua Concept (based on the MNHW, 1988)

Mental health continuum

Optimum mental health ———————————————————— Minimal mental health
(mental ill-health)

Mental illness continuum

Minimal (mild) ———————————————————— Maximum
(severe)
mental illness/disorder   mental illness/disorder

This concept and model has a number of advantages (see Table 2).

Table 2. The Advantages of the Two Continua Model of Mental Health	
1. It acknowledges that we can be ill and well at the same time	This reflects people's experience of themselves when they are "ill" (physically or mentally), and is the *conceptual* advantage of the model
2. It means that we can talk about both mental health and mental illness, rather than conflating the two, and not really talking about either positive mental health or mental illness	This is the *philosophical* advantage of the model
3. It means that people and practitioners can promote the mental health and wellbeing of people who have a mental illness	This is the *practical* advantage of the model
4. It means that practitioners can promote an holistic approach to the assessment of mental health and illness	This is the *clinical* advantage of the model
5. It assumes and argues that mental health is everyone's business (see Herrman, Saxena & Moodie, 2005), and not the territory of only one discipline, i.e., medicine	This represents both a *practical* advantage and an *interdisciplinary* advantage of the model
6. Following on from the previous point, it means that non-medical practitioners can get involved in the care of patients in psychiatric hospitals	This represents both a *practical* advantage and a *political* advantage of the model

Despite the general conflation of the term "mental health" with "mental illness", there is, nevertheless, a strong body of literature on positive mental health and wellbeing. Here I present what I consider five key contributions to our understanding of positive mental health.

1. Concepts of mental health (Jahoda, 1958)

The approach of considering the subject of mental health from a conceptual perspective was first adopted by Marie Jahoda (1907–2001). In a report to a United States Joint Commission on Mental Illness and Mental Health (note the distinction explicit in the title of this Commission) she identified six major categories of concepts:

- Mental health as indicated by the *attitudes of an individual towards themselves*;
- Mental health as expressed in the individual's style and degree of *growth, development or self-actualisation*;
- Mental health as *integration* of the above – that is, the individual's ability to integrate developing and different aspects of themselves over time; and
- Mental health based on the individual's relation to reality in terms of:
  - *Autonomy*;
  - *Perception of reality*; and
  - *Environmental mastery* (Jahoda, 1958).

These categories may be used as the basis of a (positive) mental *health* assessment (see Tudor, 2004), although they only focus on the individual, and need further development if they are to be applied to a couple, family, whanau, hapu, iwi, community, organisation, and so on.

2. Multiple intelligences (Gardner, 1983, 1993, 2000)

Gardner's work on intelligence and, specifically, multiple intelligences, is I think, a useful way of thinking about human ability, aptitude or capacity in a multi-dimensional way.   The intelligences are:

- musical–rhythmic,
- visual–spatial,
- verbal–linguistic,
- logical–mathematical,
- bodily–kinaesthetic,
- interpersonal,
- intrapersonal,
- naturalistic,
- existential, and
- moral

Whilst Gardner himself has not linked his ideas on intelligence to mental health, and there are critics of his theory, there is no doubt that his work has widened people's thinking about what constitutes "intelligence", and has had a significant impact on theory and practice in education.

Gardner has also suggested that the personal intelligences, i.e., the *inter*personal and the *intra*personal are, in effect, the intelligences with which we reflect on the other intelligences. These two intelligences amount to information-processing capacities, the combination or fusion of which provides a sense of self. Similarly to the arguments advanced by Neumann, Schroeder and Voss (1989) and the WHO (2014) (see above), I argue that this means these intelligences are criterial to having a good, holistic sense of ourselves. This brings us to the next concept of emotional literacy.

3. Emotional literacy (Steiner, 1984)

In 1984 Claude Steiner, a psychologist and radical psychiatrist, published the first article on the subject of emotional literacy. Drawing on transactional analysis and radical psychiatry, and inspired by the women's and men's movements of the 1960s and '70s, emotional literacy sought – and seeks – to promote: a) knowing what feelings we have, how strongly we have them, and why; b) recognising caringly other people's emotions, and the strengths and reasons of their emotions; and c) developing an ability to express or hold back our feelings so as to enhance the quality of our lives *as well as those around us* (Steiner, 2014). The concept has been taken up by others such as Antidote, the Campaign for Emotional Literacy (see http://www.feel.org/), Antidote and Spendlove (2008). Goleman, the author of *Emotional Intelligence* (Goleman, 1997) suggested that emotional intelligence "can matter as much as IQ in determining a person's wellbeing and effectiveness in life."

4. Mental health: Definition, concepts, and paradigms (Tudor, 1996)

In my own, original work on this subject, I made three key points:

1. That there were – and are – many definitions of mental health or wellbeing, and that it is important to acknowledge this, and that, when working with people, it is important to acknowledge their own definition and ideas about what constitutes their positive mental health or wellbeing. This represents a client- or person-centred approach to the person, an experiential approach to the subject, and an heuristic approach to research.

2. That, following Jahoda's (1958) work, it is possible to cluster such definitions into concepts or categories of concepts. At that time (I conducted the original research between 1990 and 1994), I identified eight elements of mental health, i.e., coping, tension and stress management, self-concept and identity, self-esteem, self-development, autonomy, change, and social support and movement, which, whilst they were never intended to be comprehensive, did reflect the literature in the field at the time.

3. That, following the work of Kuhn (1970) and Burrell and Morgan (1979), and in order to understand the different and differing theory and practice of mental health and its promotion, it is useful to frame different definitions and concepts by means of a paradigm analysis, into functionalist, interpretive, radical humanist, and radical structuralist paradigms (see also Tudor, 2004, 2010).

5. Flourishing and languishing (Keyes, 2002, 2007)

In a separate strand of development, some psychologists, sociologists, and researchers have moved forward the mental health agenda through studies of subjective wellbeing. Notable amongst these is Keyes who has developed a perspective on mental health, which he has referred to as flourishing, and on mental ill-health and illness, which he refers to as languishing (Keyes, 2002). He identifies thirteen dimensions of subjective wellbeing which he divides between those which are *hedonic* (as in hedonistic), which are concerned with pleasure and positive emotions, and those which are *eudaimonic*, which are to do with self-fulfilment and positive functioning, including positive *social* wellbeing (see Table 3) (Keyes, 2007).

Table 3. Positive Emotions and Positive Functioning (Keyes, 2007)
Positive Emotions (i.e. Emotional Wellbeing)
1.   *Positive Affect* – Regularly cheerful, interested in life, in good spirits, happy, calm and peaceful, full of life
2.   *Avowed Quality of Life* – Mostly or highly satisfied with life overall or in domains of life
Positive Psychological Functioning (i.e. Psychological Wellbeing)
3.   *Self-Acceptance* – Holds positive attitudes toward self, acknowledges, likes most parts of self, personality
4.   *Personal Growth* – Seeks challenge, has insight into own potential, feels a sense of continued development
5.   *Purpose in Life* – Finds own life has a direction and meaning
6.   *Environmental Mastery* – Exercises ability to select, manage, and mould personal environs to suit needs
7.   *Autonomy* – Is guided by own, socially accepted, internal standards and values
8.   *Positive Relations with Others* – Has, or can form, warm, trusting personal relationships
Positive Social Functioning (i.e. Social Wellbeing)
9.   *Social Acceptance* – Holds positive attitudes toward, acknowledges, and is accepting of human differences
10. *Social Actualisation* – Believes people, groups, and society have potential and can evolve or grow positively
11. *Social Contribution* – Sees own daily activities as useful to and valued by society and others
12. *Social Coherence* – Interest in society and social life, and finds them meaningful and somewhat intelligible
13. *Social Integration* – A sense of belonging to, and comfort and support from, a community.

The advantages of Keyes' work is that is offers a way of measuring emotions and functioning, and that it acknowledges the social dimension of wellbeing, for, as Turner (1983) put it: "the nature of the social environment is significant for health and emotional wellbeing" (p. 105).

These ideas, from a variety of traditions and disciplines, as well as other ideas about positive mental health and wellbeing, have formed the basis of the promotion of mental health.

Mental Health Promotion

A number of authors – see, for example, Tudor (1996), MacDonald and O'Hara (1998), Weare (2000), Barry (2001), Joubert (2001), Raeburn (2001), and Lahtinen, Joubert, Raeburn, & Jenkins (2005) – who have discussed and developed the field of mental health promotion have done so in the context of the more generic field of health promotion, based on:

- Health promotion charters – i.e., the Ottawa Charter for Health Promotion (1986), and the Bangkok Charter for Health Promotion in a Globalised World (2005);
- Health promotion declarations and statements – from successive international conferences held in Alma Ata (1979), Adelaide (1988), Sandsvall (1991), Jakarta (1997), Mexico (2000), Nairobi (2009), and Helsinki (2013);
- Health promotion principles – e.g., the WHO (1986); and
- Local and international health promotion policies and practice.

In the next part of the paper I offer a chronological summary of the seminal literature on mental health promotion (see Table 4).

Focus/title	Author(s)	Summary	Application
		Table 4. A Summary of the Seminal Literature on Mental Health Promotion	
On paradigms and paradigm analysis	Tudor (1996)	Offers four paradigms – functionalist, interpretive, radical humanist, radical structuralist – as a framework for analysis; and identifies eight elements of mental health: coping, tension and stress management, self-concept and identity, self-esteem, self-development, autonomy, change, and social support and movement	To the critical analysis of mental health promotion theory, policy, and practice
On mental health promotion and demotion	MacDonald and O'Hara (1998)	Identifies ten elements of mental health: environmental quality, self-esteem, emotional processing, self-management skills, social participation, environmental deprivation, emotional abuse, emotional negligence, stress, and social alienation	To the micro level of individuals, the meso level of family, workplaces, etc., and the macro level of wider systems
On the determinants of mental health	Lahtinen, Lehtinen, Riikonen and Ahonen (1999)	Identifies three areas for mental health promotion: structural level factors (social, economic, cultural), community level factors (positive sense of belonging, social support, sense of citizenship, and participation in society; and individual level (the ability to deal with thoughts and feelings, and to manage life, resilience, the ability to cope with stressful or adverse circumstances)	To policy and intervention
On a whole school approach	Weare (1999)	Describes mental, social, and emotional health in terms of: learning and academic achievement in the context of happy and effective schools; areas of school life including relationships with families and the community, management, and curriculum; and competencies for emotional literacy	In and through schools
On mental health promotion and Te Tiriti o Waitangi	Came (2003)	Identifies lessons from Te Tiriti o Waitangi for mental health promotion in Aotearoa New Zealand, including: (promoting) respectful relationships, supporting Māori sovereignty, (being) accountable to tangata whenua, (promoting) equity of outcome, acknowledging the past, (having an) awareness of Māori worldviews, and building Māori capacity	To Tiriti-based mental health promotion practice
On indigenous (Aboriginal) peoples	Kirmayer, Simpson, & Cargo (2003)	Reviews (then) recent literature examining the links between colonialism and specific government interventions and mental health	To Canadian Aboriginal peoples
On indigenous health promotion	Durie (2005)	Makes the connection between socio-economic disadvantage, colonisation, alienation, suppression of culture, and foreign rule and ill-health and illness; and between the bond with the land, tribal and personal identity, holistic philosophy, indigenous models of health, human rights, sensitive public policy, participation, partnership, and self-determination and health	To indigenous peoples
On concepts, evidence, and	Herrman, Saxena and	Makes the link between the protection of basic civil, political, economic, social, and cultural rights of people, and their mental health	In international public health

practice	Moodie (2005)		
On action areas	Jané-Llopis and Anderson (2005)	Identifies ten areas for mental health promotion: parenting and the early years of life, mental health in schools, workplace mental health, mentally healthy ageing, groups at risk [of] mental disorders, (prevent depression and suicide, (prevent) violence and harmful substance use, primary and secondary health care, and other sectors	A policy for Europe
On implementing programmes	Barry (2005), Barry and Jenkins (2007)	Offers a generic template for action in a number of settings: the community, home, schools, the workplace, primary health care, and mental health services	In a number of settings
On a lifespan approach	Cattan and Tilford (2006)	Offers views of mental health and its promotion across the lifespan, i.e., infancy (0–5 years) and childhood (6–12 years), adolescence (12–17 years) and emerging adulthood (18–24 years), adulthood (25–45 and 45–65 years), and (in) older people (65–80 and 80+ years)	To different population groups by age

Over the past fifteen years, there has also been an increasing interest in measuring and surveying mental health (see Table 5).

Table 5. Measuring Positive Mental Health		
Focus	**Author(s)**	**Summary**
On mental health indicators	Lahtinen, Lehtinen, Riikonen and Ahonen (1999), Zubrick and Kovess-Masfety (2005), and Parkinson (2007)	Including • demographic indicators, • social stress indicators, and • indicators of health and social functioning; and reflecting • subjective experience, • sense of coherence, • self-esteem, • sense of control, and • optimism; in respect of • positive mental health, and • mental health problems; and regarding the individual, i.e., • learning and development, • healthy living, • general health, • spirituality, and • emotional intelligence; regarding community, i.e., • participation, • social networks, • social support, • trust, and • safety; and regarding structural contextual constructs, i.e., • equality, • social inclusion, • discrimmination, • financial security/debt, • physical environment, • working life, and • violence
On measuring aspects of mental health	Korkeila (2000)	Including • socio-economic status and health, • neighbourhoods and urbanicity, • migration, • social networks and stressful events, • social support, • family relations, • marital quality; life events, • living conditions and social capital,

		• affect,
		• happiness and life satisfaction,
		• subjective wellbeing and psychological distress,
		• sense of personal control,
		• personality characteristics,
		• resilience,
		• hardiness and coping,
		• sense of coherence,
		• expectation of future as a resource,
		• empowerment, and
		• self-perceived aspects of health
On determinants of mental health	Zubrick and Kovess-Masfety (2005)	Demographic variables, stressful life events, social support, and quality of life
On the General Health Questionnaire as measuring positive mental health	Hu, Stewart-Brown, Twigg and Weich (2007)	Research found that the 12-item General Health Questionnaire measures both positive and negatives apsects of mental health, and could be used to measure positive mental health in population-based research
On positive emotions and positive functioning	Keyes (2007)	See Table 3 (above)

From these summaries, we can see that positive mental health and its promotion is well-theorised and well-conceptualised, the subject of numerous policies, practised widely, and thoroughly-researched.

Promoting Mental Health in Aotearoa New Zealand

We could consider that an important aspect of mental health is knowing who you are, where you come from and where you belong. This is certainly a strong part of Māori culture, and one from which, in this country, both Pākehā and Tau Iwi have learned – and hence my Pepeha at the beginning of this paper. It is clear that, if someone does not know their turangawaewae or where they stand, usually as a result of colonisation, or, out of a false sense of cultural neutrality, this is not conducive to positive mental health or wellbeing. It is significant that *The Geneva Declaration on the Health and Survival of Indigenous Peoples* refers to "health and survival", making the case that these are inextricable linked, and that neither health nor mental health can be understood outside their social, political, and cultural context.

Mental health promotion in this country must, therefore, begin from a critical analysis of the impact of colonisation and current health inequalities between Māori and Pākeha and Tau Iwi, and proceed, via the articles of Te Tiriti – regarding kāwanatanga (governorship), tino rangatiratanga (sovereignty), ōritetanga (equitable outcomes), and wairuatanga (spiritual freedom) – to a vision of a people-centred holistic health: philosophy, policies, system, and care.

Conclusions

Just as there is a relationship between health and health promotion, so there is a relationship between mental health and mental health promotion. The positive concept of mental health or wellbeing needs to be wrested from its negative connotations with mental illness – which, also, should not be treated negatively. Finally, whilst there are positive concepts of mental health and wellbeing in Western (and Northern) thinking, so there is much to learn from indigenous wisdom traditions, concepts, and models of health for the promotion of positive mental health or wellbeing. Tūhauora!.

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Biographical Note

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In terms of his interest in mental health and its promotion, Keith undetook the inititial research on the subject of (positive) mental health in 1990 at the Management Centre, King's College, University of London; between 1990 and 1996, he presented papers on mental health and its promotion at various conferences (Holland & Tudor, 1991; Tudor, 1992, 1995, 1996; Tudor & Holroyd, 1992); Mental Health Promotion: Paradigms and Practice, the first book on the subject, was published in 1996; in 1998 he was invited to contribute to the Canadian government's thinking on mental health promotion, and to speak at a conference in Canada; in 1999 he designed distance learning papers on mental health promotion for the Faculty of Nursing, Midwifery & Community Studies, University of Aberdeeen; in 2004 he had a chapter published on the subject in a book on mental health nursing; in 2004-2005 he wrote the positive mental health strategy for Grampian (a region of Scotland); and, in 2008 he prepared a paper on mental health for the Scottish government's Department for Health and Wellbeing.