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MODELS OF MENTAL HEALTH

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Abstract:
The best rationale for conceptual analysis of behavioural disorders lies on its contrast with some "normal" or "healthy" pattern of behaviour. The mental health is a multidimensional construct. In psychological disorders are present moral suffering, pain, distress and / or non functional adjustment to social situations. Finally, in this paper, the mental or behavioural disorders are conceived as self-perpetuating behaviour cycles.

Mental health is a high order theoretical construct. It has been under suspicion and has even been rejected by some behavioural theorists (Bunge, 1980; Ribes, 1990), because of its associations with medical notions and with a dualistic philosophy of mind as distinct of human organism or brain. Leaving aside such philosophical questions, mental health may be constructed as a scientific concept if it is conceived as behavioural health and is anchored in an empirical pattern of behaviours, attitudes, cognitions and emotions. Under the motto of "Eudemon Group", a group of researchers leaded by the first author of this paper, is engaged in exploring topics related to

mental or behavioural health (Fierro and Cardenal, 1993, 1996) according to the following assumptions:

(1) They consider that the best rationale for conceptual analysis of behavioural disorders lies on its contrast with some "normal" or "healthy" pattern of behaviour. Behavioural field covered by these constructs is a bipolar one. Researchers and not only clinical psychologists should pay more attention to healthy pole of this field, i.e., to conditions that positively contribute to promote it and not only to antecedents of disorder or deviation. What from a personalistic view has been designed as "healthy personality" (Jourard and Landsman, 1987) and as "fullfilling maturity" (Heath, 1991) needs a translation into behavioral and psychometric terms.

(2) Psychological or behavioural disorders and, respectively, mental health have to be considered not as categories, but as dimensional constructs. They are related to behaviours at variance within a continuum of graded severity in some dimensions (Clark, 1994). Mental health and disorders should not be described only for classification. They have to be theoretically constructed and empirically validated through clustering of continuous dimensions in an approach where taxonomy can be integrated in psychological measures and in taxonometric assessment (Achenbach, 1988; Andreasen y Grove, 1982; Reynolds, 1992).

(3) The mental health is a multidimensional construct. More than one criterion is needed to grasp its features and to determine whether a pattern of behaviour has to be considered "normal" or "deviated" (Fierro, 1984; Jahoda, 1955; Offer y Sabshin, 1991; Scott, 1958; Vázquez, 1990). In fact, various factors have been found in the structure of mental health measures (Compton, Smith, Cornish, and Qualls, 1996; Zacarés and Serra, 1998). Nevertheless not many criteria and dimensions are to be considered. Researchers of personality disorders are closest to a consensus: the domain can be characterized by a relatively small set of traits (Clark, Watson and Reynolds, 1995). So, it is needed to search for those dimensions that are strictly necessary and sufficient to account for the variance in the field of mental health / disorder.

(4) Dimensions of mental health / disorder are likely related to basic dimensions of personality. This has been

claimed and found within circumplex model (Pincus, 1994), three-factor model (Eysenck, 1994) and five-factor model (Costa and Widiger, 1993; Duijsens and Diekstra, 1996; Marshall, Wortmann, Vickers, Kusulas and Hervig, 1994; McCrae, 1994). Any dimensional model of mental health or of some of its factors, i.e., subjective wellbeing (Emmons and Diener, 1985), should prove its coherence with a model of personality structure.

To meet the above requirements a two-dimensional model has been suggested. As opposed to mental disorder, mental health has been conceived and investigated by Eudemon Group along two dimensions in which humans widely differ: those of Personal Wellbeing (PW) and Social Adaptation (SA). Dimension of Personal Wellbeing relates to the experiences, feelings and emotions of people, along a continuous of satisfaction versus dissatisfaction and discomfort. Dimension of Social Adaptation, or adjustment, relates to external and manifest behaviour, i.e., to ways in which a person adapts to reality, especially to social reality, and also to the extent to which his/her behaviour is functional in interpersonal context.

Personal Wellbeing and Social Adaptation are behavioural patterns in opposition to "distress", "pain", "suffering", and, respectively, "disability", "impairment". All these terms are mentioned in the definition of DSM-IV of mental disorders: "a clinically significant behavioural or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability..." (American Psychiatry Association, 1995). This definition may be taken as the negative side of the same construct that PW-SA model describes positively as mental health.

PW-SA model assumes that in psychological disorders are present: (a) moral suffering, pain, distress or deep discomfort of the person, and / or (b) non functional adjustment to social situations. On the other hand, with regard to mental health, under ordinary conditions of life, i.e., not extremely adverse conditions, we could hardly say in daily language that a person is "all-right" unless he or she: (1) experiences a sense of basic wellbeing (or satisfaction, or happiness) in life; (2) is

well integrated, adapted to the environment, and is able to communicate with others.

According to this model, the first author of this report has developed the "Escala de Bienestar Personal", "Personal Wellbeing Scale" (PWS) with 33 items, and the "Escala de Adaptación Social", "Social Adaptation Scale" (SAS) with 34 items. Subjects have to react with "yes" or "no", according on whether the item reflects or not his actual behaviour, feelings or attitudes. The Scales were constructed on the assumption of independence and of one-dimensionality. Each of them, PWS and SAS, was constructed to be saturated by one single factor; and they were proposed as mutually independent.

Structure and internal consistency of both Scales have been extensively studied in two different samples, one of young people (N=214), another of adult and senior people (N=1745). Coefficient alpha has been .86 in PWS and .80 in SAS in the first sample, and .85 and .79 in the second. One-dimensionality has been confirmed (Rivas, Fierro, Jiménez and Berrocal, 1998). On the contrary, mutual independence has not been confirmed. Across four studies and more than 3500 subjects in a range of age from 18 to 89, PWS and SAS showed Pearson correlations about .60 (Fierro, Jiménez and Berrocal, 1998).

Research on construct validity and personality correlates of PW and SA has focused on links of PWS and SAS: (1) with clinical dimensions, i.e., dimensions that are present in many behavioural disorders, such as anxiety and depression; and (2) with basic dimensions of personality, such as the Big Five Factors. PWS and SAS appear strongly related to various index of clinical dimensions, mainly, anxiety and depression, and not so strong, but significantly related to Big Five (Fierro, Jiménez and Berrocal, 1998).

Up to now research within the PW-SA model has remained in a descriptive and exploratory level. The search for explanations is delayed for the moment. In exploratory studies PWS and SAS have proved their discriminative power. Subjects with and without behavioural disorders differ in scores on both Scales. Moreover these scores increase in the direction of behavioural health along various stages of a programme of rehabilitation of persons who were addict to heroin (Ortiz-Tallo y Fierro-Hernández, 1998).

It is possible, however, to proceed beyond structural research in two different directions: 1) in a process approach; 2) in a capacity approach. Let us summarize these directions:

1) In a process approach, mental or behavioural disorders can be conceived as self-perpetuating behaviour cycles. Depression, phobias, anxiety, drug addiction, non functional social interactions and other disorders appear to be maintained by self-reinforcing processes, in which individual is not able to rid himself/herself from them. In contrast, mental health and personal growth consist on open streams of action towards new tasks and aims in life. This model is theoretically suggested from the notion of personality as stream or sequence of action. In the frame of this notion, healthy personality refers to a person who is able of undertaking an open course of action which is positively operant in the course of events in the external world. Psychopathological behaviour, on the other hand, tends to a circular cycle that perpetuates the same noxious conditions of life (Fierro, 1988).

2) In a capacity approach, psychological disorder and mental health can be conceived as incapacity and, respectively, active capacity of caring of oneself in order to happiness and wellbeing under ordinary conditions of life. This model is linked with constructs on "emotional intelligence". It conceives mental disorder and mental health in terms of inability and, respectively, capacity -or, at least, disposition- of taking care of oneself and of providing yourself a satisfactory experience of life (Fierro, in press).

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