Editorial

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Understanding of the determinants of mental wellbeing

Interest in mental wellbeing (positive mental health) is growing because of demonstrable protective effects on health (Pressman and Cohen, 2005), longevity (Chida and Steptoe, 2008), learning and productivity (Huppert, 2009). Although there is still debate about the nature of some aspects of mental wellbeing, there is general agreement that it represents more than the absence of mental illness and, for most authorities, that it includes both affective (feeling) and behavioural (functioning) components (Faculty of Public Health and Mental Health Foundation, 2016). In the same way that mental illness is diagnosed on the basis of feeling bad and functioning poorly mental wellbeing is thus recognised by both feeling good and functioning well.

This interest in mental wellbeing has stimulated researchers like Solin *et al.* (2019) to investigate the determinants of mental wellbeing in different parts of the world. It might be assumed that the determinants of mental wellbeing are the reverse of those well documented for mental illness (e.g. Allen *et al.*, 2014), but some have called this assumption into question (Huppert, 2009). Whilst many studies contributing to this debate are cross-sectional and thus cannot reliably distinguish causality from association, consistent findings from cross-sectional studies do make a contribution to causality criteria and perhaps more importantly inconsistent findings make causality unlikely. So it is of interest that there is less consistency in the findings of studies investigating the social determinants of mental wellbeing than there is in those investigating the social determinants of mental illness. It is also of interest that study methodology seems to dictate the findings. Thus, studies that suggest that the determinants are the same, demonstrating a positive trend for mental wellbeing with income and education, have either used continuous regression analyses or dichotomised their study populations and used logistic regression to compare the odds of low mental wellbeing with the odds of not low mental wellbeing (e.g. Dreger *et al.*, 2014). The study by Solin *et al.* (2019) uses a different approach in which both low and high mental wellbeing are compared to the middle range. Like other studies taking this approach (Stewart-Brown *et al.*, 2015; Ng Fat *et al.*, 2016), they find no evidence that mental wellbeing is related to educational level and only weak evidence that it is related to employment. These findings have been replicated in adolescent as well as adult populations (Nielsen *et al.*, 2016). It would seem that this lack of association with traditional social determinants is concealed in studies which do not seek to specifically examine the upper end of the distribution, because the strong social gradient for mental illness dominates findings.

So what do these studies show us about the determinants of mental wellbeing? The study by Solin *et al.* (2019) undertaken in Lapland points strongly to the importance of human relationships – those who are not living alone have higher mental wellbeing than those who live alone. And in both groups, the single most important determinant was social support (measured with the Social Support Scale (Meltzer, 2003)). This was protective against low levels of mental wellbeing and positively associated with high levels. Social isolation and loneliness are well documented associates of both mental and physical illness and prospective studies confirm that these are likely to be causal (Leigh-Hunt *et al.*, 2017).

The capacity to make positive relationships with others – of the sort which allow the giving and receiving of social support – is, however, embedded in the definitions of mental wellbeing (Faculty of Public Health and Mental Health Foundation, 2016). So, it is possible that lack of social support and living alone are manifestations of lack of mental wellbeing as much as determinants. People with high levels of mental wellbeing – cheerful, optimistic, confident people

who are curious about the world and interested in others – attract friends and have much to offer others. This may be why the giving of social support appears at least as protective of health, and possibly more so, than receiving it (Brown *et al.*, 2003). People who are anxious and depressed, pessimistic about the future and lacking in self-esteem do not make supportive relationships so easily. Thus, those most in need of others' support and care may become those with least provision.

What then is the solution? As Huppert (2009) and others (Faculty of Public Health and Mental Health Foundation, 2016) have clearly shown, on the basis of the research of many different disciplines, the capacity for mental wellbeing is determined to a very significant extent by the quality of family relationships in childhood. Attachment security in infancy, and parental warmth, support and appropriate levels of control in childhood and adolescence enable the development of the emotional and social brain in a way which sees other people as positive. The converse produces children who as adults have low levels of self-esteem, who are easily frightened or overwhelmed, and most importantly difficulty trusting others. Some of the more readily documented components of homes in which such children grow up have been studied under the label adverse childhood experiences and shown to be strongly related to all aspects of health in adulthood (Hughes *et al.*, 2017).

Childhood emotional and social patterning of the brain is amenable to change in adolescence and adulthood with school-based interventions and tried and tested therapeutic approaches such as CBT and PST. They may prove even more amenable to the new approaches to childhood trauma such as Trauma Release Exercises (Berceli, 2005) and Emotional Freedom Technique (Nelms and Castel, 2016) but the provision of these approaches needs to wait on the development of the evidence base. In the meanwhile whilst it is very important that we make provision to reduce social isolation and loneliness among adults we are unlikely to reduce the size of the problem or prevent its damaging consequences without very significant support for families with young children, for parents and for parenting.

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Further reading

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