The Bell Jar Rises
Social Determinants of Well-Being in Mental Health Service Users Receiving Care in the Community

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Abstract

Based on a review of existing psychological and psychiatric literature, a theoretical model of quality of life and well-being is proposed, with emphasis on the input of social capital. The impacts of mental illness on individual components of this model are then discussed, with reference to epidemiological and social research findings. Suggestions for future health policies are then proposed, drawing upon pathways from the theoretical model.

Introduction

While several studies have shown mentally-ill patients/mental health service users in community-care environments to have a subjectively higher quality of life than those in in-patient settings, it remains that their quality of life, assessed by both subjective and objective measures, is lower than that of the general population (Hansson, L. 2006). Although such disparity may partly be by virtue of differences in (psychiatric) disease status, there is considerable evidence that points to the role of social factors in well-being, namely relationships, social interactions and housing (Lehman, A.F. 1988).

It would be not be sufficient to explain lower quality of life or well-being only in terms of direct clinical effects of mental illness on these social variables. Instead, it is more likely that mental illness has more widespread and circuitous effects on quality of life, such as modifying one’s own appraisal of life circumstances. The determinants of well-being, despite this, remain relatively constant between the severely mentally ill population and the general population (Holloway, Carson 2002).
This may suggest that, in addition to effective medical treatment of the psychiatric disorders, the pathway to raising quality of life in mentally-ill individuals lies in aligning social variables with those of the general public.

‘To the person in the bell jar, blank and stopped as a dead baby, the world itself is a bad dream’ – Sylvia Plath, *The Bell Jar* (1963)

We conceive the ‘bell jar’ to be a metaphor for the restrictive effect of mental illness: depression, in the case of Plath’s novel. Policies which focus on measures of objective quality of life, such as disposable income, may be of limited efficacy in helping individuals overcome mental illness. It is argued in this paper that improving an individual’s satisfaction with aspects of life and targeting psychological percepts, such as self-esteem, are far more promising avenues, if the bell jar is to rise.

**Towards a model of global well-being**

The term ‘well-being’ is difficult to define concretely. Ryff and Singer (2008) contend that well-being is closely related to the term *eudaimonia*, expounded on by Aristotle in his *Nicomachean Ethics*. In this sense it conveys the feeling that life is going well and according to one’s true potential.

Well-being has previously been defined within the National Health Service as: ‘a concept combining an individual’s health, their quality of life, and their satisfaction’ (Wirral Primary Care Trust, 2010). Quality of life is also a nebulous term, but tends to be a more tangible concept in fields of health and social research. For the purposes of this review, we will judge _global well-being_ to be synonymous with overall _quality of life_. This, however, fails to address the ambiguity of the latter term: further definition is required, which uses a multi-faceted approach.

As part of his seminal ‘satisfaction model,’ Lehman (1988) posited that overall quality of life was the product of interplay between one’s _personal characteristics_ (such as one’s personality type) and, more significantly, _objective_ and _subjective_ indicators in various _life domains_. These life domains principally include: work, finances, housing, mental and physical health, safety, leisure, family contact and other social contact. Objective indicators are easily measurable and form an individual’s or group’s _objective quality of life_. The total hours worked a week is, for instance, an objective indicator in the life domain of work.

Alternatively, a person may feel dissatisfied at work. This is a subjective indicator and forms a person’s _subjective quality of life_. Put simply, subjective quality of life is a measure of one’s satisfaction in life domains. Objective and subjective quality of life
although conceptually isolated, are complementary to each other. Nevertheless, numerous studies show a lack of correlation between objective and subjective quality of life, supporting this conceptual isolation (Narvaez et al 2008).

Regression analysis of Lehman’s model revealed that overall quality of life or global well-being was predominantly influenced by subjective quality of life, which accounted for 24% to 31% of the variance (Holloway, Carson 2002). Objective quality of life and personal characteristics played very little role in determining global well-being (accounting for 7 to 16% and 4 to 7% of variance respectively).

The finding of a weak relationship between objective quality of life and global well-being has been replicated many times (Hansson, L. 2006), as has the observation of a strong relationship between subjective quality of life and global well-being (Vatne, Bjorkly 2008). In a similar vein, external life circumstances have been evidenced to play an insignificant role in one’s happiness. In an article entitled ‘The Pursuit of Happiness,’ Myers and Diener (1997) scrutinised the results of 1,100 surveys administered to 1.1 million participants across the world. They concluded that sex, age, ethnicity, socio-economic status and educational level had little impact on happiness, though marriage was a notable exception.

Within objective and subjective quality of life groups, there is a disparate contribution from each life domain. Illustrating this point is a Swedish study conducted by Eklund (2009), which noted that satisfaction with work activity, a subjective quality of life domain; was subordinate to satisfaction with leisure activities.

**Social determinants of quality of life**

In a recent meta-analysis of quality of life research, Vatne and Bjorkly (2008) thought that of the various life domains, leisure, family and social contact were the strongest independent predictors of global well-being. Satisfaction in these life domains is intimately entwined with the economic notion of social capital. It is thus helpful to describe the constituents of social capital and further distinguish its contribution to global well-being.

Social capital is a term that encapsulates social relationships occurring between individuals or groups. It alludes to both the quantity and quality of social interactions, as well as abstract constructs, such as trust in others. A more detailed analysis of the term is given by Putnam (1993), who establishes five components. These are: (1) community networks, voluntary, state, personal networks, and density; (2) civic engagement, participation, and use of civic networks; (3) local civic identity – sense of belonging, solidarity, and equality with other members; (4) reciprocity and norms of cooperation, a
sense of obligation to help others, and confidence in return of assistance; (5) trust in the community.

Social capital may be delineated in a fashion akin to that between objective and subjective quality of life. Participation in a sports club, for instance, is an example of structural social capital; describing activity or behavioural interactions. More conceptual or subjective social interactions, such as trust in a community or sharing values, are categorised under cognitive social capital. Using data from the World Values Survey gathered across 49 countries, Helliwell and Putnam (2004) have demonstrated a robust positive link between both structural and cognitive social capital, and global well-being. Part of this contingency may be mediated by indirect effects of social capital on physical and mental health (Kawachi et al 1999).

When evaluating social capital and subsequently formulating policies based on it, it may be useful to distinguish between social capital on an individual basis and that on a group or ecological basis. It remains a subject of contention over whether ecological social capital is a unique entity, or simply an aggregate of individual social capital (De Silva et al 2005). Accordingly, increasing ecological social capital may not necessarily increase the social capital and therefore global well-being of an individual, and vice versa.

Ecological and individual social capital may arise between groups or persons with marked commonalities, such as those suffering from the same disease. This is known as bonding social capital, whereas interactions and relationships between ‘different’ groups or individuals, such as those of different socio-economic status, is termed bridging social capital. Linking social capital describes interactions that occur through formal institutions, such as a government body. Bonding, bridging and linking social capital are all important determinants of subjective quality of life and global well-being.

**Self-related constructs**

Global well-being is not purely a weighted summary of objective and subjective quality of life. Studies in the field of positive psychology - a field that focuses on the determinants of happiness, wellbeing and good mental health - have demonstrated the contribution of specific, psychologically-grounded life dimensions to well-being. These self-related constructs are largely independent of personality or personal characteristics, but, more succinctly, reflect the manner in which life is lived and attitudes towards life.

Ryff (1995) purports there to be six main self-related constructs or, as she refers to them, life dimensions, these being: self acceptance, positive relations with other people, autonomy, environmental mastery, personal growth and purpose in life. For the
purposes of our theoretical model, we have chosen to classify ‘positive relations with others’ under social capital. Particular emphasis is placed on cognitive social capital, as this captures the perceptual elements of positive relationships with others, such as trust or empathy.

Perhaps the most influential self-related construct is that of autonomy. Autonomy refers to the qualities of self-determination and being independent. The term is not restricted to behaviours or actions, such as cooking for oneself, but also encompasses cognitive independence. Exhibiting ‘resistance to enculturation’ (Ryff, 1989) and thinking for oneself are gauges of high levels of autonomy too. Similarly, judging one’s behaviour from an internal locus – evaluating against personal standards instead of looking to others for approval, is a prominent component of autonomy. Higher levels of autonomy have been consistently linked to higher overall quality of life (Zissi et al 1998).

A related life dimension is that of environmental mastery. This relates to an individual’s ability to choose and create environments suitable to his/her personal needs and values. Someone who shows low levels of environmental mastery will typically encounter difficulty managing everyday affairs; feel unable to change or improve surrounding context; be unaware of surrounding opportunities; and lack a sense of control over the external world (Ryff, 1995). Such deficit of environmental mastery is affiliated with poorer global wellbeing and vice versa (Welch, West 1995). Highlighting this relationship, are the results from studies of residents in nursing homes. Residents given a pot plant to care for - thus promoting environmental mastery - reported higher global well-being than those owning a pot plant that is looked after by nursing home staff (Welch, West 1995).

Owing to the lack of universal adoption of Ryff’s six life dimensions in quality of life research, some studies may refer to the construct of self-efficacy. This is essentially a composite of autonomy and mastery and, unsurprisingly, is also a robust predictor of global well-being (Zissi et al 1998). A similar term combining elements autonomy and environmental mastery is that of locus of control. This connotes mastery over one’s self, expectancies of control over political institutions, and one's beliefs about the role of internal and external forces in society (Ryff, 1989).

Self-acceptance may be used interchangeably with the concept of self-esteem. This comprises having a positive view towards oneself, acknowledging the multiple facets of self, including good and bad qualities and having constructive views of past life (Ryff, 1995). Diener et al (1985) have identified a significant role of self-esteem with overall life satisfaction. The significance of self esteem in relation to global well-being varies greatly with culture. Self-esteem is considered to be less important in collectivistic nations, where personal attributes are less valued (Diener, Suh 1997).
Purpose in life or coherence is a measure of possessing goals in life, having a sense of direction in life, attributing meaning to present and past life and harbouring beliefs that give life meaning (Ryff, 1989). Purpose in life may be material, experiential or spiritual and, with regards to the latter, Ferris (2002) has reported a strong link between holding various religious beliefs and global well-being.

Tied in with this notion of purpose in life is the actual execution of these aims in life and development towards or fulfilment of goals. This is the essence of personal growth. It entails perceiving oneself as growing and realising one’s potential, as well as experiencing an improvement in self and behaviour over time (Ryff, 1995). Referring to a similar concept – perceived change, Zissi et al (1998) reported an association between sensed improvement in life and global well-being. Attainment of goals is most influential on well-being when these goals and one’s inherent psychological values are well matched. (Sheldon, Kasser 1998). Therefore, it is likely that purpose in life is the more powerful of self-related constructs.

Implementing a meditational model

Given the individual connections between the various objective, subjective and self-related factors, and global well-being, it is possible to amalgamate this into a more comprehensive framework. Zissi et al (1998) applied Lehman’s ‘satisfaction model’ (mentioned above) to psychiatric patients in Greece and found that there was not a simple, direct relationship between subjective and objective quality of life, personal characteristics, and global well-being. Lehman’s model omits the role of self-related constructs. Moreover, subjective quality of life, personal characteristics and self-related constructs seemed to operate separately from objective quality of life.

Following analysis of the inter-dependencies between these variables, it has been supposed that subjective quality of life, self-related constructs and, to a lesser extent, personal characteristics coalesce to form a secondary factor, which then interacts with objective quality of life. This secondary factor or factors are termed mediational variables (Zissi et al 1998) and represent a weighted aggregation of self-related constructs and subjective quality of the life.

Downstream in this so-called ‘mediational model of global well-being’ (Barry, M 1997), the mediational variables feed into an appraisal process, along with objective quality of life. The appraisal process arbitrates between objective life circumstances and subjective variables, namely subjective quality of life and self-related constructs. As such, appraisal may be partly conceived as a comparison between actual and ideal life circumstances. The larger the gap between ideal and actual life circumstances, the more likely there is to be a negative appraisal of life and consequent lower global well-
being. Conversely, if this gap is narrow, global well-being would, all things being equal, expected to be high. In those with medical illness, appraisal is thought to be based on various standards of comparison (Rapkin, Schwarz 2004). In this cohort, judgment of health is made with reference to previous health, extreme experiences, observations of other patients and communication with healthcare providers (Rapkin, Schwarz 2004).

In light of these findings regarding global well-being, a model of global wellbeing (see Fig. 1.) can be produced, accounting for the relative roles of self-related constructs, objective and subjective quality of life. As we are particularly concerned with social determinants of well-being, it would be pragmatic to delineate the role of social capital and its input into objective and subjective quality of life. The effect of mental illness on constituents of this model will be explored in the second part of this paper.

![Fig. 1 (p.8) A theoretical model of global well-being](image)

Social capital may be structural, for example, participation or cognitive, for example, trust. It may occur between individuals or groups. Social capital is particularly important in the assessment of ‘social’ life domains: leisure, family contact and other social contact (bottom bullet points). Structural social capital may preferentially contribute to objective quality of life, while cognitive social capital may load more onto subjective quality of life. The life domains are identical between objective and subjective quality of life, although objective quality of life involves objective indicators in these domains (italicised bullet points). Life domains do not equally influence overall global wellbeing and it has been found that housing and social domains (bold) may have a greater bearing. Similarly, subjective quality of life is of more salience than objective quality of life (larger arrow). Self related constructs, subjective quality of life and, less significantly (smaller arrow) personal characteristics combine together to form mediational variables, in concordance with Barry’s ‘mediational model of global well-being’ (Barry, 1997). These feed into an appraisal process with objective quality of life that, among other things, evaluates the distance between ideal and actual life circumstances. The output from this computation is perceived overall quality of life. This is, by our definition, synonymous with global well-being.
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Global well-being

Appraisal

PERCEIVED Quality of Life

OBJECTIVE Quality of Life

Mediational Variables

PERSONAL CHARACTERISTICS

SUBJECTIVE Quality of Life

SELF-RELATED CONSTRUCTS

LIFE DOMAINS OF SATISFACTION

Employment status
- Hours worked

Finance
- Disposable income
- Spending money

Housing
- Length of stay
- Health status
  - Frequency of medical care
- Safety
  - Frequency of transgressions

Leisure time
- Amount of activities

Family contact
- Frequency of contact

Other social contact
- Frequency

SOCIAL CAPITAL

STRUCTURAL

Example:
Meeting a friend

Example:
Meeting a community

COGNITIVE

Example:
Trust in a friend

Example:
Trust in a community

Self-esteem
Autonomy
Environmental mastery
Coherence
Personal growth

INDIVIDUAL

ECOLOGICAL
Impact of mental illness on the model of global well-being

The determinants of global well-being in mentally ill and healthy cohorts are broadly similar, as previously stated. This, however, does not imply an insignificant role for psychiatric disorders in shaping global well-being. A psychiatric disorder is prone to exert direct influence on well-being through its manifest clinical characteristics. The manner in which this occurs is, of course, contingent on the nature of the psychopathology and symptoms afflicting an individual.

The majority of quality of life research has focused on severe mental illnesses - schizophrenia, bipolar disorder, major depressive disorder and certain personality disorders (Hansson, L. 2006) - all of which may lower quality of life through emotional or affective changes, physical symptoms (such as psychomotor retardation) and through unwanted side-effects of medication. Huppert et al (2001) have reported significant relationships specifically between anxious and depressive symptomatology and reduced global well-being.

By virtue of its clinical characteristics, and through influence on psychological processes, psychiatric illness may also modulate the appraisal of quality of life. Disorders, such as depression, may engender negative attentional biases that render life events negative (Baert et al 2010), or promote internalisation of negative stereotypes (Rusch et al 2010), which result in a worse evaluation of global well-being. Some have argued that such an effect on self-appraisal is the sole factor working to reduce global well-being in the mentally ill (Hansson, L. 2006). However, this fails to account for observations of rising quality of life in psychiatric cases that are worsening or resistant to treatment, which emphasises the importance of extraneous factors, including social factors.

Mental illness and social capital

Adopting an epidemiological approach, De Silva et al (2005) conducted a systematic review of 21 studies of social capital and mental illness from the UK, USA, Netherlands, Russia, South Africa and Columbia. They distinguished between structural and cognitive social capital, as well as between individual and ecological social capital. The review showed a strong inverse relationship between individual, cognitive social capital and mental illness. In essence, there is some connection between an individual suffering mental illness and him/her lacking trust, faith or shared values in another individual. The relationship of individual, structural social capital to mental illness was less robust, although three of the constituent studies did report a strong inverse relationship (De Silva et al 2005). Ecological social capital, both structural and cognitive, bore no significant association with mental illness.
Rationalisation of this information remains speculative, predominantly due to the ‘associational’ nature of the study, meaning it cannot highlight directionality or causation between mental illness and social capital. Psychiatric illnesses, particularly schizophrenia and depression, are known to elicit the phenomenon of social withdrawal, whereby a sufferer ceases normal social interactions. This may explain the relationship between lower individual social capital and mental illness. Alternatively, environments conducive to low social capital may precipitate or exacerbate mental illness. This may explain the marked observation of higher prevalence of schizophrenia in urban areas with low social cohesion (McKenzie et al 2002).

An intriguing possibility that possibly describes the lack of association of mental illness and ecological social capital is that, in areas of low social cohesion and high unemployment, psychiatric illness affords sufferers more opportunity for social interaction with different communities (De Silva et al 2005). This example of bridging social capital may counteract reduced bonding social capital within the original low cohesion community. Although it is conjecture, generally increasing social capital without due regard to specific types of social capital may form a particularly risky avenue for policy. Supporting this postulation, is evidence from a study by Yanos et al (2001) demonstrating that structural social capital, in the form of negative social interactions, may lead to stigmatisation and reduce quality of life. This point rests purely on defining social capital as a quantitative term – policies which aim to increase the number of interactions, without scrutiny of the quality of these interactions.

**Mental illness and subjective quality of life**

Given the supposed inverse relationship between mental illness and individual, cognitive social capital - and acknowledging the significant contribution of social capital to subjective quality of life - it would be logical to argue that mental illness is linked to a lower subjective quality of life. The truth of this hypothesis is confirmed by studies of schizophrenic patients in the community. Katschnig (2000) reported a worse subjective quality of life for these patients compared to the healthy population. There are several pathways by which schizophrenia may come to diminish satisfaction with life domains. The most conspicuous route is through the inherent symptoms of the psychiatric disorder causing lower satisfaction with physical and mental health.

Another possibility is that depressive symptoms may, through negative cognitive biases, lead to lower satisfaction in other life domains: work, finances etc. Narvaez et al (2008) found that depressive symptoms were the single largest negative predictor of subjective quality of life. Both anecdotal and academic evidence make reference to stigmatisation that is intrinsic to mental illness, particularly schizophrenia. Low subjective quality of life
may stem from endeavours to either avoid or accept this stigma (Katschnig, 2000). With respect to this, efforts to avoid the negative identity associated with mental illness may compel an individual to disengage from psychiatric and social care, subsequently reducing their subjective quality of life. Alternatively, patients may engage with psychiatric and social care, but be forced to accept the associated stigma at the expense of respect and relations in the healthy population.

**Mental illness and housing**

Housing is often a prominent area of policy decision and so explaining the effect of mental illness on this quality of life domain is beneficial. Newman (2001) conducted a critical review of 32 studies into the relationship between mental illness and housing, exploring housing as an outcome of mental illness and as an input into well-being. Mental illness was shown to increase the risk of homelessness, which in turn has a significant deleterious effect on quality of life (Lehman et al 1995). In those with housing, the type and nature of housing is a significant determinant of quality of life.

Several studies have reported that living in independent housing, as opposed to shared housing, ameliorates global well-being (Newman, S, 2007). Within this context, sharing with fewer occupants is associated with greater well-being. Perhaps counter-intuitively, Newman (2007) argued that living with a greater proportion of mentally-ill occupants generated a more favourable clinical outcome in terms of mental health. While the caveat should be added that this effect was restricted to those in good-quality, non-institutional housing, this observation may be explained by an increase in bonding social capital between people of the same 'mentally ill' identity.

**Mental illness and self-related constructs**

There is a scarcity of research regarding the effect of mental illness on self-related constructs. This, in part, reflects the difficulty in quantifying such constructs. Self-esteem has been assessed by various interview or questionnaire scales. In the Rosenberg Self-Esteem Scale (Rosenberg, 1965) patients rate the personal relevance of statements such as, 'I feel I do not have much to be proud of,' or, 'I am able to do things as well as most other people.' Using interviews, Barrowclough et al (2003) noted that the severity of positive symptoms (delusions, hallucinations, thought disorder) in schizophrenia was strongly tied to low self esteem.

Augmenting this, critical attitudes from family members also significantly reduced self-esteem, insinuating the role of negative social interactions and stigma in shaping self-
related constructs. Indeed, increased perception of stigma has been associated with diminished self-esteem (Bradshaw, Brekke, 1999). While not as potent a determinant of global well-being as subjective quality of life, a Nordic multicentre study found self-esteem to be the second strongest factor, accounting for 7.3% of the variance in global well-being in mentally ill patients (Hansson et al 1999).

Environmental mastery and autonomy are other self-related constructs thought to be adversely affected by mental illness. Much of this effect may emanate from the manner in which service is provided. Studies of elderly patients in nursing homes show that the care environment is conducive to dependency on staff and subsequently low environmental mastery and autonomy (Welch, West 1995).

For example, medications are dispensed by staff, providing little opportunity for service users to remember and choose when to take medication. Interestingly, this lack of cognitive challenge has been presumed to lead to deficits in memory and negative behavioural repercussions (Welch, West 1995). The relationship between mental illness, mastery and autonomy becomes more abstruse when social interactions are also factored in. Service users may compromise living in environments of mastery and autonomy (e.g. a privately-owned house) to reap the benefits of higher social capital in less independent environments (e.g. a nursing home).

Mental illness may also considerably affect the process of appraisal in the theoretical model of global well-being. As previously stated, appraisal may be partly explained as measuring the conceptual gap between one’s actual life circumstances and one’s ideal or envisioned life circumstances. In studies of schizophrenic patients (Franz et al 2000), global well-being increased over time as patients learned to lower their ideal life circumstances, thus reducing this conceptual gap. It should be noted however, that this process of ‘accommodation’ is likely to be less significant in patients treated in the community compared to inpatients; and that this may be a product of institutionalisation – itself, linked with stigma and low global wellbeing.

The multiple effects of mental illness on the theoretical model of global well-being are illustrated in Fig 2. (see p.13).
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Global Wellbeing

Perceived Quality of Life

OBJECTIVE Quality of Life

Appraisal

CLINICAL CHARACTERISTICS

PERSONAL CHARACTERISTICS

SUBJECTIVE Quality of Life

Mediational Variables

PERSONAL CHARACTERISTICS

LIFE DOMAINS OF SATISFACTION

Work
Finance
Housing
Physical Health
Mental Health
Safety
Leisure
Family contact
Social contact

Self-esteem
Autonomy
Environmental mastery
Coherence
Personal growth

Leisure time

Family contact

Other social contact

Employment status

Hours worked

Finance
Disposable income
Spending money

Housing

Length of stay
Health status
Frequency of medical care
Safety
Frequency of transgressions

Leisure time
Amount of activities

Family contact
Frequency of contact

Other social contact
Frequency

Employment status

Hours worked

Finance
Disposable income
Spending money

Housing

Length of stay
Health status
Frequency of medical care
Safety
Frequency of transgressions

Leisure time
Amount of activities

Family contact
Frequency of contact

Other social contact
Frequency

Counterexample: Trust in a friend

Meeting a friend

Meeting a community

Example: Trust in a community

Example: Trust in a friend

Fig. 2
Improving global well-being – suggestions for future policy

Now that we have laid out a theoretical model of global well-being and examined the multiple effects of mental illness on it, it is possible to discuss target areas for mental-health policy. While our model may be hypothetical in nature, suggestions for future policy are more valid if an evidence base or precedent may be cited.

Treatment of mental illness

First and foremost, the diminution of global well-being in mental illness may be halted by continued emphasis on the prevention and treatment of psychiatric disease. It is beyond the scope of this paper to explain the aetiology of disease, but it remains possible that some life domains, for example, family and social interactions, have a causative role in mental illness. For instance, recovering schizophrenic patients released into family environments where there is ‘excessive criticism and emotional over-involvement’ (high expressed emotion), show increased relapse rates (Butzlaff, Hooley 1998). So it might be thought persuasive, while nonetheless speculative at present, that increasing satisfaction with these life domains may improve mental health, which in turn improves satisfaction: a ‘virtuous circle.’

With reference to the theoretical model, pharmaceutical and psychological treatment of diseases, such as schizophrenia will attenuate the role of clinical characteristics in lowering global well-being. Indeed, longitudinal data from the Access to Community Care and Effective Services and Supports (ACCESS) program in the USA showed that treatment of depressive and psychotic symptoms over 12 months is coupled to an increase in global well-being (Lam, Rosenheck 1999). In concordance with this, encouraging compliance with medication and engagement with healthcare services are possible strategies that are feasible within a community framework.

Shifting emphasis away from objective quality of life

The transition away from objective quality of life indicators as measures of global well-being, to that of subjective satisfaction with life domains, has been a relatively recent phenomenon. While the assessment of well-being has undergone this ‘paradigm shift,’ the policies that target well-being have been slow to catch-up. For instance, Torrey et al (2000) criticise policies based on the belief that changing work status from ‘unemployed’ to ‘employed’ engenders a rise in self-esteem in light of much evidence to the contrary.

Given the lack of influence of objective quality of life on global wellbeing, as illustrated in the theoretical model, policies ought to focus on improving the satisfaction of service
users. Admittedly, this might involve considerable overlap with objective life indicators. A service user who is subjectively dissatisfied with being unemployed may increase his/her well-being by becoming employed. Crucially, all things being equal, this new employment must be satisfying to the service user, if global well-being is to improve. Therefore, the impetus is on better assessment of service users’ needs and their satisfaction with life domains. Such assessment must take place before, during and after any interventions, with the properties of the intervention being modified in accordance with feedback from service users. Continuing the previous example: if the service user now becomes dissatisfied with work, the nature of this dissatisfaction must be evaluated and tailored-interventions, for example, altering the work environment should be implemented.

**Reducing the stigma of mental illness – promotion of social capital**

Despite symptomatic treatment of mental illness, the stigma that is associated with it may be longer-lived. Canadian sociologist Erwin Goffman (1963) eloquently decries the stigmatisation of individuals as ‘reduced in our minds from a whole and usual person to a tainted, discounted one.’ According to surveys issued by Rethink, the national mental health membership charity, 87% of service users reported negative stigma and 32% of the general public feel that mentally ill persons should not have the same right to a job (Rethink Policy Statement 31, 2008).

Referring to the theoretical model, the effect of stigma is widely distributed. Stigma may instil difficulty in forging social interactions, particularly those based on trust and mutual beliefs. Consequently, social capital, especially cognitive social capital, will suffer. Stigmatisation by service users’ own families will also impair satisfaction with the family contact life domain. Other life domains are also deleteriously affected by stigma, notably satisfaction with work, a phenomenon thought to be influenced by the burdens of finding employment (Bradshaw, Brekke 1999). Outside of subjective quality of life, the internalisation of stigma leads to the detriment of self-related constructs such as self esteem, while also negatively modulating the appraisal process.

As a result of its disseminated effects, strategies to redress stigma are likely to improve global well-being. The question of which strategies to employ, however, is difficult to answer. Much of this difficulty stems from a lack of congruence between policies that appeal to common sense and the amount of supportive evidence. Highlighting this quandary are the findings from Read et al (2006) who conducted a literature review of the ‘Mental illness is an illness like any other’ anti-stigma approach. Such an approach seems pragmatic. Its appeal lies in the notion that it may withdraw responsibility for symptoms away from the patient. Strikingly, however, the results are an indictment of
this approach: they suggest that it fuels perceptions of dangerousness and capriciousness, and increases social distance from mentally-ill people (Read et al 2006).

Promoting bridging social capital i.e. relationships between healthy and mentally ill individuals, is likely to be the best way to cut stigma. Penn et al (1994) report that knowing someone with mental illness first hand is the most powerful variable in evaluating the ‘danger’ posed by a schizophrenic patient. This strategy complements the ‘social contact hypothesis,’ that suggests exposure of key audiences to mentally ill persons will normalise and humanise diagnosis (Rethink Policy Statement 31, 2008). It would be beneficial to broaden these key audiences to include family members, friends, support workers and housing associations, in addition to healthcare professionals. Accentuating cognitive social capital, by placing emphasis on personal rather than professional relationships between service providers and service users, has previously been linked to more favourable subjective quality of life (Rosenfield, S 1992).

Education of family members about the needs and vulnerabilities of service users is another anti-stigma pathway worth pursuing. The theoretical model postulates that this will increase subjective quality of life and increase self esteem. Of course, the nature of this education must be well thought-out. Research suggests that acknowledging the significant contribution of psychosocial factors to mental illness may lessen stigma (Read et al 2006). For example, family members may be educated about the effects of domestic violence and child abuse in the development of schizophrenia. Even larger audiences may be targeted using the media: an area where negative identities of mentally ill persons are preponderant.

Symbolic changes to legislation are another avenue for counteracting stigma. Under current law, any person under section may be removed from a company board with no provision for them to return to work after recovery (Rethink Policy Statement 31, 2008). While a change in the law will have direct effect on only a small cohort of people, it is likely to be a positive symbol of equality between mentally ill and healthy persons. Analogies may be drawn to the effect of toughening hate crime laws on tackling racism in France.

On a much smaller scale, Rethink claim that the language utilised by care-givers may reinforce stigma (Rethink Policy Statement 50, 2008). Accordingly, medical labels such as ‘the mentally ill’ or ‘schizophrenics’ may perpetuate negative identity and should be dismissed in favour of terms that emphasise humanity e.g. ‘a person who experiences mental illness.’
Empowerment - cultivating autonomy and environmental mastery

Academic analysis of ‘model programmes’ of psycho-social rehabilitation - including the ‘Training in Community Living’ programme held in Wisconsin, USA and Sydney - Australia, has attributed much of their success to the development of environmental mastery and autonomy (Rosenfield, S 1992). Common to all these programmes is the utility of an empowerment approach. Empowerment may be defined as an organised process enabling people to take charge of their lives and is perhaps the most salient of well-being strategies. It may comprise initial support with daily living skills such as organising a household or broader vocational rehabilitation schemes. Aside from directly impacting upon the self-related constructs of autonomy and mastery, it may also raise self esteem. Bradshaw and Brekke (1999) conclude that better independent living skills are related to greater self-esteem.

Greater involvement of service users with decisions pertaining to their mental illness, housing, finance and social networks is another fundamental component of empowerment. Mutual decision-making may only be achieved through adequate provision of information to service users. A policy of implementing an advocate to help service users assimilate this information and facilitate their role in decision-making is likely to be fruitful. Rethink establish 8 features of empowerment that applicable to community care (Rethink Policy Statement 50, 2008):

1) Access to choice, redress and opportunities to be heard
2) Being given information
3) Dissemination of information by authorities
4) Clarifying the scope and limits of making contributions e.g. to meetings
5) Support and advocacy
6) Being given time to formulate views
7) Feedback following consultations
8) Mechanisms for being involved.

There exists a substantial body of evidence supporting the role of empowerment in aiding recovery from mental illness (Warner, 2009). Much of this therapeutic effect resides upon the development of autonomy and mastery, less adoption of the ‘sick role’ and reduced internalisation of stigma (Warner, 2009).

Appreciating the role of spirituality

We briefly mentioned the self-related construct of purpose in life and acknowledged the potential role of religion and spirituality. Psychiatrist Claude Robert Cloninger (2006) believes that spirituality is a fundamental component of self-transcendence: a character
trait associated with greater well-being. Supporting this interpretation is evidence from Spiritually Augmented Cognitive and Behavioural Therapy (SACBT) that suggests evaluating a patient’s beliefs system and accordingly using meditation, prayer or ritual may increase wellbeing and prevent relapse into psychiatric disease (D’Souza, Rodrigo 2004).

The spiritual needs of mentally ill service users are currently neglected for myriad reasons: the secularisation of Western society and the reductionist approach of neuroscience have been previously cited (Cloninger, 2006). Service providers should be made aware of the relationship between spirituality and well-being and, at the very least, a more permissive attitude to these spiritual needs ought to be adopted.

**Advocating physical well-being**

The more conspicuously ‘mental’ nature of psychiatric disorders compared to physical disorders may evoke attitudes of mind-body dualism i.e. the perspective that the mind and body are separate entities. Medical science espouses the opposite sentiment: that physical and mental health are intimately linked. So mentally ill service users may have an increased incidence of physical ailments (Smith et al 2007). Schizophrenia curtails life expectancy by 20%, with a considerable proportion of this due to cardiovascular and respiratory disease (Smith et al 2007). Additionally, people with severe mental illness are more likely to engage in unhealthy lifestyle choices – smoking, unhealthy diet, lack of exercise.

With respect to this, encouraging service users to engage with GPs, smoking cessation groups and other primary care incentives may be beneficial for both mental and physical health. Group activities may simultaneously boost social capital and consequently enhance global well-being. Indeed, Richardson et al (2005) indicate that structured group programmes incorporating moderate activity, particularly walking, have been shown to ameliorate physical and mental health and impact upon low self esteem.

**Discussion of some limitations of the model**

In summary, we have firstly created a theoretical model of global well-being by combining Lehman’s satisfaction model with Barry’s mediational model. Particular emphasis has been placed on the contribution of social capital and on the role of self-related constructs, implementing Ryff’s life dimensions. Evidence for the very existence of constituents of this model and their interrelations with one another has been derived
from published medical research. There are, nonetheless, several limitations with this approach that need to be acknowledged.

There is a lack of consensual definition of terms such as ‘quality of life’, ‘autonomy’ or ‘social capital’. So there are likely to be differences in what exactly is being measured, or inferred, across various studies. As a result, the face validity of the model - the degree to which a measurement tool actually reflects the variable it is designed to measure - is compromised. Efforts by academics to conform to an agreed and tested nomenclature will go some way to rectify this. The adoption of a specified set of rigorous, universal assessment tools will also aid this process.

Given this semantic ambiguity, it may be the case that the weak role of objective quality of life and the stronger influence of subjective quality of life on global well-being are purely a reflection of global well-being being an inherently subjective construct. Even if this is the case, it is still widely recognised that there is a poor correlation between objective indicators of quality of life and satisfaction with life or happiness. The philosophical ramifications of whether greater satisfaction with life is a valid incentive for humanity are a matter for wider debate.

The novel nature of this model also undermines its validity and the application of published research to it. We have generally referenced evidence that supports individual contingencies in the model, for example, the contribution of social capital to subjective quality of life. While such information is valuable, it does not illuminate the model as a whole. The counterpart is also true: protracted associations between components of the model and the end concept of global well-being tell us very little about intermediate steps. For instance, we have not produced direct evidence that cognitive social capital acts via subjective quality of life and then interacts with self-related constructs before going through an appraisal process. Therefore parts of the model lack nomological validity i.e the degree to which a construct behaves as it should in a set of related constructs. Accordingly, further testing of the model is needed, requiring a statistical and less qualitative approach.

In an endeavour to obtain a broad a scope of well-being research, we have utilised systematic reviews and meta-analyses where possible. Despite their advantages, particularly in controlling for differences between studies, these reviews are susceptible to selection bias. Research that shows a positive association is more likely to be published compared to research that shows a negative association. Such redaction will clearly colour the results generated by these reviews. Even with selection bias, we cannot negate the several studies that have produced evidence that are contrary to that produced in the model.
The predominance of papers that we have cited relate to psychiatric patients in the UK, Europe or USA. While it has been appreciated worldwide that objective quality of life has little bearing on global well-being, it would be interesting to see whether this model can be applied to other cultures.

While one suggestion is for the dogma of service provision to shift towards subjective quality of life, it is logistically difficult to both assess and modify this realm. It is less intellectually laborious to re-house a service user than to change his/her current housing until it is satisfying. In part, this is testament to the heterogeneity of mentally ill service users, each with differing needs, independent of the disease which afflicts them.

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**About the Author**

Haran Sivapalan has won the Royal College of Psychiatrists, London division essay prize (2009) and the British Geriatric Society essay prize (2009). He is the author of a chapter on drug addiction in the forthcoming book *House M.D. and Psychology*. Haran graduated with first class honours in Medical Sciences from the University of Cambridge (Christ’s College). While at Cambridge he won both the Darwin prize for his dissertation on Attention-Deficit Hyperactivity Disorder and the S.W.Greig prize for examination performance in Experimental Psychology. Haran has written this paper during his tenure in the research team at Lemos&Crane.

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