AOS 2 – WHAT INFLUENCES MENTAL WELLBEING?

DEFINING MENTAL HEALTH

KK1:

- mental health as a continuum (mentally healthy, mental health problems, mental disorders) influenced by internal and external factors that can fluctuate over time

WHAT IS MENTAL HEALTH?

Mental health is a state of wellbeing in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community (WHO).

- **Mentally healthy** – being in a **generally positive state** of mental wellbeing, having the ability to **cope** with and manage life's challenges, working **productively**, striving to fulfil one's **goals** and potential and having a sense of **connection with others** and the community.

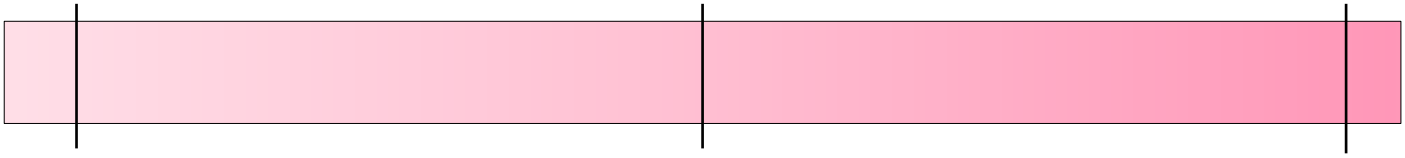
- **Mental health problem** – a problem or **concern** that affects the way a person thinks, feels and/or behaves but is **typically mild and temporary**, of a shorter duration than a mental disorder.

- **Mental disorder** – a mental health state that involves the combination of thoughts, feelings and/or behaviours which are usually associated with **significant personal distress** and **impair the ability to function** effectively in everyday life.

MENTAL HEALTH PROBLEM VS. MENTAL DISORDER

- Mental disorder is more **severe** with a higher degree of psychological impact or dysfunction in regards to thoughts, feelings and/or behaviours
- Level of **persistence** of distress or impairment – mental health problem is temporary, whereas a mental disorder has a long-term duration
- How well the individual is **functioning in everyday life**

MENTAL HEALTH AS A CONTINUUM



- The location of one's mental health is **unstable** – it may vary or fluctuate over time depending on circumstances
- No absolute clear-cut or fixed dividing lines between different points

- An individual's mental health may have **many different possible values** on a continuum if its different elements were mapped separately.

CHARACTERISTICS OF MENTAL HEALTH

MENTALLY HEALTHY	MENTAL HEALTH PROBLEM	MENTAL DISORDER
• Function at a high level • Use abilities to each full potential • Cope with and manage life's challenges • Work productively • Contribute to the community • Form and maintain good relationships • Feel, manage and express emotions • Learn from experiences • Think logically and clearly	• Feel worried, tense, low, irritable • Sadness over grief and loss • Difficulties concentrating • Forgetful • Loss of energy or motivation • Socially withdrawn • Negative attitudes towards themselves or life in general • Changes in sleep and appetite	• Clinically diagnosable dysfunction in thoughts, feelings and/or behaviours (eg. Low levels of functioning, social and emotional wellbeing) • Significant personal distress or disability in functioning in everyday life • Actions and reactions are atypical of the person and inappropriate within their culture EXAMPLES: • Anxiety disorders (ie. phobias) • Mood disorders (ie. depression) • Psychotic disorders (ie. schizophrenia)

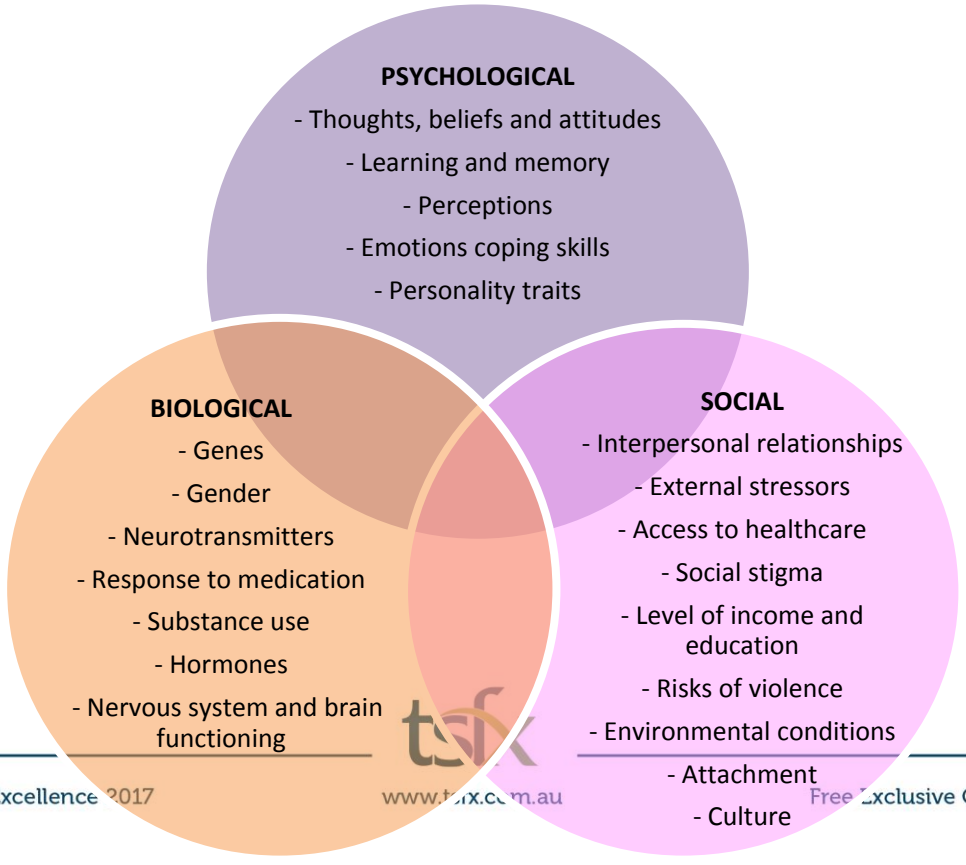
MENTAL HEALTH: AS A PRODUCT OF INTERNAL AND EXTERNAL FACTORS

Our mental health is influenced by a range of internal and external factors that can fluctuate overtime:

- **Internal factors** – influences that originate inside or within a person (biological and psychological)
- **External factors** – factors that originate outside a person (social)

BIOPSYCHOSOCIAL MODEL

This is a way of



describing and explaining how biological, psychological and social factors combine and interact to influence a person's mental health.

- Reflects a **holistic view** of mental health – the individual is considered as a 'whole person' functioning in their unique environment
- Considers specific factors within three domains and **how these combine**/interact to influence mental health and treatment that may be required

KK2:

- the typical characteristics of a mentally healthy person, including high levels of functioning, social and emotional well-being and resilience to life stressors

There are **3 characteristics** that mentally healthy people have in common:

1. High level of functioning
2. Social and emotional wellbeing
3. Resilience to life stressors

CHARACTERISTIC	DESCRIPTION
HIGH LEVEL OF FUNCTIONING	**Functioning** generally refers to how well an individual independently performs or operates in their environment. Characteristics attributed to a person with a high level of functioning include: • **Interpersonal relationships** – interact and get along with others • **School/work/occupational settings** – be productive and achieve goals • **Leisure/recreational activities** – participation in extracurricular activities, hobbies and community activities • **Daily living skills** – self-care and independent living activities such as fulfilling household duties, accessing transport and hygiene • **Cognitive skills** – learning and applying knowledge, logical and clear thinking, planning and decision making

	• **Emotions** – regulating and managing emotions and keeping worries, hassles and other stressors under control Adaptive functioning is associated with being mentally healthy, whereas maladaptive/ dysfunctional behaviour is associated with a mental disorder.
HIGH LEVELS OF SOCIAL AND EMOTIONAL WELLBEING	**Wellbeing** refers to our sense of 'wellness' or how well we feel about ourselves and our lives. **Social wellbeing** generally refers to how we feel about our relationships and interactions with others, including our ability to establish and maintain positive relationships. • Socially interact appropriately • Develop and maintain relationships • Respect and understand others • Competently resolve conflicts **Emotional wellbeing** generally refers to how well we feel about our ability to control our emotions and express them appropriately and comfortably. • Understand, regulate and express emotions suitably • Accept mistakes and setbacks and learn from them • Manage stress reactions • Make decisions with minimum worry, stress or anxiety
RESILIENCE TO LIFE STRESSORS	**Resilience** in the ability to successfully **cope with adversity** and to 'bounce back' and restore positive functioning. • It is *not a fixed ability*, meaning we can develop and enhance resilience, as well as learn knowledge and skills that promote or build resilience. CHARACTERISTICS: • Strong belief in their abilities to accomplish tasks and succeed (high self-efficacy) • Approach stress and diversity with a sense of optimism • Being adaptable, flexible and organised RELATIONSHIP WITH MENTAL HEALTH: People who are mentally healthy are also resilient and therefore are more likely to perceive a life stressor as an opportunity to excel as they have the resources to cope. Whereas, a mentally unwell person tends to be 'not resilient' in that they feel overwhelmed and challenged by life stressors, and have a low self-efficacy.

KK3:

- ethical implications in the study of, and research into, mental health, including informed consent and use of placebo treatments

INFORMED CONSENT

Informed consent refers to the process by which a researcher discloses appropriate information to a potential research participant so that the person may make a voluntary and informed choice about whether or not to participate.

People with mental disorders are vulnerable as research participants because:

- Cognitive impairments that diminish their capacity to make decisions and judgements about their participation in research, including susceptibility to harm in certain elements of the research.

A procedure used to ensure vulnerable participants give consent that is truly informed is:

- Obtained informed consent by a legal guardian or person authorised by law to do so on the participant's behalf.
- The researcher is still required to explain to the participant what the research is about and what participation involves.

PLACEBO TREATMENT

- **Placebo** – substance or treatment that appears real and resembles the actual treatment but is actually inert and neutral, having no known effect.
- **Placebo effect** – when participants believe they have been given the treatment and respond differently to match their expectations.

Placebo treatments are used in mental health research to **determine the efficacy** (effectiveness) of a new or improved medication. They are used in comparison with the actual treatment to observe the effectiveness of the actual drug in improving mental health.

Gold standard for a clinical trial that tests the efficacy of a treatment = placebo controlled double blind experiment with random assignment to groups.

Ethical issues with placebo treatment include:

- Researchers **intentionally withhold an effective treatment** from people who genuinely need the treatment and are therefore allowed to remain unwell and may also suffer as a consequence.
- Cause **severe discomfort** or distress that can inhibit recovery
- Take them **off their normal medication** to take a placebo instead – this means their symptoms may reappear or their mental health condition could worsen.
- Increases probability of **participant attrition**

FACTORS THAT CONTRIBUTE TO THE DEVELOPMENT AND PROGRESSION OF MENTAL HEALTH DISORDERS

KK4:

- the distinction between predisposing risk factors (increase susceptibility), precipitating risk factors (increase susceptibility and contribute to occurrence), perpetuating risk factors (inhibit recovery) and protective factors (prevent occurrence or re-occurrence)

4P FACTOR MODEL

- **Risk factors** – any kind of characteristic or event that increase the likelihood of the development or progression of a mental disorder
- **Protective factors** – reduce the likelihood of the occurrence or reoccurrence of a mental disorder

FACTOR	KEY QUESTION	DESCRIPTION	BIOPSYCHOSOCIAL APPROACH
PREDISPOSING RISK FACTORS	Why me?	Increase the susceptibility of developing a mental disorder.	BIOLOGICAL: Genetic vulnerability
			PSYCHOLOGICAL: Personality traits
			SOCIAL: Disorganised attachment
PRECIPITATING RISK FACTORS	Why now?	Contributes specifically to the onset or occurrence of a mental disorder.	BIOLOGICAL: Poor sleep
			PSYCHOLOGICAL: Stress
			SOCIAL: Loss of significant relationship
PERPETUATING RISK FACTORS	Why is it continuing?	Maintains the occurrence of a specific mental disorder and inhibits recovery.	BIOLOGICAL: Poor response to medication through genetics
			PSYCHOLOGICAL: Rumination
			SOCIAL: Role of stigma
PROTECTIVE FACTORS	What can I rely on?	Reduces or prevents the occurrence or reoccurrence of a mental disorder.	BIOLOGICAL: Adequate diet and sleep
			PSYCHOLOGICAL: Cognitive behaviour strategies
			SOCIAL: Support from family, friends and the community

ADVANTAGES/DISADVANTAGES OF THE 4P FACTOR MODEL:

ADVANTAGES	DISADVANTAGES
• Used to being together and organise a variety of factors believed to contribute to the development of a mental disorder • Assists mental health professionals to understand why the person developed a disorder and why it's progressing	• Limited evidence • If a person has a risk factor, this doesn't necessarily mean they will have a mental disorder

KK5:

- the influence of biological risk factors including genetic vulnerability to specific disorders, poor response to medication due to genetic factors, poor sleep and substance use

BIOLOGICAL RISK FACTORS

- Originate within the body and consequently may not be under our control.

RISK FACTOR	DESCRIPTION	EXAMPLE	EXTENT OF RISK
GENETIC VULNERABILITY	Having a risk for developing a specific mental disorder due to one or more factors associated	Schizophrenia ○ Identical twins = 50% ○ Relatives = 10%	**Predisposing risk factor** Places individual at a higher risk but doesn't necessarily mean they will develop the

	with genetic inheritance.		disorder.
POOR RESPONSE TO MEDICATION DUE TO GENETIC FACTORS	Having no or little reduction in the number or severity of symptoms despite taking medication as prescribed. • Genetic variations means people can process the same medication differently	Estimated that 45% of people with depression have a poor response to anti-depressant medication. Eg) Metabolism o Slow: build-up, more severe side effects Too fast: not absorbed properly	**Perpetuating risk factor** Risk factor for both the development and progression of a mental disorder.
POOR SLEEP	Interrupted quality or quantity of sleep is associated with a range of mental disorders.	Insomnia is common among people of all ages with depression.	**Precipitating/ perpetuating risk factor** • Mental disorders can cause poor sleep (precipitating) • Poor sleep can contribute to the onset of mental disorders (perpetuating)
SUBSTANCE USE	Refers to the use of legal or illegal drugs or other products.	Schizophrenia • Higher rate of tobacco, alcohol and other substance use than the general population.	**Precipitating/ perpetuating risk factor** Development and progression of certain mental disorders

KK6:

- the influence of psychological risk factors including rumination, impaired reasoning and memory, stress and poor self-efficacy

PSYCHOLOGICAL RISK FACTORS

- Develop within the mind, meaning there is often the potential to exert some control over their occurrence or influence

RISK FACTOR	DESCRIPTION	EXAMPLE	EXTENT OF RISK
RUMINATION	Involves repeatedly thinking about or dwelling on undesirable thoughts and feelings without acting to change them.	Depression Rumination is a significant risk factor for depression.	**Precipitating/ perpetuating risk factors** Never developing a solution to problems can initiate a disorder and cause it to continue.
IMPAIRED REASONING AND MEMORY	Reasoning: • Involves goal-directed thinking in which inferences are	Schizophrenia o Jumping to conclusions o Episodic memory impairment	**Precipitating/ perpetuating risk factors** Development and progression of mental disorders

	made. Memory: • Impacted long-term and short-term memory, particularly episodic.	associated with key symptoms of schizophrenia	
STRESS	• Very individual • Biopsychosocial vulnerabilities • Challenges exceeding their ability or resources to cope	Schizophrenia o 50% patients experienced at least one major stressful life event during 3 weeks before diagnosis	**Precipitating/ perpetuating risk factors** Development and progression of mental disorders.
POOR SELF-EFFICACY	Refers to an individual's belief in their capability to execute behaviours necessary to succeed in a specific situation or accomplish a specific task.	Anxiety and depression o Through low-self efficacy o Believe potential stressors are unmanageable o View aspects of their environment unsafe	**Precipitating/ perpetuating risk factors** Development and progression of mental disorders. Impair our ability to overcome challenges.

KK7:

- the influence of social risk factors including disorganised attachment, loss of a significant relationship and the role of stigma as a barrier to accessing treatment

SOCIAL RISK FACTORS

- Originate in the external environment
- Interact with bio and psycho factors in influencing our mental health state

RISK FACTOR	DESCRIPTION	EXAMPLE	EXTENT OF RISK
DISORGANISED ATTACHMENT	Inconsistent or contradictory behaviour patterns in the presence of a primary caregiver. • May experience fear or odd behaviours • Struggle with poor social or emotional regulation skills • Difficulty managing stress	Anxiety can result from this. Behaviours associated with disorganised attachment include: • Pulling away from caregiver • Avoiding eye contact • Odd behaviours like freezing • Lower levels of	**Predisposing/ perpetuating risk factor** Development and progression of mental disorders. Vulnerability increases risk for developing a disorder.

	• Hostile or aggressive behaviours	resilience	
LOSS OF A SIGNIFICANT RELATIONSHIP	Refers to losing a relationship which is perceived by the individual as being of considerable importance to them. • Following this, they'll like experience grief.	Depression o After one month of loss, 1/3 of people experiencing grief also experienced depression	**Precipitating/ perpetuating risk factor**
STIGMA	A mark or sign of shame, disgrace or disapproval typically associated with a particular characteristic or attribute that sets a person apart. • Social stigma: aspect of an individual's identity that is devalued in social context • Self-stigma: Stigmatising the views that they hold about themselves	Depression and anxiety o Many report the stigma and discrimination they experience is worse than the actual condition • Significant consequences • May contribute to feelings of embarrassment of seeking help, increase psychological distress and reduce treatment adherence.	**Perpetuating factor** Delays recovery or make recovery harder as they are have reduced access to treatment

KK8:

- the concept of cumulative risk.

Cumulative risk refers to the **aggregate** risk to mental health from the combined exposure to multiple biological, psychological and/or social risk factors.

- It is the accumulation of risk factors that impacts on people's mental health
- Generally, the more risk factors to which an individual is exposed, the greater their vulnerability to a mental health disorder

There have been a number of models to explain cumulative risk, such as the additive models.

Additive models propose that as the number of risk factors increases, there is also a corresponding increase in the likelihood of developing a mental disorder. Similarly, the lower number of risk factors, the lower the likelihood of developing a disorder.

APPLICATION OF A BIOPSYCHOSOCIAL APPROACH, AS A SCIENTIFIC MODEL, TO EXPLAIN SPECIFIC PHOBIA

KK9:

- the distinctions between stress, phobia and anxiety; variation for individuals with stress, phobia and anxiety on a mental health continuum

Stress is a state of **physiological and psychological** arousal produced by internal and external stressors that are perceived by the individual as challenging or exceeding their ability to cope.

Eg) Stress could result from having multiple tests in a week at school

- Stress may be positive (eustress) and negative (distress)

Anxiety is a state of **physiological** arousal associated with the feelings of apprehension, worry and uneasiness that something is wrong of something unpleasant is about to happen.

Eg) Feeling a burst of anxiety before doing an oral presentation

- May be beneficial and negative consequences of anxiety
    - Positive:
        - Short-term anxiety
        - Deal with dangerous and emergency situations
        - Resembles a fight-flight-freeze response
        - Makes us more alert and our reactions faster
    - Negative
        - However if anxiety is exaggerated and severe it can reduce concentration, judgments and us being unable to perform certain motor tasks

- Physiological responses of anxiety include:
    - Shortness of breath
    - Sweating
    - Trembling
    - Nausea
    - Dizziness
    - Feelings of suffocating

Anxiety disorder is used to describe a group of mental disorders that are characterised by chronic feelings of anxiety, distress, nervousness and apprehension or fear about the future with a negative effect.

- One is likely to be diagnosed with an anxiety disorder if their anxiety is so severe that it significantly interferes with their daily life and stops them from doing what they want to do

A **specific phobia** is an anxiety disorder involving excessive or unreasonable fear of a specific or particular object or situation that causes significant distress or interferes with everyday functioning. Often leads to avoidance behaviour.

- A phobic stimulus is the specific object or situation producing the fear associated with a phobia
- Characteristics of a phobia include:

- Excessive or unreasonable fear
- Fear response is out of proportion to reality or actual danger posed by the object or situation
- Interferes with everyday functioning

- Usually involves both stress and anxiety at severe levels
- A phobia can never be beneficial as it:
  - Inevitably causes distress and interferes with daily functioning through avoidance and other responses associated with fear
  - This is in contrast to stress and anxiety which are usually adaptive and beneficial

COMPARISON OF STRESS, ANXIETY AND PHOBIAS

- Stress – physiological and psychological responses
- Anxiety – physiological responses only

STRESS	ANXIETY	PHOBIA
Considered normal	Considered normal	Not considered normal
Eustress or distress	Distress only	Distress only
Beneficial and adaptive	Beneficial and adaptive	Maladaptive and not helpful
Can develop into mental disorder if not managed	Can develop into mental disorder if not managed	Diagnosable mental disorder
May be associated with avoidance	May be associated with avoidance	Characterised by avoidance of certain objects or situations

KK10:

- the relative influences of contributing factors to the development of specific phobia with reference to: gamma amino butyric acid (GABA) dysfunction, the role of stress response and long-term potentiation (biological); behavioural models involving precipitation by classical conditioning and perpetuation by operant conditioning, cognitive bias including memory bias and catastrophic thinking (psychological); specific environmental triggers and stigma around seeking treatment (social)

KK11:

- evidence-based interventions and their use for specific phobia with reference to: the use of short-acting anti-anxiety benzodiazepine agents (gamma-amino butyric acid [GABA] agonists) in the management of phobic anxiety and relaxation techniques including breathing retraining and exercise (biological); the use of cognitive behavioural therapy (CBT) and systematic desensitisation as psychotherapeutic treatments of phobia (psychological); psychoeducation for families/supporters with reference to challenging unrealistic or anxious thoughts and not encouraging avoidance behaviours (social).

BIOLOGICAL

CONTRIBUTING FACTORS

1. GABA dysfunction

- GABA is the primary inhibitory neurotransmitter in the central nervous system
- Works throughout the brain to make postsynaptic neurons less likely to fire

- GABA dysfunction is the failure to produce, release or receive the correct amount of GABA needed to regulate neuronal transmission in the brain
- How does it contribute to phobic anxiety?
    - GABA acts as a calming agent or 'brake' to the excitatory neurotransmitters that lead to anxiety
    - GABA dysfunction means there is less GABA in the brain
    - Fight-flight-freeze response may be more easily triggered by a variety of stimuli, which in turn may predispose them to developing a specific phobia
    - Therefore more vulnerable to anxiety

2. Role of the stress response

- When perceiving a threat the fight-flight-freeze response is activated
- Body's reaction to stress includes:
    - Increased heart rate
    - Increased blood flow
    - Increased breathing rate
    - Adrenal hormones surge into bloodstream
- Phobic anxiety is when there is a perceived threat at sight or thought of a phobic stimulus
    - This becomes problematic when the stress response is triggered in the absence of any real threat or danger
- How does it contribute to the development of a specific phobia?
    - When perceiving the sight or thought of a phobic stimulus, the fight-flight-freeze response is activated
    - Means that anxiety tends to be excessive as perception of threat is out of proportion with reality
    - Response is very severe at high level
    - GABA dysfunction also contributes to excessive stress response

3. Long-term potentiation

- LTP is the long-lasting strengthening of synaptic connections resulting in enhanced or more efficient neurotransmission across the synapse
- How does it contribute to the development and perpetuation of a specific phobia?
    - Strengthens the association between a phobic stimulus and a fear or anxiety response through its activity at the synapse
    - The more the connection is activated through each encounter with phobic stimuli, the more the connection is strengthened which perpetuates a specific phobia

EVIDENCE-BASED INTERVENTIONS

1. Use of benzodiazepines

- Benzodiazepines are a group of drugs that work on the central nervous system acting selectively on GABA receptors in the brain to increase GABA's inhibitory effects and make post-synaptic neurons resistant to excitation
- They calm down the body by reducing physiological arousal and promoting relaxation
    - Eg) Valium, Xanax

- They are classified as GABA agonists because they imitate and stimulate the activity of GABA at the site of a post-synaptic neuron and in turn, inhibit activity at the receiving post-synaptic neuron
- Reduce symptoms of anxiety through decreasing the excessive neural firing that occurs in times of high anxiety
    - Short acting – remain in the bloodstream and is cleared from the body in a short period of time
    - Long acting – accumulate in the bloodstream or take a longer time to leave the body
- Only treat the symptoms, not the cause of anxiety

ADVANTAGES	DISADVANTAGES
• Reduce excitability of neurons • Reduces communication between neurons • Therefore has a calming effect on the body to reduce symptoms of anxiety • Few side-effects in the short term	• Reduce alertness • Can be addictive • Lower inhibitions • Make some more impulsive and likely to take risks, particularly if mixed with alcohol or drugs

2. Breathing retraining

- Breathing retraining is an anxiety management technique that involves teaching correct breathing habits to people with specific phobias
- Helps people maintain correct breathing when anticipating or exposed to a phobic stimulus so it may help reduce anxiety or alleviate its symptoms
- Abnormal breathing includes hyperventilation – breathing faster or deeper than necessary which may become habitual and increase fear or anxiety
- An appropriate breathing pattern involves slow, regular breaths in through the nose and out of the mouth at a controlled rate
- The goal is to slow respiration rate and maintain the correct balance of oxygen and carbon dioxide in the blood

3. Exercise

- Two main types if exercise: aerobic and anaerobic
- Exercise may assist in the management of a specific phobia by:
    - Promoting relaxation and relief from anxiety
    - Provides a distraction from phobic stimuli
    - Alters brain chemistry - promotes release of endorphins to provide relief from anxiety
    - Increase tolerance to fear and anxiety symptoms
- Be beneficial from a social perspective in that people can exercise with others

PSYCHOLOGICAL

CONTRIBUTING FACTORS

1. Behavioural models

- **Precipitation by classical conditioning**

- A stimulus with no significance (NS) becomes by association with a fear (UCR) a sign of impending threat, danger or unpleasant event (CS) to elicit the fear response (CR). The innate, naturally occurring fear response (UCR) eventually becomes a conditioned fear response (CR), hence explaining the development of a specific phobia
- Eg) Development of arachnophobia
  - Before conditioning: NS (spider) causes no relevant response and the UCS (fear-inducing event) causes the UCR (fear)
  - During conditioning: NS (spider) is repeatedly paired with the UCS (fear inducing unpleasant event) to cause the UCR (fear)
  - After conditioning: CS (spider) causes the CR (fear) and causes the development of a specific phobia

- **Perpetuation by operant conditioning**
  - Avoidance reduces or removes the unpleasant feelings of fear and anxiety (negative reinforcement)
    - In the future, any response that removes fear will also be negatively reinforced therefore perpetuating a phobia
  - Can also contribute to the acquisition of a specific phobia through positive reinforcement
    - Strengthen the fear response and increase the likelihood of fearful behaviour the next time one encounters the phobic stimulus
    - Eg) If a child sees an animal in a body of water which causes fear, if the parents reward this fear with ice-cream, they are strengthening the child's fear response the next time they encounter a lake or body of water

2. Cognitive models

- Cognitive models focus on how the individual processes information about the phobic stimulus and related events
  - According to these models, people can create their own problems and symptoms by the way they interpret objects or situations
  - Cognitive bias is a tendency to think in a way that involves errors of judgement and faulty decision-making

- **Memory bias**
  - Refers to the distorting influences of present knowledge, beliefs and feelings on the recollection of previous experiences
    - **Consistency bias:** Memories of the past are distorted to reconstruct and fit in with what is presently known or believed – eg. only remember the one time a spider crawled on your leg compared to all the other times it didn't
    - **Change bias:** Whenever we recall a past experience we exaggerate the difference between what we felt then and what we currently feel – eg. exaggerate your memory of the spider as being larger, hairier etc. than it actually was
    - Both result in the tendency for memory recall of a phobic stimulus to focus on the negative rather than neutral information

- **Catastrophic thinking**

- A thinking style which involves overestimating, exaggerating or magnifying an object or situation and predicting the worst possible outcome
- Eg) Dog phobia
  - May think that any dog they encounter will attack them
  - Catastrophic thinking may cause the person to strengthen their fear and anxiety response and therefore contribute to the development and perpetuation of a phobia of dogs

EVIDENCE-BASED INTERVENTIONS

1. Cognitive behavioural theory

- Aim is to change thoughts and behaviour that perpetuate a phobia and improve coping skills
- Avoidance behaviour and safety behaviour is not helpful for someone with a specific phobia as the individual tends to become reliant on them which can perpetuate a phobia
- Professional will ask them to look for evidence that supports and does not support their fear cognition:
  - Promotes realistic thinking with the goal of alleviating fear or anxiety through education
  - Once they evaluate the evidence they are able to counter them with an alternative and face their fears
  - Approach their situation more rationally and objectively
  - Eg. Fear of flying – often related to misconceptions about vibrations and sounds. Do not indicate an impending crash. Airliner provide information about crashing rates and chances to reduce fear and anxiety associated with flying
- A relaxation technique (behaviour) such as breathing retraining or exercise can distract from or reduce fear and anxiety
  - Individual is taught a technique to help them cope with their fearful situation

2. Systematic desensitisation

- Systematic desensitisation is a kind of behaviour therapy that aims to replace an anxiety response with a relaxation response when an individual with a specific phobia encounters a fear stimulus

- Three step process:
  1. Teaching a relaxation technique that they can use when confronting a phobic stimulus
  2. Creating a fear hierarchy from least to most anxiety producing
  3. Graduated pairing of items in the hierarchy with relaxation by working upwards
     - Either in vivo (real life) or using visual imagery (imagination)

SOCIAL

CONTRIBUTING FACTORS

1. Specific environmental triggers

- Specific environmental triggers are specific objects or situations in the environment that produced or triggered an extreme fear response at the time, hence a type of factor contributing to the development of a phobia
- Eg. Flying with extreme turbulence – single experience of this may cause the person to develop a specific phobia of flying
- Usually a phobia develops from a specific environmental trigger in combination with other contributing factors
    - This may mean two people with the same experience may have different reactions – one may develop a phobia and the other may not
    - Eg. Person growing up with dogs may be less likely to develop a phobia if they're bitten compared to the other who is bitten when they first encounter dogs

2. Stigma around seeking treatment

- Phobias are irrational fears and can be difficult for others to empathise
- A person may be ridiculed by others or feel embarrassed as they know that their phobia is irrational
- Believe that they can't trust anyone or take them seriously
    - All these factors make people with phobias particularly vulnerable to stigmatisation
- Three reasons why individuals may not seek treatment:
    - Fear of ridicule or belittling comments
    - People believe specific phobias are less severe than other anxiety disorders
    - Embarrassment due to understanding their thoughts are irrational and other won't empathise with them

EVIDENCE-BASED INTERVENTIONS

1. Psychoeducation for families and supporters

- Involves the provision and explanation of information about a mental disorder to individuals diagnosed with the disorder to increase knowledge and understanding of their disorder and its treatment
- Based on key assumptions:
    - Increased understanding of symptoms and treatment available enables individuals with a mental disorder to cope more effectively
- Individuals may be given information about:
    - Importance of relaxation
    - Treatment available
    - Role of their phobic stimuli

- **Challenging unrealistic or anxious thoughts:**
    - Unrealistic thoughts may perpetuate a specific phobia as they overestimate how bad it will be if they become exposed to the object or situation they fear and underestimate their ability to cope
    - These can be challenged by others:
        - Model stay calm
        - Acknowledge worries
        - Encouraging that they won't be harmed

        - Eg. Phobia of moths – mother of a child could encourage them to consider that moths would want to avoid her and they won't be physically harmed because of its small size and fragility
- **Not encouraging avoidance behaviours:**
    - It is important for families and supporters to not encourage avoidance behaviours with specific phobias as:
        - Avoidance prevent them from learning that their phobia is not as frightening or overwhelming as they think
        - Never get a chance to cope with their fears and experience control over fearful situations
        - Interfere with an individual's normal routine which can make the overall experience of a phobia even more distressing
    - Supporters could overcome their avoidance by:
        - Eg. Phobia of moths
        - Encourage her to remain sitting outside and not going inside to avoid moths
        - Provide comfort and reassurance
        - Reward for bravery
        - Being gentle and calm by not encouraging avoidance and challenging behaviour

MAINTENANCE OF MENTAL HEALTH

KK12:

- resilience as a positive adaption to adversity including the relative influence of protective factors with reference to: adequate diet and sleep (biological); cognitive behavioural strategies (psychological); support from family, friends and community (social)

RESILIENCE

Resilience refers to the ability to successfully cope with adversity and to 'bounce back' and restore positive functioning.

- Considered a protective factor as it helps safeguard against the effects of risk factors for 'bad' mental health and minimises their impact
- Key qualities:
    - Ability to achieve positive results in adverse situations
    - Ability to function competently in situations of stress
    - Ability to recover from trauma
- Attributes that people with high resilience tend to have:
    - High self-esteem and self-efficacy
    - Flexibility – use a range of coping strategies to cope with different situations

PROTECTIVE FACTORS FOR MENTAL HEALTH

PROTECTIVE FACTOR	DESCRIPTION	HOW IT INFLUENCES MENTAL HEALTH	EXAMPLES
BIOLOGICAL: • Adequate diet	Eating a good amount of a variety of different foods that maintains good health and makes us feel well. Diet	Feel better and have an overall sense of wellbeing when we eat well.	Drinking lots of water: at least 8 glasses per day.

	must be balanced.		
BIOLOGICAL: • Adequate sleep	Having enough sleep so that we wake up feeling rested, refreshed and ready for the day and feel positive about ourselves and our abilities.	Inadequate sleep makes one feel irritable, have amplified emotional responses, low alertness, and difficulty concentrating and slower reaction times. Also affects relationships with others.	Poor sleep quality and quantity can result in anxiety and personality disorders.
PSYCHOLOGICAL: • Cognitive behaviour strategy	Identify, assess and correct faulty patterns of thinking or problem behaviours that may be affecting mental health and wellbeing. Cognitive – thoughts Behaviour – skills	Dysfunctional thoughts can be habitual ways of thinking that adversely impact on mental health and may lead to a mentally unhealthy feeling of helplessness or not trying in the future.	Receiving a low mark on a test: Thought – 'I am so dumb and never do well' → 'Difficult task, one bad result doesn't mean I have failed the subject' Behaviour – 'Give up and no effort in the future' → 'Try harder in the subject in the future'
SOCIAL: • Support from family, friends and the community	Social support generally refers to the assistance, care or empathy provided by people to each other. Appraisal support – help from another to improve understanding of mental health problems and coping strategies that may be needed to deal with it. Tangible support – provision of material support. Informational support – how to cope and information given relating to symptoms. Emotional support – expression of empathy and reassurance that a person is cared for.	Help them cope with a mental health problem. Warmth and nurturing can enable a person to be more confident about coping and outcomes, based on the realisation they have the support they need.	Support means a person facing a stressful event can determine how threatening the event is and reduce uncertainty and potential impact.

KK13:

- models of behaviour change with reference to the transtheoretical model including the stages of pre-contemplation, contemplation, preparation, action and maintenance/relapse.

The **transtheoretical model** is a stage-based model that describes and explains how people intentionally change their behaviour to achieve a health-related goal.

STAGE	DESCRIPTION
P **PRE-CONTEMPLATION** • No intention within next 6 months	• Not ready to change and have no intention of taking any action to abandon a behaviour • Defend their problem behaviour • Underestimate the benefits of change • 'tune out' when someone talks to them about it • Need to experience a negative emotion in relation to the behaviour to move out of this stage
C **CONTEMPLATION** • Could be in this stage for 6 months	• Think about the possibility of changing their behaviour • Still feel ambivalent and have 'mixed feelings' about taking the next step • Consider making change but don't initiate behaviour change • May remain in this stage for long time without actually making any adjustments
P **PREPARATION** • Within next 30 days	• Involves mental preparation (planning) for the desired behaviour change by formulating intentions and an action plan for change • Small steps towards desired behaviour • Highly motivated to change but may vary in how confident they are in achieving success
A **ACTION** • Changed overt behaviour for less than 6 months	• Overt attempts to abandon the problem behaviour • Actually engage in behaviour change • Commitment of time/energy • Externally recognised by others, receive a lot of support from family/friends – reinforcing effect • Relapse said to occur • When ha high level of evidence and receive positive feedback they move onto maintenance
M **MAINTENANCE** • Changed overt behaviour for more than 6 months	• Reached when people having successfully sustained the changed behaviour over relatively long period of time without relapse • Focus is preventing relapse and receive less social support because already engaged in action • Termination said to be reached when behaviour is believed to never return and individual has complete confidence to maintain the new behaviour without fear of relapse

STRENGTHS	LIMITATIONS
• Useful in understanding behaviour change that is either self-initiated or recommended by a professional as part of an intervention program. Process that may occur gradually over time. Considers it a **process,** rather than	• Not been **enough research on variables that influence stage transition** which limits the usefulness of the model for treatment interventions. More specifications needed regarding the transition through different

a single event. • Takes into account **individual differences.** People are in different stages or states of readiness and some people are not ready to make immediate and permanent behaviour change. • **Allows for minor and significant setbacks** from which an individual may recover and re-engage with their change attempt. Takes into account relapses.	stages. • Lack of research to justify the relevance or validity of **time frames** specified in the model for different stages. • Questioned whether the stages are in fact **distinct categories** and whether they are in the correct order. May be other stages that have been overlooked.