LEARNING OBJECTIVES

Upon completion of this chapter, you will be able to:

1. Define mental health.
2. Explain how mental and physical health interrelate.
3. Discuss the importance of evidence-based research in mental health promotion.
4. Describe four common threads found in approaches to mental health.
5. Compare variables that affect mental health.
6. List elements to be included in a mental health promotion assessment.
7. Develop nursing interventions to promote mental health.

KEY TERMS

Evidence-based research

Meditation

Mental health

Mental health promotion

Music therapy

Self-esteem

Socioecologic approach

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Mental Health Promotion

- Introduction
- What Is Mental Health?
- What Variables Affect Mental Health?
- Mental Health Promotion Assessment
- Mental Health Promotion
- Strategies for Promoting Mental Health
- Summary

http://go.jblearning.com/healthpromotion

For a full suite of assignments and learning activities, use the access code located in the front of your book to visit the exclusive website: http://go.jblearning.com/healthpromotion
If you do not have an access code, you can obtain one at the site.

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Introduction

The purpose of this chapter is to identify what mental health is and explore strategies for integrating mental health promotion concepts into your practice as a health promotion role model.

What Is Mental Health?

In an online Q&A, the World Health Organization (WHO) answered the question, *What is mental health?* as follows:

> Mental health is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. (WHO, 2007, p. 1)

In an earlier publication (WHO, 2004, p. 1), spirituality and healthy public policy were mentioned as important variables in individual, family, and/or community mental health.

It also issued this statement: "Mental health promotion is meant to foster activities in the field of mental health, especially those affecting the harmony of human relations." In the same manuscript, WHO participants noted that mental health can be affected by non-health policies such as education, housing, and child care. They also stated that it is impossible to be mentally healthy without a climate of safety and basic civil, political, cultural, economic, and social rights.

These objectives and functions of World Health Organization are at the core of our commitment to mental health promotion.

HEALTH PROMOTION CHALLENGE

Choose either spirituality or healthy public policy and develop a program to enhance mental health. Base it on evidence you find at www.pubmed.gov as well as Googling for mental health programs that address your choice. Share your findings with at least two other students and request feedback. If possible, implement at least one portion of your program and write up your results.

Variations on this theme can be found in other definitions. For example, a definition published on the University of Leeds Ahead4health website is:

> 'Mental health' properly describes a sense of well-being: the capacity to live in a resourceful and fulfilling manner, having the resilience to deal with the challenges and obstacles which life presents. (University of Leeds, 2006, p. 1)

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Based on these definitions, **mental health** is part of a client's health and well-being, and it can have an impact on or be affected by physical illnesses. It may be difficult to determine where the mental health aspect starts and the physical health aspect ends. There is good reason for this difficulty: Mental health encompasses not only the structure and proper physiologic functioning of the brain, but also the psychological factors that shape behavior.

What Variables Affect Mental Health?

Many variables affect mental health. One variable important in many mental health promotion efforts is assertiveness/advocacy. Clients who are involved in the decision process about their own health can reap benefits (Pickett et al., 2012) found that clients involved in a peer-led education program that empowered mental health consumers increased their assertive/advocacy skills.

Exercise is correlated with positive mental health. In one study, participants in a four-week exercise program reported a beneficial decrease in perceived stress (Stavrakakis, de Jonge, Ormel, & Oldehinkel, 2012).

In another study (Mason & Holt, 2012) that examined why physical exercise is so helpful to mental health, the researchers found a high degree of congruence in support of the themes of social interaction and social support; feeling safe; improved symptoms; a sense of meaning, purpose, and achievement; identity; and the role of the facilitating personnel. They concluded that exercise

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

interventions deserve greater emphasis both theoretically and clinically, as many service users experience them as socially inclusive, non-stigmatising, and, above all, effective.

Yoga can also enhance mental health. Smith, Greer, Sheets, and Watson (2011) compared the physical and mental benefits of an exercise-based yoga practice to that of a more comprehensive yoga practice (one with an ethical/spiritual component). They found that over time, participants in both the integrated and exercise yoga groups experienced decreased depression and stress, an increased sense of hopefulness, and increased flexibility compared to the control group. Only the integrated yoga group experienced decreased anxiety-related symptoms and decreased salivary cortisol (an indicant of reduced stress) from the beginning to the end of the study.

Exercise can even help individuals hospitalized in a forensic setting. In one study (Wynaden, Barr, Omari, & Fulton, 2012), a healthy lifestyle program, which included a formal exercise component, was introduced at the service. Participants reported that the program assisted them in managing their psychiatric symptoms, as well as improving their level of fitness, confidence, and self-esteem. In addition, all participants received education about the importance of regular exercise to their mental health and the role exercise plays in preventing chronic illness and obesity. While the benefits of exercise on mental health outcomes for people with depression and anxiety are well established, this research adds to the evidence that such programs provide similar benefits to individuals diagnosed with a psychotic illness who are hospitalized in an acute secure setting.

HEALTH PROMOTION CHALLENGE

Based on what you learned from these studies of the effect of exercise on mental health, how could you use this information for yourself and with your clients?

Come up with some ideas, then share them with at least two classmates and ask for feedback.

Massage, especially combined with lavender aromatherapy, may help with emotional distress in clients in cancer/palliative care. According to the ToT Study (Serfaty, Wilkinson, Freeman, Mannix, & King, 2012), a controlled trial to examine the clinical effectiveness of aromatherapy massage versus cognitive behavior, massage/aromatherapy produced significant results in reducing anxiety and depression and was as well-received as cognitive behavioral therapy.

One form of **meditation** called Mindfulness-Based Stress Reduction (MBSR) has a favorable influence both on biomarkers of stress regulation, such as cortisol secretion, and on sleep. MBSR teaches clients to witness what they

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

are feeling or thinking, but not to immerse themselves in it. By stepping back from painful thoughts and feelings, relaxation and calm can reign and sleep can occur (Brand, Holsboer-Trachsler, Naranjo, & Schmidt, 2012)

Nutrition can affect mental health. Sugar can affect ability to think clearly and function. Ye, Gao, Scott, and Tucker (2011) investigated intake of added sugars. Intake of mainly fructose is associated with metabolic syndrome and type 2 diabetes. The objective of their analysis was to examine whether habitual intakes of total sugars, added sugars, sugar-sweetened beverages, or sweetened solid foods are associated with cognitive function. Greater intakes of total sugars, added sugars, and sugar-sweetened beverages were significantly associated with lower mental state score on the Mini-Mental State Examination (MMSE), indicating that sugar can affect mental health.

Hypovitaminosis D is associated with cognitive decline among older adults. The relationship between vitamin D intakes and cognitive decline is not well understood. A study conducted by Annweiler, Fantino, Schott, Krolak-Salmon, Allali, and Beauchet (2012) examined whether the dietary intake of vitamin D was an independent predictor of the onset of dementia within 7 years among women aged 75 years and older. They found that women with the lowest vitamin D dietary intakes were more likely to develop Alzheimer's Disease (AD). Women who ingested the highest level of vitamin D foods had a lower risk of AD.

An Australian study (Forsyth, Williams, & Deane, 2012) examined the nutrition status of primary care clients with depression and/or anxiety. The researchers found that although some participants were low in folate and calcium intake, only magnesium intakes were significantly associated with depression. The researchers concluded that nutrition recommendations for clients with depression and anxiety should be based on the Australian Guide to Healthy Eating, with particular attention to fruit, vegetables, and whole grains.

HEALTH PROMOTION CHALLENGE

Choose to either use the nutritional evidence presented here and plan a way to use it with clients or search www.pubmed.gov for more nutritional effects on mental health studies. Either way, share your findings with at least two other classmates and ask for feedback.

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Another nutritional element important to mental health is the omega-3 family of fatty acids. Observational studies suggest an association between low concentrations of omega-3 family fatty acids (good sources include sardines, salmon, flax seeds, and walnuts) and greater risk for postpartum depression (PPD). The objective of a Brazilian study (da Rocha & Kac, 2012) was to investigate the effect of unbalanced dietary intake of omega-6/omega-3 (ratio >9:1) in the prevalence for postpartum depression. The results verified an association between omega-6/omega-3 ratio above 9:1, the levels recommended by the Institute of Medicine, and the prevalence of PPD. The results add to the evidence regarding the importance of omega-6 and omega-3 fatty acids in the regulation of mental health mechanisms.

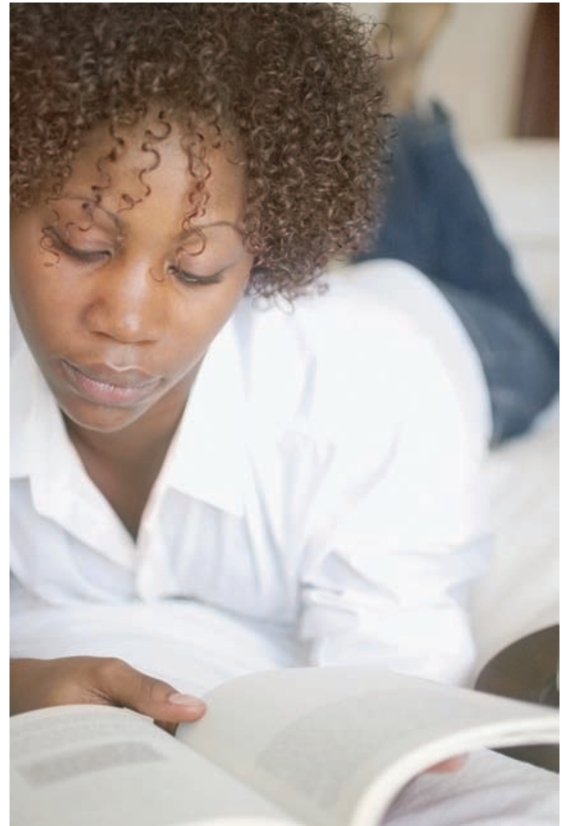
Music therapy can improve the mental health of depressed clients. It may be effective because active music-making within a therapeutic frame offers clients the opportunity for new aesthetic, physical, and relational experiences (Maratos, Crawford, & Procter, 2011).

Reading a self-help manual can reduce psychological distress in people with depression. In one study, participants in psychological distress were assigned randomly to an intervention or control group. The intervention group participants were given a self-help manual in addition to standard care and treatment while the control group received standard care and treatment. Psychological distress was measured with the Kessler Psychological Distress Scale. The findings affirm the benefits of bibliotherapy or self-help therapy in book form in helping to reduce psychological distress in people with moderate depression. The approach is easy to use and can be incorporated as an adjunct to standard care and treatment. Bibliotherapy can be used by community mental health nurses and other clinicians to reduce psychological distress and self-control.

In a series of four experiments, Rounding, Lee, Jacobson, and Ji (2012) tested the idea that religion was a cultural adaptation necessary for promoting self-control, which in turn may be a psychological pillar of support for numerous psychological and behavioral actions. If this proposal is true, the researchers reasoned, then subtle reminders of religious concepts should result in higher levels of self-control. The researchers consistently found that when

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

religious themes were made implicitly salient, people exercised greater self-control, which augmented their ability to make decisions in a number of behavioral domains. When self-control resources were minimized, making it difficult for people to exercise restraint on future unrelated self-control tasks, they found that by making implicit reminders of religious concepts, participants refueled their ability to exercise self-control.



Self-efficacy is the belief you can achieve a task or goal. Individuals with high self-efficacy believe in themselves and their ability to function, a trait correlated with mental health. Bandura (1977), who originated the term, described four ways to improve self-efficacy:

1. Successful experiences
2. Observing other's successful experiences
3. Remembering positive encouragements from other people
4. Interpreting signs of distress, e.g., "butterflies in the stomach," as normal and unrelated to ability

A study in *Complementary Therapies in Clinical Practice,* by Dellmann and Lushington (2012), focused on how natural therapists enhance positive expectations in their clients by stressing their personal strengths and ability to achieve their goals (self-efficacy).

HEALTH PROMOTION CHALLENGE

How can you use Bandura's theory and Dellmann and Lushington's research to enhance self-efficacy in yourself and clients? Write down your ideas and then share them with at least two classmates. Ask for feedback.

Another important variable in mental health is **self-esteem**, "a positive or negative orientation toward oneself; an overall evaluation of one's worth or value. People are motivated to have high self-esteem and having it indicates positive self-regard, not egotism" (Rosenberg, n.d., p. 1). Clients with low self-esteem do not have the confidence to feel good about themselves and what they are doing.

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Self-esteem is part of a broad-spectrum approach for mental health promotion. Self-evaluation is crucial to mental and social well-being because it influences aspirations, personal goals, and interaction with others. Self-esteem is a protective factor and can lead to better health and social behavior. Poor self-esteem is associated with depression, suicidal tendencies, eating disorders, anxiety, violence, and substance abuse (Mann, Hosman, Schaalma, & de Vries, 2004, p. 1). More recently, bullying has been found to correlate with low self-esteem.

RESEARCH BOX SELF-ESTEEM AND BULLYING

- BACKGROUND: Bullying is an important and increasing problem for nurses. Recent research has suggested a possible association between bullying and low self-esteem.
- OBJECTIVE: To determine the prevalence of bullying at work in a sample of Spanish nurses, to examine the association between bullying and self-esteem, and to investigate factors that determine bullying at work.
- DESIGN: A descriptive survey study was used to answer the research question.
- PARTICIPANTS: The sample consisted of 538 nurses who met the inclusion criteria of having worked for a minimum of 1 year in adult or pediatric services in the public or private healthcare system of Principado de Asturias-Spain.
- METHODS: The Rosenberg Self-Esteem Scale (RSE) and the Negative Acts Questionnaire (NAQ) standardized for Spain were used to measure self-esteem and bullying behaviors.
- RESULTS: Nearly one in five nurses (17%) experienced subjective bullying, and 8% of these cases reported weekly or daily bullying. The negative acts reported most frequently in bullied and non-bullied nurses were work-related bullying behaviors, such as "Being given tasks with unreasonable or impossible targets or deadlines" (2.71, SD = 1.33). Bullied nurses reported significantly higher rates in all questions of the NAQ, and self-reported bullying was significantly related to low self-esteem ($\chi2 = 109$; $p<0.001$).
- CONCLUSION: Prevalence of self-reported bullying is high among Spanish nurses and is clearly associated with higher exposure to bullying behaviors at work and lower levels of self-esteem.

Source: Iglesias, M.E. & Vallejo, R. B. (2012, February 10). Prevalence of bullying at work and its association with self-esteem scores in as Spanish nurse sample. *Contemporary Nurse* [Epub ahead of print], http://www.ncbi.nlm.nih.gov/pubmed/22551268

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

HEALTH PROMOTION CHALLENGE

Answer the questions on the Rosenberg Self-Esteem Scale and see how you rate. Find it at http://www.bsos.umd.edu/socy/research/rosenberg.htm If your self-esteem is lower than you wish it to be, use some of the interventions discussed in this section to boost it.

Low self-esteem is a symptom of depression and may predict relapse, while high self-esteem seems to buffer against depression. Competitive Memory Training (COMET) has shown to be effective for the enhancement of self-esteem in several conditions. In a new study, COMET is also an effective intervention for clients with depression (Korrelboom, Maarsingh, & Huijbrechts, 2012).

Compared to the patients who received only therapy as usual, patients in the COMET plus therapy as usual condition showed significant improvement with large effect sizes on indices of self-esteem, depression, and depressive rumination and remained stable after 3 and 6 months on all outcome measures or improved even more.

COMET for low self-esteem seems to be an effective intervention for depression. One Hour Cards are an example of COMET. The goal is to commit to memory and recall as many separate packs (decks) of 52 playing cards as possible. Other tasks include committing to memory and recall as many fictional numerical historic/future dates as possible and link them to the right historic event and to commit to memory and recall as many names as possible and link them to the right face. For more information on COMET, go to http://www.worldmemorychampionships.com

Sleep is also important to mental or psychological health. Nurse researchers studied the effect of sleep on self-esteem, depression, and perceived obesity stress in overweight and obese children. They found that sleeping less than seven hours a night was particularly detrimental to the investigated psychological variables in overweight, but not obese children (Kim, Ham, Kim, & Park, 2011).

Supportive relationships can also affect mental health. Research conducted at the Seoul Women's College of Nursing (Yoon, Kim, & Kim, 2011) examined the effect of teaching interpersonal relationship skills to students and then measuring the program's effect on interpersonal relationships, self-esteem, and depression. Ninety-minute groups sessions were held 10 times over a period of 10 weeks. The researchers found that compared to a control group, the interpersonal relationship program had a positive effect on improving interpersonal relationships and self-esteem, and decreasing depression in nursing students.

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Volunteering is another activity that can improve mental health, especially in older women. By volunteering to help others, participants can raise their quality of life, enhance self-esteem by increasing a sense of contributing, and find social support (McDonnall, 2011; Parkinson, Warburton, Sibbritt, & Byles, 2010; Tang, Choi, & Morrow-Howell, 2010).

Writing that is positive and expressive can help clients deal with stressful events. Expressive writing—writing about traumatic, stressful, or emotional events—often leads to improvements in physical and psychological health in non-clinical and clinical populations. Studies have shown that positive writing may also be beneficial. Research has not yet investigated whether either expressive writing or positive writing offers benefits for people with mood disorders.

In one study (Baikie, Geerligs, & Wilhem, 2012), the expressive writing, positive writing, and time management control writing groups all reported significantly fewer mental and physical symptoms for at least 4 months post-writing. When expressive and positive writing groups were combined, the resulting "emotional writing group" showed significantly lower scores on the DASS stress subscale than the control writing group at all time-points.

HEALTH PROMOTION CHALLENGE

Choose either bibliotherapy or positive/expressive writing and plan a program for yourself or a client. Discuss your ideas with at least two other students and ask for feedback. If possible, implement your plan.

Mental Health Promotion Assessment

Nursing mental health promotion assessment is in its infancy stage. The DSM-IV provides psychiatric diagnoses based on opinion. Here we present a newly-developed mental health promotion assessment for nurses. As more evidence accumulates, new questions will be added.

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Mental health promotion assessment in nursing includes many lifestyle questions and engages the client as collaborator. FIGURE 5-1 presents some questions that can help to evaluate the mental health of clients.

Below you will find a list of suggested questions to ask clients about their mental health. Revise the wording or add to them depending on your style of speaking and your experience.

1. What would you like to tell me about your mental and emotional health?
2. What are your strengths as a person?
3. What is your usual diet?
4. What are your sleep patterns?
5. How often do you listen to calming music or sing?
6. How often do you volunteer to help others?
7. What activities help you keep your mind active?
8. Everybody talks to themselves in their thoughts. What do you say in your head when you talk to yourself?
9. What do you do to cope when things get stressful?
10. How assertive are you? Are you an advocate for your own mental health?
11. Do you meditate?
12. Do you read?
13. Do you write in a journal or diary regularly?
14. What would you like to learn to do?
15. What kind of exercise do you do and how often?
16. What kinds of things do you usually think about or worry about?
17. What do you believe is your life purpose?
18. What do you think led up to your current state of mental and emotional health?
19. Who is the one person you can talk to about your feelings and feel understood?
20. How has this person helped or hindered you in getting mentally healthy?
21. What would be a sign to you that you are emotionally healthy?
22. What are your goals in relation to being mentally and emotionally healthy?
23. What goals do you have that you need help to achieve?
24. What do you need to learn to achieve your goals?
25. What can I do specifically to help you achieve your goals?
26. What story can you tell me about your life journey and struggle?
27. What kind of self-health approaches have/haven't worked for you?

(Ask about each of the activities below. Put a *yes* if it helped; *no* if didn't help. Use *NA* if not tried.)

___ acupressure	___ affirmations	___ aromatherapy	___ reading
___ energy therapy	___ guided imagery	___ hypnosis	___ puzzles
___ massage	___ prayer	___ relaxation therapy	___ yoga
___ touch therapies	___ reframing	___ exercise	___ tai chi
___ nutrition/supplements	___ music	___ writing	___ other: describe

FIGURE 5-1 Mental Health Assessment Questions

© Carolyn Chambers Clark, 2012.

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Mental Health Promotion

Mental health promotion is the same as health promotion itself in that it includes concepts of not only promotion, but also prevention. **Mental health promotion** should focus on the positive aspects of mental health and improving quality of life by building strengths and resources. In addition, prevention is key to reducing incidence and prevalence of a targeted illness, morbidity, and mortality.

Box 5-1 Common Misconceptions about Mental Illness

MYTH "Young people and children don't suffer from mental health problems."

FACT It is estimated that more than 6 million young people in America may suffer from a mental health disorder that severely disrupts their ability to function at home, in school, or in their community.

MYTH "People who need psychiatric care should be locked away in institutions."

FACT Today, most people can lead productive lives within their communities thanks to a variety of supports, programs, and/or medications.

MYTH "A person who has had a mental illness can never be normal."

FACT People with mental illnesses can recover and resume normal activities. For example, Mike Wallace of *60 Minutes*, who had clinical depression, received treatment and led an enriched and accomplished life.

MYTH "Mentally ill persons are dangerous."

FACT The vast majority of people with mental illnesses are not violent. In the cases when violence does occur, the incidence typically results from the same reasons as with the general public, such as feeling threatened or excessive use of alcohol and/or drugs.

MYTH "People with mental illnesses can work low-level jobs but aren't suited for really important or responsible positions."

FACT People with mental illnesses, like everyone else, have the potential to work at any level depending on their own abilities, experience, and motivation.

Source: © 2012 Mental Health America. http://www.nmha.org/go/action/stigma-watch

If client mental health affects the sense of well-being and quality of life, it can have two significant negative effects on efforts at promoting health. First, mental health issues can themselves be risk factors for physical health issues if they affect the individual's self-care ability. Second, mental health issues can

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

obstruct efforts by the individual and by healthcare providers to take actions to promote or improve health.

An example would be a client with clinical depression who is unable to leave the house to obtain treatment due to their depression. If this person lives in a nice home, has a high income and a good education, eats well, and is generally physically fit and healthy, by some measures quality of life is high. In terms of health-related quality of life, this person experiences poor quality of life by any measure. Severe depression by itself is manifest by poor quality of life; lack of treatment and the inability to obtain treatment extend and increase this problem and may eventually impact physical health. If this individual's condition results in the loss of a good job and leads to inability to sustain financial and family well-being, then the impact spreads to other family members and to the community at large.

HEALTH PROMOTION CHALLENGE

What options can you come up with for homebound clients who require mental health care? Investigate online treatment, home visits, self-study books, and any other formats you can find by Googling *mental health treatment for homebound clients*. Share your findings with at least two other classmates and ask for feedback.

In reviewing any approach to mental health, common threads are evident. These include that the concepts (1) be positive and constantly changing, (2) be multidisciplinary, (3) build on the principles of health promotion, and (4) be rooted in the socioecologic approach.

A Socioecologic Approach to Mental Health Promotion

The **socioecologic approach** to mental health promotion evolves from the philosophy that change needs to start at the individual level, which causes a chain reaction in affecting the family, then the community, and ultimately the society. The approach recognizes that individuals do not exist in a vacuum. They influence, and are influenced by, the social groups with which they interact, whether that means family, friends, neighbors, coworkers, teachers, or the community at large. Programs for mental health promotion need to influence these environments in which the individual, family, group, or community functions. This can mean developing a plan not only to work with the individual in support of mental health, but also developing plans to create supportive environments in

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

individual homes, or community settings of schools, workplaces, and health-care services.

Examples could include:

- a community-based program that assists developmentally disabled adults to obtain job training and placement
- a school program that teaches students self-esteem and stress reduction measures
- a work program that provides mental health promotion information and skill practice
- outreach programs for depressed adults or children
- outreach programs for clients suffering from posttraumatic stress disorder due to rape, school or work shootings, war, natural disasters, etc.
- a family-based plan developed to provide supportive care for a parent in the early stages of dementia, a pregnant or abused woman, or a client stopping smoking or taking drugs

HEALTH PROMOTION CHALLENGE

Choose one of the examples above and develop a mental health treatment plan. Use the Internet (www.pubmed.gov) to find examples of studies/programs as well as Google for ideas. Share your completed program with at least two other students and ask for feedback.

In all of these cases, interventions are targeted not only to the needs of the client, but also to alter the environment in which the client works and lives in order to accommodate mental health needs. Principles of mental health promotion build on empowerment philosophy by engaging the participants, building on their strengths, and enhancing their perspective of having control over their lives.

The Nurse's Role in Mental Health Promotion

There are two situations in which nurses work with individuals with mental illness. One occurs in a setting where an individual client is referred for health promotion activities and is not diagnosed with any form of mental issue, but displays characteristics of a mental health issue (as discussed in the section on identifying different forms of mental illness). Another is in the setting where the client has a formal diagnosis and is working with a nurse to address a diagnosed mental health concern. In the first case, the nurse may not have been

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

specifically trained to work with patients with mental health issues; in the second, it is likely that the nurse has advanced mental health training.

Why do these distinctions matter? There are several reasons. First, if you work with a client and identify a mental health issue that is outside your scope of practice, there may be legal and ethical ramifications. A licensed practical nurse who is helping a client with reducing pain from rheumatoid arthritis, for instance, may not have the authority to intervene for that client should she suspect clinical depression. Also, it would be unethical and irresponsible to attempt to address an issue for which you have not been trained (Ballard, 2008).

Second, when a physically ill client presents signs of lack of mental health, it has implications for how the health promotion activity undertaken to address the physical problem can proceed. A person with untreated or overlooked mental health issues may not have the capacity to engage in health promotion activities until the mental health issue is dealt with. Likewise, health promotion activities may prove more successful following intervention for mental distress. That is why referral to appropriate mental health services is an important part of health promotion.

In mental health promotion, the relationship between the nurse and the client takes on an important therapeutic dimension—and it is important to get that relationship right as a result. Taylor (2008) explains that:

> [t]o be truly helpful to clients, you need to understand the difference between professional and social relationships. Social relationships are interactions in which the needs of both persons are of equal importance. In contrast, professional relationships are those in which the needs of the client are paramount. To engage in professional relationships with clients, nurses must have a highly developed degree of self-awareness. Self-awareness means that nurses know those areas in which they are emotionally vulnerable . . . Nurses need to be aware that boundaries are critical in maintaining a professional therapeutic relationship. At the beginning of the relationship, an agreement or contract between the nurse and client should be established. This is an excellent opportunity to establish the rules and behaviors or boundaries that are expected between the nurse and client, such as the time and frequency of meetings; reimbursement for services; contact with family members, significant others, and other therapists; and prohibition against socialization. (p. 18)

The orientation phase of a nurse–client relationship begins when you take steps to learn about the client's biosocial history (e.g., social, cultural, spiritual, family, developmental, and occupational history as well as medical, psychiatric, and substance abuse history), the history of the present illness or complaint, and current mental and physical state (Moran, 2008). Although all of these facts are important for your understanding of the client's situation, the key

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

goal at this stage is to establish trust between you and the client. The best way to do this is to be consistent and professional, to be available when you say you will be available, and to focus on the client's needs. During this phase, and depending on the client, you may wish to ask some of the questions that appear in Figure 5-1 Mental Health Assessment Questions.

After trust is solidified, the relationship moves into a second phase, the working phase, in which the particulars of the client's circumstance are taken into account as you work to develop a strategy for helping the client. During this phase you can begin to work in collaboration with the client to plan interventions for the variables that appear in TABLE 5-1, Variables Affecting Mental Health.

The final phase, conclusion phase, occurs when the relationship comes to an end. The conclusion phase may happen either because you must refer the client on to services you cannot provide, or because the health promotion activities you and client have undertaken together have proven sufficiently successful that the client no longer needs your services.

Taylor (2008) notes that "[p]aradoxically, the more successful the relationship, the more emotionally painful is the termination" (p. 18). You and the client must let go of what is necessarily a high degree of intimacy and go your separate ways. Development of a personal relationship between a nurse and client after the working relationship is unethical, because it represents a changing of firmly established and healthy boundaries. At this stage, you know more about this client's personal experience than even close friends. Because you may be called upon to resume a professional interaction with the client in the future, you cannot risk developing a social interaction with the client, even after a successful intervention.

If you work with clients striving to become mentally healthy, you will be held accountable to various codes of ethics formulated by professional organizations and state licensing boards. It is your responsibility to know these codes and maintain close familiarity with their standards so your practice is in compliance with them.

Resources for Mental Health Promotion

TABLE 5-1, Variables Affecting Mental Health, is a good starting point for planned interventions. The Centers for Disease Control and Prevention (CDC) is in an excellent position to support the efforts of health agencies in promoting mental health (Safran, 2009). The efforts include collection of data through surveillance of mental illness, assessment of risk behaviors, and analysis of associated comorbidities of mental illness and chronic disease. The CDC also collaborates with the World Federation for Mental Health to address the stigma associated with the mental illness diagnosis, the primary barrier that prevents one from seeking effective treatment. This effort is evident through public

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Table 5-1 Variables Affecting Mental Health

FINDINGS	VARIABLES
Assertiveness/ Advocacy	Pickett et al. (2012) found that using a peer-led educational group approach with mental health consumers increased their self-advocacy/assertiveness skills.
Exercise	Stavrakis et al. (2012) found that group exercise reduces perceived stress. Mason and Holt (2011) found that exercise improves social interaction and social support; increases feelings of safety; and provides a sense of meaning, purpose, and achievement.
	Smith et al. (2011) found that exercise decreases anxiety and stress when integrative yoga is used.
Massage	Serfaty et al. (2012) found that massage combined with lavender aromatherapy decreases anxiety and depression.
Meditation	Brand et al. (2012) found that meditation improves sleep and reduces stress.
Music	Maratos et al. (2011) found that music therapy can improve the mental health of depressed individuals.
Nutrition	Ye et al. (2011) found that the intake of sugars detrimentally affects mental functioning.
	Annweiler et al. (2012) found that eating foods high in vitamin D (especially cod, salmon, sardines, and shrimp) lowers the risk for Alzheimer's Disease.
	Forsyth et al. (2012) found that a low intake of magnesium from fruits, veggies, and grains is associated with depression.
	da Rocha and Kac (2012) found that a low intake of omega-3 fatty acids from food like (sardines, salmon, flax seeds, and walnuts) is associated with a greater risk for postpartum depression.
Reading	Songprakunp and McCann (2012) found that reading a self-help manual can reduce psychological distress in depressed clients.
Religion/Spirituality	Rounding et al. (2012) found that subtly reminding clients of religious concepts can increase self-control and the ability to make better decisions.
Self-efficacy	Bandura (1977) and Delmann and Lushington (2012) found that to enhance self-efficacy in clients, you should model success in reaching the client goal, stress client personal strengths, and use positive encouragement that the client can succeed.

(continues)

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Table 5-1 (Continued)

FINDINGS	VARIABLES
Self-esteem	Menn et al. (2004) found that low self-esteem correlates with depression, suicidal tendencies, eating disorders, anxiety, violence, and substance abuse.
	Iglesias & Vallejo (2012) found that low self-esteem correlates with bullying.
	Korrelboom et al. (2012) found that competitive memory training can enhance self-esteem.
Sleep	Kim et al. (2011) found that sleeping less than 7 hours/night is correlated with obesity.
Supportive IPRs	Yoon et al. (2011) found that learning interpersonal relationship skills in a group had a positive effect on interpersonal relationships, self-esteem, and decreased depression.
Volunteering	Parkinson et al. (2010); McDonnall (2011) and Tang et al. (2010) found that volunteering to help others can reduce depression and increase social support and a sense of contribution.
Writing	Baikie et al. (2012) found that writing about trauma or difficult situations in an expressive, positive way can reduce stress.

© Carolyn Chambers Clark, 2012.

awareness campaigns and by supporting efforts of other agencies in consistent surveillance of mental illness as well as risk behaviors.

In 2002, the WHO published a document called *Prevention and Promotion in Mental Health*. The document was a result of the World Health Organization Meeting on Evidence for Prevention and Promotion in Mental Health: Conceptual and Measurement Issues, which was held in the WHO headquarters in Geneva, Switzerland, in 2001. It was attended by participants who were mental health experts from WHO regions. The role of WHO in the area of prevention and promotion in mental health includes the following:

1. To foster activities in the field of mental health, especially those affecting the harmony of human relations,
2. To promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment,
3. To study and report on, in cooperation with other specialized agencies where necessary, administrative and social techniques affecting public health and

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

medical care from preventive and curative points of view, including hospital services and social security. (WHO, 2002, p. 25)

The underlying theme of the conference was that "prevention and promotion in mental health are essential steps in reducing the increasing burden due to mental disorders" (WHO, 2002, p. 1). The document is key in mental health promotion in that it is based on the deliberations of the WHO meeting and additional sources, with special emphasis on evidence-based references. The beginning of the document outlines the rationale for the emphasis on mental health promotion,

The World Health Organization website contains excellent information about the organization's efforts to promote mental health in all countries. Go to http://www.who.int/topics/mental_health/en/ WHO initiatives are categorized according to regions, such as African Region or the Eastern Mediterranean Region; mental health resources/publications are available on the site, as well as statistical information.

The CDC provides information about mental health organizations by state plus links for governmental and nongovernmental resources. Go to http://www.cdc.gov/mentalhealth/resources.htm

HOT TOPICS

Here are some topics to explore:

- Autism
- Bibliotherapy
- Meditation
- Self-efficacy
- Self-esteem
- Nutrition and mental health

To these effects we would add:

1. Elevated instance of emotional/psychological suffering or physical dysfunction
2. Discrimination and stigma, including self-stigma (Sharac, McCrone, Clement, & Thornicroft, 2010)
3. Poor self-care, including failure to seek medical care
4. Decreased quality of life

Mental health prevention strategies work best when implemented before the onset of the mental disorders. (WHO, 2002, p. 8). Mental health promotion is geared towards improving the coping skills of the individual and addressing underlying causes, not eliminating symptoms and deficits as in the medical model.

Teaching clients good nutritional habits and assertiveness skills, as well as the other activities in Table 5-1, can provide a start toward preventing mental disorders.

One of the most compelling aspects of *Prevention and Promotion in Mental Health* is the section covering the importance of **evidence-based research** in the area of mental health promotion. The premise is that "evidence not only provides validity for effectiveness of strategies, but also stimulates decisions and actions" (WHO, 2002, p. 12). The arguments in favor of evidence-based prevention and promotion in the field of mental health are also summarized. They include:

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

1. Growing awareness of the epidemiology of mental disorders and mental health-related problems and of their large financial and social burden on society has urged governments and nongovernment organizations to develop and implement effective preventive measures.
2. Societal pressure for increased accountability for spending public funds calls for both evidence of effectiveness and cost-effectiveness. This calls for information on what works best and under what conditions.
3. The pressure to shift governmental funds from health care or other budgets to prevention and promotion has evoked resistance. Skepticism about the possibilities of effective prevention in mental health, criticism of its weak scientific base, and the need to protect healthcare budgets have raised a call for proof that such interventions can be effective.
4. Growing numbers of preventive programs and strategies have urged policy makers, health managers, and program providers to select best practices, which requires objective standards for comparison. Given the existing diversity in efficacy and effectiveness of prevention programs, consumers have to be informed about the best available preventive services and be alerted as to possible negative side effects.
5. Evaluations of the outcomes of preventive interventions and mental health promotion are subject to a variety of possible biases, leading to incorrect conclusions. Solid evidence and standards for evidence are needed to prevent such incorrect conclusions. Available resources for preventive interventions being scarce, evidence of the program's outcomes will lead to more efficient use of resources.
6. Frequently, preventive and promotional interventions are addressed at large population groups using indirect intervention strategies and are aimed at assessing long-term outcomes. These features hinder their proper assessment; specific monitoring systems are needed to make the effects visible.
7. Mental health promotion, like other sectors of health promotion, requires intersectoral action; i.e., participation and investments by sectors outside mental health. Sustainable investments can only be expected when such partners can be confident that these will generate outcomes that are also relevant to their interests (e.g., social or economic benefits).

In addition, the WHO document emphasizes that before starting the process of designing promotion and preventive programs, a needs assessment should be initiated on the following issues:

1. Prevalence and incidence of mental disorders or mental ill health
2. Populations and individuals at risk
3. Health, social, and economic outcomes of problems or disorders
4. Community perceptions of risk and the need for preventive actions
5. Biologic, psychologic, and social risk and protective factors

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

6. Developmental trajectories of health and disease
7. Comorbidity and multiproblem trajectories

Strategies for Promoting Mental Health

Strategies for mental health promotion depend in large part on understanding the varying places where there are opportunities for intervention. A great many factors contribute to reduced mental health, ranging from learned behaviors, lack of exercise, low self-esteem, nutritional deficits (e.g., vitamin D or B-vitamin deficiency contributing to depression in older adults), poor interpersonal skills, or lack of knowledge about helpful self-care measures, to biochemical imbalances, toxic exposures, posttraumatic stress disturbances, poverty, and genetic and functional alterations to the brain.

Interventions can include a combination of lifestyle modifications (exercise, nutrition, and other approaches detailed in Table 5-1) and talk therapy for concerns like depression, anxiety, and anger issues; and nursing and/or occupational therapies and low-level psychological intervention needed for moderate functional issues like personality disorders, ADHD or OCD.

For many clients, mental health promotion may require input from the client's family. Activities may need to be planned not only with the client, but also with the client's family members, particularly in the case of an individual with a significant mental disability. Family dynamics that have developed to protect or control a family member identified as the problem may prove to be obstacles to the client's ability to self-promote mental wellness and independence.

Here's an example: Imagine a large family with eight children in which the youngest son, Jeff, is diagnosed with schizophrenia at the age of 12. When he takes his medication, Jeff's symptoms are usually well controlled, but like many adolescents, he resents being different and sometimes forgets or refuses to take his medications. He also complains the medicine makes him feel like he's in a mental straitjacket. Because both of his parents work, Jeff's three oldest siblings, who have graduated high school but live and work nearby, are sometimes called upon to intervene when his condition causes Jeff to have problems in school. As a result, Jeff's siblings have developed a pattern of protecting and watching over their baby brother. This pattern lasts well past adolescence and into adulthood, with Jeff's siblings providing their brother with transportation, housing, food, and clothing from the mistaken belief or their private agendas that the young man's diagnosis prevents him from taking on these tasks himself. If Jeff wants to obtain independence and manage his own

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

mental health once he reaches maturity, the siblings may impede him from doing so, because of an entrenched dynamic that compels them to exercise control over his activities.

A nursing intervention for this client may require working not only with Jeff to help him develop better compliance with his treatment regimens and improve his life skills, but also with his family to develop healthier systems of interaction between Jeff and his oldest siblings. Be aware that a system, such as a family, struggles to maintain balance. When one individual changes behavior, the others will exert pressure to reverse the change, so build in special supports for Jeff's healthier behaviors.

Summary

Mental health encompasses complex biological, physiological, emotional, and psychosocial interactions. You can aid in mental illness prevention by helping people identify and monitor their own risk factors, assessing levels as well as their perception of stress with the effectiveness of their coping strategies, and to view the person in terms of their overall function and not just by their signs and symptoms.

Mental conditions contribute much to the worldwide disease burden; the World Health Organization estimated in 2001 that 450 million people suffered from mental disorders. According the U.S. Department of Health and Human Services, in 2000, costs related to mental illness were estimated at $150 billion annually.

In 2002, the World Health Organization published *Prevention and Promotion in Mental Health*. The roles of WHO in prevention and promotion in mental health include (1) fostering activities in the field of mental health, especially those affecting harmony in human relations; (2) promoting maternal and child health and welfare and fostering the ability to live harmoniously in a changing total environment; and (3) studying and reporting on in cooperation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security. The negative effects of mental illness listed in *Prevention and Promotion in Mental Health* included extended treatment periods, absence due to sickness, unemployment, increased labor turnover, loss of productivity, disability that can last for years, emotional and socioeconomic toll on families, and an overall increase in costs.

Mental health promotion differs from general health promotion in that it is geared toward improving the coping skills of the individual instead of eliminating symptoms and deficits, as in the medical model. The WHO document also stresses the importance of evidence-based research in mental health

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

promotion and the need for a thorough assessment prior to designing promotion and prevention programs.

Common threads found in approaches to mental health include concepts that (1) are positive and constantly changing, (2) are multidisciplinary, (3) build on the principles of health promotion, and (4) are rooted in the socioecologic model.

Variables affecting mental health that nurses can develop interventions for, based on evidence already, available include: assertiveness/advocacy, exercise, massage/aromatherpy, meditation, music, nutrition, reading, religion/spirituality, self-efficacy, self-esteem, sleep, supportive interpersonal relationships, volunteering, and writing.

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

REVIEW QUESTIONS

1. Mental illness costs the United States an estimated
   a. $150 million annually
   b. $150 billion annually
   c. $450 million annually
   d. $450 billion annually
2. Mental health promotion is geared toward:
   a. Primary prevention
   b. Secondary prevention
   c. Improving coping skills
   d. Tertiary prevention
3. Evidence-based practice:
   a. Relies on solid research studies that provide validity for effectiveness of strategies
   b. Builds on practice patterns handed down from older practitioners
   c. Does not require studies utilizing scientific methods.
4. Threads or concepts that are commonly found in approaches to mental health are all of the following except:
   a. Multidisciplinary
   b. Positive and constantly changing
   c. Static and unchanging
5. Negative effects of mental illness include all of the following except:
   a. Increased labor turnover
   b. Reduced cost of health care
   c. Extended treatment periods
6. Before starting the process of designing promotion and preventive programs:
   a. An assessment of needs should be initiated
   b. A search for funding sources should be undertaken
   c. An assessment of local professionals and their qualifications should take place

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

EXERCISES

1. Do some research on the Bright Futures national health promotion initiative. Summarize the various areas of focus in the program and gather detailed information about the Public Health Approach to Mental Health section.
2. Review the *Healthy People 2010* document portions related to mental health and then review the activities of the National Center for Mental Health Promotion and Youth Violence Prevention. In what ways does the work of this group support the goals of Healthy People?
3. Compile a literature search on an area of mental health promotion that interests you. Write up a brief summary of your findings.

REFERENCES

Annweiler, C., Fantino, B., Schott, A. M., Krolak-Salmon, P., Allali, G., & Beauchet, O. (2012). Vitamin D insufficiency and mild cognitive impairment: cross-sectional association. *European Journal of Neurology, 19*(7), p. 1023-1029.

Baikie, K. A., Geerligs, L., & Wilhelm, K. (2012). Expressive writing and positive writing for participants with mood disorders: an online randomized controlled trial. *Journal of Affective Disorders 136*(3), 310–319.

Ballard, K. A. (2008). Issues and trends in psychiatric-mental health nursing. In P. G. O'Brien, W. Z. Kennedy, & K. A. Ballard (Eds.), *Psychiatric mental health nursing: An introduction to theory and practice* (pp. 21–38). Sudbury, MA: Jones and Bartlett.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change, *Psychological Review 84*(2), 191–215.

Brand, S., Holsboer-Trachsler, E., Naranjo, J.R., & Schmidt, S. (2012). Influence of mindfulness practice on cortisol and sleep in long-term and short-term meditators. *Neuropsychobiology, 65*(3), 109–118.

da Rocha, C. M. & Kac, G. (2012). High dietary ratio of omega-6 to omega-3 polyunsaturated acids during pregnancy and prevalence of post-partum depression. *Maternal and Child Nutrition 8*(1), 36–48.

Dellmann T., & Lushington, K. (2012). How Natural Therapists enhance positive expectations of patients. *Complementary Therapies in Clinical Practice, 18*(2), 99–105.

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J., Gasquet, I., Kovess, V., Lepine, J. P., . . . Chatterji, S.; WHO World Mental Health Survey Consortium. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA, 291*(21), 2581–2590.

Forsyth, A. K., Williams, P. G., & Deane, F. P. (2012). Nutrition status of primary care patients with depression and anxiety. *Australian Journal of Primary Health, 18*(2), 172–176.

Hopkins, M. E., Caroline Davis F., Vantieghem, M. R., Whalen, P. J., & Bucci, D. J. (2012, April 30). Differential effects of acute and regular physical exercise on cognition and affect. *Neuroscience*. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/2255478

Iglesias, M. E., & Vallejo, R. B. (2012, February 10). Prevalence of bullying at work and its association with self-esteem scores in a Spanish nurse sample [Epub ahead of print]. *Contemporary Nurse*. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22551268

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Kim, H. S., Ham, O. K., Kim, J. W., & Park, J. Y. (2012, March 28). Association between sleep duration and psychological health in overweight and obese children in Korea. *Nursing and Health Science*. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22462655

Korrelboom, K., Maarsingh, M., & Huijbrechts, I. (2012). Competitive memory training (comet) for treating low self-esteem in patients with depressive disorders: a randomized clinical trial. *Depression and Anxiety, 29*(2), 102–110.

Mann, M., Hosman, C. M. H., Schallma, H., & de Vries, N. K. (2004). Self-esteem in a broad-spectrum approach for mental health promotion. *Health Education Research, 19*(4), 357–372.

Maratos A., Crawford, M. J., & Procter, S. (2011). Music therapy for depression: It seems to work, but how? *British Journal of Psychiatry, 199*(2), 92–93.

Mason, O. J., & Holt, R. (2012, April 25). Mental health and physical activity interventions: A review of the qualitative literature. *Journal of Mental Health*. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22533784

McDonnall, M.C. (2011). The effect of productive activities on depressive symptoms among older adults with dual sensory loss. *Research in Aging, 33*(3), 234–255.

Moran, C. C. (2008). The psychiatric nursing assessment. In P. G. O'Brien, W. Z. Kennedy, & K. A. Ballard (Eds.), *Psychiatric mental health nursing: An introduction to theory and practice* (pp. 39–64). Sudbury, MA: Jones and Bartlett.

National Institutes of Mental Health. (n.d.a). Post-traumatic stress disorder. U.S. Department Of Health and Human Services, National Institutes of Health Publication No. 08 6388. Retrieved from http://www. nimh. nih. gov/health/publications/post-traumatic-stress-disorder-ptsd/nimh_ptsd_booklet. pdf

National Institutes of Mental Health. (n.d.b). Statistics: Leading categories of diseases/disorders. Retrieved from http://mentalhealth. gov/statistics/2LEAD_CAT. shtml

National Institutes of Mental Health. (n.d.c). Statistics: Leading causes of death ages 18–65 in the U. S. Retrieved from http://mentalhealth. gov/statistics/3AGES1865. shtml

National Institutes of Mental Health. (n.d.d). Suicide in the U. S. Statistics and prevention. Retrieved from http://www.nimh.nih.gov/health/publications/suicide-in-the-us-statistics-and-prevention/index.shtml#factors

Parkinson, L., Warburton, J., Sibbritt, D., & Byles, J. (2010). Volunteering and older women: psychosocial and health predictors of participation. *Aging and Mental Health,14*(8), 917–927.

Perlick, D. A., Nelson, A. H., Mattias, K., Selzer J., Kalvin, C., Wilber, C. H., Huntington, B., . . . Corrigan, P. W. (2011). In our own voice-family companion: Reducing self-stigma of family members of persons with serious mental illness. *Psychiatric Services, 62*(12), 1456–1462.

Rosenberg, M. (n.d.) The Rosenberg Self-Esteem Scale. Retrieved from http://www.bsos.umd.edu/socy/research/rosenberg.htm

Rounding, K., Lee, A., Jacobson, J. A., & Ji, L. J. (2012, May 2). Religion replenishes self-control [Epub ahead of print]. *Psychology and Science*. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22555969

Rüsch, N., Angermeyer, M. C., & Corrigan, P. W. (2005). Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry, 20*(8), 529–539.

Safran, M. (2009). Achieving recognition that mental health is part of the mission of the CDC. *Psychiatric Services, 60*(11), 1532–1534.

Serfaty, M., Wilkinson, S., Freeman, C., Mannix, K., & King, M. (2012). The ToT Study: Helping with Touch or Talk (ToT): a pilot randomised controlled trial to examine the clinical effectiveness of aromatherapy massage versus cognitive behaviour therapy for emotional distress in patients in cancer/palliative care. *Psychooncology 21*(5), 563–569.

Sharac, J., McCrone, P., Clement, S., & Thornicroft, G. (2010). The economic impact of mental health stigma and discrimination: A systematic review. *Epidemiologia e Psichiatria Sociale, 19*(3), 223–232.

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397

Smith, J. A., Greer, T., Sheets, T., & Watson, S. (2011). Is there more to yoga than exercise? *Alternative Therapies in Health and Medicine, 17*(3), 22–29.

Songprakun, W., & McCann, T.V. (2012, March 1). Evaluation of a bibliotherapy manual for reducing psychological distress in people with depression: a randomized controlled trial [Epub ahead of print]. *Journal of Advanced Nursing*. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22381065

Stavrakakis, N., de Jonge, P., Ormel, J., & Oldehinkel, A. J. (2011). Bidirectional prospective associations between physical activity and depressive symptoms. *The TRAILS Study. 50*(5), 503–508.

Tang, F., Choi, E., & Morrow-Howell, N. (2011). Organizational support and volunteering benefits for older adults. *Gerontologist, 50*(5), 603–612.

Taylor, C. M. (2008). Introduction to psychiatric-mental health nursing. In P. G. O'Brien, W. Z. Kennedy, & K. A. Ballard (Eds.), *Psychiatric mental health nursing: An introduction to theory and practice* (pp. 3–20). Sudbury, MA: Jones and Bartlett.

Toblin, R. L., Riviere, L. A., Thomas, J. L., Adler, A. B., Kok, B. C., & Hog, C. W. (201U.S. Department of Health and Human Services. (2000). *Healthy people 2010*. Washington, DC: Author.

University of Leeds/Ahead4health. (2006). *What is mental health?* Retrieved from http://www. leeds. ac. uk/ahead4health/mental_health. htm

U.S. Department of Health and Human Services. (2010). Healthy People 2020. *Mental Health and Mental Disorders*. Retrieved from http://aspe.hhs.gov/health/reports/physicalactivity/

World Health Organization [WHO]. (2001). *The world health report: Mental health; new understanding, new hope*. Geneva, Switzerland: Author.

World Health Organization [WHO]. (2002). *Prevention and promotion in mental health*. Geneva, Switzerland: WHO. Retrieved from http://www. who. int/mental_health/media/en/545. pdf

World Health Organization [WHO]. (2004). *Promoting mental health: Concepts, emerging evidence and practice*. Retrieved from http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf

World Health Organization [WHO]. (2007). *What is mental health?* Retrieved from http://www. who. int/features/qa/62/en/index. html

Wynaden, D., Barr, L., Omari, O., & Fulton, A. (2012). Evaluation of service users' experiences of participating in an exercise programme at the Australian State Forensic Mental Health Services. *International Journal of Mental Health Nursing, 21*(3), 229–235.

Ye, X., Gao, X., Scott, T., & Tucker, K. L. (2011). Habitual sugar intake and cognitive function among middle-aged and older Puerto Ricans without diabetes. *British Journal of Nutrition, 106*(8), 1423–1432.

Yoon, H. S., Kim, G. H., & Kim, J. (2011). Effectiveness of an interpersonal relationship program on interpersonal relationships, self-esteem, and depression in nursing students. *Journal of the Korean Academy of Nursing 41*(6), 805–813.

INTERNET RESOURCES

For a full suite of assignments and learning activities, use the access code located in the front of your book to visit this exclusive website: **http://go.jblearning.com/healthpromotion**. If you do not have an access code, you can obtain one at the site.

© Jones & Bartlett Learning, LLC NOT FOR RESALE OR DISTIBUTION 7397