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A developmental-contextual approach to understanding mental health and well-being in early adulthood☆

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ABSTRACT

There is an increasing awareness of the social and economic burden of untreated mental illness. However, the question remains whether the individuals who are not identified as having a mental disorder are mentally healthy and socially functioning. This study aims to examine the sequence of Keyes's (Keyes, C. L. M. (2002). The mental health continuum: from languishing to flourishing in life. *Journal of Health and Social Behavior, 43*, 207–222.) mental health categories based on psychological status and well-being, and to identify qualitative differences in these categories by developmental-contextual factors and concurrent physical health status and social functioning. This study uses data from the UK 1958 National Child Development Study. Information was collected on the cohort members from childhood to age 33 years. Psychological distress (measured using the Malaise Inventory) and well-being (self-efficacy and appraisals of life circumstances) were assessed at age 33 years. Multinomial (polytomous) logistic regression models were used to examine the effects of individual characteristics and social contextual factors from childhood through adolescence on cross categorisations of psychological distress and well-being. Our findings suggest that there are similar early life predictors for both poor psychosocial functioning and mental ill-health. Our results also demonstrated a clear gradient of physical health and social functioning across mental health categories, even in the absence of mental disorder. Individual and social contextual factors in early life appear to offer clues as to why the absence of psychological distress does not always imply good mental health or social functioning.

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Introduction

The burden of undiagnosed and undertreated mental illness is often discussed (Kessler et al., 2005; Thornicroft, 2007), however, little attention is paid to the tenuous assumption that individuals who are not identified as having a mental disorder are mentally healthy and socially functioning. In contrast, well-being has become a pervasive concept in the understanding of how psychosocial factors influence levels of functioning over the life course (Hatch et al., 2007; Ryan & Deci, 2001; Schoon, 2006). This study combines these approaches to examine a cross categorisation between mental ill-health and well-being in adulthood, and prospectively identifies individual characteristics and psychosocial factors in childhood and adolescence associated with these outcomes.

Developing a cross categorisation of mental health and well-being

Social scientists, particularly psychologists, have differentiated emotional, psychological, and social factors of well-being that are represented by items such as life satisfaction, autonomy, mastery, and social participation (see Diener, Oishi, & Lucas, 2003; Ryan & Deci, 2001 for reviews). In the current study, mental health, as opposed to distress or disorder, is defined as a positive state that, in broad terms, refers to well-being or an individuals' subjective evaluation of life via appraisal of their circumstances and affective states linked to psychological and social functioning (Larson, 1993; Ryff & Keyes, 1995). Additionally, Hatch et al. (2007) contend that assessments of social functioning and well-being could be improved by including all aspects of work (e.g., formal employment and household labour).

Keyes (2005) argues that there is scientific and applied value of classifying individuals in terms of their mental *health*, a positive outcome, and functioning. Keyes (2002, 2007) suggests that shifting

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attention from dualities of mental disorder and the absence of mental disorder to a wider distribution that includes mental health and well-being will improve assessments and increase prospective approaches to treatment in contrast to managing chronic illness. Keyes (2002) developed a sequence of categories based on assessments of depression and anxiety symptoms with multiple measures of emotional, psychological, and social well-being, with inclusion in each group requiring that individuals exhibit more than half of the total symptoms or characteristics on each measure. Further, these categories are presented as a mental health continuum.

Keyes (2002, 2005) suggests the following five categories: (1) languishing and depression, (2) pure depression (combined depression and moderate well-being), (3) pure languishing (low well-being without depression), (4) moderately mentally healthy (moderate well-being without depression), and (5) pure flourishing (high levels of well-being without depression). Pure flourishing individuals are thought to express a level of adaptability and functioning that is greater than the *moderately mentally healthy*, those who are neither flourishing nor languishing in life and appear average with reference to emotional affect and functioning. In turn, the *moderately mentally healthy* group is considered to be functioning better than the languishing group. *Languishing* refers to lower levels of well-being, a sense of dissatisfaction with current life circumstances, possibly with co-occurring symptoms of depression. Keyes (2005) argues that pure languishing may be as dysfunctional as pure depression or mental illness. In theory, individuals who are languishing are not functioning as well as others, but it is suggested that there may be no clear distinction between these groups. However, these groups fare better than those who can be characterised as both languishing *and* depressed. The conceptual basis of these categories is central to this study of a general population sample, but we contend that these categories may be more accurately described as a cross categorisation of depression (or psychological distress as in this study) and well-being rather than a hierarchical continuum.

Previous studies on Keyes's mental health continuum

Keyes (2002) generated the mental health categories using cross sectional data from the Midlife in the United States study (MIDUS), a nationally representative sample of adults aged 25–74 years ($N = 3{,}032$). The results from this study indicated that there may be important differences in psychosocial functioning (e.g., perceived health, limitations in activities of daily living, and sickness absence from work) between those who were in the pure languishing group compared to those with major depression, as measured by the Composite International Diagnostic Interview Short Form (CIDI-SF) scales (Kessler, Andrews, Mroczek, Ustun, & Wittchen, 1998) using DSM-111-R criteria (American Psychiatric Association, 1987). Despite this, the results also suggested that pure languishing was as prevalent and indicative of overall poor psychosocial functioning as episodes of major depression.

Keyes (2006) has also explored the distribution of the mental health continuum in a sample of adolescents and found a gradient in the prevalence of conduct problems (e.g., having been arrested, truancy) across groups defined as mentally unhealthy and languishing, moderately mentally healthy, and mentally healthy and flourishing. In addition, a clear gradient was found in terms of psychosocial functioning (self-determination, closeness to others, and school integration) across the mental health groups.

Taken together, the findings from these studies provided the impetus for validating this method with information collected from childhood to adulthood. Thus, the present study used data from the National Child Development Survey (NCDS), a British national birth cohort, to test the validity of the order and qualitative differences between adult group types identified by Keyes (2002). Based on consistent evidence suggesting that risks for adult mental health status begin in childhood (Rutter, Kim-Cohen, & Maughan, 2006; Schoon, Sacker, & Bartley, 2003), a developmental-contextual perspective is likely to be fundamental in validating the mental health groups.

Developmental-contextual approach to mental health and well-being

Many studies have established that mental ill-health is heavily influenced by continuities in and interrelationships between adverse psychosocial and environmental factors from childhood and adolescence (Rutter et al., 2006; Schoon et al., 2003). A developmental-contextual perspective provides the framework to consider the influence of individual characteristics and social environment in early life on the likelihood of positive and negative outcomes in adulthood (Elder, 1985; Lerner, 1996; Schoon, 2006; Schoon & Bynner 2003). For example, findings from previous studies suggest that social risks during childhood and adolescence (e.g., disadvantages within the social environment) influence subsequent behaviour and psychosocial functioning (Bynner, Joshi, & Tsatsas, 2000; Schoon, 2006; Schoon et al., 2003). Socio-economic conditions and material resources within the family context, such as financial hardship, overcrowding, and access to basic amenities, have been identified as key factors in the development of individual-level abilities (e.g., educational attainment), as well as the occurrence of behavioural problems (e.g., truancy and contact with the police) (Bolger, Patterson, & Thompson, 1995; Schoon, 2006). In turn, abilities and behavioural problems are known to have long term effects on family formation and employment (Schoon & Parsons, 2002a; Schoon et al., 2003).

Consideration of the social environment which primarily revolves around the family context during childhood and adolescence can elucidate influential resources and opportunities (Williams, Karls, & Wandrei, 1989). Interactions between family members (e.g., parental divorce or separation, relationships with siblings) are likely to be important for social and health outcomes (Flouri 2004; Sigle-Rushton, Hobcraft, & Kiernan, 2005). In addition, participation in social activities may indicate the level of engagement with others within and outside of the family at individual, interpersonal, and societal levels (Keyes & Shapiro, 2004).

Study aims

The present study seeks to address three aims: (1) to identify the distribution across mental health and well-being categories in a general population sample; (2) to identify the differences in individual and social developmental factors in childhood and adolescence that predict placement along the sequence of categories; and (3) to identify differences between the categories in concurrent physical health and social functioning. We posit that there will be evidence of a gradient in developmental factors and concurrent aspects of functioning across the sequence of categories. Where possible, attempts were made to conceptually represent key aspects of the categories (e.g., life satisfaction, general happiness with life circumstances, self-efficacy or mastery, and autonomy). Further, we rely on the developmental and contextual indicators and concurrent social and physical functioning to inform any conclusions made about the sequence of the categories.

Methods

The National Child Development Study (1958 cohort) is a prospective study of over 17,000 live births in Great Britain during

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