

CHAPTER 5:

A whole-of-lifespan approach to mental health and mental illness

Our understanding of the development of mental health across the lifespan is based largely on our knowledge of the development of mental illness; unfortunately we know much less about the aetiology of mental health. However, the recent, and growing, emphasis on mental health promotion and the consequent development and evaluation of mental health programs and indicators will facilitate advancing knowledge in this area.

In contrast, our understanding of mental health problems and mental disorders is increasingly well developed. Most mental health problems and mental disorders develop along a pathway, or trajectory, with gradually increasing frequency and severity of symptoms, and there are often no clear-cut stages where a disorder is not present at one moment and present at the next (Coie et al. 1993). Some disorders develop slowly over time, such as some drug use disorders, while others can be episodic in nature, such as schizophrenia and depression. Other disorders may develop very quickly following a major trigger event. A severely traumatic event may trigger anxiety, depression or post-traumatic stress reactions in people who would otherwise not experience a mental health problem.

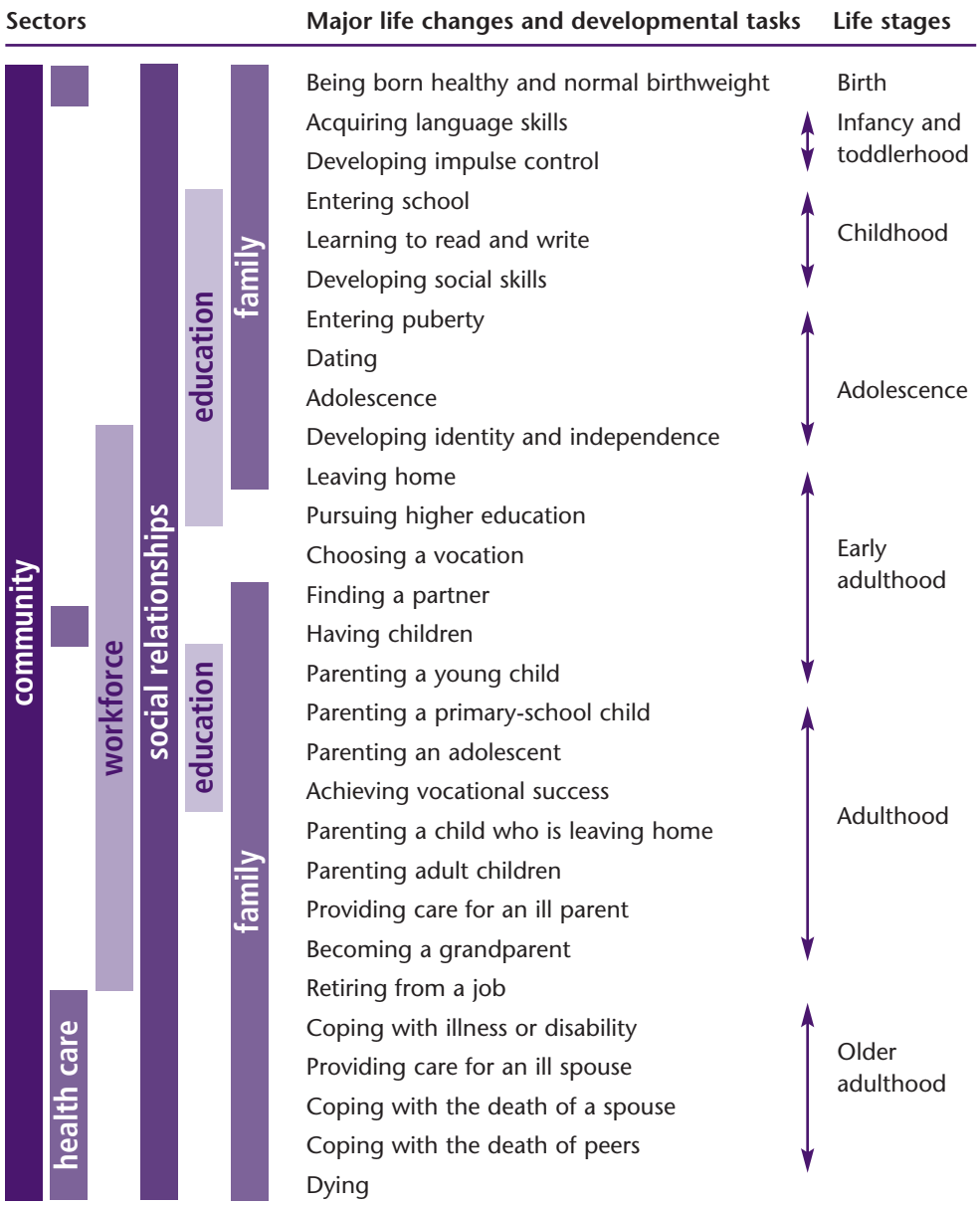
A whole-of-lifespan approach informs our understanding of the development of mental health problems and mental disorders and thereby informs our understanding of appropriate interventions. The earliest signs and symptoms of a disorder may occur at any time throughout the lifespan, but there are periods when the occurrence of particular mental health problems or mental disorders is more likely. The nature and timing of prevention and early intervention depends not just on the individual's age, but on the identified pathways to mental health problems and mental disorders, and the risk factors and critical transition points that characterise those pathways.

An optimal mix of interventions across the spectrum is needed to improve the social and emotional wellbeing of all Australians, and the nature of the combination of interventions will change as knowledge accumulates (Offord et al. 1993). While mental health promotion is always relevant, regardless of current or future health status, prevention must occur before the onset of disorder, and early intervention must occur at the point where there are signs and symptoms suggesting an at-risk mental state or indicating a first episode of mental illness.

Mental health across the lifespan

While the factors that support mental health are not as well understood as those that influence mental illness, Figure 2 presents the developmental tasks that are generally considered to be important to wellbeing across the lifespan for people in western cultures. Successful negotiation of these life changes and developmental tasks enhances mental health for many people, however, it is important to understand that many individuals do not follow this life course and, provided they live within a community that supports diversity of life choices and opportunities, their mental health is not adversely affected. Conversely, unsuccessful negotiation of these developmental tasks can indicate higher risk for mental illness for many people.

Figure 2: Developmental tasks across the lifespan



Source: Adapted from Mrazek & Haggerty (1994) p. 224, which was adapted from Kellam SG, Branch JD, Agrawal KC, Ensminger ME 1975, *Mental Health and Going to School*, University of Chicago Press, Chicago.

Mental health promotion is relevant across the entire lifespan, regardless of current health status. Effective mental health promotion enhances the structures and supports that enable people of all ages to live safe, productive and fulfilling lives and to effectively negotiate their life course. It is fundamental to the mental health of whole communities as well as their individual members, and optimises opportunities for effective prevention and early intervention. A mentally healthy community supports and nurtures individuals and families through empowering people to develop the environments that promote subjective wellbeing, optimal development, the use of skills, and the achievement of individual and collective goals.

Mental health problems and mental disorders across the lifespan

Infancy and childhood

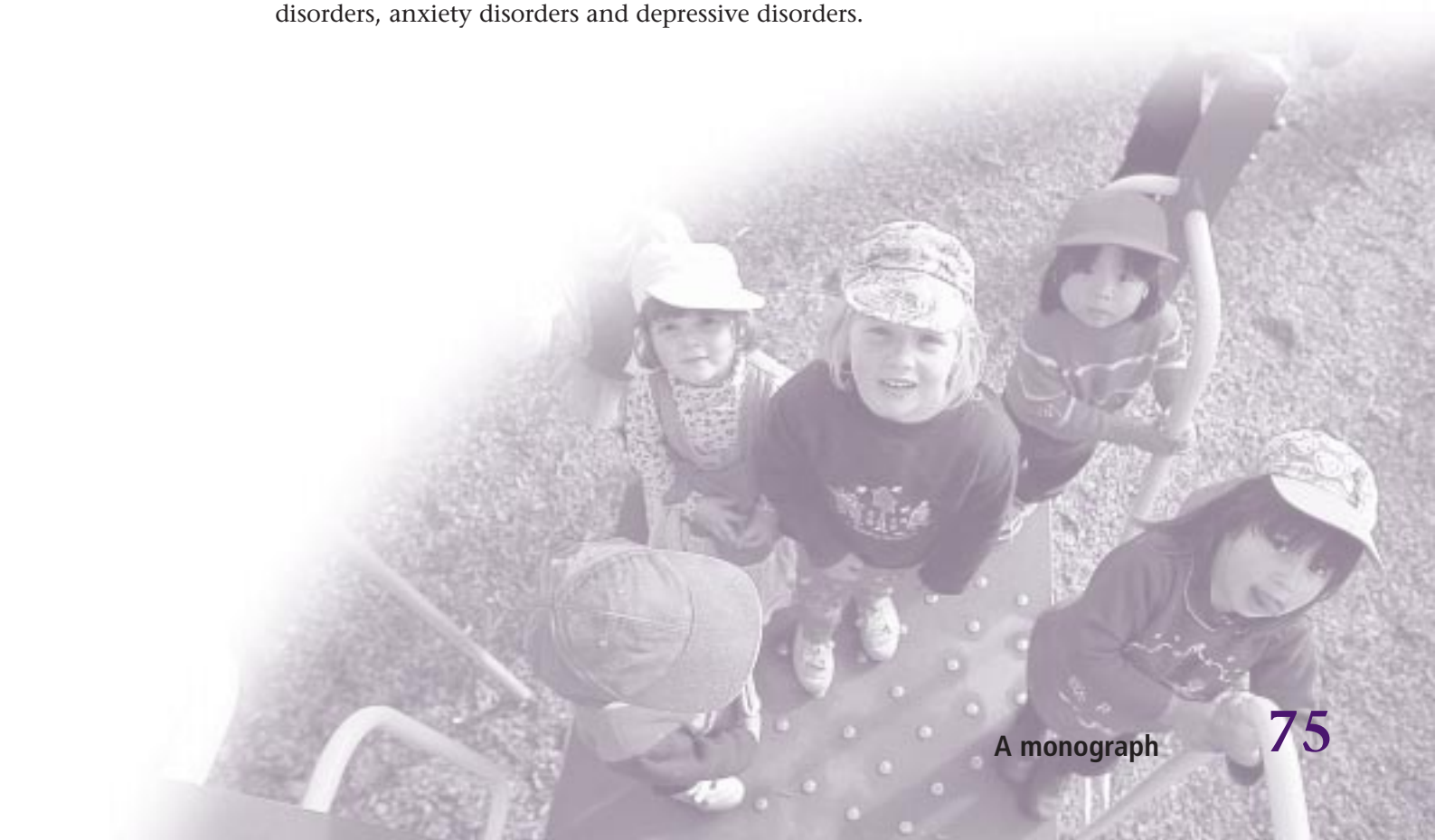
There is now evidence showing that the quality of nourishment and nurturing in the early years has far-reaching effects (Keating & Hertzman 1999). Major influences on an infant's wellbeing that help to prevent mental health problems and mental disorders later in life include sound maternal and perinatal health, adequate nutrition, secure attachment between infant and caregiver, and knowledgeable, skilled and competent caregivers who have access to support services and networks.

Possible risk factors for adverse mental health outcomes include low infant birthweight and birth complications; poor infant health; insecure attachment; inadequate cognitive stimulation; abuse and neglect; mental or physical health problems in the mother; parental substance misuse, mental disorder and criminality; and poverty. Developmental disorders, intellectual disability and genetic factors may also contribute. Children with developmental disabilities are particularly vulnerable to adverse mental health outcomes when they experience further risk factors through their family and social environments, and are protected from adverse outcomes by supportive family and social environments (Centre for Community Child Health 2000).

Experiences in childhood lay the foundation for mental health later in life. There is very clear evidence showing the continuity of disorders between childhood, adolescence and into the adult years (Heijmens Visser et al. 2000; Rutter & Smith 1995). Many prevention activities for mental health problems are therefore ideally placed in childhood. This can have the most effective impact on the developmental trajectory of mental disorders and other psychosocial outcomes, the possible cumulative effect of risk factors and the development of resilience (Department of Human Services 2000).

Prevention interventions for children are not necessarily targeted directly at the child. Interventions need to improve the environment experienced by the child so that the range of factors that can enhance resilience is supported; interventions need to increase the protective factors and reduce the risk factors within the environment. Consequently, interventions that improve the parenting skills, mental health and socioeconomic status of parents can prevent the development of mental health problems in children.

Signs and symptoms of mental health problems can be evident very early in life, although, before the ages of 3 or 4 years, risk factors for mental health problems and mental disorders, rather than actual manifestations of disorder, are more likely to be evident. Mental disorders account for 16 per cent of the disease burden in children aged 0–14 years (Mathers, Vos & Stevenson 1999), and mental health problems become increasingly prevalent during childhood. According to the 1993 Western Australian Child Health Survey, nearly one in six 4–11-year-olds have had a mental health problem compared with more than one in five 12–16-year-olds, within a 6-month period (Zubrick et al. 1995). In the recent child and adolescent component of the National Survey of Mental Health and Wellbeing, 14 per cent of children aged 4–17 years had a mental health problem in a 12-month period (Sawyer et al. 2000). This overall prevalence rate is somewhat lower than other surveys, due to methodological differences. Specifically, in the national survey, the data for children were collected from parents only, while the data for young people were collected from both the young people themselves and their parents, yet these two sources of information are not reported in combination (Raphael 2000b). Generally the earliest signs of mental disorder to emerge in childhood are those related to attention deficit hyperactivity disorder (ADHD), conduct disorders, anxiety disorders and depressive disorders.



A child showing behavioural problems lacks or has insufficient control over behaviour that is expected in a given setting and is appropriate to the child's age. Two general categories of behavioural problems are frequently differentiated: ADHD and conduct disorders. When evident in childhood, these are generic risk factors for later mental health problems and are therefore vital for prevention and early intervention.

ADHDs generally emerge earlier in childhood than conduct disorders. Australian studies have shown prevalence rates for ADHD ranging between 2.3 per cent and 11.2 per cent (Glow 1980 cited in NHMRC 1997a; Sawyer et al. 2000). In the recent child and adolescent component of the National Survey of Mental Health and Wellbeing, 19.3 per cent of boys and 8.8 per cent of girls aged 6–12 years, and 10 per cent of boys and 3.8 per cent of girls aged 13–17 years were identified with ADHD through parent reports, in a 12-month period (Sawyer et al. 2000). In the United States, the prevalence of ADHD has been estimated to be as low as 3–5 per cent (APA 1994; Barlow & Durand 1995) and as high as 15–20 per cent at the elementary (primary) school level (Gordon & Asher 1994).

Children are most likely to present for assessment and treatment for ADHD around 8–9 years of age (Hazell 1998). Parents retrospectively report, however, that specific symptoms of ADHD have been present for about three years (Hazell, McDowell & Walton 1996) and many can describe arousal problems dating back to infancy. ADHD is one of the main reasons that children are seen in mental health services, comprising up to 40 per cent of child referrals (Barlow & Durand 1995; DuPaul & Stoner 1994). Boys outnumber girls 6 to 1 in clinical settings and 3 to 1 in the community generally (Barlow & Durand 1995). While care must be taken in interpreting the figures, as diagnostic criteria have changed considerably over time, it appears that over half of all children with ADHD will continue to have some manifestation of the disorder in adulthood (Barkley 1995).

Disruptive behaviour in early childhood increases the risk of conduct disorder, substance misuse and criminality later in life (Satterfield et al. 1994; Moffitt 1990; Moffitt & Harrington 1994). There is evidence that preschoolers who show high levels of noncompliance and aggression at age 4 are at increased risk for conduct disorder (Conduct Problems Research Group 1992). Conduct disorder includes delinquent behaviour and is defined as a 'repetitive and persistent pattern of behaviour in which the basic rights of others or the major age-appropriate society norms or rules are violated' (APA 1994, p. 85). The child and adolescent component of the National Survey of Mental Health and Wellbeing revealed 4.8 per cent of boys and 1.9 per cent of girls aged 6–12 years, and 3.8 per cent of boys and 1.0 per cent of girls aged 13–17 years with conduct disorder through parent reports, in a 12-month period (Sawyer et al. 2000). Other prevalence rates for conduct disorders in general child and adolescent populations are between 6 and 16 per cent for boys and between 2 and 9 per cent for girls (APA 1994).

Strong support for interventions targeted early in the lifespan comes from research on conduct disorders. As conduct disorders begin to become evident in childhood, prevention and early intervention must occur very early in life, before the full emergence of the disorder. It is especially important to prevent conduct disorders because they are potential markers for long-term mental health problems and are a considerable burden to both the individual and the community. Conduct disorders have been shown to be extremely difficult to treat effectively, although this may be because families only seek assistance when their child's problem has become severe and is of long standing (Kazdin 1987, 1991). Evidence is accumulating that programs identifying children earlier in their pathway toward conduct disorder can be effective in both the short and long term (Sanders & Markie-Dadds 1996).

Internalising disorders such as depression and anxiety often have their earliest signs in childhood (Jaycox et al. 1994). Anxiety disorders are the most common mental health problem in childhood (Kashani & Orvaschel 1990) and if left untreated, they tend to persist: many adult psychological disorders can be traced back to anxiety disorders in childhood (Mattison 1992). Epidemiological studies have found prevalence rates of around 8 per cent for clinically significant anxiety problems in children (Bernstein & Corchardt 1991, cited in Cotton & Jackson 1996). Surveys of children using self-report questionnaires show rates of childhood anxiety disorders in the general population range from 17 to 21 per cent (Anderson et al. 1987; Kashani & Orvaschel 1988, 1990), and around 8 per cent of children will require treatment (Spence & Dadds 1996).

Rates of depression increase with age until early adulthood (Commonwealth Department of Health and Aged Care & AIHW 1999). Depressive disorder is rare in children of preschool age, with studies reporting a very low 0.9 per cent in a clinic sample (Kashani & Carlson 1987) and 0.3 per cent in a community sample (Kaplan, Sadock & Grebb 1994). Between 2 and 11 per cent of 6–11-year-olds are reported to have experienced major depressive disorder (Cohen et al. 1993). The child and adolescent component of the National Survey of Mental Health and Wellbeing reported 3.7 per cent of boys and 2.1 per cent of girls aged 6–12 years, and 4.8 per cent of boys and 4.9 per cent of girls aged 13–17 years with depressive disorder through parent reports, in a 12-month period (Sawyer et al. 2000). Childhood depression can be the antecedent of depression in adolescence (Kovacs et al. 1984).

Adolescence and young adulthood

Many first episodes of mental disorder occur in mid- to late adolescence and young adulthood (Rutter & Smith 1995). Most mental disorders—depression, substance use, anxiety disorders (Commonwealth Department of Health and Aged Care & AIHW 1999) and psychosis (EPPIC 1997)—have their peak period of incidence at this stage of the lifespan. Only behavioural disorders have their onset earlier in life and the dementias later in life. Mental disorders account for a substantial 55 per cent of disease burden in young people aged 15–24 years (Mathers, Vos & Stevenson 1999).

Anxiety disorders are the most common mental health problem in adolescence (Kashani et al. 1989). Such disorders are also very likely to be comorbid with depression, substance misuse and disruptive behaviour disorder in young people (Schatzberg et al. 1998; Anderson et al. 1987).

Around 20 per cent of young people in the community suffer from depressed mood, with up to 43 per cent reporting that they felt sad for at least two weeks in the past year (Cubis 1994). Five per cent of young people suffer from a depressive disorder and the prevalence of current major depressive disorder was found to be 2.7 per cent (NHMRC 1997b). In around two-thirds of cases of major depressive disorder, anxiety tended to precede the onset of the depressive disorder and persist after the depression (Kovacs et al. 1989).

Substance misuse disorders emerge in adolescence and peak in late adolescence and early adulthood, before gradually declining throughout adulthood (Andrews et al. 1999).

A similar pattern is evident for psychotic disorders (EPPIC 1997). Psychotic disorders generally occur after puberty, with peak age of onset in the early to mid-twenties for males and mid- to late twenties for females (Lewine 1988). These disorders affect about one per cent of the population.

Eating disorders are strongly related to age and gender, with young women being most affected (Franko & Orosan-Weine 1998). They tend to have a chronic, fluctuating course and can persist for years (Collings & King 1994). The most commonly reported eating disorders are anorexia nervosa and bulimia nervosa, which affect around 1.8 per cent and 0.4 per cent of women, respectively (Wade et al. 1997). Around one per cent of adolescents experience eating disorders (Kurtz, Thornes & Wolkind 1996). These disorders are very rare in males.

Suicidal behaviours are rare in childhood, emerge in early adolescence and increase until the mid-teens (Patton et al. 1997; Zubrick et al. 1995, 1997). Between 5 and 10 per cent of young people from early teens to mid-twenties report making a suicide attempt in any one year (Martin 1995; Zubrick et al. 1995, 1997). Suicide is at one of its highest levels in early adulthood (Cantor,

Neulinger & De Leo 1999; Cantor et al. 1998). Suicide is a leading cause of death in Australia, with Australian Bureau of Statistics figures showing that in 1998, 2,683 deaths (2,150 males, 533 females) were attributed to suicide (Commonwealth Department of Health and Aged Care 2000).

The disruptive and disabling effects of mental health problems and mental disorders are exacerbated by the mid- to late adolescence and early adulthood developmental period in which most mental disorders first occur (Kosky & Hardy 1992). This is a critical developmental period in the lifespan, particularly in terms of social and emotional wellbeing. In all developmental domains—social, emotional, physical and cognitive—major changes are occurring that determine outcomes in adulthood. For example, the process of separation from parents and the establishment of an independent individual identity occurs, critical educational and vocational decisions are made, and peer group affiliations and intimate relationships are formed. All these processes have major long-term influences on the individual.

The onset of even a relatively mild mental health problem at this time can have profound effects through crucial psychosocial changes. For example, mental health problems can reduce educational and vocational attainments, which can have ongoing consequences in adulthood (Kessler et al. 1995). Having a major mental disorder at this time can cause serious immediate and ongoing problems, with substantial disruptive effects on identity formation and the establishment of adult roles (Raphael 1986). Both the family and the individual affected can experience considerable trauma and multiple losses. Evidence shows that major damage can occur to the social and family environments and vocational prospects of a young person with psychosis for whom effective treatment is delayed (Moscarelli, Capri & Neri 1991). Similarly, for depressive disorders, the associated social withdrawal can have a major impact on adult life through reduced social and vocational opportunities (Brown & Harris 1978; Crowther 1985).

Furthermore, it is during this period that health-related behaviours are formed that are carried into adulthood. With growing independence from parents, young people become increasingly responsible for their own health actions and help-seeking behaviours. Young people monitor their own health status and take the health actions that they themselves choose and initiate. They may not, at times, be able to recognise accurately their mental status and generally do not define symptoms as requiring professional or external help. Only a very small proportion seek help from professional services; young people tend to seek help from friends or family, or try to deal with problems themselves. For example, in the Western Australian Child Health Survey, only 2 per cent of the 4–16-year-olds with mental health problems had been in contact with mental health services in a 6-month period (Zubrick et al. 1995). The child and adolescent component of the National

Survey of Mental Health and Wellbeing revealed that only 29 per cent of children and adolescents with a mental health problem had been in contact with a professional service of any type in a 12-month period, which included health, mental health and educational services (Sawyer et al. 2000). Despite the importance of adolescence and early adulthood in the aetiology of mental health problems and mental disorders, young people tend to be poorly informed, and improving the mental health literacy of young people is of vital importance for mental health.

Adulthood and older adulthood

After peaking in late adolescence and early adulthood, the prevalence of most mental disorders decreases with age (Commonwealth Department of Health and Aged Care & AIHW 1999). The incidence of new mental disorders also declines, and many disorders in adulthood are a recurrence of earlier mental health problems. Mental disorders account for 17 per cent of the disease burden in adults aged 25–64 years (Mathers, Vos & Stevenson 1999).

The 1997 National Survey of Mental Health and Wellbeing revealed that when considering the most common mental disorders of anxiety, affective and substance use disorders, anxiety disorders were the most prevalent (Andrews et al. 1999). They had affected just under one in ten adults in the past 12 months, followed by substance use disorders and then affective disorders. However, men were more likely than women to have a substance use disorder and women were more likely than men to have an anxiety or affective disorder.

For adults, stressful life events are strongly associated with the onset of mental health problems and mental disorders. In half the cases of depressive disorder, an external stressor was found to precede the depression (Judd 1997). Divorce and bereavement are particularly significant events (e.g. Raphael 1977). A period of involuntary unemployment can also be an adverse life event that contributes markedly to mental health problems and mental disorders. Imprisonment is another adverse life event that can have a negative effect on mental health. Of special concern, suicide is the leading cause of death in Australian prisons, and this risk is greater for younger people, Aboriginal peoples and Torres Strait Islanders (Dalton 1999).

Postnatal depression is a disorder of major concern to women of childbearing years. The 'blues', or brief episodes of depressed mood and tearfulness, occur in 50–70 per cent of women within one to ten days of childbirth (NSW Health 1994). The presence of the 'blues' is related to subsequent development of postnatal depression (Cooper & Murray 1998). Ten to 15 per cent of women will suffer a major depressive episode within the first 3–6 months of childbirth (O'Hara 1987). Postpartum psychosis is a rare but potentially very damaging disorder to both mother and child, and affects about two women per thousand deliveries (Boyce & Stubbs 1994).

There is also substantial evidence that the rates of mental disorders are higher among those who have physical impairments, cancer, chronic conditions such as arthritis, or are experiencing the effects of a stroke (Jorm 1995). Studies in primary care settings confirm the link between physical illness and mental disorder, particularly depression (Coulehan et al. 1990). People with severe physical illness are more likely to develop a mental disorder, and when physical illness is present, symptoms of mental disorder are more severe (Kisely & Goldberg 1996).

Mental disorders account for very little of the disease burden in adults aged over 65 years, although senile dementias account for 7.2 per cent (Mathers, Vos & Stevenson 1999). The 1997 Survey of Mental Health and Wellbeing estimated the total prevalence of common mental disorders to be about 6 per cent among those aged 65 years and over. An additional 6 per cent are estimated to have dementia. Dementia is recognised as a major contributor to the mental health problems of older adults.

The prevalence of mental health problems and mental disorders varies considerably, depending on the living arrangements of older adults. Older people who live in the community experience the best mental health across the adult lifespan in Australia. However, in hostels and nursing homes, over 28 per cent and 60 per cent of residents, respectively, have some form of dementia (Rosewarne 1997). Depressive symptoms and disorders are also more common in these settings (Parmalee, Katz & Lawton 1989). This does not mean that living arrangements determine mental health for older people, but rather that there are complex interrelationships whereby older people in residential care settings are more likely to have complex health problems and experience a range of risk factors, such as disability and social isolation, that increase the likelihood of mental health problems.