Research Article
Mental Health Promotion in College Student based on Positive Psychology

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Abstract: The aim of this study is to analyze the status of mental health promotion in college student and the role of positive psychology in promoting mental health in college student. Mental disorders account for a large proportion of the disease burden in college student in all societies. Positive psychology is the study of such competencies and resources, or what is "right" about people-their positive attributes, psychological assets and strengths. The research results proved that positive psychology was useful for mental health promotion in college student.

Keywords: College student, mental health, positive psychology

INTRODUCTION

Youth is the stage at which most mental disorders, often detected for the first time in later life, begin. College students have a high rate of self-harm and suicide is a leading cause of death in young people. A strong relation exists between poor mental health and many other health and development concerns for young people, notably with educational achievements, substance use and abuse, violence and reproductive and sexual health. The risk factors for mental disorders are well established and substantial progress has been made in developing effective interventions for such problems. Yet, most mental-health-service needs are unmet, even in wealthier societies and the rate of unmet need is nearly 100% in many developing countries. Furthermore, there is a dearth of interventions to prevent mental disorders and promote mental health (Jané-Llopis et al., 2005; Jané-Llopis, 2007; Zhaoyuan and Liangzhu, 2011).

Positive psychology is the study of what is ''right'' about people-their positive attributes, psychological assets and strengths. Its aim is to understand and foster the factors that allow individuals, communities and societies to thrive. Cross-sectional, experimental and longitudinal research demonstrates that positive emotions are associated with numerous benefits related to health, work, family and economic status. Growing biomedical research supports the view that positive emotions are not merely the opposite of negative emotions but may be independent dimensions of mental affect (Seligman and Csikszentmihalyi, 2000; Fredrickson, 2001; De Lorenzo and Zollo, 2011).

Thus, positive psychology deserves a place in health promotion and health promotion theory and methods can enhance positive psychology research and

Table 1: Studies of prevalence of mental disorders in college student

	Population size	Prevalence (%)
Australia	5300	12
Brazil11	625	17
Netherlands	390	11
Ethiopia	1500	10
Hawaii	300	9
USA	720	8
India	1032	12
South Africa	250	13
Switzerland	1012	8
UK	1300	9
Australia	2500	10

practice to improve population mental health (La Torre, 2007; Russell-Mayhew, 2006). In this study, we promote the mental health of college student from the view of positive psychology. Also, we analyze the status of mental health promotion in college student and the role of positive psychology in promoting mental health in college student.

THE PROBLEMS

Burden of mental disorders in college student: Many investigators reported prevalence rates of college students' mental disorders in their samples. Furthermore, the prevalence rates have not been stratified to enable the rates applicable to college student to be ascertained (Seligman, 2002). To summaries the data for our age-group of interest is therefore difficult. We tried to identify a set of community epidemiological studies undertaken since 1995 that included a substantial sample and used structured diagnostic instruments to establish Diagnostic and Statistical Manual of Mental Disorders or International Classification of Diseases diagnoses (Table 1). Rates of mental disorders ranged from 8% (in the Netherlands) to 57% (for college student receiving services in five sectors of care in San Diego, California,

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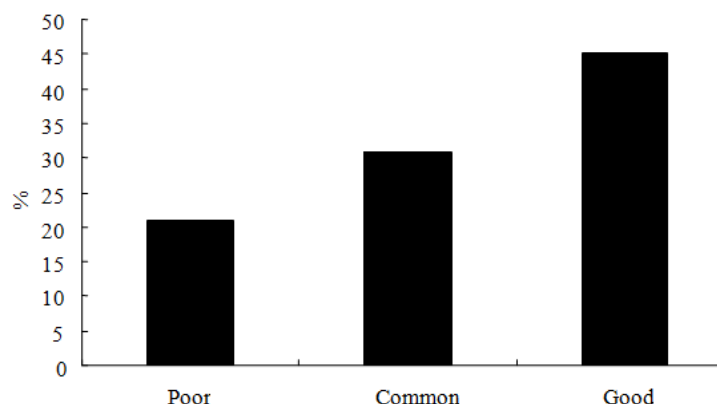
Fig. 1: The status of mental health in Chinese college student

USA). The Australian National Survey of Mental Health and Well Being reported that at least 14% of college students were diagnosable with a mental or substance use disorder in 12 months. Taking these studies together, at least one out of every four to five college student will suffer from at least one mental disorder in any given year, although much less information is available on burden in developing countries and substantial cross cultural variations are evident. Another way to show the burden of mental disorders in college student is through disability-adjusted life years (DALY). Five of the ten leading causes of DALY in people are mental disorders-unipolar depressive disorders, alcohol use disorders, self-inflicted injuries, schizophrenia and bipolar affective disorder. In a study from Victoria, Australia, mental disorders in college student contributed to 60-70% of the total DALY, reinforcing the notion that mental disorders are the major contributor to disease burden in this age-group.

Evidence is mixed for whether rates of mental disorders in college student have increased during the past few decades. For example, rates of depression in adolescence have been shown to have increased in the most recent birth cohorts. However, much of the evidence in support of this conclusion is based on recall data, for example an increase in the proportion of adults in recent cohorts that had their first episode by 18 years. Recall bias is inherent in this approach, such that older people are more likely to forget episodes of depression in their youth. This meta-analysis, which included nearly 60000 observations, showed no evidence to support the hypothesis that successive cohorts of children and adolescents report higher rates of depression, at least during the past 30 years. However, a similar review has not been undertaken specifically for college student, particularly those aged 18-24 years. Evidence is available for an increase in the rate of conduct problems in college student in the UK. A consistent increase in the proportion with severe conduct problems took place from the earlier to later cohorts.

Apart from disability, mental disorders might also exact a substantial burden on mortality in college student-in many communities, youth is increasingly a period of heightened risk of suicide. Suicide is a leading cause of death in college students in countries such as China and India. Figure 1 illustrate the status of mental health in Chinese college student. The Indian study ascertained cause of death in a rural community of 108000 people in south India during 10 years from 1992 to 2001. The investigators reported that suicide accounted for a quarter of deaths in boys and between half and three-quarters of deaths in girls. Evidence for whether suicide rates have changed over time is mixed. Rates have increased (especially in boys) for most countries where data are available from the mid-1950s until the early 1990s. This trend has been attributed to increases in the rates of depression, increased firearm availability, the diminishing influence of the family, increased freedom and increased exposure to alcohol and other drugs. However, since the early 1990s, the rate of suicide in college student has decreased in countries in which youth suicide prevention program have been promoted, such as in the USA. This decrease has been attributed by some investigators to efforts to restrict access to handguns, increased use of antidepressant drugs, falls in rates of substance abuse and violence and improved economic circumstances. Whether the high rates of suicide in college student reported from India and China in recent years represents a rising trend or an under-reporting bias in older studies is unclear; some investigators have suggested that the risk is associated with rapid social change. Injuries are another leading cause of death in college student; here too, mental disorders, notably substance abuse, are important risk factors.

Risk factors: Good evidence is available in support of a multifactor cause for mental disorders in college student (Table 2). Poverty and social disadvantage are strongly associated with mental disorder. Evidence for the pathways suggests that this association is complex and bidirectional: growing up in poor household increases the risk of exposure to adversities

Table 2: Selected risk and protective factors for mental health of college student

	Risk factors	Protective factors
Biological	Exposure to toxins (e.g., tobacco, alcohol) in pregnancy	Age-appropriate physical development
	Genetic tendency to psychiatric disorder	Good physical health
	Head trauma	Good intellectual functioning
	Hypoxia at birth and other birth complications	
	HIV infection	
	Malnutrition	
	Substance abuse	
	Other illnesses	
Psychological	Learning disorders	Ability to learn from experiences
	Maladaptive personality traits	Good self-esteem
	Sexual, physical, emotional abuse and neglect	High level of problem-solving ability
	Difficult temperament	Social skills
Social family	Inconsistent care-giving	Family attachment
	Family conflict	Opportunities for positive involvement in
	Poor family discipline	family
	Poor family management	Rewards for involvement in family
	Death of a family member	
School	Academic failure	Opportunities for involvement in school life
	Failure of schools to provide appropriate environment to support attendance and learning Inadequate or inappropriate provision of education Bullying	Positive reinforcement from academic achievement Identity with school or need for educational attainment

such as scarcity of food, poor nutrition, violence, inadequate education and living in a neighborhood characterized by absence of social networks, all of which are risk factors for mental disorder. Conversely, mental disorder contributes to educational underachievement, loss of employment and increased health-care costs. Students living in families with parental mental disorder or substance abuse, discord between parents, marital violence and breakdown, are at greater risk of mental disorders. Unsurprisingly, violence and child abuse are major risk factors; most sexual violence takes place in the context of trusting relationships (for example, peers or relatives), whereas most violence in general takes place in the school or community; in both instances, older peers are the most frequent perpetrators. In married college student, husbands and in-laws are the most common perpetrators of violence and harassment of young women. An educational pressure, especially in the context of limited employment opportunities for out-of-school students, is a risk factor for suicide and poor mental health. Some people are historically disadvantaged, notably the indigenous people of many countries, migrants from rural to urban areas, internally displaced people and refugees. For example, suicides in aboriginal people in Queensland, Australia, between 1990 and 1997 contributed disproportionately to the suicide rate for the state as a whole, especially for young aboriginal males-though only 4% of the population in this age-group, aboriginal males contributed 16% of the suicide deaths. The central theme is the lack of control that college student in these groups might have in their lives. Cultural factors are a major influence on mental health, as evidenced by the large variations in the prevalence of mental disorder between different cultures; for example, rates of mental

disorder in college student of English origin in the UK are four times greater than those of Indian origin.50 Some cultural factors might be protective, for example parental involvement in college student's decision-making and the tendency to form friendships within one's cultural group, whereas others might have the opposite effect, such as restricted autonomy for women in decision making. The emphasis on certain body shapes, fuelled by the fashion industry-which views college student as a major market-is probably a factor in explaining the finding that eating disorders are more common in developed countries. New evidence suggests that the globalization of the media is associated with an increase in eating disorders in societies in which they were previously rarely seen.

Although the final pathway for mental disorders might involve a neural basis, the precise nature of this neural basis remains unclear. Reviews and reports of histological and brain-imaging studies support the notion that brain development, with changes in structure and cognition, is evident in youth. However, how these changes relate to mental disorders associated with adolescence is uncertain. Strong evidence is available for the contribution of genetic and biological factors, particularly for depression, psychoses and severe behavior disorders. Adolescents who have a history of difficult and disruptive behaviors from childhood have a high rate of neurocognitive impairments. Neurological disorders, such as epilepsy and developmental disorders, such as learning disabilities, are also associated with an increased risk and neuroanatomical abnormalities are associated with psychoses. Genetic and biological factors interact with shared (such as family environment) and non-shared (such as school) environmental factors, to modify the risk of mental disorders. For example poor attachment

and family discord affect the timing of the onset of puberty, which in turn, could contribute to conflict with parents, low self-esteem and associations with deviant peers. A characteristic feature of the most common mental disorders in college student is the sex differences: young women are 1·5-3 times more likely to have depressive disorders and attempt self-harm, whereas young men are several times more likely to suffer from conduct or behavior disorders and schizophrenia. These variations might be due to differences in the rates of exposure to biological and environmental risk factors and different interactions between these factors in the sexes. An interaction between genetic and environmental factors, for example, might explain the increased risk of behavior disorders in boys. A differential rate in exposure to environmental factors may explain the enhanced risk of depression and self-harm in young women; for example, the high rates of gender based violence experienced by young women. Lewin applied his interactions mathematic formula to explain group phenomena:

$$B = f(P, E)$$

where, a member's personal characteristics (P) interact with the environmental factors of the group, (E) its members and the situation to elicit behavior (B). It demonstrate that people's behavior closely relate with environment.

We wish to emphasize that most college student do not have any mental disorder-even most of those who face severe adversities and multiple risk factors remain in good mental health. Protective factors are crucial to understanding how the effect of risk factors can be modified and even eliminated. Recent cross-national research from the USA and China has shown the universal role of protective factors in mitigating the risks for risk behaviors (such as delinquency, problem drinking and substance abuse) in adolescents. These factors were shown to account for a substantial proportion of the variation in problem behaviors in both settings; not only was the size of protection (and risk) similar, but the same measures of protection and risk were related to the problem behaviors in a similar way. In both settings, protective factors played a powerful role in mitigating the effect of risk factors for problem behaviors, suggesting the importance of these factors in promoting mental health.

College students' mental health matters in all countries: It is ironic that, although substantial investment has been made in mental-health promotion and interventions for college student in many developed countries, no equivalent acknowledgement of mental health needs of college student exists in developing countries. The priorities for college student seem to be different in rich and poor countries. We disagree with this dualism. College student in every society have mental health needs; it is imperative that youth mental health is actively supported and championed by international youth health-promotion program and donors. The intersectional nature of youth health is an asset to be maximized: youth mental health is not just a psychiatric issue, but affects all sectors of society.1 Apart from the arguments about burden and effective interventions, the interface of youth mental health with other important social and public-health policy priorities, for example, crime, suicide, HIV/AIDS, education and economic productivity, should provide the necessary case to achieve such a shift in attitudes.

Country-level models now exist to show such commitment: In New Zealand for example, youth concerns have been integrated within all policy formulation and all government policies are informed in relation to college student, based on principles of youth development, participation and multispectral involvement. The key to promoting youth mental health is through strengthening of the fundamental nurturing qualities of the family system and community networks while explicitly acknowledging the rights of college student. Such action would mean recognition of families and communities as major players in determining the mental health of college student. College student themselves must be at the centre of all policy-making, focusing on their concerns. Many college student face difficulties of livelihood, emotional security, education and violence and our attention must address these concerns. Policies must explicitly address strengthening capacity for addressing youth mental disorders in family settings, educational settings, in primary health care and in specialist mental health care.

MATERIALS AND METHODS

Positive psychology is the study of such competencies and resources, or what is "right'' about people-their positive attributes, psychological assets and strengths. Its mission is to understand and foster the factors that allow individuals, communities and societies to thrive.5,6 It complements theories and models of individual, community and organizational deficits with theories and models of assets.7 Positive psychology offers new approaches for bolstering psychological resilience and for promoting mental health and thus may enhance efforts of health promotion generally and of mental health promotion specifically. Similarly, clinical psychiatry and psychology have been successful in identifying, classifying and treating mental illness and disorder, resulting in better quality of life for many. However, just as the 1986 Ottawa Charter for Health Promotion13 shifted greater attention in public health from disease prevention to health promotion, positive psychology

shifts attention from pathology and dysfunction to positive emotions and optimal functioning. Underlying both of these shifts are the fundamental views that health is more than the absence of illness and that fostering individual and social resources can lead people, organizations and communities to thrive (Bull, 2008).

In public health, this shift has also become evident in the field of mental health promotion, seen as an integral part of health promotion practice. Common to both mental health promotion and positive psychology is a focus on ''positive mental health,'' an empowering resource, broadly inclusive of psychological assets and skills essential to human fulfillment and well-being. Activities and programs that foster positive mental health also help to prevent mental illness, highlighting the benefits of mental health promotion to overall population health. Assessment of positive mental health and related outcomes such as well-being can help in supporting and evaluating health promotion and public health wellness initiatives. Thus, positive psychology deserves a place in health promotion and health promotion theory and methods can enhance positive psychology research and practice to improve population mental health (Linley and Joseph, 2004).

Whereas discourse on human fulfillment is rooted in ancient Western and Eastern philosophy, as well as in more recent disciplines of human development and humanistic and educational psychology, positive psychology applies a common language. Figure 2 showed that the study area of positive psychology. This contrasts with post---World War II psychology, which concentrated on repairing damage using the prevailing disease model of human functioning (i.e., mental ill health), while largely ignoring psychological assets (e.g., courage, kindness) and positive aspects of behavior (e.g., responsibility, compassion) that could also assist in therapy. The focus on mental ill health-its causes, symptoms and consequences-resulted in stigma associated with these factors, euphemistic use of the term ''mental health'' to describe treatment and support services for people with mental illness and vague language, especially among the public, about what mental health means. Positive psychology does not claim that mainstream psychology is negative or less important because it focuses on pathology and mental illness. Its aim is not to deny the distressing or unpleasant aspects of life; the value of negative experiences on human development, coping and creativity; or the critical need to ameliorate distress. Despite what its critics say, positive psychology seeks to provide a more complete scientific understanding of the human experience-including positive and negative experiences-to better integrate and complement existing knowledge about mental illness with knowledge about positive mental health. Researchers have addressed these critics' objections, which are primarily concerned with adaptation, goals, temperament, heritability,
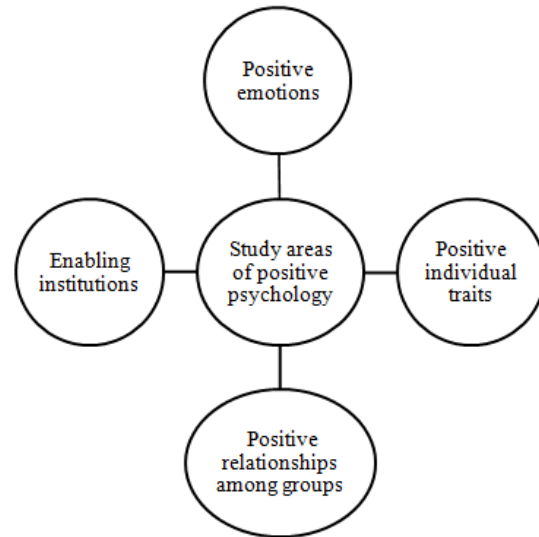

Fig. 2: The study areas of positive psychology

forecasting, recall biases and accurately measuring or intervening on well-being. Research from multiple disciplines suggests that positive mental health and wellbeing can be measured relatively accurately and that appropriately targeted interventions can affect well-being. However, more research in positive psychology that generalizes to the broad population is warranted. Given the benefits of positive emotions, positive psychology parallels efforts in mental health promotion to advance the value of positive mental health in individuals and society. We present a brief overview on the benefits of positive emotions, the recognition and impact of positive individual traits for mental health promotion and the influence of enabling social-environmental factors on positive mental health.

RESULTS AND DISCUSSION

Positive emotion: Many people know about the benefits of negative emotions such as fear, disgust and anger in securing our personal safety and survival (e.g., fight or flight) and the harms of increased stress levels, narrowed responses for action and withdrawal associated with negative emotions. Fewer know that positive emotions (e.g., joy, interest, contentment) quell autonomic arousal, signal approach and safety and prompt individuals to engage with their physical and social environments by exploring new objects, people, or situations. Although sometimes confused with related affective states such as short-term sensory pleasure (e.g., satiety, warmth) and longer-lasting positive moods, positive emotions are typically brief and result from personally meaningful circumstances (e.g., joy from a social encounter). Broaden and Build.

The Broaden and Build theory of positive emotions proposes that positive emotions broaden people's attention, expand cognition (e.g., curiosity, creativity)

and behaviors (e.g., exploration, play) and consequently foster physical, intellectual and social resources (e.g., intelligence, mastery, social competence) for optimal functioning. So, whereas negative emotions are adaptive in the short term, positive emotions may be adaptive in the longer term by building personal resources that play as psychological reserves for continued growth.

Positive individual traits: Positive individual traits include a number of positive dispositions present in individuals to different degrees, such as creativity, bravery, kindness, perseverance and optimism, which, when cultivated, can increase resiliency, buffer against psychological disorder and other adversities and promote mental health. Several methods exist to help individuals improve their resiliency and identify their positive dispositions (Gable and Haidt, 2005; Seligman *et al.*, 2005).

Resiliency and optimism: Resiliency is the process of positive adaptation in the context of adversity or risk. Resiliency helps people to cope with life's challenges and confers a sense of mastery over one's life. Promotion of resiliency can occur within persons (e.g., coping, optimism), among persons (social support) and across social levels (public health or educational systems). Studies of resiliency focus on positive adaptation and achievement and stress the importance of promoting competence through interventions. Substantial public health efforts are designed to promote resiliency among persons and across social levels. For example, prevention programs that safeguard against illness and injury might promote resiliency directly (e.g., vaccinations, nutritional fortification of foods) or indirectly (e.g., after-school programs). The US Administration on Aging supports congregate meal programs through its network of Area Agencies on Aging, not only to provide meals to older adults but also to promote social interaction and social support that may confer greater psychological resiliency. Parenting interventions and preschool interventions are effective in boosting resiliency in mothers and children.

Positive psychology offers several approaches for improving individual resiliency that maybe relevant for public health interventions aimed at schools, worksites, health care settings and Area Agencies on Aging. For example, individuals can change their ''explanatory style''-that is, how they interpret day-to-day events and their interactions with others. Specifically, they can learn skills for more optimistic ways of thinking and reacting to improve their resiliency. Besides certain personality characteristics (e.g., dispositional optimism) and the physical and social environment, explanatory style can predict depression and other negative physical health outcomes. Skills based on learned optimism-such

as challenging beliefs, avoiding thinking traps, calming and focusing and putting things in perspective-can improve psychological resiliency in individuals. These skills closely resemble ''cognitive symptom management,'' effectively used in interventions such as the Chronic Disease Self-Management Program. However, expanding the use of skills like learned optimism to the broad population holds promise for promoting mental health.

Character strengths: With respect to mental illness, professionals have applied a common language and diagnostic criteria to identify and treat mental illness using the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). However, the DSM-IV is explicitly designed to diagnose and treat mental illness but provides no guidance to assess positive thoughts, emotions, or behaviors. In 2000, with growing interest and support from the field of positive youth development, Peterson and Seligman organized a research team to develop a scientific classification scheme comparable to the DSM-IV as well as assessment strategies to identify psychological strengths. After extensively reviewing literature from multiple disciplines, this team considered cross-cultural validity, possible unintended political consequences of their effort (e.g., value-laden applications, such as selecting people on the basis of strengths) and the implications of creating a classification system versus a taxonomy. Team members assumed that character, like traits, was stable and general and that character strengths were not bound to culture. They then identified explicit criteria that guided their classification system to identify character strengths of human goodness and excellence of character (Fig. 3).

Although a comprehensive review of interventions that improve positive emotions is beyond the scope of this essay, practicing gratitude, performing acts of kindness and mindfulness relaxation (nonjudgmental focusing awareness on thoughts, sights and sounds) can increase positive emotions and well-being.

Gratitude helps people to savor their life experiences and situations, maximize satisfaction and enjoyment from those experiences and minimize adaptation. Gratitude might also help people to cope with stress and trauma by positively reinterpreting negative life experiences. Relative to control groups, participants who were asked to write down 5 things for which they were grateful (e.g., cherished interactions, overcoming obstacles) once a week for10 weeks reported greater life satisfaction, more optimism and fewer health complaints. Other gratitude exercises improved positive affect and physical activity, sleep quality and proposal behavior. Students who performed and tracked random acts of kindness increased their happiness relative to that of a control group. Additional examples of interventions that have been shown to increase individual positive emotions and well-being are available, as are examples of their use in schools.
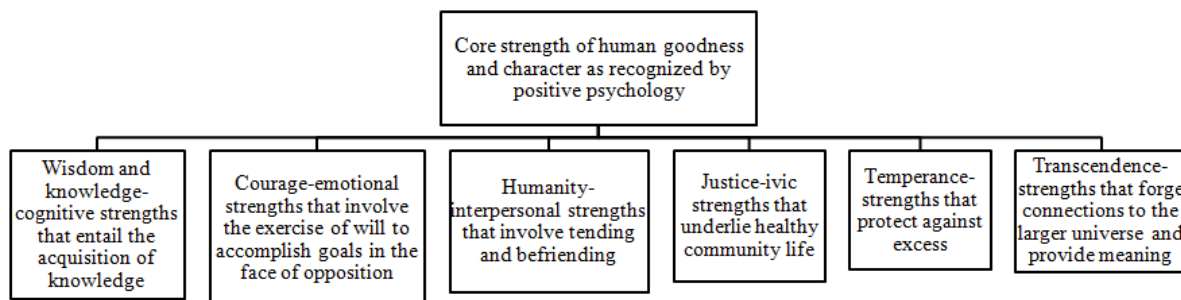
Fig. 3: Core strengths of human goodness and character as recognized by positive psychology

Positive relationships and enabling institutions: Social and economic factors influence health and mental health, including access to employment; safe working conditions; education, income and housing; stable and supportive family, social and community environments characterized by opportunities for autonomy, social inclusion and freedom from discrimination and violence; and taxation of addictive substances to prevent abuse. Institutions such as schools, homes, worksites, places of worship and health care settings that have been traditional targets for public health disease prevention and health promotion interventions also are settings for evidence-based mental health promotion interventions. Policy initiatives that affect social and economic determinants of mental health (e.g., housing, employment) and that support the integration of evidence-based mental health promotion programs in community settings are warranted to improve population health.

For those interested in fostering community or generational change for mental health promotion, Appreciative Inquiry, a method closely aligned with positive psychology, holds promise. Appreciative Inquiry is a systematic development and improvement process for management and organizational change based on deliberately positive assumptions about people, organizations and relationships. Its processes shift the focus and dialogue from problem solving to fostering assets by seeking to examine the strengths in a group, thus providing the starting point for positive change. In a typical appreciative Inquiry session, participants are led through a series of systematic and provocative but affirming questions to identify what is positive in the group and to connect people in ways that heighten energy, vision and action for change.

Appreciative Inquiry has been successfully and innovatively used by numerous private and governmental organizations, including the Cleveland Clinic, the National Aeronautics and Space Administration, the US Navy, Save the Children, the United Nations Global Compact, Imagine Chicago, Imagine Nagaland (India) and the United Kingdom's National Health Service. Nursing has also frequently used Appreciative Inquiry to enhance education, management and clinical care outcomes. It may supplement current health behavior change models for health promotion. For example, health care providers, health educators and other caregivers might incorporate Appreciative Inquiry in their interactions with patients, clients, families, or groups to help them focus on capabilities and competencies related to a healthy lifestyle. A provider might ask a patient a few questions from an Appreciative Inquiry perspective to help motivate behavior change or to help assist in sustaining behavior change. Extensive resources exist to incorporate Appreciative Inquiry principles into daily settings or to more formally structure an Appreciative Inquiry summit for groups or organizations. The implementation and effectiveness of Appreciative Inquiry in health promotion warrants more thought and study.

CONCLUSION

Positive mental health is a resource for everyday living and results from individual and community assets. The health promotion theories, methodologies and populations available through public health partners offer greater reach for positive psychology practitioners to implement and evaluate their interventions across diverse sociodemographic subgroups and community settings that currently receive little attention. Likewise, the asset-based and affirmation paradigms of positive psychology offer additional strategies for mental health promotion. Mental health promotion and positive psychology offer the public:

- An updated way of thinking about mental health that provides for the richness of human experience.
- Additional ways to describe and value the full spectrum of mental health to lessen the stigma associate with mental illness and to initiate conversations about mental health.
- Enhancement of psychological screening.
- Evidence-based individual, community and social interventions that can enhance positive mental health. Ultimately, greater synergy between positive psychology and public health might help promote positive mental health in innovative ways that can improve overall population health.

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