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The inner cabinet: how mental health impacts political decision-making

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Politicians' decisions have far-reaching societal impacts, but the mental health of representatives taking decisions remains overlooked. This article addresses this critical gap by theorizing and analyzing the link between common symptoms of poor mental health and political decision-making. Utilising data from two empirical studies involving 85 UK Members of Parliament (MPs) and a broader group of 128 international MPs, we demonstrate that poor mental health correlates with negative self-evaluations of decision-making, increased risk aversion, and heightened susceptibility to framing effects. Far from questioning the competence of those experiencing mental ill-health, these results highlight an urgent need for institutional reforms and support systems to improve job design, increase the sustainability of political careers, and assure the quality of political outcomes.

Keywords: decision-making; mental health; politicians; political leadership; political outcomes—wellbeing.

The consequences of politicians' decisions—whether taken individually or collectively—are often far reaching and impact on the public in ways that are relatively unique among modern professions. Naturally, this equation assumes that elected representatives are well and sufficiently well-informed to take such decisions. However, a nascent body of empirical research demonstrates that politicians are no different from the general population in their susceptibility to psychological

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distress or common mental disorders (CMDs) (Weinberg 2015; Weinberg 2020a; Smith et al. 2024), and some studies argue that the prevalence of poor mental health among politicians is comparatively higher than documented in other stressful occupations (Poulter et al. 2019). Recent high-profile admissions of poor mental health—from US Senator John Fetterman to Danish Defence Minister Jakob Ellmann-Jensen and Dutch Deputy Prime Minister Sigrid Kaag to name a few—have also brought this topic into sharper focus. In the UK, six MPs cited mental health in their public resignation statements ahead of the 2024 General Election. As Flinders et al. (2020: 256) observe, ‘the health of democracy may, to an extent, depend on the mental health and psychological wellbeing of those we elect to represent and take decisions on our behalf’.

Resulting questions are those pertinent to safeguarding the reasonable capacity of individuals to carry out the role of representing constituents, public interests and indeed whole nations. Perhaps most relevant are questions about the ability of politicians to make the best decisions in office whilst enduring considerable professional and personal pressures. Yet if there are still relatively few studies on the *prevalence* of mental ill-health among politicians, then the primary research base about its *effects* on politicians’ governing behaviour is even scarcer. This absence of research into politicians’ mental health stands in stark contrast to a large volume of psychological research on mass populations. Here, existing evidence suggests that episodes of mental ill-health can reflect or cause atypical energy utilisation, heighten the perceived costs of active behaviour, and impede effective decision-making by increasing risk aversion and reducing openness to change (e.g. Leahy 2001; Huys et al. 2015; for a political science study, see Bernardi and Johns 2021). Underpinning these results is a cognitive link between poor mental health and negativity bias in people’s attention, memory and interpretation of the world around them (e.g. Mathews and MacLeod 2005; LeMoult and Gotlib 2019). Where politicians are experiencing mental ill-health at similar rates to mass populations, then it is reasonable to anticipate they will exhibit similar effects.

The present article takes a step towards addressing this important gap in the literature. Drawing on previously unpublished data and analyses from two unique studies of UK politicians, we present the first empirical test of the link between symptoms of psychological distress and decision-making in political office. Study 1 uses cross-sectional and longitudinal data gathered from 85 UK MPs to assess the association between general mental health and self-evaluations of decision-making efficacy. Study 2 then analyses the link between symptoms of depression and political decision-making in a series of survey experiments completed by 128 MPs drawn from the national parliaments of the UK, Canada, and South Africa. Together, these analyses suggest that poor mental health is linked to (1) negative self-evaluations by MPs of their decision-making in office (Study 1) and (2) heightened risk aversion and susceptibility to framing effects in decision-making scenarios (Study 2).

In what follows, we start by reviewing the psychological literature on the effects of mental ill-health and outline theoretical links to political work. We then present the methods and results of each empirical study. We finish with a reflection on our results and the broader implications for politicians, parliaments, and future academic research. Far from justifying lazy and stereotypical conclusions about the incompatibility of mental ill-health and political work, we argue that our research highlights the imperative for better institutional design and support that helps to improve the sustainability and attractiveness of political careers as well as the efficacy of political outcomes.

1. Mental health and decision-making

Building on [Westerhof and Keyes \(2010\)](#), we approach ‘mental health’ as a conceptual umbrella that includes emotional (i.e. positive emotions), psychological (i.e. positive cognition), and social (i.e. positive relations with others) dimensions of well-being. Any of these facets may become more neutral and/or negative as adaptive features of a healthy life, but where those symptoms (e.g. negative feelings and thoughts about oneself) become pathological, they can impair an individual’s ability to make appropriate and effective decisions ([Mathews and MacLeod 2005](#); [LeMoult and Gotlib 2019](#)). This link between common CMDs, such as depression and anxiety, and decision-making is commonly studied from a cognitive perspective whereby rational updating of our beliefs is affected by ‘a variety of malfunctions in the evaluation of the likely costs and benefits of circumstances and possible actions’ ([Huys et al. 2015: 2](#)).

These impairments include a range of short-term deficits in cognitive performance, such as difficulties with executive functioning, attention and interpretation, working memory, and processing speed ([Chakrabarty et al. 2016](#); [Ahern and Semkovska 2017](#)). Key to these difficulties are negative cognitive schemas ([Beck 1967](#)). Individuals suffering from CMDs endorse more negative and fewer positive adjectives as self-descriptive ([Auerbach et al. 2015](#); [Connolly et al. 2016](#)), interpret ambiguous information more negatively ([Lee et al. 2016](#); [Orchard et al. 2016](#)), exhibit mood-congruent biases in memory that are defined primarily by preferential recall for negative information ([Mathews and MacLeod 2005](#)), experience difficulty inhibiting negative, but not positive, information from working memory ([Goeleven et al. 2006](#); [Joormann and Gotlib 2010](#)), and spend longer attending to negative information in their environment ([Kellough et al. 2008](#); [Armstrong and Olatunji 2012](#)).

A raft of scholarship in psychology has sought to link these symptoms with decision profiles. For example, [Allwood and Salo’s \(2012\)](#) detailed study of three public authorities in Sweden finds that employee stress correlates positively with dependent and avoidant decision-making profiles that are characterized by deference to peers and procrastination. In general population samples, [Bavolar and](#)

Bacikova-Sleskova (2020) find a direct correlation between three mental health indicators (general well-being, depression, and stress) and avoidant decision-making as well as a heightened propensity to draw snap conclusions (see also Bavolar and Orosova 2015). In laboratory and survey experiments, individuals with CMDs display higher error rates and poorer task performance (e.g. Holmes and Pizzagalli 2007; Rock et al. 2014). In these experiments, negative information appears to ‘hijack’ cognitive processing among individuals with CMDs and directs their cognitive resources away from successful task completion (for a discussion, see Gotlib and Joormann 2010).

In politics, a smaller body of research tells a similar story. Political scientists and political psychologists have documented a ‘mental health-participation gap’ (Bernardi 2021) whereby those experiencing poor mental health are significantly less likely to vote (Ojeda and Pacheco 2019; Landwehr and Ojeda 2021). Alongside this, scholars have demonstrated a cycle of negativity bias and negative rumination in the political predispositions, attitudes to political change, and political evaluations of citizens with symptoms and/or a diagnosis of a CMD (e.g. Bernardi et al. 2023; Ojeda et al. 2023). Yet despite a growing interest in the relationship between mental health and politics, there is yet to be any serious thinking about how mental health influences the cognitive performance of political elites. As new evidence on the prevalence and workplace antecedents of CMDs among politicians emerges, it seems right to ask ‘when’, ‘how’, and ‘whether’ this matters.

2. Mental health and politicians’ decision-making

Challenging the antipolitical dictum of ‘them’ and ‘us’, we suggest that politicians are just as likely, if not more so, to experience CMDs and the symptoms of those CMDs will affect their cognitive functioning in much the same way as other social and occupational groups. For example, politicians suffering from symptoms of CMDs will be more likely (than those who are not) to struggle with negativity bias in their attention, interpretation, and processing of new information or instructions. However, we argue that this change in cognitive functioning will interact with a range of institutional variables that *are* unique to politics. With this in mind, we adapt a pre-existing decision-theoretic model of elite political behaviour (Weinberg 2020b) that we propose has applicability for most scenarios in representative politics (Fig. 1).

Canonical political science scholarship on elites and their behaviour has taken a rational choice approach in which the psychology of individual MPs is merely epiphenomenal to the impact of institutional constraints on their behaviour (e.g. North 1990; Strom 1990; Pierson 2004; Hinterleitner and Sager 2015). In contrast, Fig. 1 accounts for both politicians’ internal preference formation (i.e. panels 1 and 2), group-based preferences, incentives or affiliative pressures (i.e. panel 3), and the external provision of choice (i.e. panel 4). As a result, it allows for a range of

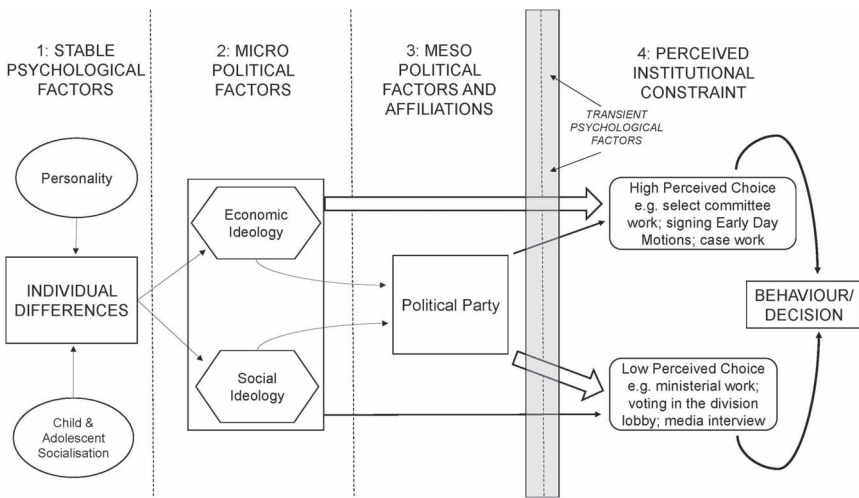


Figure 1. A psycho-political model of politicians' behaviour and decision-making.

counterfactuals that can apply in different contextual situations. Acknowledging that politicians rarely 'get their choice of choices' (Sniderman and Levendusky 2009: 437), this approach contends that politicians may engage in a particular behaviour or take a particular decision because (1) they hold it to be legitimate according to stable psychological factors and micro political factors such as personality traits or political values (i.e. *proactive* decision making), (2) they are able to unify their personal goals and values with formal and informal institutional expectations and pressures (i.e. *reconciliatory* decision making), or (3) they are coerced to a greater or lesser extent by institutional pressures and the transaction costs associated with operating alone (i.e. *reactive* decision making).

The size of the arrows in Fig. 1 indicates the theoretical causal primacy given to individual differences in personality or ideology (Panel 1/Panel 2) and/or group pressure and preferences (Panel 3) for behaviours or decisions with high and low perceived choice respectively (Panel 4). The explanatory logic here is that the likelihood of a politician engaging in *proactive*, *reactive*, or *reconciliatory* decision-making will partly depend on the level of situational constraint they perceive around each decision or behaviour. Some scenarios may naturally be perceived as presenting more choice or flexibility (e.g. working collaboratively on a cross-party select committee away from media scrutiny) and others may be perceived as presenting limited freedom or flexibility of choice (e.g. press engagements ahead of an election or ministerial policy responses during a crisis scenario).

Developing this logic further, we add a grey lens between panels 3 and 4 to represent the transient psychological factors that might influence politicians' interpretation of a choice set, the audience for said choice, or the information

provided/retrieved to aid that choice. In this paper, we focus specifically on mental health as one pertinent variable that might shape this lens, although other scholars may be equally interested here in the role of emotions, self-esteem, addiction, or a range of other heuristic mechanisms (for a discussion, see Vis 2019). Where politicians are experiencing symptoms of a CMD, we anticipate that they will perceive less institutional choice regardless of the objective context. As in the mass population, this will be fuelled by heightened attentiveness to negative information and increased negativity bias about their own capacity to make the ‘right’ decision, as well as greater sensitivity to the hypothetical risks of making the ‘wrong’ decision.

In practical terms, this may mean that politicians experiencing poor mental health are more likely to (1) fall back on the instructions or advice of their political group, (2) seek an opt-out strategy (such as delegating tasks to colleagues or subordinates), or (3) defer and/or avoid individual decisions altogether where that is possible. Scholars working on blame avoidance have previously suggested that *all* politicians make decisions with a similar bent towards ‘minimising the maximum loss’ (see Hood 2010). However, we offer a very different causal assumption here. Whilst we see *blame* avoidance to be conscious, strategic and grounded in relatively stable psychological factors such as ambition, we see *risk* avoidance by politicians experiencing symptoms of CMDs to be driven by an inescapable yet transient pull to, and upweighting of, negative information about themselves, their environment, and the consequences of their choices for self or others.

3. Study 1: Negative self-referential processing

3.1 Objective and hypotheses

As discussed, cognitive theories of mental health in Psychology have long posited the existence of negative schemas (Beck 1967). Very simply, these schemas are understood as ‘priors at a high level of abstraction (e.g. over possible, unobserved, underlying causes of observations) . . . [that combine] . . . with evidence that is inconclusive but permissive of negative interpretations (the triggers)’ (Huys et al. 2015: 8). Study 1 builds on this link by focusing on politicians’ self-efficacy in decision-making, which we argue is a highly relevant ‘transient psychological factor’ (see Fig. 1, grey panel) that might be skewed in a positive or negative direction by experiences of mental ill-health. Drawing on historic survey data collected by co-author Ashley Weinberg as part of an evaluation of changes to MPs’ sitting hours in the UK House of Commons, we test for negative self-referential processing among elected politicians by asking them to review and self-report on their own decision-making capability in politics. To assess the impact of psychological health on decision-making self-efficacy, we examine the relationship between these self-evaluations and participants’ responses to a screening

instrument for psychological distress (the GHQ-12). If the relationship between mental well-being and decision-making self-efficacy holds in politics, we expect:

H1: The higher a politician scores on the GHQ-12, the more negative their self-evaluations of decision-making ability.

3.2 Methods

3.2.1 Data collection. Questionnaires were sent to all sitting UK MPs immediately prior to the introduction of new working hours in the House of Commons in January 2003 (henceforth T1), yielding 136 responses (see [Weinberg 2015](#)).¹ Of the overall sample at T1, 85 MPs (12.9% of the target population) completed relevant measures of *both* mental well-being and decision-making, and 59 went on to do the same 6 months later (henceforth T2). This sample was broadly representative of the elected chamber at the time of data collection in terms of both demographic characteristics and party politics. The one anomaly was a slightly raised proportion of women in the sample (28.6% versus 17% in the Commons). Participating MPs had served in the role for an average of 9 years; 92.8% were married; and almost one third (31%) had children under the age of 21. Within the sample, 67% were MPs in the governing party and the average distance between Parliament and constituency was 156 miles.

3.2.2 Measures.

3.2.2.1 General health questionnaire. The General Health Questionnaire (GHQ-12; [Goldberg and Williams 1988](#)) is used widely in community and workplace settings to assess psychological symptoms of strain and screen for possible CMDs (e.g. [Comotti et al. 2023](#)). Examples of items include: ‘Have you been feeling unhappy or depressed?’, ‘Have you been losing confidence in yourself?’, and ‘Have you lost much sleep over worry?’. Respondents are invited to assess themselves against each item on a four-point Likert scale and directed to reflect specifically on how they have felt over the past month. In this study, all participants completed the GHQ-12 at T1 and 65 went on to complete it at T2. The Likert scoring method was applied here, whereby each item’s response is assigned a score of 0, 1, 2, or 3. A total score was then calculated by summing the scores across all 12 items, resulting in a range from 0 to 36. Higher scores generally indicate poorer mental health and as reported previously, prevalence of psychological distress at T1 was 16% (see [Weinberg 2015](#)).

¹Data on the mental health of 65 respondents were previously reported in a longitudinal evaluation of the impact of working hours reform and the 2010 expenses scandal on the mental well-being of MPs. Unlike that article ([Weinberg 2015](#)), the data and analyses presented here (a) utilise a larger sample of GHQ-12 responses from the dataset, (b) feature participants’ responses to a ten-item decision-efficacy scale, and (c) test for relationships between that scale and participants’ mental well-being.

There was no significant difference between MPs' GHQ scores at T1 (mean = 10.48, SD = 4.8, range = 32) and the results gathered at T2 (mean = 10.19, SD = 4.4, range = 21). Among the 65 respondents who completed the GHQ-12 at T1 and T2, there was an average change in scores of just 0.05. To limit the chances of an endogeneity problem in our inferential analysis of the relationship between the GHQ-12 and political decision-making self-efficacy, we removed item four from the scale ('Have you felt capable of making decisions about things?'). This did not substantially change the level of psychological distress recorded at T1 (mean = 9.57, SD = 4.69, range = 32) or T2 (mean = 9.31, SD = 4.31, range = 20). Furthermore, the removal of item four did not significantly alter the internal reliability of the scale. Cronbach alphas for the full scale were 0.89 and 0.85 at T1 and T2 respectively, and remained at 0.89 and 0.85 without item four.

3.2.2.2 Politician's decision-making scale. The Politician's Decision-Making Scale (PDMS) was originally configured as a ten-item survey battery devised to assess self-perceptions of job performance among MPs, with the emphasis on reported self-efficacy in making daily decisions as an elected representative. It is important to note that the PDMS was designed specifically for Study 1 in the absence of suitably tailored existing measures. Indeed, definitions and measures of decision-making self-efficacy (as opposed to general self-efficacy) vary considerably across domains of study, including health (Sebri et al. 2025) and management (Myburgh et al. 2015), and the PDMS represents one attempt to capture relevant features and mechanisms within a political work setting. Whilst increased access and time would afford the opportunity for more detailed scale development, the PDMS offers researchers a useful approach to answering the following question: do elected politicians think that they can make effective decisions under the conditions of public office?

MPs are asked in the survey rubric to contemplate four areas of decision-making before answering the questions: voting, responding to debates, media interviews and constituency requests. The scale includes items on the temporal components of such decision-making (e.g. frequency and speed), complexities in decision-making (e.g. difficulties, doubts and implications), daily challenges (e.g. interruptions and information gaps), as well as dealing with feedback on decisions (e.g. colleagues' responses and requests for help). For each item, the PDMS invites ratings on a Likert scale from 1 = 'Never' to 5 = 'Very often'. Item descriptions and response frequencies can be seen in Table 1 (results at T1) and Supplementary Appendix A (results at T2). A comparison of mean scores at T1 (3.37, SD = 0.41) and T2 (3.32, SD = 0.47) suggests no significant change in decision-making self-efficacy within the sample over time.

Given that the PDMS has not previously been reported, we interrogate the structure of the measure here using principal components analysis with varimax rotation and median imputation for missing values. We drop item 1 from this

Table 1. MPs' self-assessment of political decision-making (PDMS scale) at T1 (N = 85).

	Never	Very rarely	Sometimes	Often	Always
1. How often do you make job content decisions (e.g. about voting, media engagements, constituency comms)?	0 (0.00%)	0 (0.00%)	4 (4.71%)	22 (25.88%)	59 (69.41%)
2. Do you feel your job decisions will make a difference to the lives of others?	0 (0.00%)	4 (4.71%)	34 (40.00%)	21 (24.71%)	26 (30.59%)
3. Do you have enough time to consider these types of decisions? (T)	0 (0.00%)	11 (13.10%)	34 (40.48%)	29 (34.52%)	10 (11.90%)
4. Do you have difficulty making these types of decisions? (C)	4 (4.71%)	43 (50.59%)	35 (41.18%)	3 (3.53%)	0 (0.00%)
5. Do you cope well with interruptions in your work? (T)	2 (2.38%)	5 (5.95%)	22 (26.19%)	41 (48.81%)	14 (16.67%)
6. Do you wonder if you have made the right decision? (C)	1 (1.19%)	23 (27.38%)	52 (61.90%)	6 (7.14%)	2 (2.38%)
7. Do colleagues congratulate you on your decisions? (F)	2 (2.38%)	24 (28.57%)	46 (54.76%)	10 (11.90%)	2 (2.38%)
8. Are you able to make these types of decisions quickly? (T)	1 (1.18%)	0 (0.00%)	18 (21.18%)	48 (56.47%)	18 (21.18%)
9. Do colleagues ask for your help with their own decisions of this type? (F)	2 (2.35%)	22 (25.88%)	47 (55.29%)	13 (15.29%)	1 (1.18%)
10. Do you forget or mislay documents?	1 (1.18%)	31 (36.47%)	35 (41.18%)	15 (17.65%)	3 (3.53%)

Note: Factor loadings from Principal Components Analysis. (T) Temporal factor with three items: item 3 = 0.65; item 5 = 0.65; item 8 = 0.79. (F) Feedback factor with two items: item 7 = 0.82; item 9 = 0.88. (C) Complexity factor with two items: item 4 = 0.68; item 6 = 0.79.

analysis on the basis that it simply asks participants to recount the frequency of decision-making tasks rather than any aspect of their self-rated capability at completing those tasks. The results point to a suitable three-factor solution comprising seven items over three subscales measuring MPs' decision-making self-efficacy across temporal pressure, peer feedback and decision complexity (see Table 1).²

3.3 Analysis

To test the relationship between MPs' mental well-being and their decision self-efficacy, we start by calculating an OLS regression of decision-making self-efficacy at T1 using participants' total score for the refined PDMS as our dependent variable. Our primary predictor of interest is the GHQ-12 (minus item 4). Accounting for sample size constraints, we use Bayesian estimation and control for just three additional variables. Specifically, we account for (1) MPs' partisan affiliation on the basis that party cultures may impact a priori perceptions of choice freedom and behavioural agency (as per Fig. 1, panel 3), (2) participants' status as either 'frontbench (now or ever)' or 'backbench' on the basis that [shadow] ministerial status might imply both a greater frequency of pressured decision-making and a presumption of higher decision-making skill (as per Fig. 1, panel 4), and (3) participants' tenure in office on the basis that experience *should* correlate with higher levels of job skill and thus more measured or positive self-evaluations. To improve causal interpretability, we also estimate a lagged model in which decision-making self-efficacy at T2 is regressed on mental health at T1, controlling for baseline decision-making self-efficacy at T1 and covariates. Full details of our statistical approach can be found in [Supplementary Appendix B](#) along with corresponding results for both models.

The results of these analyses provide provisional support for H1. In line with the theoretical assumption that positive mental health will improve self-evaluated decision-making in politics, GHQ scores at T1 were negatively associated with MPs' PDMS scores [Fig. 2, Model 1: $\beta = -0.27$, 95% CrI ($-0.500, -0.043$), $pd = 99\%$]. In other words, MPs self-reported lower levels of decision-making self-efficacy if they were also suffering from lower levels of mental wellbeing at the time. In contrast, the longitudinal association between GHQ scores at T1 and decision-making self-efficacy at T2 is much weaker and uncertain once prior PDMS scores are included [Fig. 2, Model 5: $\beta = -0.10$, 95% CrI ($-0.340, 0.146$), $pd = 79\%$]. Amongst our covariates, there is indicative evidence that MPs' status (i.e. frontbench now or ever) and party affiliation (i.e. party of opposition)

²Confirmatory factor analysis of this three-factor model using robust maximum likelihood estimation also suggests a robust fit [$\chi^2 = 12.78$, Comparative Fit Index (CFI) = 0.97, Tucker-Lewis Index (TLI) = 0.95, Root Mean Square Error of Approximation (RMSEA) = 0.04, Standardized Root Mean Squared Residual (SRMR) = 0.05].

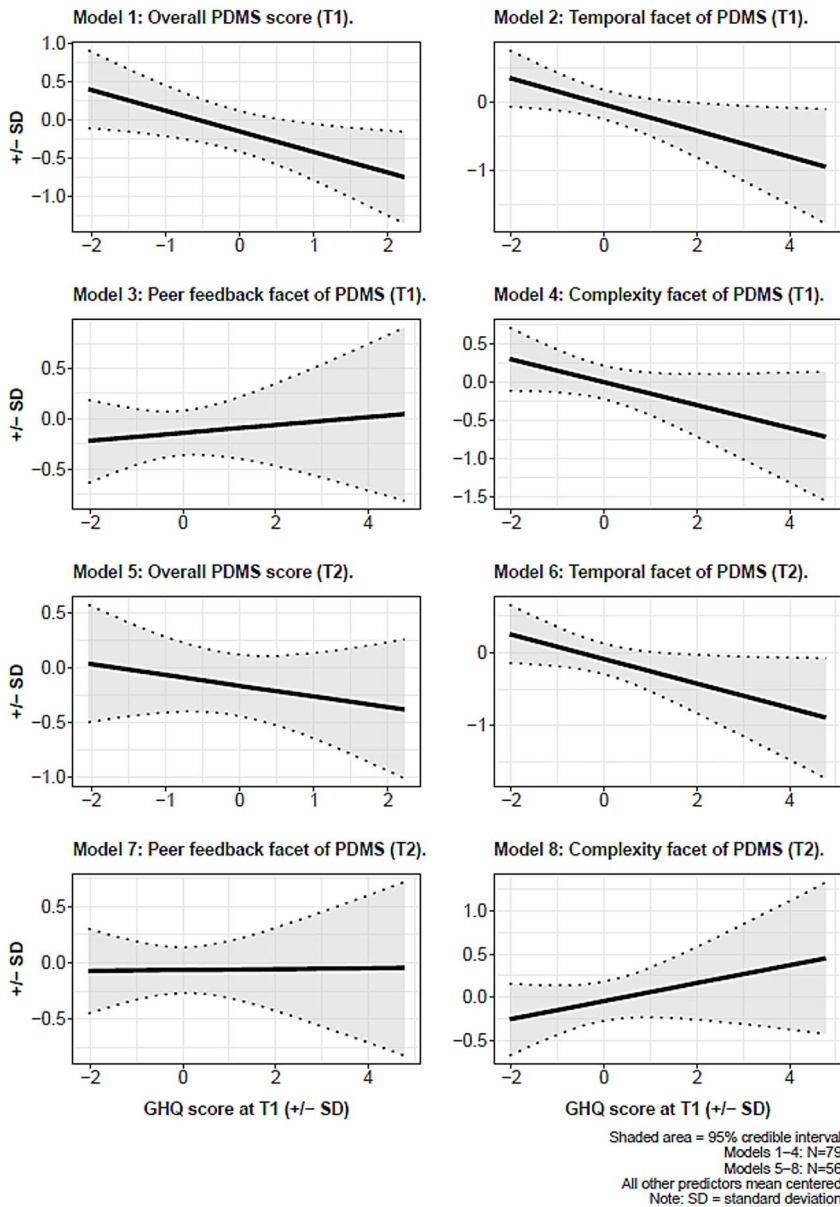


Figure 2. Regression analysis of MPs' decision-making self-efficacy (PDMS: overall and facet scores) at T1 (cross-sectional) and T2 (longitudinal). Each plot shows the conditional effects of GHQ scores ($\pm$ SDs) upon overall PDMS scores (Models 1 and 5) or PDMS facet scores (Models 2-4 and 6-8). **Note: Effects in models 1, 2, 4, and 6 reach conventional levels of statistical significance.**

predicted higher PDMS scores at T1 and T2. MPs' tenure also shares a positive association with PDMS scores at T2 but not T1.

To drill down further into these findings, we re-run our analyses using standardised factor scores for each subscale of the PDMS rather than the overall scale. [Supplementary Appendix C](#) provides model details and results for each of these analyses. Results relevant to H1 are illustrated in plots 2–4 and 6–8 of [Fig. 2](#). Once the different components of the PDMS are separated, we get a clearer picture of the relationship between decision-making self-efficacy and mental health. Specifically, this relationship is strongest for the temporal facet of decision-making self-efficacy, which shares a meaningful correlation with GHQ scores at T1 [[Fig. 2](#), Model 2: $\beta = -0.18$, 95% CrI ($-0.358, -0.011$), $pd = 98.2\%$] and in the longitudinal model at T2 [[Fig. 2](#), Model 6: $\beta = -0.16$, 95% CrI ($-0.317, 0.004$), $pd = 98.4\%$]. This finding strongly suggests that poorer mental health and wellbeing might reduce politicians' self-evaluations of their ability to take decisions quickly, deal with interruptions and changes in direction, or feel like a decision has been given sufficient time and attention.

Finally, to check for reverse causality, we re-ran our longitudinal analyses with GHQ at T2 as the dependent variable and decision-making self-efficacy as an independent variable (PDMS scores at T1), controlling for GHQ scores at T1 as well as party, ministerial status and tenure in office (see [Supplementary Appendix D](#)). In doing so, we find significant associations between both overall PDMS at T1 and GHQ at T2 as well as between the temporal and complexity facets of the PDMS at T1 and GHQ at T2. Going beyond our initial hypothesis, these findings suggest that difficulties experienced in these aspects of a politician's job performance may also feed into lowered levels of well-being as a product of reduced self-belief and/or job dissatisfaction.

3.4 Study 1 reflections

The descriptive findings from Study 1 provide insights into politicians' thoughts on their capacity to carry out arguably one of the most important components of their job, i.e. making decisions. MPs recognize the potential for their decisions to make differences to the lives of others, thus demonstrating awareness of their responsibilities, associated temporal pressures (e.g. 54% 'very rarely' or 'sometimes' feel they have 'enough time' to make decisions), and the general challenges of political decision-making (e.g. 45% 'sometimes' or 'often' 'have difficulty making [job related] decisions'). At the same time, just 29% 'rarely' or 'never' '... wonder if they have made the right decision'. The regression results at both T1 and T2 also point to improved self-perceptions of decision-making for MPs serving in the party of government, which may accord with increased perceptions of control over political outcomes, including those that align with politicians' own views (see [Fig. 1](#), panels 3/4).

The inferential findings from Study 1 indicate a link between psychological health and politicians' perceptions of their efficacy in decision-making (H1). In line with our theoretical approach, these results suggest that MPs' self-perceptions of their own skills—in this case making decisions as part of their job—are negatively impacted by transient psychological factors (Fig. 1, grey lens) such as symptoms of poor mental health. In particular, cross-sectional and longitudinal relationships demonstrate the impact of well-being on politicians' self-evaluations of their ability to take decisions under time pressure. Understandably, temporal factors are unlikely to be removed from political work, but this finding underlines the importance of appropriate job design and support structures to sustain MPs' capacity to remain in good psychological health and make effective decisions under that pressure.

At the same time, it is important to remember that MPs' perceptions of their own efficacy when making decisions are separate from whether they have objectively made good or poor decisions per se. For example—and in keeping with the point above—speedily taken decisions are not necessarily optimal ones. However, the thorny normative issue of 'What is an ideal decision or approach to decision-making?' is beyond the scope of this paper, and instead we focus on whether MPs *feel able* to take decisions according to the expectations placed on them or perceived to be placed on them, e.g. in relation to legislative voting, responding to media requests, or constituency queries. Future research may also take a different approach to measuring decision-making self-efficacy that is more tailored for ministers or other frontbench politicians who have additional agency when it comes to policy-making.

Finally, the existence of longitudinal results indicating reverse causation highlights how lowered perceptions of decision-making self-efficacy may also negatively impact politicians' well-being. This two-way relationship between mental well-being and decision-making points to a potential feedback loop whereby performance and psychological health are interlinked, working to influence one another over time. This reinforces the need not only to ensure politicians have access to suitable support mechanisms to aid them in their decision-making, but that parliamentary institutions and political parties recognise the deleterious effects of challenging working conditions and sustained decision-making under pressure.

4. Study 2: Risk aversion and heuristic susceptibility

4.1 Objective and hypotheses

Study 1 demonstrates that high-functioning national politicians with poor levels of well-being may, like the rest of the population, engage in negative schemas about their own professional decision-making capability (especially under temporal

pressure). In Study 2, we use data collected by co-author James Weinberg to test for two additional possibilities: specifically, we examine the link between politicians' mental health (this time symptoms of depression) and (1) their risk aversion when taking decisions, as well as (2) their susceptibility to framing effects when taking decisions.

Existing research suggests that negative mood and CMDs like depression reliably correlate with heightened perceptions of risk in the mass public and across a range of professional or social domains (e.g. health, crime, crises, see Robinson et al. 2013; Zhou et al. 2024). Similarly, we anticipate that politicians experiencing negative mood or depressive symptoms will perceive policy and political risks as greater than they may be objectively. Working within a range of atypical institutional constraints and constantly engaging in multi-level trade-offs in their decisions, we expect that this same psychological sensitivity to risk will present itself through an increased propensity to *reactive* decision-making among politicians who are experiencing depressive symptoms and who therefore perceive less choice or conversely greater institutional constraint. This is represented in Fig. 1 by the grey psychological lens that sits between panels 3 and 4, representing the interface between internal preference formation and the constraints of the external environment in which decisions are made. Heightened *reactive* decision-making may manifest, for example, in over-cautious policy responses, tight party alignment and avoidance of responsibility, or even pre-emptive blame avoidance.

H2: As politicians' symptoms of depression increase, the more risk averse they will be in their decision-making.

Secondly, we anticipate that poor mental health may share an association with heuristic thinking in time-pressured, complex, and highly scrutinized political environments. Specifically, we focus here on the relationship between depressive symptoms and gain vs. loss framing of information, which is known to induce risky decision-making (or a 'reflection effect') when the frame plays on losses (Tversky and Kahneman 1981; for a politics application, see Linde and Vis 2017). It is also a crucial test given that most elected representatives are presented with information second-hand and must take far-reaching decisions based on the evidence presented to them, often with very little time or resource to fact check it themselves. As we see in the findings of Study 1, politicians with poorer mental health are less likely to positively appraise their own ability to do this well.

In Psychology, relevant research suggests that individuals with depression have reduced sensitivity to gains (i.e. less motivated by positive outcomes) and heightened sensitivity to losses or avoidance of losses (Engelmann et al. 2017; Sediya et al. 2020). This may lead to one of two possible outcomes. On one hand, politicians with increased depressive symptoms may be *more* susceptible to

framing effects due to an enhanced baseline motivation towards loss minimisation as opposed to gain or reward maximisation. On the other hand, altered patterns of cognitive control and atypical reference points (i.e. expect losses, anticipate failure) may shift the subjective evaluation of what counts as a 'gain' vs 'loss' and thus nullify the effect of the frame. In the latter scenario, a general propensity towards risk aversion may hold regardless of how the situation is presented.

H3a As politicians' symptoms of depression increase, the more their decision-making will be impacted by gain vs loss framing.

H3b As politicians' symptoms of depression increase, the less their decision-making will be impacted by gain vs loss framing.

4.2 Methods

4.2.1 Data collection. Study 2 utilises online surveys fielded to national politicians via Qualtrics between mid-December 2020 and the end of January 2021. Electronic invitations were sent to every elected MP in the UK and Canadian House of Commons, and the South African National Assembly, as part of a wider international study of trust and governance (see [Weinberg 2023, 2024](#)). Alongside measures of trust, ideology and personality characteristics, these surveys included questions about mental health and wellbeing (i.e. the Personal Health Questionnaire [PHQ-9]) and three survey vignette experiments containing hypothetical decision-making scenarios. The final sample comprised 41 UK MPs (response rate of 6%), 50 Canadian MPs (15%), and 37 South African MPs (9%). All participants passed quality control checks (including response times and attention filters) and provided informed consent in accordance with ethical approval granted by the University of Sheffield (Ref. 033126).

Representative of the actual composition of each legislature, the samples were predominantly male (65–78%) with a mean age in the mid-to-late 50s for the UK and Canada (56 and 55 years, respectively) and slightly younger in South Africa (48 years). Between 75% and 91% of sampled MPs in each country held a bachelor's degree or higher. Legislative tenure varied significantly: UK MPs reported the longest mean time in office at 14 years, whilst South African MPs had the shortest at 6 years. A majority of participants in the UK (75%) and South Africa (70%) had served on the frontbench of their party (now or ever), compared to only 42% of the Canadian sample. Regarding ethnicity, the UK sample was predominantly White (95%), whereas the South African sample showed greater diversity with 47% identifying as Black, Indigenous, or Minority Ethnic. In line with the partisan divide in both parliaments at the time of sampling, Liberal/Labour and Conservative MPs formed the largest proportion of participants in Canada and the UK (46% of both samples). In South Africa, MPs from the Democratic Alliance party were over-represented in the sample (60%).

4.2.2 Measures

4.2.2.1 Personal Health Questionnaire. The PHQ-9 is the depression module of the Primary Care Evaluation of Mental Disorders (PRIME-MD) diagnostic instrument for CMDs (see Kroenke et al. 2001) contained in the DSM-5.³ Participants are asked how often over the last 2 weeks they have experienced nine different symptoms such as feeling tired or having little energy or thinking that they would be better off dead or hurting themselves. Participants score themselves against each criterion on a scale of 0 (not at all) to 3 (nearly every day) and the scores are summed to a total out of a maximum of 27. Since its introduction in 2001, the PHQ-9 has become the most used screening tool in primary care for detecting the presence and severity of depression among adult patients in multiple countries around the world (for an early summary, see Gilbody et al. 2007). Despite some contestation about appropriate cut-off scores (e.g. Levis et al. 2019), meta-analyses in the medical sciences suggest that the PHQ-9 is an effective tool for flagging ‘major’ depression in the absence of semi- or fully-structured diagnostic interviews by health care professionals (Moriarty et al. 2015). For the purpose of working with time-poor study populations like politicians, the PHQ-9 has utility because it is self-administered, completed in just a couple of minutes, and has strong reliability and validity in different settings, situations and cultures.

Using five standard cut-off scores, Table 2 shows the prevalence and severity of depressive symptoms in each country sub-sample of MPs. Whilst *most* MPs were suffering from mild depressive symptoms at the time of sampling, a significant number were suffering from either moderate symptoms ($N = 30/128$) or moderately severe or severe depressive symptoms that might accompany a medical diagnosis of major depression ($N = 14/128$). This spread of scores aligns with most diagnostic studies of depression among general populations (Levis et al. 2019: 4–5). Within the sample, rates of moderately severe or severe depressive symptoms were higher among women (19% vs. 9% of men), Black, Indigenous or Minority Ethnic participants (18% vs. 10% White participants), and those under 45 years old (22% vs. 6% of participants over 65). Across countries, South African MPs also recorded higher rates of moderate–severe depressive symptoms (Table 2). Though not the focus of this paper, this cross-country variation is deserving of a study in and of itself.

4.2.2.2 Survey experiments. MPs participated in three distinct vignette experiments designed to measure their propensity for risky decision-making under different conditions (see Weinberg, 2023). Although vignette experiments may not fully replicate ‘real-life’ contextual experience, they are well-tested in the social sciences and afford a high degree of control over the inclusion or exclusion of

³DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition.

Table 2. Levels of depression among sampled MPs in the UK, Canada, and South Africa.

Cut points:	'No'—'Mild' Depressive symptoms	'Moderate' Depressive symptoms	'Moderately Severe'—'Severe' Depressive symptoms	Descriptive statistics
Level of concern:	Common. No concern.	Occasional. Non-clinical cause for concern.	Serious. Clinical cut-point for episode of major depression.	Mean and SD
All MPs (N = 128)	62%	26%	12%	4.6 (5.1)
UK MPs (N = 41)	67%	22%	11%	4.4 (5.2)
Canadian MPs (N = 50)	69%	22%	9%	3.5 (3.6)
South African MPs (N = 37)	49%	34%	17%	6.2 (6.1)

confounding factors relative to designs using observational data (see also [Grant and Wall 2009](#); [Aguinis and Bradley 2014](#)). They are also an appropriate choice when working with target populations, such as politicians, who are either unable or unwilling to participate in field or lab experiments, or online experiments with material incentive structures.

In each experiment, the key outcome variable was a binary choice between a relatively risky option and a relatively safe option, with treatment conditions framing the scenarios as either a gain setting or a loss setting to induce reflection effects (i.e. risk aversion in the former, risk-seeking in the latter). The experiments were also strategically designed to test risky decision-making across varying hypothetical settings that manipulated both the type of decision needed and the reference points against which risk could be evaluated (policy vs. electoral dimensions).

Participants were instructed to assume that, unless told otherwise, the issues were ideologically neutral and that no consequences or alternative choices existed beyond those mentioned. To prevent order effects, participants completed the three experiments in random order and they were randomly assigned to a gain or loss treatment in each case. Quotas were used to ensure equal coverage across all treatment conditions. The stimulus materials are presented in full in [Supplementary Appendix E](#) and summarized below.

Experiment 1: Public health crisis (drastic policy/individual electoral risk)

This experiment adapted the classic [Kahneman and Tversky \(1984\)](#) 'Asian disease problem' to a public health emergency requiring a choice between two response packages—one that results in a set number of lives saved and lost, and another that has a split probability of saving or losing all lives. Risk was presented by framing the outcome probabilities of each package in terms of lives saved (gain frame) or lives lost (loss frame). MPs were instructed to treat this as a 'conscience vote', characterizing the decision primarily by drastic policy

consequences (public mortality) and individualized electoral risk (the vote is their own and publicly recorded).

Experiment 2: Party polling and public appearance (indeterminate policy/collective electoral risk)

Following the methodology of [Linde and Vis \(2017\)](#), risk presentation in experiment two was manipulated by establishing earlier expectations about party performance in the polls (better for gain setting, worse for loss setting). MPs then had to decide whether or not to appear on TV to speak about a new protest movement. The risky outcome was measured as an equal chance of improvement or deterioration in party polling as a result of this media intervention. The experiment thus induced risk appraisal with indeterminate policy consequences and collective electoral consequences (based on public opinion about the party).

Experiment 3: Economic policy interventions (indeterminate policy/individual electoral risk)

Similar to experiment two, this vignette manipulated earlier expectations regarding macroeconomic performance (specifically the unemployment rate and budget deficit). MPs then voted on whether or not to implement new economic policies that carried an equal likelihood of improving or deteriorating existing statistics. Crucially, participants were told that the decision was a whipped vote where the party had instructed them to vote against the package. This set up risk appraisal with indeterminate policy consequences but individualized electoral consequences (i.e. defy the party whip to the possible detriment of policy- or office-seeking motivations).

4.3 Analysis

The main effects for each of the vignette experiments are reported elsewhere ([Weinberg 2023](#)), so the present analysis focuses explicitly on the relationship between MPs' mental health and their performance in these experiments. To maximize the statistical power of the analysis, we collapsed the results into a single dataset of 318 complete observations. The relationship between mental health and risky decision-making was then modelled using a Bayesian hierarchical logistic regression with observations nested within participants (see [Supplementary Appendix F](#) for model details and results). Key fixed effects include MPs' PHQ scores (re-coded by cut points as per [Table 2](#)), the binary treatment variable (Loss vs Gain frame), and their two-way interaction. Following [Weinberg \(2023\)](#), control variables include MPs' electoral security ($>|<10\%$ vote margin), MPs' ideology (0–10, Left–Right), and tenure in office (years). We also include controls for participants' country and the different experimental scenarios, recognizing that each experiment deals with very different behaviours and aspects

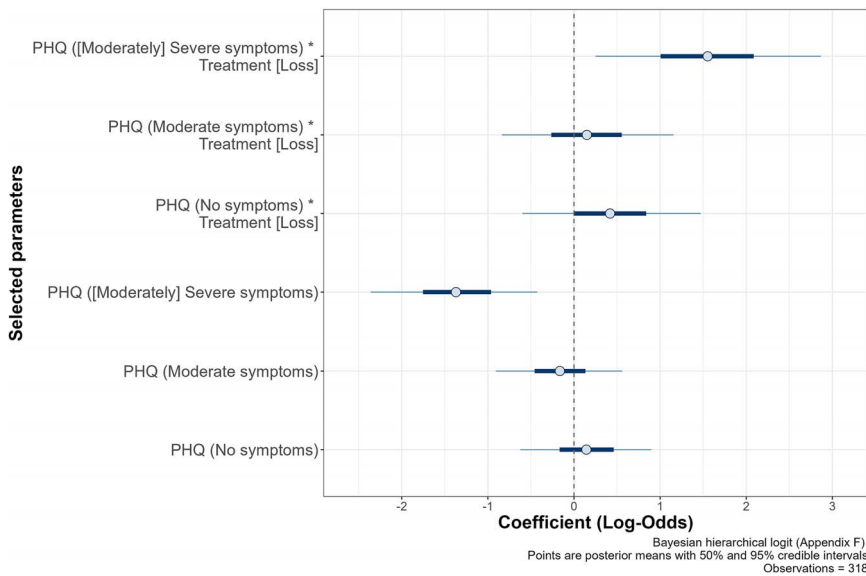


Figure 3. Regression analysis of politicians' risky decision-making (selected coefficients).

of political work that carry more or less institutional constraint and varying types of risk (as per Fig. 1, panel 4).

Our analysis provides compelling support for two of our three hypotheses in Study 2. In line with H2, participants at the top end of the PHQ scale show significantly lower odds of making a risky decision than those towards the bottom (see Fig. 3). To be precise, participants with 'Moderately Severe or Severe depressive symptoms' were less likely to take a risky decision compared to participants with 'Mild depressive symptoms' [$\beta = -1.37$, 95% CrI $(-2.57, -0.25)$, $pd = 99.3$]. We also hypothesized that depression would alter MPs' susceptibility to framing effects and heuristic thinking, meaning the difference in risky decision-making between Loss and Gain treatments would be significantly greater or smaller for participants with higher PHQ scores. In line with H3a, we find an interaction effect between participants' PHQ scores and the treatment conditions, although this appears to be a non-linear association whereby the interaction is only meaningful at the top end of the PHQ scale [$\beta = 1.55$, 95% CrI $(-0.013, 3.155)$, $pd = 97.4$]. In practice, this means that (1) the difference in risky decision-making between the 'Loss' and 'Gain' treatments only presents meaningfully among those with significant depressive symptoms, and (2) MPs suffering from acute mental health challenges are more susceptible to negative framing manipulations.

4.4 Reflections

Drawing on original data collected from MPs in three countries, we find evidence of a link between politicians' mental health, specifically symptoms of depression,

and their propensity to engage in risky decisions across different areas of political work. On one hand, politicians with moderately severe or severe depressive symptoms were less likely than their peers within the 'normal' range of symptoms to take a risky decision. As with mass population samples, this suggests an enhanced sensitivity to risk and, in line with the theory laid out in Fig. 1, an enhanced orientation to *reactive* decision-making aimed at minimising personal or political loss. On the other hand, those same politicians showed greater susceptibility to framing effects (specifically a *relative* uptick in their risky decision making) when information and associated decisions were presented in a loss frame. Put another way, the difference in their decision-making when the presentation of information and choice changes is greater than amongst their peers without depression. Practically, this suggests that politicians suffering from CMDs may be vulnerable to negative frames when it comes to making occupational decisions.

These are important observations in an extremely scant subfield. It is vital that these findings are replicated across different methodologies and samples, and with a focus on verifying causal inferences. For instance, future research may seek to measure politicians' risk perceptions in different scenarios as well as their actual decisions in order to check our underlying assumption is correct (i.e. CMDs = heightened perception of risk = reactive decision making). Although survey experiments are a useful test of causal assumptions, they are often criticised for their external validity. With that in mind, future research may also seek to co-examine politicians' actual representative choices and their mental health over a longitudinal period. This necessarily raises ethical questions that will be difficult to navigate and there is the additional challenge of accurately controlling for the type and framing of decision-relevant information consumed by each politician. Finally, with the necessary funding, future research may invest in recruiting larger samples of politicians that allow for statistical tests containing a wider range of relevant psychological controls, such as politicians' personality characteristics and ideologies (i.e. panels 1 and 2 of Fig. 1).

5. Conclusion

If mental health shapes how politicians perceive and take risks, or evaluate their own potential to make good decisions, then variation in mental health and wellbeing could partly explain differences in both leadership style and the quality of policy outcomes, crisis management, or even the boldness and ambition of policy proposals and reforms. Indeed, our findings in Study 1 also point to the existence of a two-way relationship between psychological health and self-evaluations of decision-making, which suggests a feedback loop may exist between negative experiences of political job performance and politicians' well-being.

As Rose McDermott (2007: 18) writes in her book on presidential leadership and illness, ‘powerful leaders are not exempt from illness by virtue of their position or its influence . . . [but] . . . unlike the impact of personal illness and death on a less powerful or influential individual, a leader’s illness and demise can affect the lives of many others in decisive ways’. McDermott’s reflections provide a poignant backdrop to the arguments and empirical findings of this article. It is for this reason, we argue, that the findings presented here are highly significant and provide a strong imperative for parliaments, parties, and other relevant public bodies to invest in additional targeted research on politicians’ mental health and adjacent support mechanisms.

As a starting point, practical interventions might reliably draw on existing frameworks of political stressors (see Flinders et al. 2020; McKinnon et al. 2025) in which scholars have already identified a range of macro-, meso-, and micro-level pressures on MPs’ mental health. Some, such as the growing threat to MPs’ security, have already seen positive action internationally. Between 2015 and 2022, for example, the UK’s Independent Parliamentary Standards Authority increased its budget for security-related expense claims from £77,234.67 to £4,363,937.02 (IPSA 2023). On other stressors, however, there has been little or no progress. Politicians continue to labour within toxic organizational cultures and in most cases fail to receive appropriate training or support to strengthen their technical competence, workload management, or public/media interactions (for a comparative international study, see Coghill et al. 2012). On all counts, there remains a stark disparity between the intensity of these political stressors for men and women politicians (Harmer and Southern 2021), disabled and able-bodied politicians (Evans and Reher 2024), and politicians in the global north and south (Kreuzer 2022).

Beyond taking steps to safeguard politicians’ mental wellbeing for their own sake, our research points to profound democratic vulnerabilities attached to not doing so. For example, poor mental health among elected representatives may facilitate a shift from deliberative reasoning to heuristic decision-making and risk aversion. Failure to recognise and act upon mental ill-health in legislative bodies—especially where it is a structural byproduct of an increasingly unsustainable job—may therefore result in a political class that is ill-equipped to tackle long-term policy challenges and ‘wicked problems’. For that reason, we suggest that effective interventions to support individual well-being amongst politicians must be accompanied by quality assurance protocols for major decisions and decision-makers. This might include cognitive de-biasing training, mandatory ‘reverse-framing’ briefs, shared portfolios in key positions to ensure peer moderation and joint ownership of decisions, and even mandatory occupational health checks for all politicians (especially those holding government positions). We see these ideas as the starting point for an essential conversation about how to preserve both human capital and effective decision-making within political systems.

We believe this research also has scholarly implications for the way in which political science approaches the study of elite behaviour and representation. First and foremost, we hope our findings act as a filip for broader psychological assessments of political elites—preferably longitudinal—that seek to better understand the link between fluctuations in politicians’ mental health and the quality of legislative or other representative outcomes. At the same time, we also hope that this article acts as a foil for the continued predominance of rational choice perspectives on elite behaviour. Whilst existing approaches may still view politicians’ decisions through the lens of objective vote, office and policy trade-offs, our research suggests that psychological factors like mental health might lead a politician to (1) over-weight the risks of losing votes, leading to sub-optimal policy-seeking behaviour, (2) down-weight their own professional competence in a way that dampens office-seeking behaviour, or (3) struggle to perceive these trade-offs as clearly as when they are well. Indeed, it is possible that failure to put in place appropriate support could at best lead to ‘muddling through’ and, at worst, prevent the calculation of rational goals we might expect and need of politicians.

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Supplementary data

[Supplementary data](#) is available at *Parliamentary Affairs* online.

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References

- Aguinis, H., and Bradley, K. J. (2014) ‘Best Practice Recommendations for Designing and Implementing Vignette Methodology Studies’, *Organizational Research Methods*, 17: 351–71.

- Ahern, E., and Semkovska, M. (2017) 'Cognitive Functioning in the First Episode of Major Depressive Disorder: A Systematic Review and Meta-Analysis', *Neuropsychology*, 31: 52–72.
- Allwood, C. M., and Salo, I. (2012) 'Decision-Making Styles and Stress', *International Journal of Stress Management*, 19: 34–47.
- Armstrong, T., and Olatunji, B. O. (2012) 'Eye Tracking of Attention in the Affective Disorders: A Meta-Analytic Review and Synthesis', *Clinical Psychology Review*, 32: 704–23.
- Auerbach, R. P. et al. (2015) 'Self-Referential Processing in Depressed Adolescents: A High-Density Event-Related Potential Study', *Journal of Abnormal Psychology*, 124: 233–45.
- Bavolar, J., and Orosová, O. (2015) 'Decision-Making Styles and their Associations with Decision-Making Competencies and Mental Health', *Judgment and Decision making*, 10: 115–22.
- Bavolar, J., and Bacikova-Sleskova, M. (2020) 'Decision-Making Styles and Mental Health—A Person-Oriented Approach through Clustering', *Journal of Behavioral Decision Making*, 33: 629–42.
- Beck, A. T. (1967) *Depression: Clinical, Experimental and Theoretical Aspects*, New York: Harper and Row.
- Bernardi, L. (2021) 'Mental Health and Political Representation: A Roadmap', *Frontiers in Political Science*, 2: 587588. <https://doi.org/10.3389/fpos.2020.587588>.
- Bernardi, L. et al. (2023) 'Down but Not Yet Out: Depression, Political Efficacy, and Voting', *Political Psychology*, 44: 217–33.
- Bernardi, L., and Johns, R. (2021) 'Depression and Attitudes to Change in Referendums: The Case of Brexit', *European Journal of Political Research*, 60: 339–58. <https://doi.org/10.1111/1475-6765.12398>.
- Chakrabarty, T., Hadjipavlou, G., and Lam, R. W. (2016) 'Cognitive Dysfunction in Major Depressive Disorder: Assessment, Impact, and Management', *Focus*, 14: 194–206.
- Coghill, K., Lewis, C., and Steinack, K. (2012) 'How Should Elected Members Learn Parliamentary Skills: An Overview', *Parliamentary Affairs*, 65: 505–19.
- Comotti, A. et al. (2023) 'Psychometric Evaluation of GHQ-12 as a Screening Tool for Psychological Impairment of Healthcare Workers Facing COVID-19 Pandemic', *La Medicina del Lavoro*, 114. <https://mattioli1885journals.com/index.php/lamedicinadelavoro/article/view/13918>.
- Connolly, S. L., Abramson, L. Y., and Alloy, L. B. (2016) 'Information Processing Biases Concurrently and Prospectively Predict Depressive Symptoms in Adolescents: Evidence from a Self-Referent Encoding Task', *Cognition and Emotion*, 30: 550–60.
- Engelmann, J. B., Berns, G. S., and Dunlop, B. W. (2017) 'Hyper-Responsivity to Losses in the Anterior Insula during Economic Choice Scales with Depression Severity', *Psychological Medicine*, 47: 2879–91.
- Evans, E., and Reher, S. (2024) *Disability and political representation*, Oxford: Oxford University Press.

- Flinders, M. et al. (2020) 'Governing Under Pressure? The Mental Wellbeing of Politicians', *Parliamentary Affairs*, 73: 253–73. <https://doi.org/10.1093/pa/gsy046>.
- Gilbody, S., Richards, D., and Barkham, M. (2007) 'Diagnosing Depression in Primary Care Using Self-Completed Instruments: UK Validation of PHQ-9 and CORE-OM', *British Journal of General Practice*, 57: 650–2.
- Goeleven, E. et al. (2006) 'Deficient Inhibition of Emotional Information in Depression', *Journal of Affective Disorders*, 93: 149–57.
- Goldberg, D. P., and Williams, P. (1988) *A User's Guide to the General Health Questionnaire*, Windsor: Nfer-Nelson.
- Gotlib, I. H., and Joormann, J. (2010) 'Cognition and Depression: Current Status and Future Directions', *Annual Review of Clinical Psychology*, 6: 285–312.
- Grant, A. M., and Wall, T. D. (2009) 'The Neglected Science and Art of Quasi-Experimentation: Why-to, When-to, and How-to Advice for Organizational Researchers', *Organizational Research Methods*, 12: 653–86.
- Harmer, E., and Southern, R. (2021) 'Digital Microaggressions and Everyday Othering: An Analysis of Tweets Sent to Women Members of Parliament in the UK', *Information, Communication & Society*, 24: 1998–2015.
- Hinterleitner, M., and Sager, F. (2015) 'Avoiding Blame: A Comprehensive Framework and the Australian Home Insulation Program Fiasco', *Policy Studies Journal*, 43: 139–61.
- Holmes, A. J., and Pizzagalli, D. A. (2007) 'Task Feedback Effects on Conflict Monitoring and Executive Control: Relationship to Subclinical Measures of Depression', *Emotion*, 7: 68–76.
- Hood, C. (2010) *The Blame Game: Spin, Bureaucracy, and Self-Preservation in Government*. New Jersey: Princeton University Press.
- Huys, Q. J., Daw, N. D., and Dayan, P. (2015) 'Depression: A Decision-Theoretic Analysis', *Annual Review of Neuroscience*, 38: 1–23.
- Independent Parliamentary Standards Authority (IPSA) (2023) 'Other payment data: security assistance.' <https://www.theipsa.org.uk/other-payment-data>, accessed 9 April 2024.
- Joormann, J., and Gotlib, I. H. (2010) 'Emotion Regulation in Depression: Relation to Cognitive Inhibition', *Cognition and Emotion*, 24: 281–98.
- Kahneman, D., and Tversky, A. (1984) 'Choices, Values, and Frames', *American Psychologist*, 39: 341–50.
- Kellough, J. L. et al. (2008) 'Time Course of Selective Attention in Clinically Depressed Young Adults: An Eye Tracking Study', *Behaviour Research and Therapy*, 46: 1238–43.
- Kroenke, K., Spitzer, R. L., and Williams, J. B. (2001) 'The PHQ-9: Validity of a Brief Depression Severity Measure', *Journal of General Internal Medicine*, 16: 606–13.
- Kreuzer, P. (2022) *Killing Politicians in the Philippines: Who, Where, When, and Why*, 2, DEU: Social Science Open Access Repository.

- Landwehr, C., and Ojeda, C. (2021) 'Democracy and Depression: A Cross-National Study of Depressive Symptoms and Nonparticipation', *American Political Science Review*, 115: 323–30.
- Leahy, R. L. (2001) 'Depressive Decision Making: Validation of the Portfolio Theory Model', *Journal of Cognitive Psychotherapy*, 15: 341–62.
- Lee, J. S. et al. (2016) 'Magnitude of Negative Interpretation Bias Depends on Severity of Depression', *Behaviour Research and Therapy*, 83: 26–34.
- LeMoult, J., and Gotlib, I. H. (2019) 'Depression: A Cognitive Perspective', *Clinical Psychology Review*, 69: 51–66.
- Levis, B., Benedetti, A., and Thombs, B. D. (2019) 'Accuracy of Patient Health Questionnaire-9 (PHQ-9) for Screening to Detect Major Depression: Individual Participant Data Meta-Analysis', *BMJ*, 365: 11476.
- Linde, J., and Vis, B. (2017) 'Do Politicians Take Risks like the Rest of us? An Experimental Test of Prospect Theory under MPs', *Political Psychology*, 38: 101–17.
- Mathews, A., and MacLeod, C. (2005) 'Cognitive Vulnerability to Emotional Disorders', *Annual Review of Clinical Psychology*, 1: 167–95.
- McDermott, R. (2007) *Presidential Leadership, Illness, and Decision Making*. Cambridge: Cambridge University Press.
- McKinnon, M., Reher, S., and Weinberg, J. (2025) 'Challenges Facing Members of Parliament', in Leston-Bandeira, C., Meakin, A., and Thompson, L., (eds.) *Exploring Parliament*, 2nd edn. Oxford: Oxford University Press.
- Moriarty, A. S. et al. (2015) 'Screening and Case Finding for Major Depressive Disorder Using the Patient Health Questionnaire (PHQ-9): A Meta-Analysis', *General Hospital Psychiatry*, 37: 567–76.
- Myburgh, W., Watson, M. B., and Foxcroft, C. D. (2015) 'Development and Validation of a Managerial Decision Making Self-Efficacy Questionnaire', *SA Journal of Industrial Psychology*, 41: 1218.
- North, D. C. (1990) 'A Transaction Cost Theory of Politics', *Journal of Theoretical Politics*, 2: 355–67.
- Ojeda, C., and Pacheco, J. (2019) 'Health and Voting in Young Adulthood', *British Journal of Political Science*, 49: 1163–86.
- Ojeda, C., Bernardi, L., and Landwehr, C. (2023) 'Depression and the Gender Gap in Political Interest', *Electoral Studies*, 82: 102598.
- Orchard, F., Pass, L., and Reynolds, S. (2016) 'Associations between Interpretation Bias and Depression in Adolescents', *Cognitive Therapy and Research*, 40: 577–83.
- Pierson, P. (2004) *Politics in Time: History, Institutions, and Social Analysis*, Princeton, NJ: Princeton University Press.
- Poulter, D. et al. (2019) 'Mental Health of UK Members of Parliament in the House of Commons: A Cross-Sectional Survey', *BMJ Open*, 9: e027892.

- Robinson, O. J. et al. (2013) 'The Impact of Anxiety upon Cognition: Perspectives from Human Threat of Shock Studies', *Frontiers in Human Neuroscience*, 17: 203.
- Rock, P. L. et al. (2014) 'Cognitive Impairment in Depression: A Systematic Review and Meta-Analysis', *Psychological Medicine*, 44: 2029–40.
- Sebri, V., Cincidda, C., and Pravettoni, G. (2025) 'Perceived Self-Efficacy in Decision-Making: The Influence of Personality and Cognitive Variables', *Psychooncology*, 34: e70322.
- Sediyama, C. Y. N., de Castro Martins, C., and Teodoro, M. L. M. (2020) 'Association of Loss Aversion, Personality Traits, Depressive, Anxious, and Suicidal Symptoms: Systematic Review', *Clinical Neuropsychiatry*, 17: 286–94.
- Smith, A. et al. (2024) 'The Weight of Office? A Scoping Review of Mental Health Issues and Risk Factors in Elected Politicians across Democratic Societies', *International Journal of Social Psychiatry*, 71: 223–38.
- Sniderman, P. M., and Levendusky, M. S. (2009) 'An Institutional Theory of Political Choice', in Dalton, R. J., and Klingemann, H.-D., (eds.) *The Oxford Handbook of Political Behaviour*, Oxford: Oxford University Press.
- Strom, K. (1990) 'A Behavioral Theory of Competitive Political Parties', *American Journal of Political Science*, 34: 565–98.
- Tversky, A., and Kahneman, D. (1981) 'The Framing of Decisions and the Psychology of Choice', *Science*, 211: 453–8.
- Vis, B. (2019) 'Heuristics and Political Elites' Judgment and Decision-Making', *Political Studies Review*, 17: 41–52.
- Weinberg, A. (2015) 'A Longitudinal Study of the Impact of Changes in the Job and the Expenses Scandal on UK National Politicians' Experiences of Work, Stress and the Home-Work Interface', *Parliamentary Affairs*, 68: 248–71.
- Weinberg, J. (2020a) 'Emotional Labour and Occupational Wellbeing in Political Office', *British Journal of Politics and International Relations*, 23: 430–50.
- Weinberg, J. (2020b) *Who Enters Politics and Why? Basic Human Values in the UK Parliament*. Bristol: Bristol University Press.
- Weinberg, J. (2023) 'Feelings of Trust, Distrust and Risky Decision-Making in Political Office. An Experimental Study with National Politicians in Three Democracies', *Comparative Political Studies*, 56: 935–67.
- Weinberg, J. (2024) *Governing in an Age of Distrust. A Comparative Study of Politicians' Trust Perceptions and Why they Matter*. Oxford: Oxford University Press.
- Westerhof, G. J., and Keyes, C. L. (2010) 'Mental Illness and Mental Health: The Two Continua Model across the Lifespan', *Journal of Adult Development*, 17: 110–9.
- Zhou, R. et al. (2024) 'The Relationship between Risk Perceptions and Negative Emotions in the COVID-19: A Meta-Analysis', *Frontiers in Psychology*, 15. <https://doi.org/10.3389/fpsyg.2024.1453111>.