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Both positive mental health and psychopathology should be monitored in psychotherapy: Confirmation for the dual-factor model in acceptance and commitment therapy

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ABSTRACT

The dual-factor model of mental health suggests that enhancing positive mental health and alleviating psychopathology do not automatically go hand-in-hand. This study investigates the relationship between the effectiveness on depression/anxiety symptoms and positive mental health of Acceptance and Commitment Therapy (ACT). It draws on RCT data ($n = 250$) of a self-help ACT. Patients' depression/anxiety symptoms and positive mental health were completed at baseline, at post-intervention after nine weeks, and at follow-up after five months. Percentage of unique variance of depression/anxiety symptoms explained by positive mental health (and vice versa), and the degree of classificatory agreement between improvements in positive mental health and depression/anxiety, were examined using regression analysis and Reliable Change Index (RCI). Positive mental health, i.e. baseline and change, explained 15% and 12% of the variance in follow-up depression and anxiety symptoms, beyond the 7% and 9% that was explained by baseline levels of depression and anxiety. Depression and anxiety symptoms, i.e., baseline and change, explained 10% and 9% of the variance in follow-up positive mental health, on top of the 35% that was explained by baseline levels of positive mental health. Cross-classification of the Reliable Changes showed that 64% of the participants that improved during the ACT-intervention, improved on *either* depression symptoms *or* positive mental health, and 72% of the participants improved on *either* anxiety symptoms *or* positive mental health. The findings support the dual-factor model and suggest that it is important to systematically implement measures of both psychopathology and positive mental health in mental health care and therapy evaluations.

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In addition to the absence of disease and illness, positive mental health has been increasingly recognized as a key element of population health and well-being (Keyes, 2005b; World Health Organization, 2004, 2005). To be categorized as exhibiting excellent positive mental health, or *flourishing*, an individual should not experience psychopathology, and additionally exhibit high levels of emotional well-being as well as high levels of psychological and social, societal functioning. The need to improve positive aspects of mental health, such as positive emotions, self-acceptance, purpose in life, positive social relations and social integration (Keyes, 2002), has recently appeared on policy agendas throughout the world (Barry, 2009). In mental health care, this emerging focus on positive mental health is reflected by the increased development and availability of psychotherapeutic interventions that explicitly aim to increase participants' well-being, such as Well-being Therapy (Fava & Ruini, 2003), Positive Clinical Psychology (Wood & Tarrier, 2010), and Positive Psychotherapy (Seligman, Rashid, & Parks, 2006). These interventions complement the more traditional problem-oriented psychotherapies, such as Cognitive Behavioural Therapy (CBT), that mainly aim at alleviating psychopathology (e.g., Gloaguen, Cottraux, Cucherat, & Blackburn, 1998; Hofmann & Smits, 2008; Westen & Morrison, 2001). Whenever these traditional psychotherapies do aim to improve general well-being outcomes, such as quality of life or functioning (e.g. Hofmann, Wu, & Boettcher, 2014), this focus is still not in alignment with positive mental health defined as excellent, optimal emotional, psychological and social functioning and thriving. Furthermore, whenever

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present, the aim to enhance general well-being is often secondary to a focus on reducing psychopathology, or it might be implicitly assumed that a reduction in psychopathology will automatically lead to gains in well-being.

The dual-factor model of mental health suggests that enhancing positive mental health and alleviating psychopathology do not automatically go hand-in-hand (Keyes, 2005a). A wide range of studies have shown that positive mental health and psychopathology are not simply opposite poles, but form two negatively related dimensions of mental health (Greenspoon & Saklofske, 2001, pp. 81–108; Keyes et al., 2008; Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011; Lyons, Huebner, Hills, & Shinkareva, 2012; Westerhof & Keyes, 2009). However to date, it is unknown whether this dual-factor model of mental health can be confirmed in studies on psychotherapeutic interventions. Especially in treatment, the dual-factor model might be of significance, because it could be that a therapy that is effective in enhancing positive mental health may not necessarily be effective in alleviating psychopathology and vice versa. This lack of research underlines the need to evaluate the effectiveness of the dual-factor model on both dimensions of mental health and the interrelatedness between the two mental health dimensions. The dual-factor model of positive mental health and psychopathology as two related yet distinct dimensions evokes some interesting questions in psychotherapy. For example, are the people who benefit in terms of positive mental health the same people who benefit in terms of psychopathology? Does psychotherapy have independent effects on both outcomes? And do all people who increase in positive mental health during the psychotherapeutic intervention also decrease in their level of psychopathology and vice versa? The answers to these questions are highly relevant in the light of the recent developments in health services which aim for a mentally healthy population with both improved well-being and psychopathology (Slade, 2010).

Several meta-analyses have shown that a broad range of psychological interventions such as positive psychological interventions (Bolier et al., 2013; Lyubomirsky, King, & Diener, 2005), existential therapies (Vos, Craig, & Cooper, 2015, pp. 115–128), and CBT (Spek et al., 2007) are effective in increasing positive mental as well as in alleviating psychopathological symptoms. However to our knowledge, studies on the effectiveness of psychotherapy have only investigated effects on psychopathology and positive mental health independently. To date, no research has investigated the relationship between the effects on both mental health dimensions.

In order to address this lack in the scientific literature, the present study aimed to investigate the relationship between the effectiveness on positive mental health and on depression and anxiety symptoms as indicators of psychopathology of a self-help therapy. In particular, we selected to use Acceptance and Commitment Therapy (ACT; Bohlmeijer, Lamers, & Fledderus, 2015; Fledderus, Bohlmeijer, Pieterse, & Schreurs, 2012; Hayes, Luoma, Bond, Masuda, & Lillis, 2006). Face-to-face and self-help ACT can significantly improve outcomes including acceptance skills, depressive and anxiety symptoms in a large and heterogeneous range of somatic and psychiatric disorders (A-Tjak et al., 2015; Cavanagh, Strauss, Forder, & Jones, 2014). Critics do pose, however, that more studies of high methodological quality are necessary to supplement the present evidence base for ACT, particularly for diagnoses where present quantity of evidence is modest (Powers, Zum Vörde Sive Vörding, & Emmelkamp, 2009; Öst, 2014). More so than for its effectiveness, we included ACT in this study as ACT is explicitly aligned with many elements of both mental health dimensions. ACT focuses on reducing unhelpful experiences, cognitions and behaviors that create a context for experiential avoidance of these experiences, an important vulnerability for psychopathology (Biglan, Hayes, & Pistorello, 2008). Experiential avoidance is reduced in ACT to enable reinforcement of several psychological resources (e.g. acceptance, present-moment awareness) that will help individuals to undertake actions in line with intrinsically motivating values. This focus directly creates a context for living a meaningful and fulfilling life (Bohlmeijer et al., 2015; Ciarrochi & Kashdan, 2013). These considerations are in line with the significant effects of the ACT intervention in this study in increasing positive mental health and decreasing depression and anxiety symptoms, making it a good case study to investigate the relationship between the two mental health dimensions (Bohlmeijer et al., 2015; Fledderus, Bohlmeijer, Smit, & Westerhof, 2010; Fledderus et al., 2012).

Since positive mental health and psychopathology are distinct yet moderately related dimensions of mental health, we hypothesized that baseline levels of positive mental health and changes in positive mental health during the intervention could moderately predict the effectiveness of the intervention on depression and anxiety symptoms at follow-up. In addition, at baseline levels of depression and anxiety symptoms and changes in depression and anxiety symptoms could moderately predict the effectiveness of the intervention on positive mental health at follow-up. Moreover, we hypothesized that some people would improve on both positive mental health and depression/anxiety symptoms during the ACT-intervention, while others would improve on *either* positive mental health *or* psychopathology. More specifically, we expected to find a *moderate* interrelationship between the latent constructs and changes in positive mental health and psychopathology during the intervention ($r = -0.40$ to -0.50). Based on this hypothesis and the subsequent expected shared variance between measures of positive mental health and depression/anxiety symptoms, we exploratory hypothesize that the majority of participants will improve on either positive mental health or depression/anxiety symptoms but not the other. The latter result would not be possible from a traditional model that views positive mental health and psychopathology as mere opposites. Under this traditional model, the majority of participants can be expected to improve on both positive mental health and psychopathology (given expected intercorrelations between latent constructs and measures ≥ 0.75). Consequently, a majority of people improving on either positive mental health or depression/anxiety symptoms, but not the other, would comply with the dual-factor model of mental health.

1. Method

1.1. Participants and procedure

The present study draws on data from the Randomized Controlled Trial (RCT) by Fledderus et al. (2012). The study was approved by an independent medical ethics committee (METIGG; no. 9212) and recorded in the Dutch primary trial register for clinical trials (NTR1985). For an extensive description of the RCT's design and procedure, please refer to Fledderus et al., (2012). In the RCT, participants were included if they were 18 years or older and had mild to moderate depression symptoms (>10 and <39) as determined by the Center of Epidemiological Studies Depression Scale (CES-D; Radloff, 1977) and/or anxiety symptoms (<3 and <15) as determined the Hospital Anxiety and Depression Scale – Anxiety subscale (HADS-A; Zigmond & Snaith, 1983). Exclusion criteria were severe depressive symptomatology and/or anxiety (more than one standard deviation above the population mean on the CES-D and HADS-A), receiving psychological or psychopharmacological treatment within the last three months, and/or a high suicide risk as measured by the Web Screening Questionnaire (Donker, van Straten, Marks, & Cuijpers, 2009). After signing informed

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