



A randomized controlled trial of strong minds: A school-based mental health program combining acceptance and commitment therapy and positive psychology

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ABSTRACT

To date, most early intervention programs have been based on emotion regulation strategies that address dysfunctional cognitive appraisals, problem-solving skills, and rumination. Another emotion regulation strategy, 'acceptance' training, has largely been overlooked. To examine the efficacy of this strategy, a school-based mental health program combining positive psychology with acceptance and commitment therapy (Strong Minds) was evaluated in a randomized controlled trial with a sample of 267 Year 10 and 11 high-school students in Sydney, Australia. Mixed models for repeated measures examined whether the program led to reductions in symptoms amongst students who commenced the program with high depression, anxiety, and stress scores, and increased wellbeing scores amongst all students. Results demonstrated that compared to controls, participants in the Strong Minds condition with elevated symptom scores ($n = 63$) reported significant reductions in depression ($p = .047$), stress ($p = .01$), and composite depression/anxiety symptoms ($p = .02$) with medium to strong effect sizes (Cohen's $d = 0.53, 0.74, \text{ and } 0.57$, respectively). Increased wellbeing ($p = .03$) in the total sample and decreased anxiety scores ($p = .048$) for students with elevated symptoms were significant for Year 10 students with medium effect sizes (Cohen's $d = 0.43 \text{ and } 0.54$, respectively). This study tentatively suggests that including the emotion regulation strategy of acceptance in early intervention programs may be effective in reducing symptoms and improving wellbeing in high school students. Further research to investigate the generalizability of these findings is warranted.

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1. Introduction

Mental illnesses are increasingly being recognized as a global public health issue and are a leading cause of disability in high-income countries (Vos and Mathers, 2000). Although mental illnesses contribute more to impairment DALYs than physical health problems, only 5% of health spending is directed towards improving mental health in high-income countries (World Health Organization, 2013). While the focus has generally been on the treatment of mental disorders, it may be more prudent to place early intervention, which is more cost-effective (Access Economics, 2009), at the forefront of public mental health initiatives.

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Approximately 50% of adult mental disorders begin by the age of 14 years (Kessler et al., 2005) suggesting that early intervention at the adolescent level may prevent adult mental health problems from emerging. Early intervention can also address the high rates of adolescent mental health problems, which are found to be higher than for all other age groups (Australian Bureau of Statistics, 2008).

Emotion regulation has been cited as instrumental to psychological health and wellbeing as far back as Freud (1946). Emotion regulation is the ability to monitor, evaluate, and modify emotional reactions (Thompson, 1994). Evidence suggests that emotion regulation has a causal role in the development of almost all mental illnesses, particularly in the disorders of mood, anxiety, substance use, eating, and personality (Aldao, Nolen-Hoeksema, and Schweizer, 2010; Berking and Whitley, 2014; O'Driscoll, Laing, and Mason, 2014). Longitudinal data suggests that poor emotion regulation precedes the onset of depression and not vice versa (Aldao et al., 2010). There are likely countless techniques to regulate emotions although the literature commonly refers to four emotion regulation strategies, three are considered to be generally adaptive and one generally maladaptive (Aldao et al., 2010). Adaptive emotional regulation strategies are: (a) 'reappraisal' which involves modifying an interpretation of a situation to reduce its emotional impact; (b) 'acceptance' whereby an individual accepts their emotional experience, as opposed to avoiding or suppressing them; and (c) 'problem-solving' where a situation is modified in order to reduce its emotional impact. For example, an individual may reframe a difficult task as a 'challenge' rather than 'impossible' (reappraisal), accept the feelings of anxiety that accompany the task, and find solutions to resolve the problem. The maladaptive emotion regulation strategy is 'rumination' whereby negative thoughts or memories are repeatedly replayed. For example, in facing a difficult event an individual may replay the event in their mind while focusing on failure. A meta-analysis of 114 studies found that the strategies of poor acceptance and rumination were positively correlated with anxiety, depression, disordered eating, and substance-related disorders (Aldao et al., 2010). A negative association was found for the strategies of acceptance, problem-solving, and reappraisal with these same four psychopathologies.

Most young people are underequipped to manage the emotional impact of stressors. The ability to regulate emotions follows other developments in the cognitive, social, and physiological domains, gradually emerging from infancy to adulthood (Zeman, Cassano, Perry-Parrish, and Stegall, 2006). Adults are better equipped than their younger counterparts due to their experiences in learning and practicing emotion regulation strategies (Garnefski, Legerstee, Kraaij, Van Den Kommer, and Teerdts, 2002). While younger children may have even less experience than adolescents, they may benefit from the external emotion regulation provided by their parents (e.g., a parent consoling an upset child; Zeman et al., 2006). Adolescents are at a precarious stage where they are more likely to reject the emotion regulation provided by their caregivers but have not yet gained sufficient experience and practice in dealing with stress. In addition, neurological and hormonal changes during this period compound the difficulties adolescents experience in dealing with stress (Arnsten and Shansky, 2004; Saz, Bittencourt-Hewitt, and Sebastian, 2015; Susman et al., 1987). Learning emotion regulation strategies is therefore likely to benefit this population and improve rates of emerging mental health disorders.

Most early intervention programs for adolescents teach emotion regulation strategies based on the techniques espoused in Cognitive-Behavioral Therapy (CBT). For programs focused on addressing depression symptoms these include: (a) reinterpreting negative cognitions; (b) engaging in pleasant activities; (c) teaching problem-solving skills; and (d) enhancing social skills (Stice, Shaw, Bohon, Marti, and Rohde, 2009). The outcomes from these programs have been mixed and a meta-analysis has found that less than half significantly reduced depression symptoms (Stice et al., 2009). While some researchers have attributed these disappointing results to the lack of statistical power in several studies, this is insufficient to fully explain these findings. Reported means in some trials, even those that reported statistical significance, suggest no clear advantage for the early intervention condition (e.g., Horowitz, Garber, Ciesla, Young, and Mufson, 2007; Merry, McDowell, Wild, Bir, and Cunliffe, 2004; Quayle, Dziurawiec, Roberts, Kane, and Ebsworthy, 2001). A notable omission in most early intervention programs for adolescents is the focus on the emotion regulation strategies of acceptance. An evaluation of an early intervention program that addresses this component in adolescents is indicated.

Acceptance and Commitment Therapy (ACT), developed by Hayes, Strosahl, and Wilson (1999), combines mindfulness with behavioral principles and an understanding of personal values (see Hayes, 2004). Mindfulness is the purposeful direction of attention to the present moment with an open-minded and curious attitude. The direct attention component of mindfulness assists

Table 1
Baseline characteristics of participants.

Condition	Strong Minds	Control	p-Value	Cohen's <i>d</i>
Age (years), mean (SD)	16.37 (0.65)	16.34 (0.64)	.64	.06
Sex (males), <i>n</i> (%)	87 (63%)	75 (59%)	0.50	.08
Baseline depression score, <i>n</i>	139	128		
Mean (SD)	11.3 (10.0)	11.3 (10.0)	.98	.002
Baseline anxiety score, <i>n</i>	139	128		
Mean (SD)	9.6 (8.4)	9.4 (8.6)	.85	.02
Baseline stress score, <i>n</i>	139	128		
Mean (SD)	13.7 (9.2)	14.0 (8.9)	.82	.03
Baseline total DASS score, <i>n</i>	139	128		
Mean (SD)	34.6 (25.0)	34.6 (24.4)	.99	.001
Baseline FS score, <i>n</i>	138	122		
Mean (SD)	41.2 (9.0)	42.8 (7.2)	.12	.20

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