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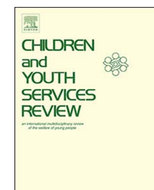

# A dual-factor model of mental health and social support: Evidence with adolescents in residential care

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## 1. Introduction

According to the positive psychology background, the focus on constructive dimensions of individual functioning implies a critical change on the paradigm from the merely analysis focused on individual pathology (and on the need to repair the damage) to an approach focused on self-actualization and well-being (Seligman & Csikszentmihalyi, 2000). Despite the progressive investment in this area, the study of distress and disorders has been greater than in the positive individual functioning. As such, in order to address the limitations of traditional models of mental health, a range of theoretical models, with different labels but focused on the same conceptual meanings, has emerged from the positive psychology framework. For instance, there are authors proposing a Dual-factor system of mental health (Greenspoon & Saklofske, 2001), others The two continua model of mental illness and health (Westerhof & Keyes, 2010) and others the Dual-factor model of mental health (Wang, Zhang, & Wang, 2011). All these models suggest that mental health must be viewed as a complete state, reflecting the integration of a positive (well-being) and a negative (psychopathology) dimension of adjustment, in two continuums but related factors (Wang et al., 2011; Westerhof & Keyes, 2010).

This conceptualization of mental health has been empirically tested and results supported the model with two separate dimensions (Keyes, 2005; Wilkinson & Walford, 1998). This evidence of a dual-factor model of mental health allows the classification of individuals and the emergence of diverse groups with distinct status of mental health (Wang et al., 2011). Different approaches of classification could be adopted, with the quartered classification theory suggesting that mental health status can be understood in four groups: 1) *Complete mental health* [average/high well-being and low psychopathology]; 2) *Vulnerable* [low well-being and low psychopathology]; 3) *Symptomatic but content* [average/high well-being and high psychopathology] and 4) *Troubled* [low well-being and high psychopathology] (Suldo & Shaffer, 2008; Suldo, Thalji, & Ferron, 2011). These options of classification allowed addressing some limitations of traditional theoretical models of mental health. For instance, people that reveal low levels of psychopathology but reveal also low levels of well-being are typically overlooked in terms of mental health by these models, and consequently, they tend to have less support from services (Suldo & Shaffer, 2008). As such, the absence of psychological problems is not a sufficient condition to show higher levels of mental health (Suldo et al., 2011).

Analyzing how mental health outcomes varies according to supportive relationships during adolescence, results suggest that youth in the group of *Complete mental health* (or Positive mental health as the authors named this group) reported greater perceived support from family than all other groups, and from peers compared with *Vulnerable* and *Troubled* groups. The *Symptomatic but content* group showed significantly higher support from family, peers and teachers than *Vulnerable* and *Troubled* groups (Antaramian, Huebner, Hills, & Valois, 2010). These results may underline the importance of perceived social support as a protective factor (Sarason, Levine, Basham, & Sarason, 1983), and the importance of interpersonal relationships to the psychological adjustment in the adolescence (Ackard, Neumark-Sztainer, Story, & Perry, 2006; Moon & Rao, 2010).

Specifically, considering the young people in residential care, mental health conceptualization and measurement is particularly challenging. In this manuscript we are particularly focused on young people who were taken from their families and placed in care as derived from their need of alternative protection. As such, it is relatively consensual that young people in care have increased developmental challenges compared with normative youth. Not only they might overcome difficulties arising from their previous vulnerability and risk experiences, they also must deal with their current living conditions, and with those developmental challenges that all young people have to deal with (Jansen, 2010). In fact, the literature with young people in residential care reveals that they are a vulnerable group in what concerns mental health outcomes, since they show significant emotional and behavioral difficulties (Kjelsberg & Nygren, 2004; Schmid, Goldbeck, Nuetzel, & Fegert, 2008; Simsek, Erol, Öztop, & Münir, 2007). On the other hand, the research on mental health in care following a positive framework and focused on human potential and well-being has been less developed (Dinisman, Montserrat, & Casas, 2012). The studies with young people in residential care (those who were taken from their families derived from protection reasons) reveal that worse subjective

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well-being tends to be reported by young people in care, even with slightly different results. Some of them reveal significant lower scores on overall life satisfaction and specifically considering a set of indicators of subjective well-being (e.g., health, school, social relations) (Dinisman et al., 2012; Llosada-Gistau, Montserrat, & Casas, 2014). Others reported significant differences merely on specific dimensions of well-being - i.e., significant differences were found on negative affect but neither on positive affect nor on life satisfaction (Poletto & Koller, 2011).

Although these results are very important for understanding mental health outcomes in care, an integrated and holistic approach is needed (i.e., considering both mental distress and well-being). As such, in this work we go beyond the traditional models of mental health focused merely on the absence of difficulties, emphasizing our analysis also on aspects of self-actualization and well-being (Seligman & Csikszentmihalyi, 2000; Wang et al., 2011). Similarly, given the significant relevance of supporting relationships for mental health (Chu, Saucier, & Hafner, 2010), and consistently with previous evidence using a dual-factor model approach (Antaramian et al., 2010), we will explore the relationship between different status groups of mental health and a set of social support components and resources (i.e., formal and informal). Both types of social support are relevant, given that young people in residential care identifies different sources of support, peers or adults both from care settings and outside (e.g., biological family, school) (Bravo & Del Valle, 2003). Generally, these supportive relationships are important for youths' mental health being associated with fewer adjustment problems (Pinchover & Attar-Schwartz, 2014); in contrast, the lack of supportive caregiving is related to more mental health problems (Erol, Simsek, & Munir, 2010). These supportive relationships may help these adolescents to deal with difficulties and challenges during their developmental trajectories (Bravo & Del Valle, 2003; Martín & Dávila, 2008).

## 2. Research problems and objectives

As we postulated before, the literature with young people in residential care tends to be more focused on negative outcomes, and less in positive functioning. On the other hand, the literature that has been testing paradigms focused on these two dimensions of mental health (i.e., dual-factor models of mental health) are mostly focused on measures of subjective well-being (i.e., life satisfaction, positive affect) (Antaramian et al., 2010), and lesser on eudaimonic dimensions. Moreover, those studies that include psychological well-being dimensions tend to be developed with adults, less evidence existing with adolescents (Keyes, 2006). Besides, to our best knowledge, the studies developed within this theoretical paradigm do not include adolescents in care, and for that reason, in the present study we are looking for evidence on mental health as a complete state with this population. As such, this study aims to: 1) test the suitability of a dual-factor model with young people in care; and to 2) explore how different mental health groups may differ on social support dimensions from different sources (formal and informal).

## 3. Method

### 3.1. Participants

A sample of 369 Portuguese adolescents (54% males), from 59 residential care settings, participated in this study ($M = 14.75$; $SD = 1.83$). These adolescents came from at-risk families characterized mainly by neglectful parental practices (66%). Also, additional risk factors were also found in these families, namely, unemployment (47%), parental divorce or separation (36%) and alcohol abuse (35%). The placement in the present residential setting is the first one for 57% of these young people. These residential settings, as defined by our law, aim to "contribute to the creation of conditions that guarantee the adequate physical, psychological, emotional and social needs of children and young people and the effective exercise of their rights, favouring their integration in a safe socio-familial context and promoting their education, well-being and integral development" (Law 142/2015, p. 7221). Moreover, these settings may be specialized namely, therapeutic settings or apartments for autonomy. In this work we did not include specialized settings. All residential care settings included in this study are dealing with youth who were taken from their families for protection concerns. These settings vary significantly in their dimension (there are larger facilities with 45 children but also smaller units with 6 children), and are diverse in their typology, namely, including settings for both sexes (42%), others that receive merely female children/youth (25%), and finally others that receive merely male children/youth (32%).

### 3.2. Measures

#### 3.2.1. Questionnaire of institutional support

Formal social support was assessed using an adapted version of the Questionnaire of Institutional Support (Calheiros, Graça, Patrício, Morais, & Costa, 2009; Calheiros & Paulino, 2007). Three dimensions of functional support were assessed (23 items), each of them considering both social workers and educators: 1) Esteem - it involves young people perceptions that they are valued by social workers/educators (6 items, e.g. "Do you think that in this institution social workers/educators value you as a person?"), 2) Emotional/relational - it involves young people perceived concern, care and empathy from social workers/educators (7 items, e.g. "To what extent do you think social workers/educators are available to attend you?"), and 3) Evaluative/informational - it involves young people perceived information, guidance or feedback provided by social workers/educators that can help them to solve a problem (7 items, e.g. "Do you think that in this institution the social workers/educators well evaluate your problems?"). Young people might answer each item using a scale from Never (1) to Ever (5) (Calheiros & Paulino, 2007; Calheiros et al., 2009). This scale revealed adequate reliability and validity evidence (Magalhães, 2015).

#### 3.2.2. Social support questionnaire

Informal social support was assessed in terms of perceived satisfaction and availability of social support using a short version of the Social Support Questionnaire (Sarason et al., 1983) adapted to the Portuguese context by Moreira et al. (2002). This questionnaire contains six items that allows the assessment of these two dimensions of perceived social support: 1) the perceived availability (i.e., the number of individuals who are available to provide support) and 2) the perceived satisfaction (i.e., the perceived satisfaction with this support). Each item requires two answers: 1) the participants list the number of people who may support them using a scale from (0) "Nobody" to (9) "Nine people"; and 2) they might indicate their degree of satisfaction with that support (on a scale from (1) "very dissatisfied" to (6) "Very satisfied") (Moreira et al., 2002; Sarason et al., 1983). Validity and reliability evidence was found in residential care (Magalhães, 2015).

#### 3.2.3. Reynolds adolescent adjustment screening inventory (RAASI)

In the present study a Portuguese version of the RAASI, translated and adapted for youth in residential care (Calheiros et al., 2009) was used. A four dimensional structure composed by 22 items was obtained in a previous study testing construct validity of this measure (Magalhães, 2015): Antisocial Behavior (youth's troubled behaviours in different contexts, 6 items; *Cronbach's Alpha* = 0.78); Anger control problems (youth's oppositional behaviours, 5 items; *Cronbach's Alpha* = 0.72); Emotional distress (youth's general distress, excessive anxiety and worry, 7 items; *Cronbach's Alpha* = 0.81), and Positive Self (difficulties of self-esteem and sociability, 4 items; *Cronbach's Alpha* = 0.58). Those 4 items from Positive self are written in a positive way, which means that they should be reversed to reflect psychological

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