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The Polish adaptation of the Mental Health Continuum-Short Form (MHC-SF)

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ABSTRACT

The Mental Health Continuum-Short Form (MHC-SF) developed by Keyes (2009) is the tool that allows for continuous assessment of subjective well-being (including its three aspects: emotional, psychological, and social), as well as for the categorical diagnosis of the presence of mental health and the absence of mental health (understood as flourishing and languishing). This paper presents the result of the validation and psychometric parameters of the Polish MHC-SF. The participants included 2115 respondents aged 16–81 (55.6% women) from Poland. The findings confirmed the reliability of MHC-SF, external validity, three-dimensional structure of subjective well-being, and supported two-continua model of mental health, where mental health and mental illness are two related but distinguishable dimensions, not at the ends of the same continuum.

1. Introduction

Until recently, mental health has been understood as the absence of mental illness. But in last few decades, this view has changed considerably. The current definition of mental health, created by World Health Organization (2004, p.12) states: "Mental health is a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." This definition is consistent with a general definition of health, which describes health as a state consisting of the presence of well-being and not only the absence of illness or disability (World World Health Organization, 1948).

When mental health is defined positively, well-being is an important component. Subjective well-being (SWB) – individuals reports of their own well-being – consists of two conceptual traditions, the hedonic and the eudaimonic. The first of which equates well-being with feeling good about (i.e., positive emotions toward) one's life, while the second with functioning well in life as an individual and a citizen. The hedonic tradition focuses on ***emotional*** well-being through the measurement of satisfaction with life and positive affect (Diener, 1984). The tradition of eudaimonia focuses on ***psychological*** (Ryff, 1989) and ***social*** (Keyes, 1998) well-being, both measured with multidimensional scales. The euaimonic stream assesses how well individuals see themselves functioning in life against secular standards of excellence such as purpose, contribution, integration, autonomy, intimacy, acceptance, and mastery. Studies support the tripartite structure of SWB, consisting of emotional, psychological, and social well-being in U.S. (see e.g., Gallagher, Lopez, & Preacher, 2009; Robitschek & Keyes, 2009) and increasingly across cultures (Keyes, 2013a; Keyes, 2013b).

The Mental Health Continuum "short form" (MHC-SF) was created to address the problem of the diagnostic threshold and to create a version more efficiently administered in epidemiological surveillance. The MHC-SF derives from the long form (MHC-LF) used in the Midlife in the United States (MIDUS) study (Keyes, 2002). While the MHC-LF consisted of 40 items, the MHC-SF consists of 14 items representing the construct definition for each facet of well-being. Three items indicate emotional well-being, six items represent the six dimensions of psychological well-being, and five items represent the five dimensions of social well-being. The response option for the short form was changed to measure the frequency (from "never" to "every day") with which respondents experienced each sign of mental health during the past month.

Keyes (2002) argues that good mental health is a syndrome of feeling good and functioning well. In the same way that depression

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requires symptoms of *an*-hedonia, mental health consists of symptoms of hedonia. But, feeling good, in the same way as only feeling sad or losing interest in life, is not sufficient for the diagnosis of a clinical state. Rather, and in the same way that major depression consists of symptoms of *mal*-functioning, mental health must also consist of symptoms of positive functioning.

In turn, the mental health continuum (Keyes, 2002) consists of three levels of positive mental health: flourishing, moderate, and languishing mental health (although researcher can use the "flourishing" and "not flourishing" categorization). Individuals with flourishing mental health report feeling at least one measure of hedonic well-being plus six or more of the measures of positive functioning almost every day or every day during the past month. Individuals with languishing mental health, however, report feeling at least one measure of hedonic well-being with six or more measures of positive functioning never or maybe once or twice during the past month. Languishing is the absence of mental health – a state of being mentally ***un***healthy – which is tantamount to being stuck and stagnant, or feeling empty or that life lacks interest and engagement. Individuals who are neither flourishing nor languishing are diagnosed with moderate mental health.

The short form of the MHC has shown excellent internal consistency (>.80) and discriminant validity in adolescents and adults in the U.S., but increasingly cross-culturally (Keyes, 2013a; Keyes, 2013b). Lamers, Westerhof, Bohlmeijer, ten Klooster, and Keyes (2011) evaluated the measurement invariance of the MHC-SF using data from a large representative sample of Dutch adults. This study used item response analysis to examine differential item functioning (DIF) by seven demographic variables (e.g., age, education, sex), health (i.e., whether a respondent had any of 18 disease conditions or not), and over time (i.e., respondents were followed up 4 times over a 9 month period). Of the 14 items in the MHC-SF, none showed DIF over time or health status, and only 4 showed DIF by demographics (one social well-being item by sex and one by education, and two psychological well-being items by age group). Adjustment for DIF on the 4 items did not affect the results of mean comparison, indicating that the DIF was small on those 4 items. Overall, the MHC-SF items have the same meaning by demographics, health, and over time.

Similarly, Joshanloo, Wissing, Khumalo, and Lamers (2013) found support for the factor structure (emotional, psychological, and social) and full metric invariance of the MHC-SF across three cultures: Netherlands, South Africa, and Iran. Metric invariance means that the strength of the relationships between the MHC-SF items and latent factors are equivalent across the populations. As such, comparisons of MHC-SF scores across these three cultures reflect group differences rather than differential item meaning by culture. In addition, the long and short forms of the MHC have been useful in improving the scientific understanding of the risk of future mental illness (MDE, GAD, and panic attacks; see Keyes, Dhingra, & Simoes, 2010), risk of premature mortality (Keyes & Simoes, 2012), healthcare utilization, missed days of work, disability as measured by limitations of ADL (Keyes, 2007), resilience (Keyes, 2009), and self reported academic impairment among colleges students (Keyes et al., 2012).

The research presented in this article is the first attempt to validate the MHC-SF one in the context of Eastern Europe. To that end, we investigate the psychometric properties of the Polish adaptation of MHC-SF, focusing on the following: (1) internal alpha consistency; (2) structural validity assessed via confirmatory factor analysis; (3) measurement invariance across gender and educational groups assessed in multi-group confirmatory factor analysis; (4) external validity, assessed by inspection of correlation with different measures of some aspects of well-being; and (5) validity of the two-continua model assessed by factor analysis of well-being and mental illness measures.

2. Methods

2.1. Participants

The participants included 2115 (55.6% females) adults from Poland, aged 16–81 (M = 28.89, SD = 10.62). They completed the study measures as an anonymous self-report questionnaire.

The data were collected in 2013 in four studies in four different samples. In Study 1, there were 655 participants (49.8% females) aged 25–60 (M = 37.16, SD = 5.22), 0.3% with primary education, 4.7% with vocational education, 23% with secondary education, and 35% with higher education. In Study 2, 835 respondents participated (56.1% females) aged 16–81 (M = 29.56, SD = 12.281), 5% with primary education, 4% with vocational education, 55.6% with secondary education and 27.6% with higher education. In Study 3, 477 participants took part (63.3% females) aged 18–33 (M = 21.51, SD = 1.961). All of them were students. In Study 4, there were 148 participants attending high school (53.4% females) aged 16–19 (M = 17.24, SD = .788).

2.2. Measures

Mental Health Continuum-Short Form (MHC-SF, Keyes, 2013a; Keyes, 2013b). The MHC-SF consisted of 14 items that represent various facets of well-being (the items were chosen from the longer version of this tool, as the most prototypical for each facet of well-being). The answering scale is 6-points, and describes the frequency of experiencing various symptoms of well-being. The scale ranges from *never* to *everyday* (during the past month).

This questionnaire allows for two kinds of assessment. On one hand, with MHC-SF we can assess the level of well-being (and its three dimensions: social, psychological, and emotional). On the other, this tool also allows for categorization into three types of mental health: flourishing, languishing, and moderate mental health.

To be diagnosed with *flourishing*, one should answer *everyday* or *almost everyday* (during past month) at least once in the emotional well-being scale, and at least six times across eleven items measuring social and psychological well-being. To be diagnosed with *languishing*, one has to experience *never* or *once or twice* during the past month for at least one item from the emotional well-being scale and at least six items on the psychological functioning (social and psychological well-being) scales. The respondents classified neither as flourishing nor as languishing are *moderately mentally healthy*.

General Health Questionnaire (GHQ-28). The Polish version of GHQ-28 (Goldberg & Hillier, 1979; Polish adaptation: Makowska & Merecz, 2001) is the questionnaire, where the respondent is asked to assess his or her health frequency of experiencing various psychical and physical states during the last couple of weeks. The main objective of this questionnaire is for measuring various mental disorders.

The questionnaire has 28 items comprising four scales: somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression. The responding scales range from *not at all* to *much more than usual*, *better than usual* to *much worse than usual,* and *definitely no* to *definitely yes.* The GHQ-28 was used in Study 2 and its reliability was assessed with Cronbach's alpha which ranged from .793 (Somatic Symptoms) to .880 (Severe Depression).

Positive and Negative Affect Schedule – Expanded Form (PANAS-X). The Polish version of PANAS-X (Watson & Clark, 1994; Polish adaptation: Fajkowska & Marszał-Wiśniewska, 2009) includes 60 items measuring positive and negative affect and is composed of 12 subscales (presented in Table 4) using a 5-point Likert scale, ranging from 1 (*not at all*) to 5 (*extremely*). A respondent has to assess the intensity of experiencing various