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Shorter communication

Flourishing in people with depressive symptomatology increases with Acceptance and Commitment Therapy. Post-hoc analyses of a randomized controlled trial

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ABSTRACT

Mental health is more than the absence of mental illness. Rather, both well-being (positive mental health) and mental illness are actually two related continua, with higher levels of well-being defined as "flourishing." This two-continua model and existing studies about the impact of flourishing on psychopathology underscore the need for interventions that enhance flourishing and well-being. Acceptance and Commitment Therapy (ACT) is a model of cognitive behavioral therapy that aims not only to reduce psychopathology but also to promote flourishing as well. This is the first study to evaluate the impact of ACT on flourishing. A post-analysis was conducted on an earlier randomized controlled trial of a sample of adults with depressive symptomatology who participated in a guided self-help ACT intervention. This post-analysis showed a 5%–28% increase of flourishing by the participants. In addition, the effects on flourishing were maintained at the three-month follow-up. When compared to participants in a control group, the flourishing of the ACT-trained participants increased from 5% to about 14% after nine weeks. In addition to levels of positive mental health at baseline, an increase of psychological flexibility during the intervention was a significant predictor of flourishing at the three-month follow-up.

Introduction

Recognition that mental health is more than simply the absence of mental illness has grown substantially in the last decade. The World Health Organization (WHO) defined mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2004, p.12). Keyes (2005) developed the two-continua model of mental health that states that well-being (or positive mental health) is related to, but different from, mental illness. This specific model builds on earlier research underscoring the need to distinguish between positive and negative affect (e.g. Bradburn, 1969; Huppert & Whittington, 2003) and has been corroborated in many studies across different countries and cultures (e.g. Keyes et al., 2008; Lamers, Westerhof, Bohlmeijer, Ten Klooster, & Keyes, 2010). In congruence with the WHO definition and based upon extensive reviews of psychological and sociological theories, well-being has been operationalized as emotional well-being, psychological well-being and social well-being (Diener, 1984; Keyes, 1998; Ryff, 1989). The Mental Health Continuum – Short Form (MHC-SF) was developed to measure these three main models of well-being: emotional, psychological, and social well-being (Keyes, 2002). Each of these models consist of several dimensions. The MHC-SF is a short questionnaire based a longer Mental Health Continuum, and reflects each theory-based dimension of well-being by one item. Emotional well-being consists of the dimensions positive affect, happiness, and satisfaction with life; Psychological well-being consists of the six dimensions of Ryff's (1989) model, including one item on each of the dimensions of autonomy, environmental mastery, personal growth, positive relations with others, purpose in life and self-acceptance); and Social well-being consists of the five dimensions of Keyes' (1998) model, including one item on each of dimensions of social acceptance, social actualization, social contribution, social coherence and social integration. This instrument allowed for developing a

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classification model of mental health (Keyes, 2007) that distinguishes between people who are flourishing, people with moderate mental health and people who are languishing. When individuals score high on at least one dimension of emotional well-being and at least six dimensions of psychological and social well-being, they are classified as "flourishing." When individuals score low on at least one dimension of emotional well-being and at least six dimensions of psychological or social well-being, they are classified as "languishing." People who do not fit the criteria for either flourishing or languishing are classified as "moderately mentally healthy."

Some initial studies found that flourishing is not just a desired end state of itself, but possibly buffers against (mental) illness as well. Keyes, Dhingra, and Simoes (2011) showed that changes of levels or diagnoses of mental health between 1995 and 2005 strongly predicted the prevalence and incidence of mental illness in 2005. Using data from the Midlife in the United States study, Keyes and Simoes (2012) also found that the absence of flourishing increased the probability of all-cause mortality for adults, even after adjustment for known causes of death. Lamers et al. (under review) demonstrated that changes in mental health as measured with the MHC-SF explained 18% of the variance of psychopathology at the three-month follow-up in a large sample of representative Dutch adults, on top of initial levels of psychopathology. The absence of psychological well-being has also been found to be an important long-term risk factor for depression (Wood & Joseph, 2010).

The two-continua model and existing studies about the impact of flourishing underscore the need for interventions that enhance flourishing and mental health (Keyes, 2007). In the past, a cognitive-behavioral intervention for increasing psychological well-being (well-being therapy) has been developed and found to be effective in diverse populations such as people with generalized anxiety disorder (Fava et al., 2005) and affective disorders (Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998). Another therapeutic approach that fits well with a mental health promotion framework is Acceptance and Commitment Therapy (ACT). ACT has been defined as a distinctive model of behavioral and cognitive therapy with a strong focus on the context of behavior (Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013). It is based on a relational frame model that links behavioral principles to both pathology and flourishing (Ciarrochi & Kashdan, 2013; Hayes et al., 2013). "The aim of ACT is, quite simply, to maximize human potential for a rich, full and meaningful life" (Ciarrochi & Kashdan, p. 2). Experiential acceptance or mindfulness is a core process within ACT and has been found to relate to well-being (Brown & Ryan, 2003; Carmody & Baer, 2008). Additionally, promoting valued or engaged living is a primary focus of ACT. Commitment to choices and goals based upon intrinsic values and motivations has been found to predict well-being (Ryan & Deci, 2000; Sheldon & Elliot, 1999; Steger, Merriman, & Kashdan, 2013). The capacity to live mindfully or accept present experiences and to act in accordance with one's core values has been defined as psychological flexibility (Ciarrochi & Kashdan, 2013; Hayes et al., 2013).

Randomized controlled trials have shown the efficacy of ACT as a treatment of distress (e.g. Bohlmeijer, Fledderus, Rokx, Pieterse, 2011; Kocovski, Fleming, Hawley, Huta, & Antony, 2013; Trompetter, Bohlmeijer, Veehof, Schreurs, 2015) and as an intervention that enhances well-being (Fledderus, Bohlmeijer, & Westerhof, 2011, Fledderus, Bohlmeijer, Pieterse, Schreurs, 2012; Fledderus, Oude Voshaar, ten Klooster, Bohlmeijer, 2012). However, the intriguing question whether ACT is indeed able to have an impact on flourishing (the ability to live a full, rich and meaningful life) as a distinct category of optimal mental health has yet to be answered. In order to evaluate the impact of ACT on flourishing, we conducted post-hoc analyses of a randomized controlled trial (Fledderus, Bohlmeijer, et al., 2012; Fledderus, Oude Voshaar, et al., 2012) that evaluated the efficacy of a guided self-help ACT intervention on depressive symptomatology. In addition we explored whether an increase of psychological flexibility might predict flourishing as a successful treatment response.

Method

Procedure and participants

Participants of 18 years or older with mild to moderate depressive symptoms were recruited through advertisements in Dutch newspapers. People who were diagnosed as having a severe depression with the Mini International Neuropsychiatric Interview (Sheehan et al., 1998) were excluded. Other exclusion criteria were: (a) the absence of depressive symptoms, (b) receiving psychological or psychopharmacological treatment within the last 3 months, and (c) high suicide risk. A total of 625 people responded to the advertisements. After the screening procedure, 376 participants were randomly assigned to one of the following three conditions: (1) the ACT intervention with minimal email support (ACT-M; n = 125), (2) the same intervention with extensive email support (ACT-E; n = 125), or (3) a waiting list (W-L; n = 126). In the present study, we combined the ACT condition with extensive email support and the ACT condition with minimal email support into one ACT condition ($n = 250$), because the groups did not differ in effectiveness (Fledderus, Bohlmeijer, et al., 2012; Fledderus, Oude Voshaar, et al., 2012). The participants were on average 42 years old (range 18–73 years). The majority was female (70%) and highly educated (86%). For further details on the procedure, see Fledderus, Bohlmeijer, et al., 2012; Fledderus, Oude Voshaar, et al., 2012.

Intervention

Participants of the experimental condition received the self-help book *Voluit Leven (Living life to the full;* Bohlmeijer & Hulsbergen, 2009). The book comprises nine modules. The modules are based on the core processes of ACT that together promote psychological flexibility. Each module uses informative texts, experiential exercises, metaphors and (10–15-min) mindfulness exercises. At the end of a week in which participants worked through a module, they were invited to send an email with a report of the progress and questions about the program. They would then receive feedback by email from a counselor. For further details on the program, see Fledderus, Bohlmeijer, et al. (2012) and Fledderus, Oude Voshaar, et al. (2012).

Measures

Flourishing was measured with the Mental Health Continuum-Short Form (MHC-SF) questionnaire (Keyes et al., 2008; Lamers, Westerhof, Bohlmeijer, Ten Klooster, & Keyes, 2011) which measures positive mental health by 14 items on emotional (3 items), psychological (6 items), and social well-being (5 items). Participants were asked to rate how often they had experienced feelings of well-being in the past month on a scale ranging from 1 (never) to 6 (everyday). The MHC-SF has shown good psychometric properties in the Dutch population (Lamers et al., 2011) as well as stability of the item parameters over time and across demographical characteristics (Lamers, Glas, Westerhof, & Bohlmeijer, 2012). In the present study, the positive mental health scores were categorized in accordance with the method described by Keyes (2009). To categorize participants into flourishing and not-flourishing, Keyes' categorical diagnosis was used (Keyes, 2009). The diagnosis of flourishing was made if a participant rated at least one of the three