
COMMENTARY

The Dual-Factor Model of Mental Health in Youth

Beth Doll

University of Nebraska—Lincoln

Suldo and Shaffer (2008) should be roundly applauded for pursuing an empirical examination of relations between the presence of wellness and the absence of psychopathology in adolescents. The possibility that psychopathology and wellness make related but distinct contributions to mental health has been widely recognized in the American Psychological Association's agenda on positive psychology (Keyes & Haidt, 2003), in Rutter and Sroufe's (2000) descriptions of the challenges facing the science of developmental psychopathology, and in Greenspoon and Saklofske's (2001) empirical description of a two-factor model of mental health with a Canadian sample of elementary students. Despite its importance, psychological wellness has not been incorporated into the day-to-day practice of psychology in any notable ways. Outside of public agencies like schools and juvenile justice, access to mental health services is linked to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; DSM-IV-TR; American Psychiatric Association, 2000) diagnoses, which are based predominantly on negative symptoms and dysfunction. Most items on prominent measures of psychosocial adjustment (Reynolds & Kamphaus, 2004; Achenbach & Rescorla, 2001) describe mal-

adaptive behaviors, and even when subscales assess positive behaviors, the subscales' scores are more sensitive measures of the degree of maladjustment (the presence of pathology and the absence of well-being) than adjustment (the absence of pathology and the presence of well-being).

The omission of psychological wellness from operational definitions of "mental health" is particularly striking when preventive interventions are examined. The National Institute on Mental Health (1998) has generally restricted the national mental health research agenda to the prevention of psychopathology, omitting references to the promotion of wellness. This narrow definition has been challenged by leaders in prevention research, who argue that mental health services must necessarily include health promotion, youth development, and competence enhancement (Weissberg, Kumpfer, & Seligman, 2003; Weisz, Sandler, Durlak, & Anton, 2005). The stakes are high for school mental health practices. School settings are among the least restrictive settings for the provision of preventive mental health services, and school practices would benefit greatly if the National Institute on Mental Health adopted a broad model for research that also examined preven-

Correspondence regarding this article should be addressed to Beth Doll, University of Nebraska—Lincoln, 114 Teachers College Hall, Lincoln, NE 68588-0345; E-mail: bdoll2@unl.edu

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tive interventions targeting peers, families, or communities of affected youth.

One of the most ubiquitous signs of pathology-dominated mental health is the widespread use of logically inconsistent terms like *mental health disorder* or *mental health diagnosis*. If a phenomenon represents “health,” it should not be simultaneously cast as a “disorder.” An alternative term, *mental disorder*, firmly embeds the phenomenon in medical or disease models of psychopathology. Still, it also allows for the possibility that mental health is not defined solely by the absence of maladjustment.

In their article, Suldo and Shaffer (2008) join other researchers in proposing that subjective well-being might be a reliable, valid, and practical index of the positive dimensions of “health” in mental health. They appropriately indicate that, to date, there are only a few empirical tests of the relations that exist between the presence of psychopathology and the absence of psychological wellness. As such, their study provides a valuable first step towards accruing empirical evidence indicating that measures of subjective well-being can add important predictive power to school-based assessments of children’s needs for school mental health services. Their study’s rigor is commendable in a number of other respects: They were careful in their measurement of key variables, using both teacher ratings and student ratings to assess psychopathology, incorporating both externalizing and internalizing disorders into their operational definition of psychopathology, and including existing school data to assess the outcome of academic success (e.g., attendance, grade point average, standards tests) in addition to self-reported academic perceptions and goals. Finally, Suldo and Shaffer acknowledge important weaknesses in their research design, including their use of a convenience sample and their overreliance on self-report measures. The latter can lead to significant difficulties with shared method variance. For example, shared method variance could explain some of the relations identified between subjective well-being and self-reports of health, because self-reports of health could be influenced by

the somatization of students particularly dissatisfied with their current life situations.

In other respects, Suldo and Shaffer (2008) have not fully acknowledged the challenges faced by current research on subjective well-being. Foremost among these is the incomplete conceptual framework that defines subjective well-being and complicates the interpretation of research examining its relation to psychopathology. Second, research designs have not yet addressed the complexity of psychopathology with particular attention to distinctions that have been repeatedly demonstrated between externalizing and internalizing disorders and to the critically important phenomenon of internalizing–externalizing comorbidity. Third, current research describing interrelations between subjective well-being and psychopathology is hampered by the frequent use of categorical groupings to describe students with high versus low psychopathology and high versus low subjective well-being. Categorical analysis masks some of the variance in the data and relies on the uncertain viability of the cut points that are used to form the categories. Fourth, and finally, some of the findings that delineate important contributions of subjective well-being to diagnostic measures of psychopathology could be artifacts of the categorical diagnostic conventions currently used in the United States. The remainder of my comments will expand on these four challenges, and will extend Suldo and Shaffer’s recommendations for the “next steps” in the research on subjective well-being.

What Is Subjective Well-Being?

Although the theoretical concept of subjective well-being has been amply defended by Suldo and Shaffer (2008) as a likely index of psychological wellness, the meaning of operational measures of self-rated subjective well-being is not altogether established. For example, is the presence of high ratings of life satisfaction equivalent to the absence of psychopathology? The possibility is raised by Suldo and Huebner’s (2006) study showing that adolescents with life satisfaction ratings in the upper 10% of their sample also had ex-

tremely low rates of psychopathology (i.e., less than 2%); participants with average life satisfaction ratings had relatively low rates of psychopathology (i.e., less than 3%); and high rates of psychopathology occurred principally among those with low ratings of subjective well-being. Within every study, some participants have been identified who break with this pattern. For example, both Suldo and Shaffer (2008) and Greenspoon and Saldofsky (2001) identified some children with both high rates of psychopathology and high life satisfaction; Greenspoon and Saldofsky suggest (and their discriminant functions support) that these may be children with externalizing rather than internalizing symptoms.

What Is the Relation Between Subjective Well-Being and Psychopathology?

This raises a second question: Is it possible that the positive statements defining “life satisfaction” could be operationally equivalent to low rates of internalizing symptoms? In fact, Huebner, Funk, and Gilman (2000) reported strong negative correlations between adolescent life satisfaction and internalizing disorders. Alternatively, in a study with middle-aged adults, Keyes (2002) reported that only 28% of their participants with low ratings of life satisfaction also endorsed symptoms of depression. To fully examine this possibility, a complete examination of internalizing disorders must include anxiety disorders as well as depression. Although both depression and anxiety are marked by high rates of negative cognitions, there is some suggestion that only depression is also characterized by low rates of positive cognitions (Chorpita & Southam-Gerow, 2006). Perhaps, then, high rates of subjective well-being are most closely linked to low rates of depressive symptoms. Clearly, answers to this question will require carefully conducted validity studies that examine interrelations among various measures of psychopathology (total scores, depression, anxiety) with various indices of subjective well-being. It will also be important to move beyond rating scales, which are ultimately unsatisfactory

as a sole indicator of psychopathological diagnosis, and to use measures other than self-report scales as indices of psychopathology. (Suldo and Shaffer, 2008, have made an important move in this respect.) Results could demonstrate that indices of internalizing and externalizing psychopathology have different relations with subjective well-being.

A robust finding of developmental psychopathology research is that children who simultaneously meet criteria for internalizing and externalizing disorders are particularly at risk for poor therapy outcomes and detrimental life outcomes. A comprehensive examination of the interface of psychopathology with subjective well-being could determine whether youth with such comorbidity might be the same youth who comprise Suldo and Shaffer’s (2008) “very troubled” participants.

What Is Lost Through Categorical Analysis?

Following the model used by Greenspoon and Saldofsky (2001), Suldo and Shaffer (2008) have used measures of psychopathology and subjective well-being to divide their participants into four groups: mentally healthy (with high subjective well-being and low psychopathology), vulnerable (with low subjective well-being and low psychopathology), symptomatic but content (with high subjective well-being and high psychopathology), and troubled (with low subjective well-being and high psychopathology). On the face of it, this categorization is appealing in its conceptual clarity and allows for simpler data analyses. However, the use of categorical analyses can mask much of the complexity that marks interrelations among psychopathology and subjective well-being.

There is evidence that large numbers of children have “messier” data than simple classification schemes would indicate. Greenspoon and Saldofsky (2001) found that only 58% of their sample “fit” in the discriminant function analyses that they conducted; data from 42% of their participants was discarded. Although the cut points that Suldo and Shaffer (2008) used to form their categories are logi-

cally reasonable, other strategies for categorization could also be proposed, and an important question is whether results would be sufficiently robust if different cut points were substituted. Regardless, using Suldo and Shaffer's categorical rules, it would be possible for two students who differed by a single point on the Youth Self Report (Achenbach & Rescorla, 2001) to be assigned to different categories. Analyses that used participants' actual scores, instead of the collapsed data, could provide a more precise description of the interrelations among the variables.

Suldo and Shaffer (2008) collapsed their "internalizing" and "externalizing" indices into a single variable of "psychopathology" but, as I have argued earlier, these are two very distinct phenomena that could have very different relations to ratings of subjective well-being. It is possible that subjective well-being is more closely correlated with internalizing disorders, while it is less correlated with externalizing disorders. Perhaps the isometric relationship that has been described between subjective well-being and psychopathology is an artifact of the similar relationship between internalizing and externalizing disorders in which the two are correlated but distinct. Ultimately, empirical investigations will need to clarify these interrelationships.

Continuous Versus Categorical Systems of Diagnosis

An important debate occurring among developmental psychopathologists is whether diagnosis should be dichotomous (as is the case with the current DSM-IV-TR) or dimensional (Lopez et al., 2006). Within a dimensional system, diagnoses would be represented as points along a continuum anchored by the absence of psychopathology at one end and the extreme presence of psychopathology at the other end. Some of the dissatisfactions that Suldo and Shaffer (2008) raise are related to the current convention of using dichotomous classification systems to describe psychopathology (Rutter & Sroufe, 2000). As one example, it is the dichotomous feature of current mental health diagnoses that makes it possible

for a child to "miss" criteria for a diagnosis by minor deviations in symptoms while still requiring significant sources of support. At present, evidence describing the continuous nature of many psychopathological conditions exists principally within the research literature, but the existence of these dimensional models presents an important opportunity. It should be possible to carefully examine interrelations between ratings of subjective well-being and continuous measures of a mental disorder, teasing out even more precise models for the interface between psychological wellness and disturbances.

Summary Comments

I agree fully with Suldo and Shaffer (2008) when they assert that "simple absence of clinical levels of problems is not sufficient to guarantee the best adjustment in areas of life central to healthy child development" (p. 66). At the same time, it will not be sufficient to focus the profession's attention on categories of "vulnerable" or "symptomatic but content" children. Instead, it will be important to carefully validate promising measures of psychological wellness (such as measures of subjective well-being), arriving at a clearer understanding of the meaning of current measures. Distinctions must be drawn between these measures of psychological wellness and existing measures of psychopathology, and the operationalizations of psychopathology will need to distinguish among internalizing, externalizing, and comorbid conditions. At a minimum, this will require that noncategorical analyses be used, to capture the full complexity of the variance in wellness and psychopathology. Even more exciting, studies that use emerging dimensional measures of psychopathological conditions could provide even sharper descriptions of the interrelationships. Of course, alternatives to subjective well-being should be examined, including measures of coping, resilience, or life successes. Clearly, the Suldo and Shaffer study is only a first step towards this very ambitious agenda for research, but it is a very important first step nevertheless.

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Date Received: December 31, 2007

Date Accepted: January 2, 2008

Action Editor: Thomas Power ■

Beth Doll is Professor and Director of the School Psychology Program at the University of Nebraska—Lincoln. Her research addresses the emotional and social characteristics of classroom learning environments, and the contributions that these make to children's psychological health and well-being.