On the Effectiveness of Well-Being Therapy in Mental Health, Psychopathology, and Happiness in Methamphetamine-Dependent Men

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Abstract

Objective: The present study was conducted with the aim of examining the effectiveness of well-being-therapy in mental health, psychopathology, and happiness in male substance-dependent addicts (Methamphetamine). **Method**: For this purpose, a quasi-experimental research design along with pre-test, post-test and control group was used for the conduct of the present study. The research sample consisted of six men with similar educational background, age, social class, duration and dose of methamphetamine use who were randomly assigned to experimental and control groups. Then, the treatment was individually conducted on each member of the experimental group. Each of the participants of the experimental group received twelve weekly 50-minute sessions of well-being-therapy. Then, they were evaluated in pre-test and post-test using Mental Health Continuum-Long Form (MHC-LF), Lambert Outcome Questionnaire, and Oxford Happiness Questionnaire. **Results**: The results showed that well-being-therapy has had a significant effect on the improvement of mental health, psychopathology, and happiness. **Conclusion**: The results of the present study can be beneficial in the evaluation, treatment planning interventions, and directions for future studies among methamphetamine consumers.

Keywords: well-being therapy, mental health, psychopathology, happiness, methamphetamine, addiction

Introduction

At present, substance use disorders and the unpleasant consequences are among the most important public health problems in the world (Dalley & Marlatt, 2005) while the consequent harmful effects will badly influence the individual, the family, and the entire community. Addiction is the fourth disease in Iran (Naghavi, 2006) and methamphetamine use has grown 150 times from 2008 to 2005 (Radfar & Rawso, 2014). Studies on diseases show addiction is among the ten main diseases that constitute the major load of diseases in the world (Mathers et al., 2003). Continued drug use and its long-term toxic effects on normal performance of addicts lead to the incidence of disorders in the family, workplace, and, a larger entity, i.e. in society over time (Leshner, 1999). Hence, addiction treatment is of great importance. The growing statistics of addiction in the world, including Iran have converted the field of addiction into one of the research priorities in research communities and have created a great interest to addiction treatment as a solution to the related social and health problems (Kimberly & McLellan, 2006).

Although the emergence of a variety of treatments in this area has been experienced in recent years, it is still observed that some patients fail in these treatment programs and drug abuse remains persistent and high levels of relapse are operative (Adrian, 2001). Studies have shown that the status of most addicts experiences a relapsing situation following the treatment cessation and generally about 50 to 60% of them 6 months after treatment and 80% of them within 1 year after treatment turn to drug use again (McLellan, McKay, Forman, Cacciola & Kemp, 2005). Psychotherapy is one of the important components in the treatment of addiction that increases the treatment outcomes (Barry, 1999). One type of the psychotherapies that can have a significant role in addiction is the therapeutic methods that are focused on positive psychology, such as well-being therapy. Well-being therapy is a new therapeutic treatment in the field of positive psychology that has been derived from cognitive-behavioral therapy (Fava, Rafanelli, Cazzaro, Conti & Grandi, 1998). This method has been used in various studies either alone or in combination with cognitive behavioral therapy (Fava et al., 1998) and its effectiveness in the treatment of mood disorders and increased emotional and psychological well-being has been confirmed (Rafanelli, Park & Fava, 1999). Well-being therapy is a short-term (eight sessions) organized, derivative, and problem-oriented program that has been designed based on Ryff's Model of Psychological Well-being (Ryff, 1989) wherein self-observations, regular diaries, patients and therapists' interactions are used to increase the psychological well-being of patients (Seligman, 2004). Ryff's Model of Psychological Well-being contains six dimensions, namely environmental mastery, personal growth, purpose in life, autonomy, self-acceptance, and positive relations with others. The purpose of therapists in using well-being therapy is to help treatment-seekers reach the high levels of all the

six dimensions of psychological well-being from low levels of these functions (Fava et al., 1998). Therapists help patients achieve the optimum level of these functions from the level of functional damage and find well-being experiences in their past and present lives since these experiences are thought-provoking whatever they are short and brief. After treatment seekers became entirely aware of well-being effects in their lives, therapists help them identify the beliefs and thoughts that disturb the well-being of their experience and also understand the feelings followed by well-being in the next step (Fava et al., 1998). This stage of treatment resembles the identification of automatic thoughts (Rafanelli, Park & Fava, 1999) or irrational beliefs in conventional therapies with this difference that the patients' self-observations of their thoughts in well-being therapy are more based on well-being rather than discomfort and tension (Ruini & Fava, 2004). In general, the main methods of helping treatment-seekers to overcome the existing defects in psychological well-being include cognitive restructuring of automatic thoughts, scheduling the activities that produce a sense of pleasure, mastery and control; and training of courage and problem-solving (Ruini & Fava, 2004). There is a model, called complete state model of mental health, that offers a concept of mental health and therapists use it to provide treatment seekers with a balanced approach (Keyes & Lopez, 2002). According to this perspective, patients should be assessed and evaluated based on the degree of mental illness symptoms (high or low) and the level of well-being signs (high or low). Outcome Questionnaire (OQ-45; Lambert & Finch, 1999) and Mental Health Continuum-Long Form (MHC-LF) (Keyes, 2002 and 2005) are two desirable scales that therapists can use. With the amalgamation of these continua together, it is possible to help a treatment-seeker in one of the following alternatives: 1) full mental health or flourishing state; 2) full mental illness or floundering condition; 3) incomplete mental health or languishing condition; and 4) incomplete mental illness or struggling condition. According to complete state model of mental health, therapists can define the position of the treatment-seeker based on these four items and talk about them with the clients so that they can discuss the fruitful goals of the treatment with the clients. The pervasive outbreak of stimulant use and its negative individual, family, and social effect as well as the promising effects of positive therapies, including well-being therapy on the treatment of mood disorders should be taken into account. Accordingly, the present study aimed to evaluate the effectiveness of well-being therapy in mental health, psychopathology, and happiness in methamphetamine-dependent men.

Method

Population, sample, and sampling method

A quasi-experimental research design along with pre-test, post-test and control group was used for the conduct of the present study. All methamphetamine-dependent men who had referred to the therapeutic community center in Karaj

and were under treatment in 2013 constituted the population of this study. The research sample consisted of six men with similar educational background, age, social class, duration and dose of methamphetamine use. None of them were dependent on other substances than methamphetamine and suffered retardation or severe psychiatric disorders or certain physical diseases. Three participants were randomly assigned to experimental group and the other three ones were randomly assigned to control group. Each of the participants in the experimental group individually received twelve weekly 50-minute sessions of well-being-therapy.

Instruments

Mental Health Continuum-Long Form (MHC-LF): This questionnaire has been designed by Keyes in 2002 to assess the dimensions of mental well-being in the field of positive psychology. This questionnaire contains 35 items whose addition together constitutes a total score of well-being in the range of 39 to 271 and the higher scores indicate higher levels of well-being. This questionnaire consists of three dimensions, namely emotional well-being, psychological well-being, and social well-being. The total scores of the three dimensions of emotional well-being, psychological well-being, and social well-being range from 5 to 40, 18 to 126, and 15 to 105, respectively. Social well-being has the approximate correlation of .30 with low mood symptoms indicators (Keyes, 1998). Keyes & Lopez (2002) reported the average correlation coefficient of.50 to exist between the dimension of psychological well-being and standard depression scales, such as Center for Epidemiologic Studies Depression Scale (Radloff, 1977) and Zung Self-Rating Depression Scale (Zung, 1965). The confirmatory factor analysis of Center for Epidemiologic Studies Depression Scale and psychological well-being scales in America and South Korea revealed a two-factor model where one latent factor of mental health and one factor of mental illness had the best fit with the data (Keyes et al., in press). In the same study, the subscales of depressed mood in Center for Epidemiologic Studies Depression Scale were negatively correlated with the data (-.68) (Keyes, 2002).

Outcome Questionnaire (OQ-45): This questionnaire was constructed by Lambert & Finch in 1996. It consists of 45 items that has been designed to assess the progress level and the outcome results of treatment seekers in three subscales, namely symptom distress, interpersonal relationships, and social role. The items are scored using a 5-point Likert scale in which zero response represents "almost always" and 4 denotes "never". The sum score of 45 items will lead to a total score, ranging from zero to 180 where the higher scores indicate the higher problems and disorders. This questionnaire has been developed to measure a variety of disorders and symptoms in adults. Test-retest reliability coefficient of this scale fluctuated from .82 over a time span of two weeks to .66 in a period of ten weeks. The internal consistency coefficient of the scale has been reported to range from .70 to .93 (Lambert et al., 1996).

Oxford Happiness Questionnaire: This scale consists of 29 items. Argyle & Crossland's definition of happiness constitutes the theoretical basis of this questionnaire (1987). Twenty-one items of the questionnaire have been extracted from Beck Depression Inventory. Similar to Beck Depression Inventory, each item of Oxford Happiness Questionnaire has four alternatives and each alternative takes up from zero to three points and the participant should choose one of them according to his/her current state. The achievement of a higher score in this test represents more happiness. Scores than lower 22 suggest low happiness, scores 22 to 44 indicate moderate happiness, scores 44 to 68 represent high happiness, and scores 68 to 87 demonstrate very high happiness. The highest score that a person can gain on this scale equals 87, which indicates the highest degree of happiness, whereas the lowest score is zero, which indicates the participant's dissatisfaction with life and depression. The normal score of this test is between 40 and 42. Hills & Argyle have reported high and acceptable construct validity for Oxford Happiness Questionnaire through correlation with self-reported measures of personality traits and human strengths. In addition, the internal consistency coefficient of this scale has also been reported satisfactory (Hills & Argyle, 2002).

Procedure

After the administration of the pre-test, the well-being therapy intervention for twelve 50-minute- sessions was held for the experimental group. After the end of the treatment, post-test was performed. After the finish of the study, four sessions of individual counseling were held for the members of the control group in order to comply with the ethical tenets. The content of therapy sessions for the experimental group has been presented in the table below.

Table 1: Content of well-being therapy sessions

Session	*Content*
First	Clinical interview
Second	Definition of the process of educational-therapeutic program and the objectives of the addicted participants, offer of the forms and dairy notebooks, stipulation of bilateral commitments in the program, and the administration of the pretest
Third	Discussion about the framework of well-being therapy, the therapist's role and the responsibilities of the client, the role of the absence of positive emotions in the continued drug dependence (worksheet introduction of participant's registration)
Fourth	Checking the previous session's assignments, identification of well-being courses by means of the discovery of positive emotions, encouragement of the person to record events in the diary (worksheet of extricating from hatred)
Fifth	Checking the previous session's assignments, optimism and hope, orientation of the clients to think about the situation they fail in an important responsibility, then the clients were asked to take heed what other doors open when one door closes (worksheet of opening new doors in life)

Table 1: Content of well-being therapy sessions

Session	*Content*
Sixth	Checking the previous session's assignments, self-acceptance and its role in psychological comfort, acceptance of frustrating experiences rather than their denial or attempt to forget them (worksheet of hope letter)
Seventh	Checking the previous session's assignments, the use of public places in the discovery of irrational reasoning, the purposefulness of response to long-term goals to shape life (worksheet of blessings)
Eighth	Worksheet of blessings, forgiveness as a powerful tool that can transform anger into positive emotions, dominating the environment as a component of mental health (worksheet of forgiveness)
Ninth	Checking the previous session's assignments, personal growth and evaluation of social and cognitive development or the periods of possible recession, role of dysfunctional cognition in the incidence of a recession (registration worksheet of emotions)
Tenth	Checking the previous session's assignments, appreciation was discussed as durable thanks and good and bad memories were highlighted again with an emphasis on appreciation, practical examples of the impact of optimism and pessimism on drug use and its abstention (worksheet of appreciation)
Eleventh	Checking the previous session's assignments, presentation of the components of autonomy and positive relations with others, the review of progress and achievement, presentation of a summary, and conduct of the posttest
Twelfth	Separation from group, setting the periodic meetings with the experimental group, and the presentation of the results after data analysis

Results

The descriptive statistics of the variables have been presented for each group and test stage in the table below.

Table 2: Descriptive statistics of the variables for each group and test stage

Variable	*Group*	*Pretest*		*Posttest*	
		Mean	*SD*	*Mean*	*SD*
Cognitive well-being	Experimental	44.00	12.28	31.00	5.19
	Control	66.00	10.14	56.33	13.27
Social well-being	Experimental	46.66	9.29	33.66	14.04
	Control	66.66	7.09	52.33	8.32
Emotional well-being	Experimental	22.33	.57	18.66	1.15
	Control	23.33	2.51	23.33	3.78
Psychopathology	Experimental	130.33	13.79	151.00	7.81
	Control	97.00	7.54	123.66	22.85
Happiness	Experimental	131.33	38.37	151.33	11.93
	Control	104.33	40.73	121.33	8.71

Multivariate analysis of covariance-must (MANCOVA) should be used to examine the effectiveness of well-being therapy in mental health components. Before the conduct of MANCOVA, the assumption of the equality of variances

was assessed via Levene's test and the equality of covariance matrices was assessed through Box's test. The results of Levene's test showed that the assumption of the equality of variances has not been met. Similarly, the assumption of equality of covariance matrices was not satisfied, either. Thus, Pillai's trace test was used instead of Wilks's lambda. The results of multivariate analysis of covariance indicated the non-significance of the results (P>.05, F=3.180, Pillai's trace=.80).

The results of univariate analysis of covariance, examining the effectiveness of well-being therapy in psychopathology and happiness, are presented in the table below.

Table 3: Results of univariate analysis of covariance for examining the effectiveness of well-being therapy in psychopathology and happiness

Variable	*Mean Square*	*F*	*Sig.*
Psychopathology	1.84	.07	.93
Happiness	203.18	.41	.41

As it is seen in the above table, well-being therapy has not led to the significant reduction of psychopathology and increase of happiness.

Discussion and Conclusion

About one decade ago, specialists in the field of prevention and treatment were mainly interested in studying the weaknesses of individuals (Seligman, 2004). This interest has been for several reasons. The first reason is because of this view that "before helping happy people, we must resolve the grief of those who are taking pains and sympathize with them." The second reason is action-oriented and historical. After World War II, clinical psychology was directed to focus on the diagnosis and treatment of disorders by "model medical condition" (Maddox, 2002). The third reason lies in the area of human nature and psychological processes. Baumeister, Bratslavsky, Finkenauer & Vohs (2001) wrote "bad is stronger than good". They reviewed the related literature and stated that negative events are more severe and intense than positive events; and the information about ill topics are evaluated and examined more completely compared with information about good topics. It seems that psychology is in need of an efficient plan about human performance at the present time more than every other time. The future responsibility of positive psychology is to understand the factors that build capabilities. Finally, positive psychology is in need of the expansion of effective interventions to increase and strengthen these processes. The present study was also conducted in parallel with the approach change from the problem-focused approach to capability development. The aim of this study was to evaluate the effectiveness of well-being therapy in mental health, psychopathology, and happiness in male substance-dependent addicts. The results showed that well-being therapy has had no significant effect on the improvement of the studied indexes in drug-dependent patients. Although no

similar study has been conducted yet, research has been done on the basis of well-being therapy intervention. In a study, entitled "Increasing Psychological Well-Being and Resilience by Psychotherapeutic Methods", Fava & Tomba (2009) examined the effectiveness of well-being therapy. They found that well-being and resiliency can be created by means of specific interventions that lead to positive self-assessment, sense of sustainable growth, belief in significant positive life, the process of positive relations with others, the ability to effectively manage life, the sense of self-determination. In addition, the decreased level of vulnerability to depression and anxiety has been shown by well-being therapy. In as study, entitled "Well-being therapy (WBT) for depression", Moeenizadeh & Kumar (2010) carried out the research on a sample of 40 participants in 2010 and showed that there was a significant difference pretest and posttest scores of the therapy. In addition, they reported that well-being therapy was more effective than cognitive-behavioral therapy. The results also represented the feasibility and benefits of adding clinical well-being therapy to the other complex therapeutic techniques. Fava, Rafanelli, Cazzaro, Conti & Grandi (1998) applied well-being therapy as a new therapeutic approach for the remaining symptoms of mood disorders (major depression, panic disorder with agoraphobia, social phobia, generalized anxiety disorder, obsessive-compulsive disorder) that had been successfully treated by behavioral or pharmacological methods. The researchers randomly divided these participants into two groups of well-being and cognitive-behavioral therapy. The results showed that both well-being and cognitive-behavioral therapies were associated with a significant reduction in the remaining signs. In addition, Golbar Yazdi, Sherbaf, Mousavifard & Moeenizadeh (2011) demonstrated that well-being therapy will reduce stress and enhance psychological well-being in infertile women. The following explanations were offered to discuss the whyness of non-significance of well-being therapy based on literature review and clinical experiences.

One of the reasons that accounts for the non-significance of the intervention has been the timing of pretest and posttest. Indeed, the above-mentioned research intervention was done on a sample with the history of one-month stay in the center, which coincided with the honeymoon phase. At this stage, pretest has been conducted whereas the end of the three-month therapeutic process has occurred at the wall stage. Thus, the high scores of pretest and not that high scores of posttest (non-significance) are justified and understandable. Details of the honeymoon and wall stages are presented in the table below.

Table 4: Details of the honeymoon and wall stages in substance-dependence disorders

Dimension	*Honeymoon stage (15-45 days)*	*Wall stage (45-120 days)*
Behavioral	High energy, unfocused behavior	Loss of energy
Cognitive	Inability in prioritization	Making excuse for relapse
Emotional	Overconfidence or strong feeling of being treated	Inability in enjoyment and pleasure
Relational	Denial of addiction disorder	Restlessness, blame, and impatience

Another reason is the absence of visual representations in cognitive-behavioral protocol. Cognitive-behavioral therapies, which mainly rely on pen and paper, are often less able to conform to the needs of methamphetamine consumers; hence, the lack of visual and visual aspects is strongly felt. Therefore, due to damage to short-term (working) memory in methamphetamine-dependent individuals, cognitive-behavioral therapies, including well-being therapy are less effective since they are reliant upon words and do not use visualization and imagery (Rawson et al. 2002). Another reason is the individuality of the therapy against group treatment. Interaction with a homogeneous group with common features can be associated with treatment efficacy (Barnett & Swindle, 1997). Swindle et al (1995) randomly studied 466 patients in two treatment programs of alcohol dependence. The first treatment program presented an individualized comprehensive treatment program and the second one relied on interaction with the homogeneous group. The patients who entered the second program showed better health outcomes that represent the potential importance of homogeneous group in alcoholism treatment programs (Noroozi, 2010). Therefore, group therapy has the advantage that others in the group can also say they feel better and, thereby, the experience and support of others are important in the treatment process (Rawson & Richard, 2014). Another reason was the small sample size. Due to small sample size (three units in each group) and, consequently, the increased measurement error, the significance of findings needs very dramatic changes; thus, this factor can also be one of the possible causes in the non-significance of the findings.

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