Relation Between Cognitive and Behavioral Strategies and Future Change in Common Mental Health Problems Across 18 Years

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Major depressive disorder (MDD), generalized anxiety disorder (GAD), and panic disorder (PD), constitute common mental disorders that may have chronic and disabling courses. Cognitive and behavioral theories posit that lack of engagement in certain strategies (goal persistence, self-mastery, positive reappraisal) increases vulnerability toward these disorders. Further, scar effect theories assert that experiencing more of these disorders may diminish engagement in such strategies within individuals across time. However, dynamic longitudinal associations between cognitive–behavioral strategies (CBS) and disorder counts across adulthood are not well understood. Using bivariate latent difference score models, this study aimed to test the dynamic trajectories between disorder counts and each CBS across 18 years. Participants were 3,294 community-dwelling adults ages 45.62 years (SD = 11.41, range = 20–74; 54.61% female) who took part in 3 waves of measurement spaced 9 years apart. Self-mastery, disorder counts, and their change were not significantly related. However, higher within-subject increase in goal persistence (but not self-mastery or positive reappraisal) led to greater future decline in disorder counts, but not vice versa. Last, within individuals, greater prior levels of goal persistence and positive reappraisal predicted larger subsequent reduction in disorder counts, and vice versa. The reciprocal, bidirectional associations between specific CBS (goal persistence, positive reappraisal) and disorder counts support both vulnerability and scar models of depression and anxiety. Treatments for MDD, GAD, and PD should attempt to enhance perseverance and optimism. Theoretical and clinical implications are further discussed.

General Scientific Summary
Greater within-subject increased goal persistence (but not positive reappraisal or self-mastery) led to larger future declines in disorder counts. However, within-subject change in disorder counts did not substantially influence future change in each cognitive or behavioral strategy. Further, higher initial levels of goal persistence and positive reappraisal (but not self-mastery) predicted subsequent larger decrease (or smaller increase) in disorder counts, and vice versa.

Keywords: chronicity, depression, anxiety, strategy, latent difference

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This study was conducted in compliance with American Psychological Association ethical standards in the treatment of human participants and approved by the Institutional Review Board (IRB). Informed consent was obtained from participants as per IRB requirements at Harvard University, Georgetown University, University of California at Los Angeles, and University of Wisconsin. Because this study used a publicly available data set, it was exempt from IRB approval.

Additional analyses, as well as all syntax, results, and Open Science Framework references, are provided in the online supplemental materials. The data used in this publication were made available by the Data Archive on University of Wisconsin—Madison Institute on Aging. Since 1995 the Midlife Development in the United States study has been funded by the John D. and Catherine T. MacArthur Foundation Research Network, National Institute on Aging Grant P01-AG020166, and National Institute on Aging Grant U19-AG051426. The original investigators and funding agency are not responsible for the analyses or interpretations presented here. The authors do not have any conflicts of interest or financial disclosures.

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creased health care utilization, suicidality, disability, unemployment, and absenteeism (Birnbaum et al., 2010; Neuman, Belik, Bolton, & Sareen, 2010; Newman, Llera, Erickson, Przeworski, & Castonguay, 2013). Enhancing the understanding of the relations between these disorders and cognitive or behavioral strategies (CBS) is thus essential.

Convictions that one has the capacity to direct processes and outcomes of multiple life domains (self-mastery; Bandura, 2012; Lachman & Weaver, 1998) and persevering in goal-striving despite hardships (goal persistence; Wrosch, Heckhausen, & Lachman, 2000) predict fewer mental disorders. Further, viewing the bright side of unfortunate events (positive reappraisal; Lambert, Graham, Fincham, & Stillman, 2009) is associated with lower psychopathology. Thus, decreased frequencies of MDD, GAD, and PD relate to either directly addressing the issue at hand (problem-focused coping) or interpreting events adaptively (emotion-focused coping; Folkman & Moskowitz, 2004). These tactics also reflect degree of perceived control. Self-mastery and goal persistence are attempts to mold the environment (primary control), whereas positive reappraisal enables people to alter themselves to suit the situation (secondary control; Heckhausen, 1997). Taken together, goal persistence and self-mastery reflect problem-focused primary control strategies, whereas positive reappraisal is a form of emotion-focused secondary control. Self-mastery, goal persistence, and positive reappraisal are theorized and shown to be malleable targets and mechanisms of change in cognitive–behavioral therapy (Bandura, 1977, 1988, 2012; Craske et al., 2009; Gallagher et al., 2013; Goldin et al., 2012; Zautra et al., 2012). Collectively, higher level of engagement in these cognitive and behavioral tactics tends to be linked to fewer disorders. Accordingly, improving the understanding of these changeable CBS constructs is important.

Multiple theories propose how anxiety and depressive disorders can precede, be a consequence of, or relate dynamically to deficits in CBS repertoire. The triple vulnerability model postulates that dysregulated worry, panic, and depression are intrinsically linked to inadequate efforts toward self-mastery, positively reappraising adversities, or pressing on toward one’s goals across time (Barlow, 2000, 2002). The learned helplessness theory (Maier & Seligman, 2016) proposes that disorders of anxiety and depression are prospectively connected to hopelessness, pessimism, diminished motivation, and behavioral inactivity. Goal-based coping models (Carver & Connor-Smith, 2010) argue that anxiety and depressive disorders tend to correspond with lack of problem-focused coping in controllable situations (reducing the chance of self-mastery across time) and inadequate emotion-focused coping in uncontrollable situations. Furthermore, these prevalent forms of psychopathology tend to dovetail with goal disengagement that hinders opportunities for learning to cope with distress. In the context of inalterable stressors, however, emotion-focused coping (i.e., positive reappraisal) is entwined with reduced presence of MDD, GAD, and PD. At the same time, experience of anxiety or depressive disorders without intervention can entrench certain maladaptive habits, mindsets, and attitudes (cf. scar effect theories; Lewinsohn, Steinmetz, Larson, & Franklin, 1981; Uliaaszek et al., 2012).

A wealth of between-subjects evidence supports these theories. Several two-wave longitudinal studies showed that higher self-mastery was associated with greater future depressive symptoms across individuals (e.g., Elliot, Thrash, & Murayama, 2011; Ma-
chronic remitting—relapsing course of these disorders (e.g., Eaton et al., 2008; Hardevelt, Spijker, De Graaf, Nolen, & Beekman, 2010; Yonkers, Bruce, Dyck, & Keller, 2003). Further, the community sample herein extends studies conducted on clinical treatment-seeking samples (e.g., 14-year study by Ramsawh, Raffa, Edelen, Rende, & Keller, 2009). Also, identifying naturalistic growth trajectories of specific strategies connected to reductions in disorder counts may help to refine treatment. Collectively, testing these relations may advance cognitive and behavioral theories (Clark & Beck, 2010; Kanter et al., 2010; Leyro, Zvolensky, & Bernstein, 2010). Overall, such analyses can test the putative coupling between each CBS and disorder count across time within subjects.

On the basis of the outlined rationale and evidence, we tested two overarching hypotheses to extend the understanding of the dynamic, within-subject associations between each CBS (self-mastery, goal persistence, positive reframing) and disorder counts. Based on cognitive vulnerability theories (Hong & Cheung, 2015), Hypothesis 1 asserted that within subjects, increasing or heightened engagement in a specific CBS would predict larger future decrease in disorder counts. In Hypothesis 2, based on scar effect models (Bucurca & Iacono, 2007), we predicted that within subjects, high or increased disorder counts would lead to more subsequent decline in CBS.

**Method**

**Participants**

The current study used the Midlife Development in the United States (MIDUS) dataset with three waves of data collection: 1995–1996 (Time 1 [T1]), 2004–2005 (T2), 2012–2013 (T3; Ryff et al., 2017). Because this study used a publicly available dataset, it was exempt from Institutional Review Board approval. Sample sizes were 7,108 at T1; 4,963 at T2; and 3,294 at T3 (see Vittengl, 2017, for information on attrition and missing data). The 3,294 adults in the current sample participated in all three waves. Individuals averaged 45.62 years (SD = 11.41, range = 20–74), 54.61% were female, and 42% were college-educated. Ethnic distribution was 89.01% White; 3.25% African American; and 7.73% Native American, Asian, Pacific Islander, or others. Dropout versus completer analyses are presented in the online supplemental materials.

**Measures**

**Goal persistence.** The five-item Persistence in Goal-Striving scale (Wrosch et al., 2000) was used to measure goal persistence. Items (e.g., “When I encounter problems, I don’t give up until I solve them”) were rated on a 4-point scale ranging from 0 (not at all) to 3 (a lot). Cronbach’s alphas were .760, .773, and .784 at T1, T2, and T3, respectively.

**Self-mastery.** The four-item Personal Mastery scale (Lachman & Weaver, 1998), which tapped into self-efficacy (e.g., “I can do just anything I really set my mind to”), was used to assess self-mastery. Items were rated on a 7-point scale ranging from 0 (strongly disagree) to 6 (strongly agree). Cronbach’s alphas were .730, .744, and .745 at T1, T2, and T3, respectively.

**Positive reappraisal.** The four-item Positive Reappraisal scale (Wrosch et al., 2000) was used to assess positive reappraisal. Items (e.g., “I can find something positive, even in the worst situations”) were rated on a 4-point scale ranging from 0 (not at all) to 3 (a lot). Cronbach’s alphas were .799, .786, and .773 at T1, T2, and T3, respectively. Table 1 presents the items of the CBS measures.

**Disorder counts.** Diagnoses for past 12-month MDD, GAD, and PD at each wave were made using the Composite International Diagnostic Interview—Short Form (CIDI–SF: Kessler, Andrews, Mroczek, Ustun, & Wittchen, 1998; Wittchen, Zhao, Kessler, & Eaton, 1994) based on criteria in the Diagnostic and Statistical Manual of Mental Disorders (3rd ed., rev.; DSM–III–R; American Psychiatric Association, 1987). Specificity and sensitivity of the CIDI–SF for MDD were 93.9 and 89.6, respectively. For GAD, specificity was 99.8 and sensitivity was 96.6, and for PD, specificity was 99.5 and sensitivity was 90.0 (Kessler et al., 1998). Disorder counts was defined as the number of current disorders, ranging from 0 (absence of disorders) to 3 (presence of all three disorders).

Table 1

<table>
<thead>
<tr>
<th>Construct</th>
<th>Item</th>
<th>Coding scheme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persistence in goal striving</td>
<td>1. When things don’t go according to my plans, my motto is, “Where there’s a will, there’s a way.”</td>
<td>0 = Not at all</td>
</tr>
<tr>
<td></td>
<td>2. When faced with a bad situation, I do what I can to change it for the better.</td>
<td>1 = A little</td>
</tr>
<tr>
<td></td>
<td>3. Even when I feel I have too much to do, I find a way to get it all done.</td>
<td>2 = Some</td>
</tr>
<tr>
<td></td>
<td>4. When I encounter problems, I don’t give up until I solve them.</td>
<td>3 = A lot</td>
</tr>
<tr>
<td></td>
<td>5. I rarely give up on something I am doing, even when things get tough.</td>
<td></td>
</tr>
<tr>
<td>Positive reappraisal</td>
<td>1. I find usually learn something meaningful from a difficult situation.</td>
<td>0 = Not at all</td>
</tr>
<tr>
<td></td>
<td>2. When I am faced with a bad situation, it helps to find a different way of looking at things.</td>
<td>1 = A little</td>
</tr>
<tr>
<td></td>
<td>3. Even when everything seems to be going wrong, I can usually find a bright side to the situation.</td>
<td>2 = Some</td>
</tr>
<tr>
<td></td>
<td>4. I can find something positive, even in the worst situations.</td>
<td>3 = A lot</td>
</tr>
<tr>
<td>Self-mastery</td>
<td>1. I can do just about anything I really set my mind to.</td>
<td>0 = Strongly disagree</td>
</tr>
<tr>
<td></td>
<td>2. When I really want to do something, I usually find a way to succeed at it.</td>
<td>1 = Somewhat disagree</td>
</tr>
<tr>
<td></td>
<td>3. Whether or not I am able to get what I want is in my own hands.</td>
<td>2 = Disagree</td>
</tr>
<tr>
<td></td>
<td>4. What happens to me in the future mostly depends on me.</td>
<td>3 = Neither agree nor disagree</td>
</tr>
</tbody>
</table>

*Note.* CBS = cognitive and behavioral strategies.
Data Analyses

To ensure adequate power, we performed a priori Monte Carlo simulations (gold standard approach for power analyses; Muthén & Muthén, 2002; Thoemmes, MacKinnon, & Reiser, 2010) mirroring our study conditions. Power was based on an effect size of Cohen’s $d = .10$ for level and change of CBS predicting change in disorder count, and vice versa. After 20,000 replications per condition, we found 94.8% to 95.1% chance to detect all within-subject regression estimates.

Next, we conducted a series of structural equation models using the lavaan package in R (Rosseel, 2012). First, we assessed whether the study variables were time-invariant. To examine longitudinal measurement invariance, we used the weighted least square estimator with means and variances adjusted given the ordinal nature of the data. Configural invariance was tested with confirmatory factor analyses (CFAs) during each wave. Subsequently, we performed multiple-wave CFAs for all waves concurrently based on these factor structures: one-factor model for each CBS and three-factor model of all CBS. Next, we progressively tested the more restrictive multiple-wave CFAs to determine whether factor loadings ($As$) were equal across waves (metric invariance) and whether both $As$ and intercepts ($ts$) were equal across waves (scalar invariance). Last, we examined whether $As$, $ts$, and residual variances ($εs$) were equal across waves (strict invariance). A statistically significant $Δχ^2$ difference test (i.e., $χ^2$ value for the constrained model is greater than for the unconstrained model) indicates the data fit substantively worse than for the unconstrained model (Bollen, 1989). However, because $Δχ^2$ is sensitive to large sample sizes despite trivial misfit changes, we used change in practical fit indices to test invariance at each step (Cheung & Rensvold, 2002; Meade, Johnson, & Braddy, 2008). Change in comparative fit index ($ΔCFI$) values of $≤−.010$, change in root-mean-square error of approximation ($ΔRMSEA$) values of $≤.015$, and change in standardized root-mean-square residual ($ΔSRMR$) of $≤.030$ from the unconstrained to constrained model reflects measurement invariance (Chen, 2007; Cheung & Rensvold, 2002).

Next, we conducted bivariate dual LDS models to test the longitudinal within-subject directional relations between each CBS and disorder counts. Advantages of this approach included accounting for temporal precedence, allowing for causal inferences, controlling for regression to the mean, and modeling change by adjusting for measurement error (Grimm et al., 2017; McArdle, 2009; McArdle, Hamagami, Chang, & Hishinuma, 2014). To test our hypotheses, we focused three bivariate LDS models on the within-subject change-to-change regression effects ($δs$; impact of $T_1–T_2$ change in a CBS on $T_2–T_3$ change in disorder counts, and vice versa). Three other bivariate LDS models centered on within-subject level-to-change coupling effects ($γs$; impact of the level of a construct on subsequent change in the other construct). Thus, our bivariate dual LDS models were based on model parsimony, practical fit indices, and theory.1 Figure 1 illustrates our bivariate LDS models.

For all LDS models, full information maximum likelihood with robust standard errors were used to handle missing data, appropriate under the missing at random assumption (Enders & Bandalos, 2001). We provided unstandardized regression coefficients ($bs$) and robust $SE$s. Alpha values were set at .01 instead of the typical .05 level given the large sample size. To assess model fit, we used these structural equation modeling (SEM) fit indices and heuristic cutoffs (Kline, 2016a, 2016b): $CFI \geq .95$ (Bentler, 1990; McDonald & Marsh, 1990), $RMSEA \leq .060$ (Browne & Cudeck, 1993; Steiger, 1990), and $SRMR \leq .050$ (Hu & Bentler, 1999).

Results

Longitudinal Measurement Invariance

Across all waves, there was equivalence of factor structure (configural invariance), $As$ (metric invariance), $ts$ (scalar invariance), and $εs$ (strict invariance). Table 2 presents the fit indices for all invariance models for the three-factor model (see the online supplemental materials for more information on measurement invariance for each of the one-factor models). Based on acceptable absolute and relative fit indices, strict invariance was supported. Latent CBS variables were

1 Self-feedback loops may be removed from latent difference score analyses if there is a theoretical rationale (Grimm, An, McArdle, Zonderman, & Resnick, 2012; Grimm, Ram, & Estabrook, 2017). Inherent to CBS and scar theories are feedback loops. Given that such feedback loops are not a confound to examining dynamic effects of cognitive–behavioral strategies on disorder counts (and vice versa), it would be theoretically inconsistent to control for them in our models. Thus, we did not include the proportional change effects ($βs$) and coupling effects ($γs$) in the same model, because both estimates were highly collinear, rendering the resulting parameter estimates uninterpretable.
Table 2
Longitudinal Measurement Invariance of Cognitive and Behavioral Strategies (CBS) Across Time (Standardized Estimates)

<table>
<thead>
<tr>
<th>Model</th>
<th>$\chi^2$</th>
<th>df</th>
<th>$p$</th>
<th>CFI</th>
<th>RMSEA</th>
<th>SRMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three-factor model of CBS</td>
<td>516.075</td>
<td>62</td>
<td>&lt;.001</td>
<td>978</td>
<td>.049</td>
<td>.046</td>
</tr>
<tr>
<td>Time 1</td>
<td>508.530</td>
<td>62</td>
<td>&lt;.001</td>
<td>978</td>
<td>.050</td>
<td>.047</td>
</tr>
<tr>
<td>Time 2</td>
<td>395.927</td>
<td>62</td>
<td>&lt;.001</td>
<td>982</td>
<td>.045</td>
<td>.041</td>
</tr>
<tr>
<td>Configural (varying $\Lambda$, $\tau$, $\epsilon$ across time)</td>
<td>1,140.921</td>
<td>186</td>
<td>&lt;.001</td>
<td>980</td>
<td>.048</td>
<td>.045</td>
</tr>
<tr>
<td>Metric invariance (equal $\Lambda$, varying $\tau$, $\epsilon$ across time)</td>
<td>1,531.652</td>
<td>206</td>
<td>&lt;.001</td>
<td>978</td>
<td>.048</td>
<td>.046</td>
</tr>
<tr>
<td>Scalar invariance (equal $\Lambda$, $\tau$, varying $\epsilon$ across time)</td>
<td>1,662.495</td>
<td>226</td>
<td>&lt;.001</td>
<td>976</td>
<td>.047</td>
<td>.048</td>
</tr>
<tr>
<td>Strict invariance (equal $\Lambda$, $\tau$, $\epsilon$ across time)</td>
<td>1,713.251</td>
<td>252</td>
<td>&lt;.001</td>
<td>976</td>
<td>.045</td>
<td>.050</td>
</tr>
</tbody>
</table>

Note. $N$ = 3,294. Construct may either be a specific strategy or disorder counts. $T1$–$T3$ = Time 1–Time 3; ST = cognitive or behavioral strategy; DX = disorder counts; CFI = comparative fit index; RMSEA = root-mean-square error of approximation; SRMR = standardized root-mean-square residual; AIC = Akaike information criterion; SABIC = sample-adjusted Bayesian information criterion. ** $p < .01$.

thus assessed on the same scale across each wave, and the latent scores can be meaningfully compared across various time points.

Bivariate Latent Difference Score (LDS) Models

Tables 3 and 4 show change-to-change ($\delta$s) and coupling effects ($\gamma$s) estimates, respectively (lengthier versions of analyses including other estimates are in the online supplemental materials). The input R syntax for all models herein have been uploaded to the Open Science Framework at https://osf.io/sy4n/?view_only=7a0cad41c5af4686a7e234980f25e040. All six bivariate LDS models showed excellent fit. Larger future decline in disorder counts was significantly predicted by bigger increase in goal persistence ($b = -.727, SE = .281, z = -2.585, p = .010$) but not positive reappraisal ($b = -.341, SE = .260, z = -1.311, p = .190$) or self-mastery ($b = .056, SE = .166, z = .339, p = .735$). Change in disorder counts did not affect future change in goal persistence ($b = -0.988, SE = .498, z = -2.002, p = .045$), self-mastery ($b = 1.100, SE = 1.501, z = .733, p = .464$), or positive reappraisal ($b = -2.759, SE = 2.081, z = -1.326, p = .185$).

Degree of baseline self-mastery did not predict change in future disorder counts ($T1$ self-mastery $\rightarrow T1$–$T2$ change in disorder counts: $b = .496, SE = .412, z = 1.205, p = .228$; $T2$ self-mastery $\rightarrow T2$–$T3$ change in disorder counts: $b = .322, SE = .472, z = .682, p = .495$). Likewise, disorder counts did not lead to future change in self-mastery ($T1$ disorder counts $\rightarrow T1$–$T2$ change in self-mastery: $b = .860, SE = .613, z = 1.404, p = .140$; $T2$ disorder counts $\rightarrow T2$–$T3$ change in self-mastery: $b = .883, SE = .626, z = 1.409, p = .159$). However, self-mastery did not change across time (see expanded Tables 3 and 4 in the online supplemental materials).

Higher degree of goal persistence significantly prospectively led to greater subsequent reduction in disorder counts ($T1$ goal persistence $\rightarrow T1$–$T2$ change in disorder counts: $b = -.885, SE = .246, z = -3.599, p < .001$; $T2$ goal persistence $\rightarrow T2$–$T3$ change in disorder counts: $b = -0.903, SE = .252, z = -3.584, p < .001$). Further, more disorder counts substantially predicted larger subsequent decrease in goal persistence ($T1$ disorder counts $\rightarrow T1$–$T2$ change in goal persistence: $b = -1.175, SE = .264, z = -4.457,$

Table 3
Bivariate Latent Difference Score Models to Assess Within-Subject Change-to-Change Coupling Effects

<table>
<thead>
<tr>
<th>Coupling and model fit</th>
<th>Goal persistence</th>
<th>Self-mastery</th>
<th>Positive reappraisal</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\Delta ST_{T1-T2} \rightarrow \Delta DX_{T2-T3}$</td>
<td>$-0.727^{**}$</td>
<td>$0.56$</td>
<td>$-0.341$</td>
</tr>
<tr>
<td>$\Delta DX_{T1-T2} \rightarrow \Delta ST_{T2-T3}$</td>
<td>$-0.998$</td>
<td>$1.000$</td>
<td>$-2.759$</td>
</tr>
</tbody>
</table>

Model fit indices

<table>
<thead>
<tr>
<th>$\chi^2$</th>
<th>df</th>
<th>$p$</th>
<th>CFI</th>
<th>RMSEA</th>
<th>SRMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.097</td>
<td>8</td>
<td>&lt;.001</td>
<td>.990</td>
<td>.038</td>
<td>.019</td>
</tr>
<tr>
<td>24,576.974</td>
<td>36,008.794</td>
<td>26,517.612</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24,632.500</td>
<td>36,064.320</td>
<td>26,576.060</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. $N$ = 3,294. Construct may either be a specific strategy or disorder counts. $T1$–$T3$ = Time 1–Time 3; ST = cognitive or behavioral strategy; DX = disorder counts; CFI = comparative fit index; RMSEA = root-mean-square error of approximation; SRMR = standardized root-mean-square residual; AIC = Akaike information criterion; SABIC = sample-adjusted Bayesian information criterion. ** $p < .01$. 
Within-subject coupling (level-to-change) effects (γs)

Note. N = 3,294. ST = cognitive or behavioral strategy; DX = disorder counts; CFI = comparative fit index; RMSEA = root-mean-square error of approximation; SRMR = standardized root-mean-square residual; AIC = Akaike information criterion; SABIC = sample-adjusted Bayesian information criterion.

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This study was the first to examine the within-subject prospective directional relations using bivariate dual LDS models among disorder counts, specific CBS, and their change over 18 years. Thus, it extends prior research (e.g., Hong, Lee, Tsai, & Tan, 2017) on coping strategy–symptom severity links that used LGCMs, which provide information on only correlational, between-subjects effects. We found that higher increase in only LGCMs, which provide information on only correlational, disorder counts; CFI = comparative fit index; RMSEA = root-mean-square error of approximation; SRMR = standardized root-mean-square residual; AIC = Akaike information criterion; SABIC = sample-adjusted Bayesian information criterion.

***p < .001.

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***p < .001.
models highlight the importance of putting oneself in various feared situations to learn to cope with distress and disconfirm negative expectancies. Our data are also consistent with emerging evidence on the efficacy of behavioral activation treatments for chronic worriers (e.g., Chu et al., 2016). Taken together, perseverance fosters a sense of purposefulness that results in sharper reductions in frequency of disorders.

Several possibilities can explain why level of positive reappraisal led to subsequent change in disorder counts and disorder count levels resulted in prospective change in positive reappraisal. Generally, this finding aligns with the optimism literature, such that more sanguine and hopeful people tend to have fewer mental health problems (Chopik, Kim, & Smith, 2015). Applying positive reappraisal when undergoing adversities nurtures optimism and the feeling that life is meaningful, comprehensible, and manageable, thus contributing to fewer disorder counts over time. Positive reappraisal may thus develop individuals’ inner resources by helping them be more accepting toward uncontrollable life stressors. Moreover, focusing on the bright side can directly decrease worry, depression, and anxiety. Attending to aspects over which one has influence can motivate one to adopt or maintain healthy lifestyles and habits. These assertions are consistent with evidence that positive reappraisal and optimism dampen rises in negative affect and depressive symptoms (Lambert et al., 2009, 2012). Last, positive reappraisal may facilitate optimal processing of all aspects of the evidence to make realistic assessments.

Why level but not change in positive reappraisal affected future change in disorder counts merits attention. The long 9-year period may explain the discrepancy, because the dynamic change-to-change effects between disorder counts and positive reappraisal are likely to occur across shorter occasions (e.g., days, weeks, months; Butler, Gross, & Barnard, 2014; Nezlek & Kuppens, 2008). Observing increased shifts in positive reappraisal contributing to more reduction in disorder counts hence unfolds across specific contexts or events occurring at smaller timescales. However, general tendency toward positive reappraisal may facilitate longer term change in disorder counts. Future work with varying time lags should examine these ideas.

Remarkably, more disorder counts predicted steeper decreases in perseverance and positive reappraisal. This buttresses scar effect theories; that is, presence of untreated psychopathology increases future persistence and positive reappraisal and optimism dampen rises in negative affect and depressive symptoms (Lewinsohn et al., 1981). It also accords with studies showing elevated symptomology led to more subsequent self-sabotaging actions, hopelessness, and thinking errors (Khint, Kleinjan, Janssens, & Scholte, 2015). This observation occurs particularly across long durations (LaGrange et al., 2011). However, unlike in previous studies, we included categorical diagnoses and used within-subject, bivariate LDS models across three waves in a large, community adult sample. Thus, we extended prior two-wave regression models on the relations between CBS and dimensional symptom severity or episodes in children, adolescents, and young adults (Burcusa & Iacono, 2007; Stewart et al., 2004). On the whole, findings support bidirectional models of risk factors and disorder presence (e.g., Calvete, Orue, & Hankin, 2013).

The clinical applications of our study merit attention. To facilitate treatment, clinicians should help clients to metaphorically view the glass as half full (Korn, Sharot, Walter, Heekeren, & Dolan, 2014) and integrate personal goals within the treatment frame (cf. Michalak & Holtforth, 2006). For instance, a key message to relay continually in therapy is the vicious cycle caused by goal disengagement (e.g., giving up on important projects), which may offer temporary emotional relief but increase risk of disorder recurrence as regret and disappointment set in. Another important point to communicate is that boosting patients’ optimism and resilience via perseverance in goal-striving despite obstacles will inevitably generate positive mood states and a sense of purpose. Doing so curtails the negative self-perpetuating effect of worry, panic, and depression symptoms. Absence of any clinical diagnoses of anxiety and depression in turn fosters more motivation to accomplish tasks and expand one’s capabilities, thereby promoting confidence. Last, the transition from early to middle and middle to late adulthood presents more interpersonal, occupational, and financial autonomy as well as physical health changes. Individuals who habitually practice these strategies may thus be better able to manage aging-related demands better than those who do not.

Our study had several shortcomings. First, our data cannot speak to whether patterns found here apply to disorders other than MDD, GAD, and PD. It is possible that more positive reappraisal and goal persistence might also lead to reduced posttraumatic stress, social anxiety, and alcohol use disorder symptoms (e.g., Hawley, Rector, & Laposa, 2016; Smyth, Hockemeyer, & Tulloch, 2008; Worley et al., 2012). Future research should replicate these analyses with a wider range of disorders. Second, unmeasured third variables (e.g., genetic tendency toward disorders) may have explained the findings. Third, with the long 9-year interval, shifts in disorder status or CBS between waves may have been missed. Further, CIDI–SF scales were based on the DSM–III–R. Changes to the criteria with the DSM–5 (American Psychiatric Association, 2013) could alter the findings (e.g., endorsing five out of nine depressive symptoms compared to four out of seven for MDD). Replication with the DSM–5 is thus needed.

Key strengths of this report include use of reliable and valid measures, strong statistical power, bivariate dual LDS approach, and long duration. To conclude, findings clarified the dynamic longitudinal within-subject relations among the naturalistic trajectories of specific CBS and disorder counts across 18 years of adulthood. Heightened tenacious goal pursuit and positive reappraisal led to larger future reductions in disorder counts (and vice versa) within subjects. Although change in disorder counts had no effect on change in each CBS, larger increased goal persistence forecasted steeper subsequent declines in psychopathology.

References


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