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If You're Not Ill, Why Aren't You Well? Mental Health and Psychological Well-Being in Frederick Herzberg's Psychosocial Perspective

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Abstract

Health promotion programs, particularly those targeting vulnerable groups like university students, frequently treat mental health (the absence of illness) and psychological well-being (the presence of optimal functioning) as synonymous. Drawing theoretical inspiration from the World Health Organization's definition of health – that health is "not merely the absence of disease" – this article utilizes Frederick Herzberg's Two-Factor Theory (Motivation-Hygiene) to formally distinguish these two concepts within a unified, dual-continuum psychosocial framework. The paper argues that, much like Herzberg's finding that the opposite of dissatisfaction is not satisfaction, the absence of psychopathology does not equate to the presence of psychological well-being. Specifically, mental health is linked to Herzberg's hygiene factors (extrinsic, contextual elements like housing, security, and institutional policies), which, when inadequate, cause distress but, when adequate, only lead to a neutral state of "no illness". Conversely, psychological well-being is linked to Herzberg's motivator factors (intrinsic, content-related elements like achievement, meaning, and contribution), which are necessary to actively promote a state of high satisfaction and flourishing. This model clarifies four psychological states (Flourishing, Languishing, Fragility/Burnout, and Illness) and offers a crucial theoretical and practical tool for tailoring interventions to target the appropriate Hygiene (stability, safety) or Motivator (purpose, growth) factors.

Keywords: Mental health, psychological well-being, psychosocial perspective, Herzberg's Two-Factor Theory.

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1. Introduction

Nowadays, there is a lot of talk about mental health and psychological well-being, especially since the COVID-19 pandemic (Otu et al., 2020; Hawke et al., 2022). Several programs have been launched all over the world and Europe to promote health and well-being, such as PRO-BEN in Italy, a project funded by the Ministry of University and Research (MUR) and aimed at university students (Nosè et al., 2025a, b).

University students, as research shows (Du Plooy et al, 2025; Storrie et al., 2010; Macaskill, 2013; Zarowski et al., 2024), are among the primary beneficiaries of programs promoting mental health and psychological well-being, due to their young age and possible vulnerability (Tommasi et al., 2022). Such programs usually involve organizing counseling services, guidance upon entry, during the university course, and upon exit, as well as initiatives for sharing through workshops and seminars (Ceschi et al., 2022).

One feature of these programs is that they refer to mental health and psychological well-being interchangeably, as if they were synonymous and overlapping terms, which they are not (Payton, 2009). This may cause confusion among both recipients and professionals, especially among those who work more specifically in the field of well-being, such as psychologists and sociologists, and those who work more specifically in the field of health, such as doctors and psychiatrists. In fact, in the case of the above programs, the question becomes: who should deal with mental health? And who should deal with psychological well-being?

Theoretically speaking, the terms mental health and psychological well-being refer to distinct, albeit related, aspects of human life and experience (Payton, 2009). Mental health generally refers to the absence of diagnosable mental illnesses, such as those listed in the DSM (the *Diagnostic and Statistical Manual of Mental Disorders*) or in the ICD (the *International Classifications of Diseases*), while psychological well-being focuses on the presence of positive functioning and optimal human experience, mainly due to such dimensions as satisfaction and motivation, aspects that are emphasized more strongly by that theoretical-practical approach known as *Positive Psychology* (Costantini & Sartori, 2018).

The well-known definition of health that the World Health Organization (WHO) gave in 1948 states as following: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1948, p.100). Leaving aside criticism of the adjective “complete” (Schramme, 2023), this definition implies that not being ill would not necessarily mean being well; and therefore, when it comes to

mental health, that not suffering from psychopathology would not necessarily mean enjoying psychological well-being (Sartori et al., 2025).

In work and organizational psychology, there is Herzberg's Two-Factor Theory, which argues that not being dissatisfied does not necessarily mean being satisfied (Herzberg et al., 1959; Herzberg, 1968). According to this theory, the same applies to the concept of motivation: not being demotivated does not necessarily mean being motivated. And, extending the concept even further, the fact that a state of discomfort is not detectable in a certain context does not mean that, in that context, there is necessarily well-being (Sartori & Ceschi, 2013). Herzberg concludes that dissatisfaction and well-being are not two poles of the same dimension. He derives dissatisfaction from the absence of what he calls *hygiene factors* and well-being from the presence of what he defines as *motivator factors*.

Starting from these premises and considerations, the article aims to clarify the two concepts of mental health and psychological well-being, arguing that the former depends on the presence of hygiene factors as postulated by Herzberg (i.e., mental health would be at risk in the absence of hygiene factors), while psychological well-being depends on the presence of motivator factors as postulated by Herzberg (i.e., once hygiene factors are guaranteed as protective factors for mental health, the presence of motivator factors would stimulate a state of psychological well-being).

In developing our argument, we adopt a psychosocial perspective, since both hygienic and motivator factors can be located either within (psychological factors) or outside (sociological factors) people, which is consistent with the perspective considering such concepts as *intrinsic motivating factors* (internal drivers such as curiosity, personal satisfaction, enjoyment, or purpose) and *extrinsic motivating factors* (external drivers such as money, praise, or avoiding punishment) (Ryan & Deci, 2023).

For example, hygiene psychological resources can be coping skills, emotion regulation, mental health literacy and help seeking pathways, while hygiene social resources can be, for example, economic security, accessible services, institutional fairness and freedom from discrimination. In the same way, psychological motivators factors can be, for example, autonomy, mastery and personal goals, while social motivators factors can be, for example, recognition, belonging, meaningful roles and structured opportunities to contribute.

It follows that both mental health (intended as distress and psychopathology) and psychological well-being (intended as flourishing and meaning) depend simultaneously on the absence or presence of psychological and social factors.

2. The concept of mental health from a psychological and a sociological perspective

Mental health is most often defined in relation to the absence or presence of psychological disorder.

Another definition given by the WHO in 2014 states that mental health is “a state of well-being in which an 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”.

This recalls the definition of guidance provided by the UNESCO Seminar held in Bratislava in 1970, according to which guidance means enabling individuals to become aware of themselves and to progress in their studies (education) and profession (work), in relation to the changing demands of life and age, with the dual purpose of contributing to the progress of society and the development of the individual.

While the definition that the WHO gave in 2014 incorporates elements of well-being, its operationalization in clinical settings relies heavily on the criteria present in the DSM and the ICD (Ma, 2021). Thus, people are traditionally considered to have “good mental health” if they are free from symptoms meeting the threshold for conditions like major depressive disorder, anxiety disorders, or schizophrenia. The focus here is primarily on the reduction of deficit and psychopathology (deficit-based approach).

From a sociological point of view, on the other hand, mental health is often intertwined with labeling theory and social control. The definition of “illness” is codified by institutional bodies, like the American Psychiatric Association (APA) via the DSM or the World Health Organization (WHO) via the ICD, creating a system of institutional gatekeeping. The focus on psychopathology often results in significant societal stigma attached to mental health diagnoses. This stigma is a major sociological challenge, leading to issues of discrimination in areas like employment and housing. Public policy initiatives rooted in mental health predominantly focus on downstream interventions such as crisis management, treatment access, and compliance.

3. The concept of psychological well-being from a psychological and a sociological perspective

Psychological well-being represents the positive end of the mental spectrum – a state of thriving (strength-based approach). Psychological well-

being is broadly conceptualized through two dominant traditions (Ryan & Deci, 2001; Deci & Ryan, 2008):

1. *Hedonic well-being*: Defined by the presence of positive emotions, the absence of negative emotions, and overall life satisfaction (often measured as subjective well-being).
2. *Eudaimonic well-being*: Defined by optimal functioning, meaning, and self-realization.

A prominent model of psychological well-being is Carol Ryff's six-factor structure, which includes: 1. Self-acceptance, 2. Positive relations with others, 3. Autonomy, 4. Environmental mastery, 5. Purpose in life, and 6. Personal growth (Ryff, 1989).

A more recent model is the PERMA model, developed by Martin Seligman in 2011, which includes five dimensions (Seligman, 2018): 1. Positive emotions, 2. Engagement, 3. Relationships, 4. Meaning, 5. Achievement (from which the acronym PERMA).

From a sociological point of view, psychological well-being is fundamentally linked to social determinants of health and the concept of social capital. High psychological well-being indicators (such as autonomy and environmental mastery) are difficult to achieve without access to stable social networks, economic security, and structural support. From this point of view, psychological well-being shifts the focus from an individual's internal defect to the quality of the external environment. Poor psychological well-being in a population is often viewed sociologically as an indicator of systemic failure (e.g., poverty, resource scarcity, or lack of civic engagement). Therefore, psychological well-being-focused policy prioritizes upstream interventions, such as improving community cohesion, promoting positive social environments, and reducing structural inequalities to ensure the entire population has the necessary conditions to flourish.

Historically, mental health and psychological well-being were treated as opposites on a single continuum: poor mental health at one end, and high well-being at the other. However, extensive research, notably by Corey Keyes, supports a dual-factor model (Keyes, 2002), arguing that these constructs operate as two separate, but intersecting, dimensions.

This understanding derives not only from the definitions provided by the WHO, but also from a theory developed in the field of work and organizational psychology between the 1950s and 1960s by Frederick Herzberg, known as the Two-Factor Theory.

4. The Two-Factor Theory by Frederick Herzberg

The Two-Factor Theory, also known as the Motivation-Hygiene Theory, was developed by psychologist Frederick Herzberg to explain job satisfaction and motivation in such organizations as businesses and companies (Herzberg et al., 1959; Herzberg, 1968). Subsequently, the theory was extended to other contexts, such as sports and volunteer associations (Lamb & Ogle, 2019), schools and universities (Clifford et al., 2004; DeShields et al., 2005). Its core assertion is that satisfaction and dissatisfaction are not opposites on a single continuum. Instead, they are influenced by two distinct sets of factors:

1. *Hygiene Factors* (*Dissatisfiers*): These are factors extrinsic to the job itself, related to the work context or environment. Examples include salary, company policies, supervision, working conditions, and job security. When these factors are inadequate or even missing, they cause (job) dissatisfaction. However, making them excellent only serves to prevent dissatisfaction – it does not create true satisfaction or motivation. The opposite of dissatisfaction is simply "no dissatisfaction". In practice, the absence or inadequacy of the hygiene factors causes dissatisfaction, but their presence only prevents dissatisfaction and does not lead to genuine satisfaction or motivation.
2. *Motivator Factors* (*Satisfiers*): These are factors intrinsic to the job content, related to the actual work. Examples include achievement, recognition, responsibility, advancement, and work itself. The absence of such factors does not necessarily cause dissatisfaction, but their presence in the context actively leads to (job) satisfaction and strong motivation. The opposite of satisfaction is "no satisfaction". In practice, the presence of the motivator factors leads to high satisfaction and motivation, but their absence does not necessarily cause dissatisfaction: it merely leads to a state of "no satisfaction" or neutrality.

It follows that satisfaction and dissatisfaction are not opposite poles of the same dimension, since dissatisfaction depends on the absence of hygiene factors, while satisfaction depends on the presence of motivator factors. Similarly, we can say that psychological distress (lack of mental health) depends on the absence of hygienic factors, while psychological well-being (presence of optimal functioning) depends on the presence of motivator factors, as shown below.

5. Using the Two-Factor Theory to distinguish mental health and psychological well-being

Herzberg's Two-Factor Theory can be used to clarify the concepts of mental health and psychological well-being. As mentioned above, we can link

mental health to the hygiene factors of the theory and psychological well-being to the motivator factors, as shown in Table 1.

Table 1. Herzberg' Two-Factor Theory for mental health and psychological well-being.

Herzberg's Factor	**Psychological Construct**	**Sociological Correlates**	**Effect**
Hygiene Factors	Mental Health (Prevention of Illness)	Extrinsic/Contextual (e.g., adequate income, housing security, access to healthcare, freedom from discrimination, social safety nets, institutional justice)	Mental Illness (High Distress /Dissatisfaction). Neutral State (No Illness but not necessarily Thriving).
Motivator Factors	Psychological Well-Being (Promotion of Wellness)	Intrinsic/Content (e.g., meaningful social roles, genuine community belonging, opportunities for personal growth, contribution, civic engagement, autonomy/agency)	High Well-Being (High Satisfaction /Motivation). Neutral State (No Satisfaction but not necessarily Illness).

Applying the dual-continuum framework yields four distinct psychological states, moving beyond the simple dichotomy of "ill" or "healthy" (see also Keyes, 2002):

1. *High Hygiene*, *High Motivation* (*Flourishing*): The ideal state. Individuals have high stability and low distress (mental health) while also experiencing high purpose and engagement (well-being).
2. *High Hygiene*, *Low Motivation* (*Languishing*): Individuals are not clinically distressed and maintain stability, but lack joy, purpose, and engagement. They are "fine" but not fulfilled. This is the state where the absence of illness is mistaken for the presence of health.
3. *Low Hygiene*, *High Motivation* (*Fragility/Burnout*): Individuals are highly engaged, purposeful, and driven, but struggle with inadequate coping mechanisms or high-stress environments. They are productive but perpetually on the verge of breakdown (e.g., high-achieving students with severe anxiety). The motivation is not buffered by stability.
4. *Low Hygiene*, *Low Motivation* (*Illness*): The most detrimental state. Individuals suffer from psychopathology and lack any sense of purpose or fulfillment.

As for Keyes (2002), we can say that his theory describes the two-dimensional structure of mental health and psychological well-being, whereas

the model by Herzberg provides an explanatory and design-oriented mechanism that links kinds of determinants to kinds of intervention. In other words, hygiene conditions explain why distress persists when protective context is insufficient, and motivator conditions explain why flourishing requires active opportunities for meaning, autonomy, contribution, and growth. In this sense and in the present article, Herzberg is not offered as a replacement for Keyes, but as a translational bridge from structure to intervention.

6. Conclusion

The central aim of this article was to use Frederick Herzberg's Two-Factor Theory to resolve the conceptual ambiguity between mental health and psychological well-being. By applying the Motivation-Hygiene model, it was established that these are not merely opposite poles of a single dimension, but two separate constructs requiring different types of conditions and interventions. Mental health is fundamentally a matter of stability and protection, dependent on hygiene factors that minimize distress and prevent clinical illness. Psychological well-being, conversely, is a dynamic state of striving and fulfillment, dependent on motivator factors that actively promote purpose, achievement, and engagement.

This dual-continuum framework carries significant implications for policy and practice. Current health programs often excel at providing the "hygiene" needed to move individuals out of the Illness state – offering counseling, crisis support, and basic structural security. However, they frequently fail to move people from the Languishing state (High Hygiene, Low Motivation) to Flourishing (High Hygiene, High Motivation), because they neglect the crucial motivator factors.

Here are some examples that help make hygiene versus motivator logic practically usable and would demonstrate the value of the Herzberg lens. In the student context, for example, hygiene-oriented actions could include economic and housing support, accessible counseling services, clear referral pathways, and anti-discrimination enforcement; motivator-oriented actions could include peer mentoring, service learning, structured opportunities for participation and role, tutoring communities, and workshops on purpose and future projects. Outcomes should be assessed with indicators of distress and clinical risk as well as indicators of flourishing, meaning, and engagement, because each dimension can move independently.

The WHO, which has been mentioned several times in this article, defines health promotion in the Ottawa Charter published in 1986 during the first *International Conference on Health Promotion* as "the process of enabling people to

increase control over and improve their health"(World Health Organization, 1986, p.1). Consequently, to cultivate a genuinely healthy population, interventions must be two-fold.

First, public and institutional policy must guarantee the essential hygienic elements – reducing systemic inequality, ensuring stable social safety nets, and providing adequate access to care. This addresses the challenge of mental health.

Second, and equally vital, programs must focus on stimulating motivator factors by creating tangible opportunities for personal growth, genuine civic engagement, meaningful social roles, and autonomy.

Only by addressing both the necessity of preventing illness (Hygiene/Mental Health) and the necessity of cultivating purpose (Motivators/Well-Being) can we design systems that move people beyond merely not being ill towards fully being well.

Mental illness is often the direct consequence of societal failure to provide foundational, extrinsic resources. Socio-structural determinants like poverty, precarious employment, systemic discrimination, inadequate housing, and lack of social support function as "dirty" or deficient hygiene factors. Their presence (as deficits) actively causes mental distress and illness. A society that provides sufficient "hygiene" (e.g., universal basic income, robust public healthcare, strong anti-discrimination policies, and safe communities) simply moves its population from a state of active illness/dissatisfaction towards a neutral baseline of "no mental illness", analogous to Herzberg's state of "no dissatisfaction".

Crucially, fixing these structural deficits eliminates psychopathology but does not automatically instill deep fulfillment. Just to be clear, addressing unemployment may prevent anxiety and depression, but only meaningful work or social contribution can foster true well-being (Tommasi et al., 2023; Tommasi et al., 2025).

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