Lay Perspectives on Mental Health: A Qualitative Study

Master thesis

Department: Behavioral Sciences

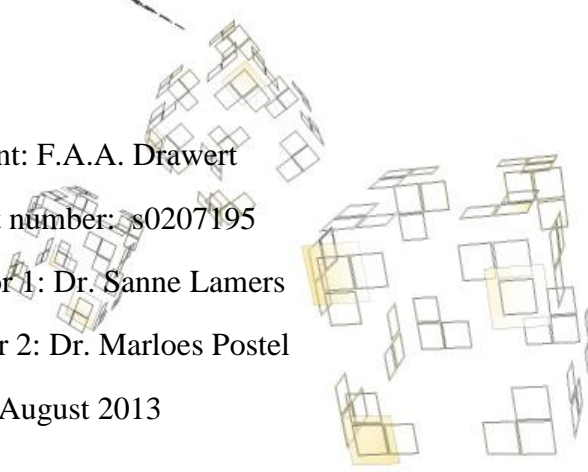Program of study: Mental Health Promotion

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Abstract

Background: This study aimed at exploring lay perspectives on mental health. Research defined mental health as not only the absence of mental illness but also the presence of emotional, psychological and social well-being. Nevertheless, mental health services still focus mainly on mental illnesses. The inclusion of lay perspective may therefore lead to aligned mental health promotion strategies and treatments. Theory-based definitions of mental health may differ from lay perspectives. Hence, the current study investigated whether or not lay perspectives fit to the Two-Continua Model of health and illness (Keyes, 2005). This model assumes that mental health reflects both aspects of positive mental health and psychopathology. **Methods:** This study adopted a qualitative research approach. Eight Dutch adults between 21 and 72 years of age participated; half of them were male. A semi-structured interview was developed to assess lay perspectives on mental health. Moreover, two self-report questionnaires were assessed, which represented the participants' level of mental illness (BSI-18) and positive mental health (MHC-SF). All interviews were audio-recorded, transcribed and imported into Atlas. ti, a computer-aided qualitative data analyses software. The data analysis began with bottom-up coding and proceeded to a top-down approach by linking lay perspectives on mental health to the Two-Continua Model of mental health and illness. **Results:** Almost all of the participants mentioned both aspects of psychopathology and positive mental health, including aspects of emotional, psychological and social well-being. These results confirm the Two-Continua Model of health and illness and underline the relevance of separating these three components. Furthermore, new topics were found regarding aspects of spiritual well-being such as belief/faith and serenity. **Conclusion:** The current study provided an understanding of lay perspectives on mental health. Lay people perceive holistic concepts of mental health including both aspects of psychopathology and positive mental health. This is in line with theory-based findings. Nevertheless, clinical psychology still focuses mainly on psychopathology, accompanied by the risk to neglect valuable strengths and resources in people. The findings of this study underline the importance of addressing positive aspects in addition to psychopathological phenomena when promoting or treating mental health. This is not only desirable for individuals and mental health care institution, but also our collective society.

Table of Content

Introduction

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Throughout psychological history, a variety of theory-based views on mental health have been presented. For a long time psychological research and practice defined mental health as a lack of psychopathology (Helman, 1991; Kovacs, 1998). This is why we most likely tend to associate problems, weaknesses or reparation of damage with the term mental health. Due to this illness-based view current theoretical frameworks and scales for the measurement of mental health are largely characterized by assessing the absence or presence of illness. The current approach of clinical psychology mainly focuses on illness.

Within the last years the theoretical definition of mental health has changed. In 2004, the World Health Organization published a report on mental health promotion, describing mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (WHO, 2004, p.12). In other words, mental health is clearly not just the absence of illness but also encompasses positive aspects of well-being, such as happiness or positive functioning.

The utility of a positive approach to mental health is supported by the positive psychology movement. By addressing the study of well-being, quality of life, strengths and resources (Seligman & Csikszentmihalyi, 2000), positive psychology represents a significant shift from traditional deficit-oriented approaches. Instead of almost exclusively paying attention to psychopathology, the field of positive psychology underlines the importance of taking positive aspects into account (Seligman, 2011). Hence, mental health is seen as a positive phenomenon that is more than the absence of psychopathology (Westerhof & Keyes, 2010; Lamers, 2012).

Recently, Keyes (2002, 2005, 2007) and colleagues demonstrated that aspects of well-being and psychopathology reflect two independent but correlating components of mental health (Huppert & Whittington, 2003; Suldo & Shaffer, 2008; Davidson, Drake, Schmutte, Dinzeo, & Andres-Hyman, 2009). Thus, the absence of psychopathology does not necessarily ensure a productive and fruitful life. Moreover, the presence of psychopathology may be accompanied by aspects of well-being (Keyes, 2005).

Theory-based vs. Lay Perspectives

All of the definitions of mental health that are currently used within psychological research originate from theory-based concepts which are influenced by academic knowledge. On the one side, theory-based concepts are very useful for providing a basis for evidence-based research and practice. Theories reflect abstract explanations of empirical reality. On the other side, there is always the risk for distancing of theory-based concepts from lived experience and knowledge (Milburn, 1996). Mental health for each person is influenced by experience in everyday life, in schools, or at work (Lehtinen, Riikonen & Lahtinen, 1997). Correspondingly, lay perspectives may differ from theoretical perspectives since they are perspectives of non-expert people. Lay people may have important insights that researchers or health professionals may overlook (Oliver, 1995). Consequently, the current study aimed at investigating whether or not lay perspectives fit in with theory-based definitions of mental health, including both psychopathology and positive aspects in life (Keyes, 2005).

The inclusion of lay perspectives may lead to aligned mental health promotion strategies or treatments. Entwistle et al. (1998) argued that lay people may improve the quality of research by enhancing understandings in assessing health interventions. Further examples of the contributions lay people make to research include identifying relevant topics, raising funds, and/or increasing the acceptance of findings (Oliver, 1995; Goodare & Smith, 1995). The involvement of lay people may also be seen as a democratic decision making process with respect to publicly funded research or health services offered (Entwistle et al., 1998).

Psychopathology

Nowadays, clinical psychology mainly focuses on assessing and treating psychopathology. The term psychopathology is often described as the science of mental or psychological suffering (Vandereycken, Hoogduin, & Emmelkamp, 2008). Approximately one out of four adults in the European Union (between 18 and 65 years of age) suffers from at least one mental disorder (Wittchen & Jakobi, 2005). Within the field of clinical psychology, there is an emphasis of evidence-based practice to ensure effective interventions that reduce mental illnesses. Specific manuals have been developed in order to classify psychopathological symptoms and thereby associated diagnoses.

On the one hand, the classification of psychopathological symptoms and maladaptive behaviors yields benefits. Reliable and valid instruments allow evidence-based research and practice. In addition, theoretical models provide an understanding of risk criterions that may lead to mental illnesses. Nevertheless, the classification of mental disorders also leads to a distinction of normal and abnormal behavior (Widiger & Samuel, 2005). This in turn may lead to stigmatization, which distracts people from seeking mental health care (Corrigan, 2004). The exclusive focus on mental disorders is accompanied by the risk to neglect individual strengths and resources (Seligman & Csikszentmihalyi, 2000).

In the Netherlands, the Diagnostic and Statistical Manual of Mental Disorders (DSM) serves as an official and established guideline for diagnoses of psychopathology (DSM-VI; American Psychiatric Association, 2000). The amount of registered diagnoses as well as psychopathological phenomena is considerable high. Accordingly, this study outlined *psychopathology* in terms of the most frequent observed psychiatric disorders in primary health care (Hanel et al., 2009), namely: mood, anxiety and somatic disorders. In 2007, results from the Netherlands Mental Health survey (NEMESIS-2, De Graaf et al., 2010) demonstrated that the Dutch population between 18 and 65 years of age, was most prevalent affected by mood disorders (20,1 %), anxiety disorders (19,6 %), and somatic disorders (16,1 %). Table 1 presents a brief description of these common disorders:

Table 1.

Mood, anxiety and somatic disorders (based on DSM-IV)

Diagnose	Description
Mood disorder	Depressed mood, loss of interest and pleasure (e.g. major depression, bipolar disorder, substance-induced disorders)
Anxiety disorder	Excessive and uncontrollable fear (e. g. panic disorder, stress disorder, or generalized anxiety disorder)
Somatic disorder	Medically unexplained physical symptoms (e.g. pain disorder, conversion disorder, or somatization disorder)

Positive Mental Health

There is increasing interest in exploring the concept of positive mental health as an entity that is more than the absence of illness (Barry, 2009). According to the WHO (2004) there is no health without mental health. Hence, a good mental health can be considered as an integral part of overall health and is therefore fundamental to every individual at any time in life.

The theoretical definitions of positive mental health that are currently used within psychological research are primarily derived from two distinguished philosophical conceptualizations of well-being (Keyes, 2002; Ryan & Deci, 2001; Waterman, 1993), namely the hedonic and the eudaimonic tradition. The hedonic view equates well-being with subjective experiences of happiness or pleasure (Diener et al., 1985; Pavor & Diener, 2008). This view fits well to Keyes (2007) aspects of *emotional well-being* (see Table 2), including happiness, positive affect and life satisfaction. At present, there is a consensus that emotional well-being also implies the presence of positive affect and the absences of negative affect (Diener et al., 1999; Westerhof, 2001).

Table 2.

The dimensions of emotional, psychological and social well-being (based on Keyes, 2005)

Dimension	Description
Emotional well-being	
Happiness	Feeling happy.
Positive affect	Feeling pleased, full in life, happy and satisfied.
Life satisfaction	Feeling satisfied with one's life.
Psychological well-being	
Self-acceptance	Positive attitudes towards aspects of oneself and past life.
Environmental mastery	Capability to manage complex environment according to one's own need.
Positive relations with others	Having warm, satisfying, trustful relationships and being capable of empathy.
Personal growth	Having the insight into one's own potential for self-development.
Autonomy	Giving yourself your own direction by one's own socially accepted internal standards

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Table 2. (continued)

Dimension	Description
Purpose in life	Holding the belief that life has a meaning.

Social well-being

Social contribution	Feeling that one's own life contributes to society and is valued by others.
Social integration	Having a sense of belonging to a community.
Social actualization	Believing that people have potential and grow positively.
Social acceptance	Holding a positive attitude towards people's differences.
Social coherence	Being able to make meaning of what is happening in society.

In contrast, the eudaimonic view equates well-being with optimal functioning in accordance with one´s own capabilities. This view dates back to Aristotle who argued that realizing one's true potential is essential for a good life (Waterman, 1993; Ryff & Singer, 2008). Striving for optimal functioning is also in line with Keyes aspects of *psychological well-being*, which includes six aspects such as autonomy and environmental mastery (see Table 2). Originally, Ryff (1989) designed these six aspects, which were later adopted by Keyes (2005). Each of the six aspects is important to realize one´s own potential.

Keyes (1998) argued that each individual is connected to social communities so that well-being is not merely an individual development. Consequently, Keyes (2005) composed five aspects of *social well-being* (see Table 2) in order to imply social aspects in his research on mental health. Recently, Keyes (2002, 2005, 2007) has attempted to unify the hedonic and eudaimonic tradition. More precisely, Keyes (2005) found that a mentally healthy person experiences aspects of emotional, psychological as well as social well-being. There is research supporting this three-folded structure (Gallagher, Lopez, & Preacher, 2009). In addition, these three dimensions match the core components of the World Health Organization´s definition of positive mental health (Westerhof & Keyes, 2008). Accordingly, this study defined positive mental health in terms emotional, psychological and social well-being (see Table 2).

Two-Continua Model of Mental Health and Illness

Now that the concepts of psychopathology and positive mental health have been clarified, it will be explained how positive mental health relates to psychopathology. Keyes (2005) proposed the Two-Continua Model of mental health and illness and argued that psychopathology and positive mental health reflect two distinct, but correlating components of mental health. Consequently, the absence of mental illness does not guarantee the presence of positive mental health (Huppert & Whittington, 2003). One continuum reflects the presence or absence of psychopathology and the other continuum reflects the presence or absence of positive mental health. At all times, every combination of negative and positive states of mental health is possible (Lamers, 2012).

In practice, individuals free of mental illnesses may experience low levels of positive mental health, such as few positive emotions. At the same time, an individual may suffer from mental illnesses and experience high levels of positive mental health (Keyes, 2005, 2007). Thus, it is possible to experience high positive mental health while being mentally ill, and not all psychopathological symptoms have to disappear to lead a meaningful and pleasant life (Davidson et al., 2009).

Many empirical studies support the Two-Continua Model (Keyes, Eisenberg, Dhingra, Perry, & Dube, in press; Huppert & Whittington, 2003; Suldo & Shaffer, 2008; Keyes, 2009; Westerhof & Keyes, 2010; Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011). The model has been replicated across U.S. adolescents and adults (Keyes, 2005, 2006, 2007), South-African adults (Keyes et al., 2008) and Dutch adults (Westerhof & Keyes, 2010). Due to these findings, it can be reasoned that a combined diagnosis of mental health and illness predicted psychosocial functioning better than a single diagnosis does, demonstrating that mental health and mental illness are complementary (Keyes, 2002, 2005; Lamers et al., 2011). Hence, this study assessed both the participants' level of mental illness and positive mental health (see *Methods*) to ensure an adequate picture of the participants' level of mental health.

There are also studies which showed that positive mental health may predict future levels of psychopathology (Wood & Joseph, 2009; Keyes, Dhingra, & Simoes, 2010). A change in positive mental health predicted the prevalence and incidence of major depressive disorders, panic disorders, and generalized anxiety disorders ten years later (Keyes et al., 2010). Thus, positive mental health may act as a buffer against psychopathology (Wood &

Joseph, 2009; Keyes et al., 2010). Improving levels of positive mental health may also contribute to a reduced number of mental illnesses (Keyes, Dhingra, & Simoes, 2010). Clearly, these findings underline the importance of addressing positive aspects in addition to psychopathological symptoms when promoting or treating mental health.

Promoting a Good Mental Health

Keyes (2005) argued that current mental health care systems mainly focus on reducing the number of mental illnesses - with the underlying aim of increasing mental health. However, it was acknowledged in literature that treating illnesses alone cannot adequately address the increasing numbers of mental illnesses (Andrews, Issakidis, Sanderson, Corry, & Lapsley, 2004; Cuijpers, van Straten, Smit, Mihalopoulos, & Beekman, 2008). Consequently, instead of simply reacting to mental illnesses or preventing those at risk, Keyes (2005) called for an adoption of another strategy, namely promoting and maintaining a good mental health in order to decrease the risk of future illness (Keyes, Dhingra, & Simoes, 2010).

Studies aimed at mental health promotion and prevention detected some strategies to increase the public's mental health, such as enhancing public attitude towards seeking help from mental professionals (Jorm, Barney, & Christensen, 2006), reducing the stigmatization and discrimination of individuals with mental health problems (Bourget, & Chenier, 2007) and increasing public awareness (Angermeyer, & Dietrich, 2006). However, despite small or moderate mental health complaints, many individuals do not consult mental health services because of not appearing 'mentally ill' according to either personal or clinical definition (Bebbington et al, 2000; Andrews, Issakidis, & Carter, 2001). As these individuals continue to live in suboptimal ways, this most likely provokes a public health problem (Ahuriri-Driscoll, 2000).

Due to this, mental health care has to develop promotion strategies that stimulate early help-seeking behavior. Early treatments prevent worsening complaints and therefore prevent long-term usage of mental health services (Cuijpers, van Straten, & Smit, 2005). This is why early interventions, in combination with the promotion of a good mental health, are related to significant cost savings. Mentally healthy persons function better than individuals with a poor mental health, concerning better physical health, less health care consumption and better work performance (Keyes, 2002, 2005, 2006, 2007; Keyes & Grzywacz, 2005). Moreover,

individuals who experience a good mental health are less likely to seek professional help (Keyes & Grzywacz, 2005). This could be a benefit for not only individuals or mental health services but our collective society.

One's attitude towards mental health is closely related to help-seeking behavior (Jorm, 2000; Hughner, & Kleine, 2004). Ajzen´s theory of planned behavior may serve as theoretical background to determine how attitudes relate to help-seeking (Ajzen, 1991). For example, a person who associates stigma or illnesses with mental health care may be less likely to seek professional help (Amato, & Bradshaw, 1985; Surgenor, 1985; Kushner & Sher, 1991) because of the fear to be labeled as a crazy or psychopathological patient. In contrast, a person who associates a better quality of life with mental health care is more likely to seek help at early stages. Several studies have demonstrated that people who have sought professional help in their lives have more positive attitudes towards mental health care than those who have not (Cash, Kehr, & Salzbach, 1978; Surgenor, 1985). Hence, understanding lay perspectives on mental health may inspire promotion and treatment strategies related to a good mental health as well as help expand theoretical frameworks.

Qualitative Studies

Despite the clear additional value of lay perspectives on mental health, very little research has specifically considered lay people. There is an extensive literature on lay perspectives on mental illness (Furnham, 1988) or psychological problems (Furnham & Henley, 1988). Research on lay perspectives has clearly focused more on illness than on health. Only one unpublished, qualitative study assessed lay perspectives on mental health (Matel, 2012). This is why the current study used a qualitative approach to ensure that new and unexpected information could arise (Boeije, 2008). The use of a qualitative approach, such as open-ended questions, provides information about the participants' perspectives on mental health. Especially qualitative approaches can be helpful for investigating new facets that are not represented in theory-based research yet (Silverman, 2013).

Matel (2012) asked 12 Dutch participants, aged 55 and older, about their vision of mental health by applying a self-designed and open-ended interview. Most of the participants mentioned four main aspects concerning their associations with mental health, namely Faith/Belief; Healthy Body; Psychopathology; and Social Contacts. Mental health was also

defined in terms of Having a Good Memory, Coping with Life, and Being Satisfied. Some of her participants experienced it as very challenging to describe the term mental health. Nevertheless, all of the participants associated aspects related to both positive mental health and psychopathology. However, Matel (2012) focused on a limited age range (aged 55 and older).

Adopting both quantitative and qualitative techniques, Delle Fave and her colleagues (2011) investigated happiness, goals and meaningfulness. In particular their investigation of happiness is relevant for the current study due to the fact that happiness and mental health are still often used as synonyms in scientific literature. Delle Fave et al. (2011) asked 666 people to describe the term happiness, including a questionnaire with a set of eight questions. Six of them were open-ended. Their study involved participants between 30 and 51 years of age from seven different countries. The participant's definition of happiness was related to either psychological or domain-related components. Three psychological categories were mentioned the most: firstly, Harmony/Balance (25,4%), which comprised items such as self-acceptance, inner peace, and positive relations with others. Secondly, Emotions/Feelings (16,6%), including items such as positive emotion, joy, and moments of pleasure. Finally, Well-Being (11,8%), encompassing general answers such as psychological and mental well-being. Moreover, several other psychological aspects were reported by the participants such as autonomy, satisfaction or spirituality/religion. However, there are also some concerns related to Delle Fave et al (2011) study due to a limited age range (between 30 and 52 years of age), educational level (high school or college) and residence (urban areas). In addition, Delle Fave te al (2011) examined happiness as a positive phenomenon and therefore excluded aspects of psychopathology and positive mental health.

The present study included a diversified group with respect to gender, age and educational level in order to guarantee multifaceted perspectives on mental health (see *Participants*). A self-developed questionnaire was designed in order to assess the participants' perspectives on mental health. Open questions were intentionally expressed in a neutral way in order to prevent biased answers (see *Interview Schedule*).

Research Question

The current study aimed at examining lay perspectives on mental health. Thus, the following main research question was designed: *"What are the lay perspectives on mental health?"*. Additionally, it was investigated whether or not lay perspectives fit in with Keyes (2005) Two-Continua Model of mental health and illness, including both aspects of positive mental health and psychopathology. This model assumes that both of these aspects reflect mental health. Moreover, aspects of positive mental health and psychopathology are related to each other, even though the relationship is not perfect (Keyes, 2005). Hence, it was also assessed whether participants possibly perceive a correlation between mental health and illness, as it is assumed by the Two-Continua Model of mental health and illness. On the basis of these assumptions the following sub research questions were designed:

Sub question a) *Which aspects of lay perspectives correspond to positive mental health?*

Sub question b) *Which aspects of lay perspectives correspond to mental illness?*

Sub question c) *To what extent do lay perspectives fit to the Two-Continua Model?*

Furthermore, this study assessed both the participants' level of mental illness and positive mental health (see *Methods*) to ensure an adequate picture of the participants' level of mental health. Additionally, it was useful to assess the participants' level of mental health in order to inspect contextual variables that might influence perspectives on mental health (Milburn, 1996).

Method

The current study was conducted in the Netherlands in June 2013 and was approved by the University Ethics Committee. Due to the exploratory nature of this study, a qualitative approach was chosen. It involved semi-structured, face-to-face interviews, concerning the personal perspectives on mental health of eight participants.

Participants

Inclusion was based upon the ability to speak Dutch. Additionally, all of the participants had to be aged 18 or older. Due to limited age ranges in earlier studies (Delle Fave et al., 2011; Matel, 2012) this study included a diversified group in order to guarantee multifaceted perspectives on mental health. Table 3 presents the characteristics of the participants (N = 8). Half of the participants were male. The researcher interviewed participants between 21 and 72 years. The majority of participants (*n* = 5) were from a higher educational background. In addition, two of the participants' occupation was related to mental health care.

Procedure

The recruitment took place by approaching people via phone, e-mail and face-to-face. All of the participants (N = 8) were recruited in Enschede, the Netherlands, in collaboration with acquaintances of the researcher. Verbal information about the content and practical matters of the study was given. As soon as people agreed to voluntarily participate in the study, an appointment was scheduled. The response rate was 100 %. All of the

Table 3. *Characteristics of participants*

Characteristics	Total (N = 8)
	n
Gender	
Male	4
Female	4
Age	
18 - 24	2
25 - 64	4
65 or older	2
Educational level	
Low	1
Medium (MBO)	2
High (University)	5
Occupation related to mental health care	
Yes	2
No	6

participants signed an informed consent document. The interviews were conducted at places where participants felt comfortable. Most of the interviews were conducted at the participant's home. It took participants approximately 30 minutes to complete the interview as well as two self-report questionnaires (see *Interview Schedule*) concerning the participants' level of mental health. All of the interviews were audio-recorded and typewritten.

Interview Schedule

Lay perspectives on mental health were investigated by the use of a self-developed and semi-structured interview (see Appendix B). All of the questions were expressed in Dutch. The first part of the interview was designed to assess demographic variables and information about the participants, including gender, age, educational level, and occupation (see Table 3).

The aim of the second part of the interview was to assess the participants' perspectives on mental health by using six main questions. The first three open-ended questions examined the participants' associations with the term mental health (e.g. *What do you think of when you hear "mental health"*?). These questions were intentionally expressed in a neutral way in order to prevent biased answers. Thus, the researcher provided a flexible framework for interviews to be guided by the topic of each participant. After inviting all of the participants to describe their personal perspectives on mental health and mentally healthy persons, the participants were asked to fill in the following two self-report questionnaires concerning the participants' level of mental health:

Brief Symptom Inventory – 18 (BSI-18): The BSI-18 (BSI; Dutch Version: Beurs & Zitman, 2006) assesses degrees of psychopathology over the past week and consists of 18 items, representing various aspects of mental illnesses (see Appendix C). The BSI-18 measures three subscales: depression (6 items), anxiety (6 items), and somatization (6 items). Respondents indicate the degree to which they have experienced diverse psychological symptoms using a 5-point Likert scale, ranging from 1 = "*not at all*" to 5 = "*a lot*". A total score was calculated by summing the scores on the individual items and subsequently compared with corresponding norm populations (*very low / low / below averag*e */ average / above average / high / very high*). The BSI-18 has been shown to be a reliable tool for psychiatric assessments (Derogatis, 2001).

Mental Health Continuum – Short Form (MHC-SF): The MHC-SF (MHC; Dutch Version: Lamers et al., 2011) assesses positive mental health over the past month and consists of 14 items. These items represent three categories: emotional well-being (3 items), psychological well-being (5 items), and social well-being (6 items). Respondents indicate the degree to which they have experienced diverse aspects of well-being, using scores on a 6-point Likert scale ranging from 0 = "*never*" to 5 = "*every day*". The total score was assessed by summing the scores on the individual items and dividing this by the number of items. Afterwards, the total score was compared with corresponding norm populations (*below average / average / above average*). The MHC-SF fits in with the hedonic and eudaimonic well-being research and showed good psychometric properties (Keyes et al, 2008; Lamers, 2012).

These two self-report questionnaires were deliberately placed after assessing the participants' perspective on mental health. The questionnaires represent psychopathology (BSI-18) and positive mental health (MHC-SF), as defined in this study. On the one hand, these questionnaires were conducted to adequately assess the participants' level of mental health. It is useful to inspect contextual factors, such as current levels of mental health, which might influence given answers (Milburn, 1996). On the other hand, these two questionnaires were conducted in order to give the participants an idea about two different approaches to mental health, respectively illness. This was particularly useful for either exploring new views on mental health or engrossing already existing views. After filling in the questionnaires, all participants were asked, which perspective (psychopathology or positive mental health) fit to their personal perspective on mental health and why (e.g. *According to you which of the two questionnaires measures mental health in a good way?*). Ultimately, all participants were asked if they had any mental disorders in their lives and if they received professional help. This provided a meaningful context for a more detailed exploration of their perspectives on mental health.

Data Analyses

All interviews were audio-recorded, transcribed and imported into *Atlas. ti* (Muhr, 1997) for the purpose of analyses. *Atlas. ti* is a computer-aided qualitative data analysis (QDA) software in academic research. This software package allows the identification of reoccurring themes

by analyzing common patterns. Moreover, the QDA software enables the researcher to code transcribed interviews in a transparent way.

The data analysis began with bottom-up coding and proceeded to a top-down approach (Hsieh & Shannon, 2005) by linking lay perspectives on mental health to the Two-Continua Model of mental health and illness (Keyes, 2005). The researcher began the bottom-up phase by reading the transcribed interviews carefully and identifying relevant text fragments, i.e. words and phrases that were meaningful to the research focus. Each new perspective on mental health was given a new code. Text fragments which expressed a common idea were grouped into categories. For example, categories such as "having good friends" and "feeling connected to society" reflected social aspects of well-being. Systematical comparison helped identifying associated categories (Pope, Ziebland, & Mais, 2000). Each category represented a cluster of relevant text fragments. After the categories were identified, the top-down phase began. Each category was linked to elements of the Two-Continua Model (Keyes, 2005), including both positive mental health (*emotional, psychological* and *social well-being*) and psychopathology, as defined in this study (*mood disorders, anxiety disorder,* and *somatic disorders*).

Additional categories needed to be created for responses that did not match the Two-Continua Model. These responses were either ascribed the category *other aspects of mental illness* or the category *other aspects of mental health*. Here, the category *other aspects of mental illness* comprised either general psychopathological answers such as "people with mental illnesses" or "psychological institutions". By adopting a bottom-up approach again, the category *other aspects of mental health*, comprised aspects such as "belief/faith" or "serenity" and therefore reflected the umbrella term *spiritual well-being*.

Results

The purpose of this study was to examine lay perspectives on mental health. It was investigated whether or not lay perspectives correspond to the Two-Continua Model of mental health and illness (Keyes, 2005). The results will be grouped into the three sub research questions which reflect the main research question "*What are the lay perspectives on mental health?"* Example quotes were presented in order to illustrate each perspective on mental health. To protect anonymity, only participants´ gender (M=Male/F=Female) and age was indicated following each quotation.

Sub question a) Which aspects of lay perspectives correspond to positive mental health?

Aspects of emotional well-being: The majority of participants (*n* = 6) named aspects of emotional well-being. Here, most of the participants (*n* = 6) associated <u>happiness</u> with the term mental health (see Table 4). One of the participants described a mentally healthy person as followed: "*when a person is happy […] in a natural way"* (Male, 25). Moreover, half of the participants (*n* = 4) thought of <u>positive affect</u>, such as "*gladness… and joy"* (Female, 23) when hearing the term mental health. In addition, <u>life satisfaction</u> was mentioned by four out of eight participants. One of the participants argued: "*when you embrace your life – your life will embrace you in turn*" (Male, 29).

Table 4.

Example quotes and frequencies of aspects concerning emotional well-being

Aspects	Example quotes	Total (N = 8) *n*
Happiness	"*... then you are very happy."* (M, 29)	6
Positive affect	"*...a satisfied person."* (M, 25)	4
Life satisfaction	"*It's important to feel pleased with your life."* (F, 65)	4

Aspects of psychological well-being: All participants (*n* = 8) named at least one aspect of psychological well-being (see Table 5). Therefore, psychological well-being was the most

frequently mentioned dimension in the current study. Almost all of the participants (*n* = 7) thought of <u>autonomy</u> when they were asked to describe a mentally healthy person: *"A person who has his own opinion"* (Female, 65). <u>Environmental mastery</u> was stated by the majority of participants (*n* = 6). One of the participants underlined the importance of managing one's surrounding world. Accordingly, this participant argued that a mentally healthy person *"can cope with problems and setbacks"* (Female, 65). Furthermore, <u>positive relations with others</u> was mentioned by more than half of the participants (*n* = 5). One of the participants declared that *"if you are a mentally healthy person, you will have many friends"* (Male, 21). Some of the participants (*n* = 3) associated <u>self-acceptance</u> with the term mental health (see Table 5). Hence, one of the participants described a mentally healthy person as follows: *"...he has a positive attitude towards himself"* (Female, 65). Only one of the participants mentioned the aspect of having a <u>purpose in life</u> by underlining the importance of working towards personal life goals (see Table 5). None of the participants mentioned aspects of <u>personal growth.</u>

Table 5.

Example quotes and frequencies of aspects concerning psychological well-being

Aspects	Example quotes	Total (N = 8) *n*
Autonomy	*"...that you express your own thoughts and views in a confident way."* (M, 25)	7
Environmental mastery	*"...if something bad happens... you do not give up – you just put it in perspective."* (M, 29)	6
Positive relations with others	*"Finally, it is very important to have a large social network."* (M, 21)	5
Self-acceptance	*"...that I feel comfortable in my own skin."* (F, 65)	3
Purpose in life	*"You need to work towards life goals. Yes, goals are very important."* (M, 21)	1
Personal growth	-	0

Aspects of social well-being: The majority of participants (*n* = 6) associated social aspects of well-being with the term mental health. Half of the participants (*n* = 4) expressed social acceptance when thinking of mentally healthy persons: *"...they think in a nice way. They would not think "oh no! What a person! Who is that person...! [...] We are all equal"* (Female, 65). Moreover, some of the participants (*n* = 3) named aspects referring to social integration. One of these participants underlined the benefits of having a sense of belonging to a Christian community: *"If you believe in god there is always someone for you"* (Male, 21). Furthermore, two of the participants described aspects of social contribution: *"...maybe it's a little bit philosophic, but I think that every human being wants to contribute something to society [...] human beings are social animals"* (Male, 29). Social coherence was mentioned by one participant who emphasized the importance of knowing what is good or bad within a social context: *"They know this is good, this is bad; what is allowed"* (Male, 42). None of the participants mentioned the concept of social actualization.

Table 6.

Example quotes and frequencies of aspects concerning social well-being

Aspects	Example quotes	Total (N = 8) *n*
Social acceptance	*"...that you take everyone on his own values and standards."* (F, 72)	4
Social integration	*"...extensive relationships. For example, that you feel connected to the world."* (M, 25)	3
Social contribution	*"When you are mentally healthy [...] you are socially committed [...] society gives you strength back"* (M, 21).	2
Social coherence	*"They know this is good, this is bad; what is allowed"* (M, 42)	1
Social actualization	-	0

Other aspects concerning mental health: Half of the participants (*n* = 4) described mental health in a way that did not exactly fit to the components of emotional, psychological and/or

social well-being. These aspects were attributed to the pre-set category "other aspects concerning mental health" (see Table 7). For example, two of the participants associated their belief in a god with the term mental health. These participants felt deeply connected to their personal faith. One of these participants mentioned: *"I think most of the people who pray can be considered mentally healthy"* (Male, 21). Furthermore, one of the participants emphasized a harmonious relationship between body and mind: *"It's the balance between body and mind. If you believe in dualism […] balance of body and mind is the definition"* (Male, 29). In addition, one of the participants associated serenity with the term mental health: *"I think mental health includes keeping a serene attitude"* (Male, 25).

Table 7.

Example quotes and frequencies of other aspects concerning mental health

Aspects	Example quotes	Total (N = 8) *n*
Balance/Harmony	*"It's the balance between body and mind. If you believe in dualism […] balance of body and mind is the definition"* (M, 29)	1
Serenity	*"I think mental health includes keeping a serene attitude"* (M, 25).	1
Belief/Faith	*"if God says it is over, it is over"* (F, 72)	2

Sub question b) Which aspects of lay perspectives correspond to psychopathology?

Almost all of the participants (*n* = 7) mentioned at least one aspect relating to mental illness in terms of psychopathology. Most of the participants (*n* = 6) associated mood disorders, respectively depression, with the term mental health (see Table 8). One of the participants described a mentally healthy person as "*little neurotic or depressive*" (Male, 29). Another participant mentioned: "*Mental health? I directly have to think of […] depression. And suffering […] when you hear the term mental health…you very likely think of people who are*

not doing well in their heads" (Female, 65). Moreover, some of the participants ($n = 3$) associated the absence of <u>anxiety disorders</u> with the term mental health (see Table 8). One of the participants explained: *"Mental health implies [...] having no fear"* (Male, 25). Furthermore, three of the participants underlined the importance of assessing aspects of <u>somatic disorders</u> when measuring mental health (see Table 8). One of the participants emphasized the development of physical complaints due to stressful periods in life: "*if you are experiencing a stressful period in your life you may develop physical complaints*" (Female, 50).

Table 8.

Example quotes and frequencies of aspects concerning psychopathology

Aspects	Quotes	Total (N = 8) *n*
Mood disorders	*"Loneliness destroys a lot. Other people cannot look inside you…so they do not see if you are sad"* (F, 72)	6
Anxiety disorders	*"…people with specific fears, or panic [...] I think the first questionnaire focuses on these things and therefore really deals with mental health"* (M, 42)	3
Somatic disorder	*"The first questionnaire measures physical complaints [...] these questions clearly indicate that you are distressed"* (F, 23)	3

Furthermore, half of participants ($n = 4$) mentioned aspects which did not correspond to mood, anxiety or somatic disorders. Thus, the following aspects were attributed to the category "other aspects concerning mental illness". This category comprised either general answers such as *"psychiatry"* (Male, 42); *"psychological institutions"* (Female, 50); or *"people with mental illnesses"* (Female, 23) or more specific answers concerning particular

disorders such as *"ADHD"* (Female, 50); *"Schizophrenia"* (Male, 42); *"Dementia"* (Female, 65); and *"Alzheimer"* (Female, 23).

Sub question c) To what extent do lay perspectives fit to the Two-Continua Model?

As described before, the Two-Continua Model of health and illness reflects both positive mental health and psychopathology. Almost all of the participants (*n* = 7) named positive as well as negative aspects of mental health. Only one of the participants exclusively emphasized positive aspects of mental health. In addition, three out of seven participants explicitly spoke about their perceived relationship between positive and negative aspects of mental health. According to these participants psychopathology and positive mental health were rather independent but correlating constructs. "*You can be a bit mentally ill but still functioning well […] everyone has problems…the sun cannot always shine […] and everyone can pretend to be happy from the outside but you may not feel good on the inside*" (Male, 42). Another participant expressed: "*I think you can be satisfied if you are not happy*" (Male, 25). Moreover, one of the participants argued: *"there are also periods in life when you are not mentally healthy… but still function well in society"* (Male, 29).

Test scores of participants – mental illness (BSI-18) and health (MHC-SF): Table 9 presents the participants' total test scores on the self-report questionnaires (BSI-18; MHC-SF) in proportion to the average population. High total tests scores on the BSI-18 (*high* or *very high*) represent high levels of mental illness. In contrast, high total tests scores on the MHC-SF (*above average*) reflect high levels of positive mental health. In this study, high scores on the BSI-18 are mostly in accordance with low scores on the MHC-SF (see Table 9).

Based on the total scores on the BSI-18, the majority of participants (*n* = 5) experienced high or very high levels of mental illness. Four of these participants had sought professional help before (see Table 9). Furthermore, one of the participants experienced average levels of mental illness whereas two of the participants experienced less psychopathological symptoms than the average population (see Table 9). Due to the total scores on the MHC-SF only one of the participants experienced high levels of positive mental health. Some of the participants (*n* = 3) reported average levels of positive mental health and half of the participants (*n* = 4) experienced low levels of positive mental health (see Table 9).

Table 9.

Total test scores (BSI-18; MHC-SF)* in proportion to the average population; test preferred to measure mental health; participants who have had seek professional help before

Participants	BSI-18	MHC-SF	Test preferred	Seek help before
1. F (72)	High	Below average	-	No
2. F (23)	High	Below average	BSI-18	Yes
3. F (50)	Below average	Average	BSI-18	No
4. F (65)	Very high	Average	MHC-SF	Yes
5. M (29)	Very high	Below average	MHC-SF	Yes
6. M (42)	Average	Average	BSI-18	Yes
7. M (25)	Very high	Below average	MHC-SF	Yes
8. M (21)	Below average	Above average	MHC-SF	No

Note:***** Brief Symptom Inventory – 18; Mental Health Continuum – Short Form (for description see *Interview schedule*)

Preferences Questionnaires: All of the participants were asked which of the two questionnaires (BSI-18; MHC-SF) quantifies mental health the best. The BSI-18 represents psychopathology whereas the MHC-SF reflects positive mental health. Table 9 states the participants´ chosen answers (see *Test preferred*). Some of the participants ($n = 3$) indicated that the BSI-18 would measure mental health the best whereas half of the participants ($n = 4$) preferred the MHC-SF. One of the participants could not answer this question due to a limited capacity for remembering.

Participants who preferred the BSI-18 ($n = 3$) commonly argued that it was important to assess psychopathological symptoms in order to identify mood disorders. One of the participants mentioned: *"I think that one's feeling strongly depends on one's level of mental health. If you do not feel comfortable in your own skin… you might feel lonely or depressed"* (Female, 23). Additionally, two of these participants emphasized the importance of addressing suicidal thoughts: *"Suicidal thoughts. This item is very important. If this item is marked with a cross…you can be sure that this person actually intends to do it"* (Male, 42). Furthermore, some of the participants ($n = 2$) underlined the importance of addressing the relationship between mental illness and somatic disorders: *"mental illness can lead to physical complaints"* (Female, 50).

In contrast, participants who preferred the MHC-SF (n = 4) emphasized the importance of assessing positive aspects when measuring mental health. Nearly all of these participants (n = 3) mentioned the importance of assessing positive thoughts towards life: *"These questions indicate if you have a positive attitude towards life"* (Male, 29). Other participants (n = 2) referred to social aspects of well-being: *"I think that relationships with other people are very important. Yes, warm and familiar. If you have a family that always supports you and friends with who you can talk to…that's great and leads to mental health"* (Male, 21). In addition, some of the participants (n = 2) selected the MHC-SF due to different time-span, with the MHC-SF assessing positive mental health over the past month, and the BSI-18 assessing psychopathology over the past week: *"the second questionnaire assesses a longer period of time - a month instead of a week. This is not a current assessment and that makes it more meaningful"* (Male, 25).

Discussion

The current study explored lay perspectives on mental health. Specifically, it was investigated whether or not lay perspectives correspond with Keyes (2005) Two-Continua Model of mental health and illness, including both aspects of positive mental health and psychopathology. This model assumes that both aspects, positive mental health as well as psychopathology, reflect mental health and that they are independent, but still related to each other (Keyes, 2005).

Two-Continua Model of Mental Health and Illness

The findings reported above provide an understanding of lay perspectives on mental health and confirm the Two-Continua Model of mental health and illness (Keyes, 2002, 2005, 2007). Almost all of the participants mentioned aspects related to both positive mental health and psychopathology. In addition, some of the participants explicitly described a distinct correlation between these aspects. Hence, perspectives on mental health were found to be generally holistic as well as positively oriented towards well-being.

All participants mentioned several aspects of positive mental health, including *emotional, psychological* and/or *social well-being* (Keyes, 2005). These results underline the relevance of three separated components of well-being, including aspects of the hedonic and eudaimonic approach. One-sided approaches of assessing either hedonic or eudaimonic well-being are increasingly debated in research (Kashdan, Biswas-Diener, & King, 2008; Waterman, 2008). However, the current study shows that aspects of hedonic and eudaimonic well-being need to be distinguished as well as taken into account in well-being research. Some researchers already argued that these approaches are not mutually exclusive (Ryan & Deci, 2001; Keyes, 2005; Lamers, 2012).

Remarkably, participants who experienced high levels of mental illnesses (BSI-18 assessment) reported numerous aspects of positive mental health. Positive aspects in life may become even more precious as people experience levels of mental illnesses. Another possible explanation is that participants may be informed about positive approaches due to earlier help-seeking behavior. Participants might have spoken to psychologists who emphasized holistic views on mental health. Nevertheless, this was conflicting with the fact that current mental health services still and almost exclusively represent illness-based approaches (Slade, 2010).

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One would expect public visions of mental health to have an influence on lay perspectives and vice versa. However, individual differences in neuroticism and extraversion (Costa & McCrea, 1980), self-awareness (Fenigstein, Scheier, & Buss, 1975) and esteem (Luhtanen & Crocker, 1992) characterize people as either attentive to situational or internal information. Clearly, perspectives on mental health are highly subjective and always related diverse life experiences or personality types. Due to the fact that more than half of the participants reported high levels of mental illness, future qualitative research on mental health could include people free of psychopathological symptoms. This might lead to different perspectives on mental health.

All participants who experienced high levels of mental illness also had a job or a study. Consequently, these participants consistently experienced that psychopathological symptoms are somehow interoperable with their daily life. Participants may therefore unconsciously combine both aspects of mental illness and health in their lives. This might also explain that some of the participants explicitly described their perceived correlation between positive mental health and psychopathology – even though it was not explicitly asked for it.

Despite the presence of psychopathological symptoms all of the participants may experience a fruitful and meaningful life – addressed to their unique needs and wishes. There are millions of unique views on mental health which vary as a function of time, culture and context (Rogers & Pilgrim, 2005; Kovess-Masfety, Murray, & Gureje, 2005). Every individual has to decide on his or her own if they experience a life worth living. According to Hebb's Law neurons that fire together wire together (Hebbs, 1949). What this means in practical terms is that the brain changes itself. Each time a person repeats a particular thought he or she strengthens the connection between a set of brain cells or neurons. Thus, people have the opportunity to either direct their attention, respectively energy, to deficits and problems or strengths, goals, and personal developments.

New Aspects

Participants mentioned a total of three aspects of mental health which did not correspond to the Two-Continua Model (Keyes, 2005). These three aspects reflected the umbrella term *spiritual well-being*. Spirituality is the personal quest for understanding ultimate answers about life, meaning or relationship (Koenig, McCullough, & Larson, 2001). According to

Kreitzer et al. (2009), spirituality is considered to be a broad construct, including dimensions such as serenity and harmony. Thus, the aspects mentioned in relation to *serenity* and *harmony/balance* are in line with the designed category spiritual well-being. In addition, some of the participants emphasized a connection between *religious belief* and mental health. Mayers (2000) highlighted that religion fosters well-being and life satisfaction. Moreover, Koenig et al. (2001) underlined the protective effect of religion, faith and/or spirituality related to mental health. Having a spiritual life can give people strength and improve their well-being (Miller, & Thoresen, 2003).

These results reflect Delle Fave et al. (2011) category of spirituality/religion as well as Matel's (2012) category faith/belief. Due to these repetitive findings, it is worth considering expanding the Two-Continua Model of health and illness. The dimension of *spiritual well-being* seems to be closely related to the participants' concepts of mental health, in particularly a good life. Individuals often face the question "why am I here". Spirituality offers one answer and is therefore a source of meaning for many. The interpretation of reality through the attribution of meanings to environmental or personal situations is a peculiar feature of human beings (Jablonka & Lamb, 2005). The dimension of spirituality, respectively meaning, seems to be closely connected to one's subjective level of well-being.

Focusing on sources from which people draw meaning is also useful for promoting a good mental health. It would be desirable to integrate aspects of spiritual well-being in future interventions. Hence, positive mental health may be exemplarily promoted by enhancing mindfulness (Brown & Ryan, 2003). Mindfulness-based approaches pay particular attention to the importance of personal resources. Additionally, mindfulness-based approaches create greater harmony and serenity as well as decrease levels of depression, anxiety or personality disorders (Didonna, 2009). Therefore, this strategy might fit very well to the findings of the current study.

Not Mentioned Aspects

Not all aspects of the Two Continua Model (Keyes, 2005) were mentioned. For example, participants did not emphasize aspects of *personal growth* and *social actualization*. Nevertheless, the fact that these aspects were not mentioned does not necessarily reflect their intrinsic value. A possible explanation is the relatively small sample size. Some aspects of

positive mental health were only mentioned once or twice. Different questions concerning mental health might have evoked these aspects. Also, a lack of self-awareness may potentially prevent people from perceiving aspects of personal growth or social-actualization (Fenigstein, Scheier, & Buss, 1975).

Personal growth is about self-development by undertaking activities that improve one's strengths and talents in order to fulfill one´s full potential in life (Keyes, 2005). It can be an enjoyable experience as people begin to observe and realize personal improvements in their lives. Social actualization captures the vision of optimal growth and development (Keyes, 1998). Realizing one´s social potential is similar to concepts such as self-realization (Maslow 1968), eudaimonic happiness (Waterman 1993), and personal growth (Ryff 1989).

The self is both a private product and a public process (Mead, 1934). Especially infant research provides an empirical basis by proving the great importance of relationship and interaction (Dornes, 1993). According to the Self Determination Theory (SDT) relatedness is one of the basic psychological needs (Deci & Ryan, 1985). The SDT addresses the human need for relatedness in order to function in optimal and healthy ways (Deci & Ryan, 2000). Keyes (1998) already argued that each individual is connected to social communities so that well-being is not merely an individual development. Clearly, aspects of personal growth and social-actualization will represent an important role in promoting a good life, too.

Implications of This Study

Several implications became apparent with respect to existing mental health treatment and promotion strategies. The findings of this study underline the importance of addressing positive aspects in addition to psychopathological phenomena when treating or promoting mental health. Keyes (2007) and colleagues already emphasized that the combination is crucial for optimal health care, including diagnostic and treatment (Gudmundsdottier, 2010; Bohlmeijer, 2012). This is in line with Slade (2010), who argued that more emphasis needs to be placed on the person's own goals and strengths. Consequently, it is advisable to incorporate positive aspects of mental health (WHO, 2004) in mental health care organizations in order to conjointly promote a good mental health.

Despite evidence-based findings (Huppert & Whittington, 2003; Keyes, 2005; Suldo & Shaffer, 2008; Keyes, 2009; Westerhof & Keyes, 2010; Lamers et al., 2011), holistic

definitions of the WHO (2004) and positively oriented lay perspectives on mental health, current mental health services and promotion strategies mainly cover mental illnesses. However, problem-focused treatments may not be effective for all of the patients. Ahmed & Boisvert (2006) exemplarily found that schizophrenic patients responded positively to interventions aimed at improving their strengths, whereas patients seemed to respond less favorably to problem-focused interventions. Apparently, some people of the mental health population prefer treatments that enhance strengths and resources, as advised by the positive psychology movement (Seligman & Csikszentmihalyi, 2000; Seligman, 2011). The involvement of specific lay groups in research and practice may therefore lead to improved mental health treatments (Entwistle et al., 1998).

It is noteworthy that one of the participants, who associated almost exclusively psychopathological aspects with mental health, worked as a mental health worker. The participant´s perspective on mental health reflects current illness-based approaches of mental health services. Slade (2010) already reported that the typical health worker will know a lot about treating illness, but far less about promoting well-being. It would be particularly desirable if mental health workers develop the ability to have an eye for strengths (Seligman & Csikszentmihalyi, 2000). This would involve the development of further skills of mental health workers. Here, solution-focused therapy (de Shazer, 1985) may serve as a guideline. Solution-focused therapy is based on the premise that knowledge about a problem is not always necessary to find a solution (Watzlawick, Weakland, & Fisch, 1974). Due to this, solution-focused workers focus on the clients' strengths. Additionally, solution-focused workers consider the client as an expert and therefore act as a coach toward the client's goal (De Jong & Berg, 2008).

Adapting positive approaches in mental health services will involve fundamental changes as well as financial support. Psychological research could integrate aspects of well-being in the Statistical Manual of Mental Disorders (DSM) in order to integrate a holistic view in established frameworks. Positive approaches may complement existing frameworks instead of replacing them. Clinical psychology may also assess positive mental health (e.g. MHC-SF) in order to holistically measure mental health.

Furthermore, there is a broad range of possibilities to enhance positive mental health in individuals and communities. As soon as we understand the health care needs of special populations, promotion strategies can more successfully meet individual needs (Barry, 2009).

For example, a person experiencing low levels of psychological or emotional well-being may profit from interventions that include elements of Well-being Therapy (Fava et al., 1998; Fava et al., 2005). Well-being Therapy aims at Keyes´ (2005) dimension of psychological well-being and uses cognitive-behavioral strategies to enhance aspects such as autonomy or personal growth and ultimately increase levels of positive mental health. Furthermore, there are interventions which aim at both, reducing psychopathological symptoms and enhancing well-being. For example, Acceptance and Commitment Therapy reduces distress as well as improves positive mental health by stimulating the skills of acceptance (Fledderus et al., 2012).

In particular people with small or moderate mental health complaints should be addressed in order to prevent a public health problem (Ahuriri-Driscoll, 2000). Mental health care systems as well as financial supporters may argue that people who experience high levels of mental illnesses do have priority. However, these interest groups also have to face the fact that treating solely mental illness is not enough to address the growing burden of mental illnesses (Andrews et al., 2004; Cuijpers et al., 2008). Mental health care has to develop promotion strategies that stimulate early help-seeking behavior. Early treatments prevent worsening complaints and therefore prevent long-term usage of mental health services (Cuijpers, van Straten, & Smit, 2005). This also leads to high potential cost savings.

The presumably most effective promotion and protection strategies of good mental health start in the early childhood. Due to Bowlby´s attachment theory (1958), the social and emotional development of a child is fundamentally influenced by the quality of the relationships with attachment figures. Therefore, the child´s future level of emotional well-being is greatly influenced by his earlier experiences with primary care givers (Bowlby, 1979), such as parents or kindergarten teachers. It would be very beneficial if kindergarten teachers would also adopt solution-focused strategies in order to identify and highlight personal strengths in children. This enables children to develop a greater self-esteem and efficacy (Dornes, 1993). Self-efficacy beliefs are central to a good mental health (Carpinello, Knight, Markowitz, & Pease, 2000; Dupéré, Leventhal, & Vitaro, 2012).

Seligman (2011, p.28) emphasized that "as our ability to measure positive emotion, engagement, meaning accomplishment, and positive relations improves […] we can ask with rigor if our school systems are helping our children flourish". Further qualitative and quantitative evidence-based research is required in order to understand aspects that improve

and maintain levels of well-being, respectively mental health. Public knowledge about positive mental health and related improvement strategies have to be enhanced by working with the mass media. Finally, mentally healthy people with their strengths and resources are not only desirable for individuals and mental health care institution, but also our collective society.

Study Strengths and Limitations

This was the first study that focused on a broad group of lay people. Therefore, this study provides an understanding of various perspectives on mental health. Gaining such insights was acquired through the use of a self-developed, semi-structured interview (see APPENDIX B) in combination with the use of the transparent qualitative analysis program ATLAS ti. This program allowed a systematical analysis of perspectives related to mental health. Although the adaption of qualitative methods can increase the complexity of analyses, which includes increased time-consumption and analytical efforts, the richness of subjective in-depth data is invaluable. In this study, adopting a qualitative approach led to highly multifaceted responses as well as new findings. The identification of themes as reported in literature, created a significant degree of coherence within the study. In addition, it was very useful to assess the participants´ level of positive mental health (MHC-SF) and mental illness (BSI-18) in order to inspect contextual variables that might have an influence on perspectives on mental health (Milburn, 1996). Finally, the current study laid a good foundation for future investigations concerning mental health (see *Future Research*).

The current study also had some limitations that need to be acknowledged. Almost all of the participants experienced high levels of mental illness. Due to this, perspectives on mental health may have been influenced by the presence of psychopathological symptoms. The chosen sample does not represent the total population but reflects lay perspectives on mental health. Nevertheless, generalizations are possible with regard to content findings (e.g. spiritual well-being) which may be applied to already existing theoretical frameworks such as the Two-Continua Model of health and illness.

Furthermore, some of the participants might have given socially desirable answers. To minimize this possibility the researcher explicitly expressed in advance that this research would seek for personal as well as diverse perspectives on mental health. Moreover, the

research method may have limitations. Self-designed questions of the semi-structured interview may additionally have influenced given answers (Hoogstraten, 2004). Furthermore, the participants' quotes were translated from Dutch to English, hence specific nuances may have gotten lost in translation. Finally, there is no inter-rater reliability due to the fact that the analysis has not been peer-reviewed.

Future Research

Following research has to investigate treatment and promotion strategies with respect to individual differences. Lay perspectives from specific mental health populations may enhance an understanding for aligned treatments and promotion strategies concerning positive mental health. Bigger sample sizes may support the generalization of findings. In particular people with small or moderate mental health complaints may be addressed in order to prevent a public health problem (Ahuriri-Driscoll, 2000). Consequently, research has to develop promotion strategies that stimulate early help-seeking behavior. It is important to understand help-seeking patterns (or absence thereof) in order to adequately react to consumer needs by developing tailored interventions. Quantitative as well as qualitative research may provide better insights in help-seeking intentions in order to reduce possible barriers.

Moreover, it is interesting to explore mental health care workers´ perspectives on mental health. Problem-focused and solution-focused workers may have different visions on mental health which in turn maybe related to the efficiency of treatments. Furthermore, research on lay perspectives may also assess contextual factors (Milburn, 1996), such as the participants´ level on mental health, personality traits, or self-awareness (Fenigstein, Scheier, & Buss, 1975). All of these individual differences may influence the participants´ perspectives on mental health.

Future research may implement the Two-Continua Model of mental health and illness (Keyes, 2005) in treatment and promotion strategies in order to test its long-term effectiveness. Aspects of spirituality may also make a contribution to mental health promotion. However, understanding how and why spirituality contributes to well-being represents the next steps of research. Quantitative research is essential to conceptualize important aspects of spiritual well-being.

Within psychological research there is still a lack of clarity in the terms and concepts used. For example, terms such as happiness and mental health are often used as synonyms. Still, there is no common agreement on terminology (Lamers, 2012). The diversity in categories and approaches underlines the importance of providing clear definitions of terms and concepts used in research. Hence, the researcher recommends linking qualitative findings to theory-based frameworks such as the Two-Continua Model of mental health and illness - especially in the beginning of conceptualizing categories related to mental health. A definite long-term aim is to obtain a clearer definition of mental health and related aspects of well-being.

Conclusion

The current study provided an understanding of lay perspectives on mental health. Lay people perceive holistic concepts of mental health including both aspects of psychopathology and positive mental health. This is in line with theory-based findings. Nevertheless, clinical psychology still focuses mainly on psychopathology, accompanied by the risk to neglect valuable strengths and resources. The findings of this study underline the importance of addressing positive aspects in addition to psychopathological phenomena when promoting or treating mental health. This is not only desirable for individuals and mental health care institution, but also our collective society.

Acknowledgements

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Appendix

Appendix A) Toestemmingsverklaring

<div align="center">TOESTEMMINGSVERKLARING</div>

_____

Welkom. Ten eerste wil ik u bedanken voor uw tijd. Dit onderzoek wordt gedaan in het kader van mijn master scriptie aan de Universiteit Twente, Nederland. Voordat u deelneemt aan mijn onderzoek "Leken perspectief over geestelijke gezondheid" wil ik u vragen om dit formulier goed door te lezen.

Doel: Mijn onderzoek gaat over uw persoonlijke perspectief over geestelijke gezondheid. Ik ben dus geïnteresseerd in uw mening over geestelijk gezondheid.

Procedure: Ik zal u vragen stellen over uw perspectief over geestelijke gezondheid. Bovendien ga ik u vragen om twee korte vragenlijsten in te vullen. Het deelnemen aan dit onderzoek zal ongeveer 30 minuten duren. Het zou erg behulpzaam zijn als u ermee instemt om deze conversatie op te nemen. Uw deelname is vrijwillig. Het interview kan op ieder moment gestopt worden.

Risico´s: Er zijn geen risico's verbonden aan het deelnemen van dit onderzoek.

Vertrouwelijkheid: Dit interview is strikt vertrouwelijk. Namen zullen worden veranderd – uw identiteit zal niet tot uiting komen in de verkregen data. De audio tapes zullen worden verwijderd, wanneer alle data is verkregen en geanalyseerd.

Uitnodiging: Mijn master scriptie zal worden afgerond in augustus. Als u geïnteresseerd bent in mijn resultaten, is het mogelijk een korte, digitale versie van mijn scriptie te ontvangen.

Contact: Heeft u vragen of opmerkingen over uw deelname of bent u geïnteresseerd in een korte samenvatting van mijn resultaten, kunt u graag contact met mij opnemen:

Naam: Antje Drawert
E-mail: f.a.a.drawert@student.utwente.nl
Telefoonnummer: 0644897758

Ik begrijp dat mijn deelname vrijwillig is en dat ik ten alle tijden kan stoppen met dit interview. Het doel van dit onderzoek is voldoende uitgelegd. Door middel van mijn handtekening stem ik toe om deel te nemen aan dit onderzoek.

Handtekening: Datum:

_____   _____

Appendix B) Interview schema

INTERVIEW

Demografische gegevens

➢ Wat is uw geslacht?
O Man   O Vrouw

➢ Wat is uw leeftijd?
_____

➢ Wat is uw hoogst genoten opleiding?
O Geen opleiding

O Basisonderwijs

O Lager beroepsonderwijs

O MAVO, M(ULO), 3-jarige HBS, VMBO

O Middelbaar beroepsonderwijs (MBO)

O 5-jarige HBS, HAVO, MMS, atheneum, gymnasium

O Hoger beroepsonderwijs (HBO)

O Wetenschappelijk onderwijs (WO)

O Anders, namelijk _____

➢ Wat voor een werk of studie doet u?

_____

Perspectief op geestelijke gezondheid
_____

1. Waar denkt u aan als u "geestelijke gezondheid" hoort?

Indien ondervraagde de vraag niet begrijpt: "geestelijk" omschrijven als "psychisch" of "mentaal"

Doorvragen: Hoe zou u geestelijke gezondheid kunnen definiëren/omschrijven? Welk beeld hebt u voor ogen? – Wat verstaat u onder geestelijke gezondheid? Kunt u mij hier iets meer over vertellen/concreter beschrijven?

2. Als u een geestelijk gezonde persoon in gedachte neemt; welke omschrijving is dan van toepassing voor deze persoon?

Indien ondervraagde de vraag niet begrijpt: u zei net dat u …. onder geestelijke gezondheid verstaat. Kent u misschien een persoon/situatie bij welke u omschrijving van toepassing is?

Doorvragen: Hoe zou u iemand beschrijven die u als geestelijk gezond ervaart?
Hoe ervaart u deze persoon? Wat maakt dat u de persoon als geestelijk gezond ervaart? Waar merkt u het aan? Hoe denkt u over de persoon?

3. Als u nog eens een andere geestelijk gezonde persoon in gedachte neemt; wat maakt dat u deze persoon als geestelijk gezond ervaart?

Indien ondervraagde geen andere persoon benoemt = direct doorgaan naar vragenlijsten (MHC-S, BSI-18)

Doorvragen: In hoeverre ervaart u die persoon als geestelijk gezond? (…op dezelfde manier als de van u eerder genoemde persoon? Wat maakt dat u de persoon als geestelijk gezond ervaart?)

➔ Vragenlijsten invullen (MHC-S, BSI-18)

Beschrijvende introductie: er zijn wetenschappelijke vragenlijsten om geestelijke gezondheid te meten. Nu gaat het om u persoonlijke geestelijke gezondheid. Daarom vraag ik aan u om twee korte vragenlijsten in te vullen. Ik denk dat dit ongeveer 5 - 10 minuten zal duren. Als u klaar bent met het invullen van de vragenlijsten zal ik u drie afsluitende vragen stellen. Vindt u dat goed?

➔ Als respondent klaar is met het invullen van de vragenlijsten, doorgaan met laatste twee vragen

4. Welke van de twee vragenlijsten meten volgens u goed geestelijke gezondheid?

Indien ondervraagde de vraag niet begrijpt: U hebt net kennis gemaakt met twee verschillende manieren om geestelijke gezondheid te meten. Welke manier vindt u het geschiktst om geestelijke gezondheid te meten? In hoeverre?

Doorvragen: Waar baseert u dit op? Kunt u hier iets meer over vertellen?

5. Welke vragen uit de vragenlijst van geestelijke gezondheid vindt u het belangrijkst?

Doorvragen: Wat maakt dit zo belangrijk? In hoeverre vindt u dit belangrijk?

6. In hoeverre hebt u weleens psychische klachten gehad?

Indien "ja": Welke precies? In hoeverre bent u toen op zoek geweest naar professionele hulp?