# The overlap between well-being and recovery: A systematic comparison

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## Abstract

*Background.*

Increasing confusion around the concepts of well-being and recovery has emerged in literature and clinical practice. Mental health care users demand more recovery-oriented practice but treatment, as clinicians call for, also needs to be scientifically validated. To clear some of this confusion, this paper aims at exploring the differences and overlaps between the approaches of psychological well-being (PWB) and personal recovery (PR) and how they might be combinable in clinical practice.

*Methods.*

A systematic comparison was conducted. Three aspects of PWB and PR were considered: (1) existing models (2) measurement tools (3) treatment programmes. For each aspect two representing materials were compared.

*Results and Discussion.*

A great overlap between the approaches of PWB and PR was found in underlying values toward the meaning and expression of well-being. Yet, differences dominated, and the approaches were not interchangeable. Historically, PWB originated from researchers and clinicians. In contrast, PR emerged through the empowerment movement led by mental health care users demanding more holistic treatment. The PWB approach corresponds to clinical recovery and cultivates the traditional gap in power relations between the “patient” and therapist, while in the PR approaches the “patient” is called “mental health care service user”, who is seen as on par with health care workers. PR advocates the possibility living and being well without complete symptom remission, while in the PWB approach mental illness is seen as incompatible with PWB.

*Conclusion.*

Research is needed to explore how the service users' demand for a more holistic and recovery-oriented care, and the need of scientifically validated guidelines on the other hand, can be integrated best in clinical practice. Together, the approaches could work towards a future that is less pathology-focused and more person-centered, to enable all individuals to live meaningful and enjoyable lives.

# 1. Introduction

For a long time, the phenomenon of positive mental health was not seen as a research worthy topic and mental health was generally regarded as the mere absence of mental illness (Ryff, 1995, Anthony, 1993; Maddux, 2012). This is mirrored by the traditional treatment objectives being symptom remission and relapse prevention (American Psychiatric Association, 2013; Anthony, 1993; Maddux, 2012; Gladis, Gosch, Dishuk & Critis-Christoph, 1999). However, lots of research has since been done to explore positive mental health (e.g. Keyes, 2002; 2005; 2006; 2007; Maddux, 2012; Hanlon & Carlisle, 2008). The current notion of mental health does not equal the mere absence of illness (Keyes, 2002; 2005; 2007) but further includes the presence of positive functioning and a positive state of capacities, or: mental health as a complete state of well-being. Being mentally healthy means to flourish and lead a meaningful life (Keyes, 2006; 2007, WHO, 2005; Cowen, 1991).

In the last two decades, nurturing positive mental health and promoting well-being instead of only treating mental illness has become a more popular subject matter in research and clinical practice (Slade, 2010; Keyes, 2006; 2007; WHO, 2004; Jeste, 2005; Hanlon & Carlisle, 2008; Maddux, 2012; Slade, Oades & Jarden, 2017). Correspondingly, the former president of the American Psychiatric Association, D. V. Jest, M. D. (2015), said the following at the end of his presidency in 2013: '*I expect that the future role of psychiatry will be much broader than treating psychiatric symptoms. It will seek to enhance well-being of people with mental or physical illnesses. [...] and we will seek new ways to promote resilience, optimism, and wisdom through psychotherapeutic interventions.'.* Hence, the fundamental shift in how mental illness and mental health are approached in professional environments have reached more global acceptance.

Next to the professional faction in mental health care and research, a movement from the side of mental health care users was rising in the 1960's and 70's. Users of mental health

care services were fighting forced and inhumane treatment, stigma, and discrimination and questioning the medical model. They were demanding a more holistic approach to recovery and alternatives to traditional mental health care services, as for example peer support and self-help. The assumption was that patients could recover in a more holistic way and (re)learn to lead a meaningful and satisfying life integrated into the community (Chamberline, 1990; Frese & Davis, 1997; Tomes, 2006). Simultaneously, the deinstitutionalization process began, allowing patients to leave large institutions and get treatment in their neighborhood, where also daytime treatment was offered by teams including social workers and physicians. In general, their degree of freedom massively increased and so did quality of life (Chamberline, 1990; Frese & Davis, 1997; Tomes, 2006; Nolen-Hoeksema, 2014).

Today, the descendants of the so-called consumer movement, empowerment movement or patients' right movement does not only aim at ending stigma and changing health-care systems, but mainly focuses on empowering mental health care users (Kersting, 2005; Tomes, 2006). By using the term empowering here, it is referred to having the right to make one's own mental health care choices (Tomes, 2006). Since the beginning of the movement, many ex-patient-/user-run services have emerged, such as the National Empowerment Center which allows users to find all sorts of information about topics related to mental health, empowerment and illness related issues, help and support, links to other empowerment websites. They state their mission to be carrying "[...] *a message of recovery, empowerment, hope and healing to people with lived experience with mental health issues, trauma, and and/or extreme states*." (National Empowerment Center, 2018).

With the understanding that mental illness is not necessarily permanent (Davidson & Roe, 2007) and that mental health is a concept distinct and independent of mental illness (Keyes, 2002; 2005; 2007), the interest in recovery aroused (Resnick, Fontana, Lehman & Roseneck, 2005). Well-being and its achievement has become a popular research field which can also be seen in the offer of university programmes focusing on mental health and well-

being or positive psychology, for example The Bradford University (2019) or the University College London (2019). While newer research shares the view that mental health is more than the absence of illness, concise ideas about guiding definitions, values and measurements of well-being and recovery are still lacking (e.g. Keyes, 2002; Slade, Oades & Jarden, 2017; Forrest, 2014; NIMHE, 2004).

Despite the general development moving away from a pure pathogenic approach, the general treatment approach in clinical practice is still often very pathology-focused, especially in inpatient settings (Tsai & Salyers, 2008; Sainsbury Centre for Mental Health, 2006; Bartholomew & Kensler, 2010; Hyde, Bowles & Pawar, 2015) and the idea of recovery-oriented care is still far from being adapted in the most psychiatric institutions (Leonhardt, Huling, Hamm, Roe, Hasson-Ohayon, McLeod & Lysaker, 2017). Despite persistent effort to implement new practice approaches, various factors, such as limited resources (e.g. staff, beds..), violence or poor leadership (Brennan, Flood & Bowers, 2006; Cleary, 2004), hinder the integration of new evidence-based findings and innovations into practice, resulting in poor uptake of new approaches in practice. (Grol & Grimshaw, 2003; Grol, Bosch, Hulscher, Eccles & Wensing, 2007; May, Finch, Mair, Ballini, Dowrick, Eccles, Grask, … & Heaven, 2007).

There seems to exist a gap in the view of what recovery is and what it means for clinicians and service users respectively and how well-being can be achieved in service users. While in clinical practice the focus lies on the reduction of symptoms and complaints, service users demand that recovery encompasses more than the reduction of symptoms and complaints (Aston & Coffey, 2012; Empowerment Center, 2018). Further, conceptual confusion around the definitions of well-being and recovery remains (Slade, Oarden & Jarden, 2017). Till now, literature on how the relation between recovery and well-being behaves and how they interact, is quite rare. The questions is how those two approaches may overlap and could jointly contribute towards a more positive approach in mental health care, each with their own point

of view. Hence, the goal of this research is to explore this relation and compare the two approaches to each other. In the following, the approach of well-being and recovery will be introduced and the research questions guiding this study will be formulated.

### 1.1. Well-being

The WHO provides a definition of 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 contribute to his or her community' (WHO, 2004). Hence, well-being is introduced as the fundamental element of mental health and a multidimensional concept. Researchers have been interested in the concept of human well-being for a long time and accordingly rich and diverse are conceptualizations and general literature about well-being (McGillivray, 2007; Keyes, 2006). The multifactorial concept of well-being as introduced by Keyes (2006), encompasses two dimensions - the *hedonic* and the *eudaemonic tradition*, which can be traced back to the Greek (Ryff, 2014). The *eudaemonic tradition* follows the pursuit of positive functioning, while the *hedonic tradition* focuses on happiness, e.g. maximizing happiness/pleasure and minimizing pain (Veenhoven, 2003; Ryan & Deci, 2001; Waterman, 1993). Moreover, Keyes (2006), splits well-being into three components - *emotional, psychological and social well-being*. Thereby, *psychological* and *social well-being* fit in the *eudaimonic tradition*, while *emotional well-being* fits the *hedonic tradition.*

Thence, Keyes (2005a, 2006) strongly argues that a society needs to enable its individuals to develop their eudaemonic capacities, instead of merely encouraging them to seek hedonic well-being in order to assist the development of a prosperous and flourishing society. This view on mental health as a complete state is generally referred to as the *two continua model, dual continua model* or *complete state model of health* (Keyes, 2005; Franken, Lamers, Ten

Klooster, Bohlmeijer & Westerhof, 2017). In this paper, the term dual continua model will be used.

*Dual continua model*

In agreement with the WHO (2004) definition of mental health, Keyes (2005; 2006; 2007) also highlights the individual's well-being in the definition of positive mental health. He describes mental health as a syndrome expressing itself through the symptoms of well-being, meaning how individuals perceive and evaluate their overall quality of life, their affective states and the level of positive functioning (Keyes, 2002). Thus, according to Keyes (2002; 2005; 2007), mental health and mental illness are not opposite ends of one single continuum, but two highly correlated phenomena, which can, but must not, coexist. According to the model, one can also be experiencing mental illness and well-being at the same time (*struggling*), not experiencing mental illness nor well-being (*languishing*) or experiencing mental illness and the absence of well-being (*floundering*) (Keyes, 2002; 2005; Franken, Lamers, Ten Klooster, Bohlmeijer & Westerhof, 2017). Complete mental health (*flourishing*) should be regarded as a complete state of high well-being and the absence of mental disorders (Keyes, 2006; Cowen, 1991).

Despite the acknowledged importance and growing interest in positive mental health (e.g. Keyes, 2002; 2005; 2006; 2007; Maddux, 2012; Hanlon & Carlisle, 2008) lots of research still dismisses to study the presence and absence of mental health and well-being independent from mental illness (Keyes & Grzywacz, 2005). Correspondingly, Keyes (2002; 2007) points out to the often overseen phenomenon *languishing* and its detrimental effects. Languishing could be understood as a state of stagnation, emptiness, despair and generally poor emotional health. It was shown to be as prevalent as pure episodes of depression and having similar levels of psychosocial impairment. Further it was also associated with severe

limitations in daily activities, such as work cut back and increased rate of lost work days (Keyes, 2002).

*The six-factor model of Psychological Well-being*

While Keyes includes emotional, social and psychological well-being in this complete state model of mental health, Ryff (1989) did research on psychological well-being as an independent concept. As there existed no guiding theory in successful ageing or well-being in the later years in the 1980s, Ryff (1989) aimed at generating a model for well-being based on existing theories and developed the six-factor model of PWB, which includes six dimensions that constitute positive functioning. In this sense, she followed the eudaimonic tradition and highlights that human well-being is more than feeling happy (Ryff & Keyes, 1995, Ryff, 2014). The six dimensions (*Autonomy, Environmental Mastery, Personal Growth, Positive Relations with Others, Purpose in Life, Self-Acceptance)* , and elements that constitute the dimensions, are presented in Table 1 after the following paragraph.

The six-factor model of PWB has been widely used and applied in the field of well-being research (i.e. Ryff et al., 2017; Clarke, Marshall, Ryff & Wheaton, 2001; Gao & McLellan, 2018; Gigantesco, Stazi, Alessandri, Medda, Tarolla & Fagnani, 2011; Fava, 1999). To measure PWB, Ryff (1989a) developed a scale corresponding to the PWB model - the six-factor model of PWB. It consists of six subscales that match the six dimensions of the six-factor model of PWB (Ryff, 1989a). Its psychometric quality has been proven and adjudged to be good (Ryff & Singer, 2006). Further, it has also been used for clinical practice and has been stated as being easy to applicate to clinical populations (Rafanelli, Park, Ruini, Ottolini, Cazzaro & Fava, 2000; Fava, Rafanelli, Ottolini, Ruini, Cazzaro & Grandi, 2001). In addition to this, the six-factor model of PWB was selected for developing a short-term therapy

that would enhance PWB (Fava & Ruini, 2003). This therapy is called the Well-being Therapy and was developed by Giovanni A. Fava (1999). At the heart of the therapy lies the technique of self-observation, which takes place by using a structured diary and the patient-therapist interaction (Fava & Ruini, 2003; Fava, 2016). The six-factor model of PWB adequately reflects the concept of well-being which is to be explored and compared to the concept of PR in the following.

Table 1

*Dimension of the Six-factor model of PWB* (Ryff, 1989; Ryff & Keyes, 1995; Ryff, 2014)

| | |
|---|---|
| Self-Acceptance | Positive attitude towards self, (self-acceptance, self-confidence, self-reliance) acknowledges and accepts multiple aspects of self (good and bad) qualities, feels good about past life |
| Positive Relations with others | Warm, satisfying, trusting relationships with others; concerned about welfare of others, capable of strong empathy, affection and intimacy; understands give and take of human relationships |
| Autonomy | Self-determining and independent; able to resist social pressures to think and act in certain ways; regulates behavior from within; evaluates self by personal standards |
| Environmental Mastery | Sense of mastery and competence in managing the environment; controls complex array of external activities; makes effective use of surrounding opportunities; able to create or choose contexts suitable to personal needs and values |
| Purpose in Life | Goals in life and sense of directedness; feels there is meaning to present and past life; holds beliefs that give life purpose; has aims and objectives for living |
| Personal Growth | Feeling of continued development; sees self as growing and expanding; open to new experiences; sense of realizing his/her potential; sees improvement in self and behavior over time; is changing in ways that reflects more self-knowledge and effectiveness |

*Note*. Adapted from "Beyond Ponce de Leon and life satisfaction: New directions in quest of successful ageing", by C. D. Ryff, 1989, *International Journal of Behavioral Development, 12(1)*, p. 35-55. "Psychological Well-Being Revisited: Advances in Science and Practice", by C. D. Ryff, 2014, *Psychotherapy and Psychosomatics, 83(1)*, p. 10–28. "The Structure of Psychological Well-Being Revisited", by C. D. Ryff and C. L. M. Keyes, 1995, *Journal of Personality and Social Psychology, 69(4)*, p. 719-727.

### 1.2. Recovery

The American Psychiatric Association defines recovery from mental disorder as "*a process of change through which individuals improve their health and wellness, live a self-*

*directed life, and strive to reach their full potential*." (American Psychiatric Association, 2018). Unfortunately, this is no universally accepted definition. In relation to mental illness, the term *recovery* has been interpreted in many ways and even though many reviews have delivered useful definitions (e.g. Davidson & Roe, 2007; Leamy, Bird, Le Boutillier, Williams & Slade, 2011; Slade, 2010; Onken, Craig, Cook, Ralph and Ridgway, 2007; Noordsy, Torrey, Mueser, Mead, O'Keefe & Fox, 2002), no concise definition exists (Forrest, 2014; NIMHE, 2004). Recovery has been conceptualized as functional improvement or regeneration, symptom reduction, which corresponds to the view of the medical model and DSM-5 guidelines (American Psychiatric Association, 2013), or as a social process or a personal and individual journey (Onken, Craig, Ridgway, Ralph, & Cook, 2007). While the perceived inability to agree on a concise definition of recovery complicates research in the mental health field (Onken, Craig, Ridgway, Ralph, & Cook, 2007), attempts to find a solution for this are made. A reason for the present confusion and ambiguity of the recovery term has been offered by Davidson and Roe (2007). They identified two main complementary meanings of recovery, which derive from two different backgrounds. The first and older concept *recovery from* mental illness emerged when it became clear that mental illness was not always permanent and some people even returned to their pre-illness functioning levels, while others did partly and some not at all. Thus, there seemed to be a way of recovering from mental illnesses in a similar way as recovering from physical illnesses or disturbances, for example, a broken hip. Hence, *recovery from* mental illness is described as '*the amelioration of symptoms and the person's returning to a healthy state following onset of the illness".* This definition presents recovery as a rather linear, clear process with a relatively easily measurable outcome. Therefore, it is comfortable for clinicians and researchers to accept this concept. The second concept, described as *recovery in* mental illness appeared later, when personally affected individuals proved the black and white thinking of traditional diagnostic practice wrong. It became more apparent that recovery is a multidimensional and personal

process. In this view, recovery is not dependent on the remission of symptoms, neither does it guarantee a return to normal functioning. In this sense, mental illness is just seen as a part of an individual's life, affecting daily activities and other personal life areas. Hence, two different meanings of recovery have been developed till today, but because both are referred to as *recovery*, it contributed to the inconsistency in which the term recovery is described by different people (Davidson & Roe, 2007).

However, researchers, clinicians and other health service practitioners nowadays focus more on promoting well-being and mental health than on merely fighting mental illness (Ryff, 1995), thus distancing themselves from the *recovery from* approach. Among the difficulty around the ongoing attempts to find a concise definition of recovery, the concept of personal recovery (PR) has emerged and offers a rather new approach to treating people affected by mental illness (Leamy, Bird, Le Boutillier, Williams & Slade, 2011).

*Personal recovery*

Literature on PR is mostly based on qualitative methods, using narratives syntheses (e.g. John, Jeffries, Acuna-Rivera, Warren & Simonds, 2015; Gillard, Turner & Neffgen, 2015), which might add to the existing diversity of definitions. This also highlights, that recovery simply seems to mean distinct things to different individuals who experienced mental illness. Experience experts, meaning individuals who have experienced mental illness themselves, generally highlight the regain of lost potential and control over personal and social activities and life roles (Ramon, Healy, & Renouf, 2007), strengthening one’s self-concept, being hopeful concerning future stressors and engage in social roles and activities (Pitt, Kilbride, Nothard, Welford, & Morrison, 2007). The most common concept definition describes PR as ‘a deeply personal, unique process of changing one’s attitudes, values

feelings, goals, skills and/or roles . . . a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness (Anthony, 1993). In line with that, the recovery researcher Mike Slade (2010) point out to the importance of one's individuality and thus individual way of recovering. He describes the core idea as that individuals aspire and actively work towards mental health despite the ongoing presence of mental illness (Slade, 2010). In such wise, PR is, in contrast to clinical recovery, a process or a continuum, rather than an outcome. It is subjectively defined by the individual who is in recovery and should therefore should also be "rated" by him-or herself. Hence, because of those many individual meanings of recovery, it is not easy to provide a shared and clear definition of PR, even though there are aspects that are shared by many different people (Slade, Oades & Jarden, 2017).

Regarding its historical development, the earlier described empowerment movement, which started in the 1960/70s, paved the way for the development of today's concept of PR, by a returning power to mental health service users. Till today, this movement fights for the empowerment of service users and can be said to be patient advocates in the mental health field (Tomes, 2006). Thence, this movement enabled what is known today as PR. In addition to that PR has a lot in common with the older concept of *recovery in*, which views recovery as a multidimensional, not black and white, process. Hence, it can further be assumed, that PR has developed from the *recovery in* approach and not the *recovery from* approach, which mainly focuses on the remission of symptoms (Davidson & Roe, 2007) and describes what clinical recovery is about. So, in this paper, the approach of PR will be explored.

Hence, a crucial value in PR is that there is no correct prescribed path to follow, but one chooses her or his own pace and way according to individual needs, desires, goals and circumstances. PR in the long-term view, might also include a change in identity, for example in the recovery from addictive behaviors. For instance, recovery might not only mean to socially rehabilitate or normalize former addicts but also includes finding more personally

satisfying and authentic ways of living and finding meaning in life. Personal growth and reorienting in life in general can often mean a fundamental shift of one's values, preferred activities, relationships to others and the self, which in the end leads to a change in identity (Koski-Jännes, 2002).

In line with this view, individuals who have experienced mental illness themselves demand the acknowledgment that a life beyond illness, even with ongoing illness, is possible (Empowerment Center, 2018). Those people demand alternatives to traditional care. Indeed, such alternative or additional institutions and organization have started to emerge, building on the concept of *peer support* (Delman, Delman, Vezina & Piselli, 2014; Slade, Oades & Jarden, 2017). Peer support comprises, amongst other, mutual support groups, creating user-run programmes and hiring people with experiences of mental illness as mental health care providers (UPSIDES, 2019; Slade, Oades & Jarden, 2017).

### *CHIME Model*

In order to clarify what PR means and to provide a framework of PR, a systematic review was undertaken (Leamy, Bird, Le Boutillier, Williams and Slade, 2011). The result of this review and narrative synthesis was the the CHIME model. It provides a conceptual framework for the recovery process, consisting of five dimensions: *Connectedness, Hope and optimism about the future, Identity, Meaning in life* and *Empowerment*; building the acronym CHIME (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). The five dimensions, and the various elements the dimensions encompass, are illustrated in Table 2 at the end of this section.

Hence, by demonstrating how and which elements are included in the recovery journey, the CHIME model provides a base for a better understanding of the processes and

stages in recovery and finding accurate measurement instruments for recovery. The model reflects the broad concept of PR, that is explored and compared to the concept of PWB in this paper. The CHIME model has been sufficiently assessed and shown to be a valid and relevant conceptual framework for the use in practice as well as research (Bird, Leamy, Tew, Le Boutillier, Williams & Slade, 2014). Further, the CHIME model applied in a review that aimed to identify and analyze recovery measures in relation to their fir with recovery and their psychometric quality. The criteria for determining their fit with recovery was assessed according to their fit with the CHIME framework. The scale which mapped most closely to the CHIME model, thus best measuring PR according to the CHIME model, was the Questionnaire about the Process of Recovery (QPR) (Shanks, Williams, Leamy, Bird, Le Boutillier & Slade, 2013). The QPR will also be used in this study.

Among others, the QPR was also used in the development and evaluation of the REFOCUS programme (RP) and REFOCUS Intervention (RI). This programme also used the CHIME model as theoretical base and framework (Slade et al., 2017). The so-called RP started, in 2009, as a five-year research programme. The original aim of this research was to identify means to turn the practice in the community-based adult mental health services in England more recovery-oriented. As part of the programme, the RI consists of two main components. The first component focuses on the working relationship between staff and service users, which is central to PR, by skills training in coaching. The second component aims at supporting personally-defined recovery. This is done by providing training and supporting behavior change of staff in different working practices. Ultimately, service users should benefit from the attitude and behavior change of mental health care workers and their mental health outcomes improved. The RI was implemented, evaluated and a manual created. The manual is written for all those who are willing to start embedding a recovery-oriented approach into their daily practice. The manual describes the intervention, which how to implement it in detail.  (Slade et al., 2017).

Table 2

*Dimensions of the CHIME model*

| | |
|---|---|
| Connectedness | Peer support & support groups (availability and/or becoming a peer support worker or advocate), (intimate) relationships, support from others (professionals und private, being part of the community) |
| Hope and Optimism about the Future | Belief in possibility of recovery, motivation to change, hope-inspiring relationships (role models), positive thinking (and valuing success), having dreams and aspirations |
| Identity | Dimensions of identity (ethnic, sexual and collectivistic notions of identity, culturally specific factors), rebuilding/redefining positive sense of self (self-esteem, self-acceptance, self-belief, self-confidence), overcoming stigma (self-stigma and stigma at a societal level) |
| Meaning in Life | Meaning of mental illness experience (accepting or normalizing illness), spirituality (including development of spirituality, quality of life (well-being, meeting basic needs, education, work, leisure activities), meaningful life and social roles (Identification and active pursuit of previous or new roles), meaningful life and social goals (Identification and active pursuit of previous or new goals), Rebuilding life (daily activities and routine, developing new skills) |
| Empowerment | Personal responsibility (self-management: coping skills, self-help, resilience, managing symptoms, maintaining good physical health and well-being, crisis planning, goal setting, positive risk-taking), control over life (choice; knowledge about illness and treatments, regaining independence and autonomy, access to services and interventions), focusing on strengths |

*Note*. Adapted from "Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis," by M. Leamy, V. Bird, C. Le Bouttilier, J. Williams & M. Slade, 2011, *The British Journal of Psychiatry, 199*, p. 445-452.

### 1.3. Aim of Research and Research Questions

Hence, a common base of the approaches of PWB and PR is their shared holistic view on the individual and the provision of means for a more holistic approach towards mental health. In the introduction, both of approaches were described independently from each other, but it appeared that some mentioned characteristics of one approach could also be used to describe the other approach, as for instance, the importance of personal growth, which in the end often leads to a change in identity (Koski-Jännes, 2002). This was mentioned in the recovery section, but it also applies to PWB. Therefore, a systematic comparison would be useful to clarify where overlaps and differences actually are.

And even though mental health care services in general are more holistic and recovery oriented nowadays, they still often do not match the service user's needs and expectations as a person. Different views on what recovery is exist between patient and professional perspective, but what are those differences between the approach of PWB and PR? Or might the concepts in fact share more than assumed? Even though there are literature reviews covering similar topics (i.e. by Leamy, Bird, Le Boutillier, Williams and Slade (2011) or Onken, Craig, Cook, Ralph and Ridgway (2007), there has - to current knowledge - no research been done to provide a holistic overview of the interplay of those approaches. In this way, it is hoped to clear some confusion about the concepts and provide a base for more recovery- and patient-oriented service in mental health care.

Thence, this research aims at clearly delineating overlaps, differences and the nature of relations by executing a systematic comparison. By that, aspects might be uncovered which might lead to mutual benefit in how they provide service to mental health care users. The aim is to explore what values they share and if or how they might be combinable in practice. This is the driving force behind this research. So more precise, the questions aimed to be answered are the following:

*Main Research Question:* What are the overlaps and differences between the approaches of *personal recovery (PR)* and *psychological well-being (PWB)*?

*Research Question 1 (RQ 1):* What are the conceptual overlaps and differences between the dimensions of the CHIME model and the dimensions of the Six-Factor Model of PWB?

*Research Question 2 (RQ 2)*: What are the overlaps and differences between the used instruments and measurement methods in Ryff's scales of Psychological Well-Being (RSPWB) and the Questionnaire about the Process of Recovery (QPR)?

*Research Question 3 (RQ3):* What are the overlaps and differences between the REFOCUS Intervention (RI) and Well-Being Therapy (WBT)?

## 2. Methods

In order to answer the research questions (RQs), for each sub question, different literature for each of the approaches of PWB and PR, was selected and compared to each other. A systematic comparison was executed.

### 2.1. Selection process

To find target articles that adequately represent the respective approaches, searches were carried out on the searching platform Scopus. Matching articles were then screened for their adequacy by relevance, number of citations, and fit with the approaches of PWB and PR.

#### 2.1.1. Six-factor model of PWB and the CHIME model

To explore the conceptual overlaps and differences of PWB and PR, two models were chosen. For PR, the CHIME model by Leamy et al. (2011) has been selected, while the six-factor model of PWB by Ryff (1989) was picked for PWB. Both are popular models and widely used in their respective fields (Scopus, 2018, 2018a).

*Psychological Well-being*

Applying the search terms “well-being” AND “mental health”, in title, abstract and keywords, AND “Ryff”, in authors, on the platform Scopus, the article by Ryff (1989) appeared as the oldest article and has been cited 317 times since its publication (Scopus, 2018a). Other articles written or co-written by Ryff came up as well, some having been cited more frequently than the original study of 1989. An article by Ryff and Singer (1993) has been cited 476 times for instance. Still, the first article by Ryff (1989) does not only provide the content definitions of the six dimensions but also describes the whole development process, the background and the original sources of the model. To explore the six-factor model of PWB the original article by Ryff (1989) has been selected because of its superior ability to provide first-hand information. In addition to the main article by Ryff (1989), two other articles by Ryff (Ryff & Keyes, 1995; Ryff, 2014) were taken into consideration, although solely to gain further understanding of the dimensions of the model.

*Personal Recovery*

Applying the search terms “personal recovery” AND “mental health” AND “CHIME”, for title, abstract and keywords on the platform Scopus, the article by Leamy et al. (2011) appeared as the oldest article. Alongside other articles containing the CHIME model, the article by Leamy et al. (2011) is the original article, which provides all the background and development process of the CHIME model. Additionally, with 565 citations, it was the most cited article on Scopus using those search terms (Scopus, 2018). The CHIME model has been applied by various researchers (e.g. Brijnath, 2015; Piat, Seida & Sabetti, 2017; Slade et al., 2014; Neil, Kilibride, Pitt, Nothard, Welford, Sellwood & Morrison, 2009; Stuart, Tansey & Quayle, 2017).

### 2.1.2. Ryff's scales of Psychological Well-Being (RSPWB) and the Questionnaire about the Process of Recovery (QPR)

For the second RQ, material regarding the measurement tools and practices for each concept was needed. Regarding the chosen models for RQ1 - the six-factor model of PWB and the CHIME model - the chosen scales should represent those concepts. By this, coherence in the analysis and results should be generated.

#### *Psychological Well-being*

For PWB, the 42-item version of the Ryff's scales of Psychological well-being (RSPWB) was chosen. Besides the 42-item version, a shortened 18-item version (Ryff & Keyes, 1995) exists. As the 42-item version is more statistically sound than the 18-item version (Ryff et al., 2007), the 42-item version will be used for this study. The RSPWB are based on the six-factor model of PWB and accurately measure PWB (Ryff & Singer, 2006; Abbott, Ploubidis, Huppert, Kuh, Wadsworth & Croudace, 2006; Abbott, Ploubidis, Huppert, Kuh & Croudace, 2010). Nevertheless, the model has also received some criticism (Springer, Hauser & Freese, 2006; Ryff & Singer, 2006). Also, the RSPWB seem to be most valuable for measuring average levels of PWB and less valuable for discriminating between high levels PWB (Abbott, Ploubidis, Huppert, Kuh & Croudace, 2010). Moreover, it has been claimed that the model does in fact not measure six distinct dimensions of PWB (Springer & Hauser, 2006). Yet, Ryff and Singer (2006) argue that researchers who have substantive interest in the topic of well-being trust and use the RSPWB. There is no better alternative to the six-factor model of PWB has emerged till now and the RSPWB do measure PWB and is therefore an acceptable scale to access PWB (Ryff & Singer, 2006). All in all, the RSPWB have been used

in many studies (e.g. Clarke, Marshall, Ryff & Wheaton, 2001; Gao & McLellan, 2018; Gigantesco, Stazi, Alessandri, Medda, Tarolla & Fagnani, 2011; Ryff et al., 2007).

*Personal Recovery*

For PR, the Questionnaire about the Process of Recovery (QPR), which evaluates the PR process, was chosen. A systematic review (Shanks, Williams, Leamy, Bird, Le Boutillier & Slade, 2013) identified, analyzed, and compared different measures of recovery in relation to their fit to the CHIME recovery processes and their psychometric adequacy. It was shown that although the QPR was not the most widely used or published scale among the 13 identified scales, it most closely maps to the CHIME model of recovery. After all, all items of the QPR reflect the dimensions of the CHIME model. In turn, the Recovery Assessment Scale (RAS) was used and published most (Shanks, Williams, Leamy, Bird, Le Boutillier & Slade, 2013; Corrigan, Salzer, Ralph, Sangster & Keck, 2004), but did not match all items of the CHIME model. Both scales met four out of nine possible psychometric properties (Shanks, Williams, Leamy, Bird, Le Boutillier & Slade, 2013). Even though the QPR was developed with individuals experiencing psychosis and was mainly constructed for measuring recovery in/from psychosis (Neil, Likibride, Pitt, Nothard, Welford, Sellwood & Morrison, 2009), it has been acknowledged by other researchers as useful for assessing PR in general (Argentzell, Hultqvist, Neil & Eklund, 2017; Chien & Chan, 2013).

Furthermore, the QPR shows good internal consistency as well as good construct validity and reliability (Neil, Kilibride, Pitt, Nothard, Welford, Sellwood & Morrison, 2009; Law, Neil, Dunn & Morrison, 2014; Shanks, Williams, Leamy, Bird, Le Boutillier & Slade, 2013).

In addition to the 22-item version, a 15-item version has been developed (Law, Neil, Dunn & Morrison, 2014). The latter was shown to be less burdensome and slightly more

robust than the 22-item version (Williams, Leamy, Pesola, Bird, Le Boutillier & Slade, 2015). Nevertheless, the 22-item version still showed adequate psychometric properties (Williams, Leamy, Pesola, Bird, Le Boutillier & Slade, 2015; Argentzell, Hultqvist, Neil & Eklund, 2017; Chien & Chan, 2013). Thence, because the 22-item version provides more data to analyze, it makes it more suitable for comparing it to the 42-item version of the RSPWB and the chance of getting more nuanced results increases. Therefore, the 22-item version was chosen over the 15-item version in this research.

### 2.1.3. Well-Being Therapy (WBT) and the REFOCUS Intervention (RI)

#### *Well-being*

For the PWB, the Well-Being Therapy (WBT) by Fava (1999) was selected. The WBT is built upon Ryff's six-factor model of PWB (Fava & Ruini, 2003; Fava, 1999). Searching on the platform Scopus, using the search terms "well-being" AND "therapy" and sorting on relevance, the first 18 articles listed are about the WBT by Fava (1999) (Scopus, 2018b). For this study, the main used sources about the WBT are the original article by Fava (1999) describing the WBT and its conceptual and technical issues as well as the book "Well-Being Therapy" (Fava, 2016), which provides all information about the background of the WBT as well as how to embed the WBT in practice.

#### *Personal Recovery*

For PR, the RI has been chosen. The RI was part of the RP (2009-2014) (Bird, Leamy, Le Boutillier, Williams & Slade, 2014) which involved various studies aiming at supporting

mental health services to become more recovery-oriented. The RP is also responsible for initiating research that led to the systematic review, carried out by Leamy et al. (2011), which resulted in the CHIME framework (Slade et al., 2017). As the theoretical basis of the RI is built upon the CHIME model and additionally uses the QPR as primary evaluation assessment method, the RI is viewed as a suitable practice form to analyze in this research. Regarding a search on the platform Scopus, using the search terms "REFOCUS Programme" OR "REFOCUS Intervention", 11 matches showed up, but only one actually was about the RI, written by researchers working for the RP. Hence, research on or including the RI, external to the RP, was not available. Nevertheless, the RI adequately reflects the concept of PR that is to be explored in this paper and is therefore used in this study.

## 2.2. Analysis

### 2.2.1. Six-factor model of PWB and the CHIME model

To get an overview of the articles providing the respective models, the articles were scanned and the information about the general aim of the research, the used methods and the results were summarized in Table 3. This information was subsequently described in the text and the aims, methods and results were respectively compared to each other.

To compare the dimensions of the six-factor model of PWB and CHIME model to each other, Table 4 was created. All elements, meaning the elements belonging the dimensions, were each screened for overlaps with the other model respectively. Furthermore, elements of each dimension of the models that were not included in the other model were listed. After having executed the comparison, the table was coded.

Six categories were generated. No overlap was signed as “X”. For an overlap of one to five or more matches between two elements of each model was signed as “+” to “+++++”. The number of possible matches was not limited. An overlap was defined as such if the wording was very similar or when the underlying concepts were similar, which was then described in more detail in the text below. The sections that indicated that elements that were not included in the other model at all were signed with “0” , for no missing elements, till ”3” , for three missing elements. For no dimension, more than three elements were missing.

Moreover, the CHIME model sometimes listed several sub elements that were very similar regarding content, as for instance *managing symptoms*, *coping skills* and *self-help*, which are sub elements of the element *care planning.* Those sub elements were then handled as one element, i.e. *care planning*.

### 2.2.2. Ryff’s Scales of PWB (RSPWB) and the Questionnaire about the Process of Recovery (QPR)

Two broad aspects of the RSPWB and QPR were held as relevant to explore: (1) How the two scales were constructed, their objectives and focus groups and formal characteristics, and (2) their content and meaning, thus the meaning of each item. Thence, a first table described all formal characteristics of the QPR and RSPWB - for example, what response format was used. Each category was either assigned with a “+”, indicating overlap, or a “-”, indicating no overlap between the scales. Because of their lengths, the generation of the scales and their items and their sample validation studies were only analyzed in text, where details were described and all comparisons between the two scales were made.

For the comparison of the content and meaning of the items, a second table listed all items of the QPR. The items of RSPWB that overlapped with items of the QPR were then assigned to those. An overlap designated a conformity of concept between the QPR item and

the RWPWB item and/ or a similarity in wording of an RSPWB item to the corresponding QPR item. Each item of the RSPWB could be matched to more than one item of the QPR. For instance, the RSPWB item “I have the sense that I have developed a lot as a person over time” matched 7 QPR items, for example “I feel better about myself.” or “I can recognize the positive things I have done.”. How many items overlapped with each of the items of the QPR was indicated as well. In order to match the items of the two scales adequately, all negative items of the RSPWB were read positively, meaning that the formulation was reversed for the analysis. For example, item P7 “I sometimes feel as if I've done all there is to do in life” was read as “I feel as if there is still a lot to do in life”.

Finally, a last table was created to get an overview of the results from the perspective of the overlap of QPR items with the RSPWB items. This table can be found under appendix D.

### 2.2.3. Well-Being Therapy (WBT) and the REFOCUS Intervention (RI)

To demonstrate the overlaps and differences between the WBT by Fava (1999) and the RI (Slade et al., 2017) all information about the WBT and the RI was put in a table by creating categories which were arranged in accordance with the gathered information. For example, after having gathered information about the diagnosis procedure in the WBT, the category “diagnosis” was added, and the information filled in. Eight categories could be generated, for example “Target group” and “Working mechanism”. The comparison of the WBT and the RI was accomplished per categories, for instance in the category “Target group”, the target groups of the WBT and RI were compared to each other in a text below the table and it was stated whether there was more overlap or difference in this category and why this might be the case.

## 3. Results

The results are displayed in the order of the three RQs. To make this section more comprehensible, each of the three comparisons is introduced by a compendious answer to the respective RQ. After the answer to the RQ, the table(s) are illustrated, a description of the table and the analysis follow – explaining how the answers to each RQ were developed.

### 3.1. Six-Factor model of PWB and the CHIME model

*Answer to RQ1: "What are the conceptual overlaps and differences between the dimensions of the CHIME model and the dimensions of the six-factor model of psychological well-being?"*

All in all, the overlap in wording and specific behavior descriptions between elements is rather low and elements of both models are spread out among various dimensions. However, there is a lot of latent overlap, especially the content of the PWB model is reflected in the CHIME model, whose elements are mostly applied to recovery specific topics and specific behaviors or attitudes. Thence, the six-factor model of PWB is kept more general than the CHIME model which could be said to build upon the elements described in the PWB model, but adjusted for people in recovery, who search well-being, just as every individual does. Nevertheless, the models are not interchangeable.

*Comparison between the Six-Factor model of PWB and the CHIME model*

To establish an overview and to have a baseline for comparison between the six-factor model of PWB and the CHIME model, a comparison of the research aims, methods and design of the two articles that describe the development of the models was made. The results

are presented in Table 3. After the description and analysis of Table 3, the comparison of the models' dimensions is made and presented and Table 4.

Table 3

*General overview of articles by Ryff (1989) and Leamy, Bird, Le Boutillier, Williams and Slade (2011)*

| | Ryff (1989) | Leamy et al. (2011) |
|---|---|---|
| Aim of research | To generate a theory-guided model well-being in the later years | To synthesize descriptions/models of PR into a conceptual framework |
| Method | Review of theories on successful ageing | Systematic review on PR conceptualizations |
| | Synthesis of theories | Narrative synthesis |
| Results | 6 core constructs extracted | 5 processes and 13 characteristics of recovery |

The aim of research of the six-factor model of PWB and CHIME model are similar. Both aimed at generating a new model or framework on the base of literature. Further, both name the absence of an existing framework/model in their topic of research as a reason for their investigation; there was no guiding theory in successful aging or theory providing an adequate basis for defining well-being in the later years at that time (Ryff, 1989), neither a clear and empirically based conceptualization for (personal) recovery (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). Still, the specific content of the models is different. Ryff (1989) aimed at creating a model for successful aging and Leamy, Bird, Le Boutillier, Williams and Slade (2011) wanted to build a framework for PR.

With regard to the used methods, both synthesized existing literature. For the six-factor model of PWB, existing theories were gathered through a review of previous approaches to the study of successful ageing. Those theories came from the fields of mental health (Jadoha, 1958), self-actualization (Maslov, 1968), optimal functioning (Rogers, 1961),

maturity (Allport, 1961) and developmental lifespan (Buhler, 1935; Erikson, 1959; Galbraith, Strauss, Jordan-Viola & Cross, 1974; Neugarten, 1968; 1973). Ryff (1989) then summarized those theories and integrated those different theoretical perspectives into a new model of well-being in the later years. She called it the six-factor model of PWB (Ryff, 1989).

The development of the framework for PR started by executing a systematic literature review on research papers which described or developed conceptualizations of PR from mental illness. Those conceptualizations had to be either a visual or narrative model of recovery, or themes of recovery that emerged from an analysis of primary data or a synthesis of secondary data. From 5,208 identified papers and 366 reviewed, 97 papers were included in the execution of a narrative synthesis. After developing a preliminary synthesis, relationships within and between studies were explored. In the end, the robustness of the synthesis was assessed (Leamy, Bird, Le Boutillier, Williams & Slade, 2011).
Hence, even though both reviewed existing literature and subsequently synthesized existing theories or conceptualizations, Leamy et al. (2011) gave more concrete information about the gathering of information and the approach to literature and theory. Their general approach gives a more objective impression than Ryff's (1989) approach, as Leamy et al (2011) followed certain guidelines. In Ryff's (1989) article, it is not clarified how the selection of certain theories took place, which election criteria were determined or on what basis other theories were excluded.

Moreover, Ryff (1989) based her model of PWB exclusively on theories, while Leamy et al. (2011) included only articles containing primary analyses or articles about theories which were based on empirical studies.

In the end, Ryff (1989) could extract six core constructs out of the theories in the fields mentioned above. Those core constructs were self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life, and personal growth (Ryff, 1989).

Leamy et al. (2011) generated a conceptual framework out of the synthesis. The framework of PR consists of (1) 13 characteristics of the recovery journey and (2) five recovery processes; connectedness, hope and optimism about the future, identity, meaning in life, and empowerment and (3) recovery stage descriptions which mapped onto the transtheoretical model of change. Those five processes of PR build the acronym CHIME and the five dimensions of the CHIME model.

Table 4

*Chime model dimensions and dimensions of six-factor model of PWB compared*

| | **CHIME model** | Connectedness (6) | Hope and Optimism about the Future (5) | Identity (4) | Meaning in Life (7) | Empowerment (5) | Missing elements of PWB model in CHIME model |
|---|---|---|---|---|---|---|---|
| **Six-factor model of PWB** | | | | | | | |
| Self-Acceptance (3) | | X | + | +++ | ++ | + | 1 |
| Positive Relations with others (4) | | +++++ | + | X | + | X | 2 |
| Autonomy (4) | | ++ | + | +++ | +++++ | ++++ | 3 |
| Environmental Mastery (4) | | ++ | X | X | ++++ | +++++ | 0 |
| Purpose in Life (4) | | + | +++ | X | ++++ | ++ | 0 |
| Personal Growth (6) | | ++ | +++++ | + | +++++ | +++++ | 0 |
| Missing elements of CHIME model in PWB model | | 2 | 2 | 2 | 2 | 1 | |

*Note.* Numbers in brackets behind dimensions indicate the number of elements of each dimension. X = no overlap; + = one match between elements, ++ = two matches, +++ = three matches, ++++ = four matches,

+++++ = five or more matches; 0 = no elements missing; 1 = one elements missing; 2 = two elements missing; 3 = three elements missing

To start, an example is given that illustrates what an overlap (+) looks like. The overlap between the dimension *Autonomy* of the PWB model and *Hope and Optimism about the Future* of the CHIME model is found between the elements *Evaluating self by personal standards, being independent and self-determining* (PWB model) and the element *Positive thinking and valuing Process* (CHIME model). This example illustrates that overlaps were not always obvious or exact overlaps regarding the wording, but often more about underlying motives or values. When not even underlying values or motives were found between any elements of dimension, the respective field was marked by a "X", as for instance between the dimensions *Self-acceptance* (PWB) and *Connectedness* (CHIME).

*Overlap*

Generally, there exists a predominant overlap between the dimensions of the two models. In total, 24 out of 30 possible overlaps between different dimensions were found. The overlaps varied in their level of overlap, indicated through the number of pluses, each representing one overlap between two elements of dimensions. Out of the 24 overlaps between dimensions, nine showed a high level of overlap (i.e. four or five pluses) and 15 a lower level of overlap (i.e. three and less pluses).

The CHIME model dimension *Meaning in Life* shows the highest overlap with the dimensions of the six-factor model of PWB. It has overlap with all dimension of the PWB model. Of the PWB model, the dimension *Personal Growth* has overlap with all dimensions of the CHIME model. Its substantial overlap is suggested to be due to the character of the whole recovery journey which is naturally tied to personal growth, as in recovery one grows as a person by relearning/redefining/identifying/rebuilding aspects in one's life. To illustrate

this, elements of the *Personal Growth* dimension are, amongst others, the *Feeling of continued development* and *Changing in ways that reflects more self-knowledge and effectiveness*. Many elements of the CHIME model are recovery-related, like for example *positive thinking and valuing success, Personal responsibility (self-management: coping skills, crisis planning, goal setting)* and reflect the *Personal-Growth* dimension.

*No overlap and Missing elements*

No overlap between dimensions was found a total of six times, of which three times the dimension *Identity* of the CHIME model was involved. Moreover, more elements of the CHIME model were missing in the PWB model than vice versa. In total, eight dimensions, out of the total 11 dimensions, were missing one to three elements in the other model respectively, while the other three dimensions did not miss any element. All elements of those three dimensions (*Environmental Mastery, Personal Growth* and *Purpose in Life* of the PWB model) were covered in the CHIME model.

Half of dimensions of the six-factor model of PWB missed one or more elements in the CHIME model. In contrast, each dimension of the CHIME model missed at least one element in the PWB model. The reason for this might be that the elements of the CHIME model were often very specific and recovery-related and therefore naturally not included in the PWB model, as for instance the element *knowledge about illness and treatment.* As the six-factor model of PWB is about PWB, mental illness and recovery are not relevant for this model. Still, the underlying motivations, feelings and characteristics of the elements of the CHIME model dimensions are described in the PWB model. To illustrate this; *Feeling good about the past* (PWB) is not explicitly mentioned in the CHIME model, but another element which might be interpreted as reflecting this was *meaning of mental illness experience*

*(accepting and normalizing it).* Hence, in the CHIME model any other negative, or positive, past events that are not related to mental illness are not considered.

As the element *accepting or normalizing illness experience* (CHIME model), might lead to feeling good or better about the past, but must not, the element *Feeling good about the past* (PWM model) is also an example of an element that was not exactly represented in the CHIME model and was therefore marked as missing and as overlap at the same time. One might accept the mental illness experience but accepting something about the past does not equal feeling good about it. Because of such an equivocal character of some items, about half of the items marked as not having a match, were also marked as overlaps.

An element which was missing completely in the CHIME model was the element *Spirituality or the development of it* of the dimension *Meaning in Life* in the PWB model.

*Mode of overlap*

Hence, as stated in the beginning, overlap was not always exact but could also be latent, for example when elements did reflect the same concept but were either applied to different situations or behaviors or formulated more specific than the other. For example, overlaps between the elements of the dimensions *purpose in life* and *meaning in life,* which are similar concepts, were different from overlaps between *purpose in life* and *connectedness*, which were not that similar. In relation to this, an overlap between those dimensions was found between the elements *Being a part of the community (=active citizen, contributing to community)* (CHIME) and the element *sense of directedness in life and holding beliefs that give life purpose* (PWB). There was no exact overlap, but being an active citizen and contributing to community, as stated in the CHIME model, probably reflects that a person is holding the belief that being an active citizen is beneficial and important, so the individual has a sense of directedness which also provides a purpose in daily life. Overlap between the

dimensions *Purpose in Life* and *Meaning in Life* are, for example, more exact, because all elements highlight similar values, such as finding meaning in life, the importance of goals in life, purpose giving beliefs or spirituality and goal-directed living.

Further, many CHIME model elements were not formulated in the general form as the elements in the six-factor model of PWB were. The CHIME model elements were formulated more as concrete applications and descriptions, mostly applied to the recovery journey. Thus, for example, instead of *having aims and objectives for living*, in the *Purpose in Life* dimension, the CHIME model points out to the *Identification and active pursuit of previous or new life or social goals* in the dimension *Meaning in Life*.

Moreover, the elements of both models are spread out among various dimensions of the other model respectively, instead of mapping to only one dimension. For instance, can *Purpose in Life*, of the PWB model, be found in the CHIME model dimension *Connectedness, Meaning in Life* and *Empowerment*.

Another outcome was the different view on relationships described in the two models, mostly in the dimension *Positive Relations with others* (PWB model) and *Connectedness* (CHIME model). For instance, the dimension *Positive Relations with others* lists the importance of *positive feelings in and towards relationships* and *positive and caring feelings about others*. The CHIME model mentions *intimate relationships* in the dimension *Connectedness*, but in general, the focus lies on receiving support (in recovering) from family, professionals or groups. In opposition to this, the PWB model focuses on giving as well as taking, includes the intrinsic motivation to help and the involvement and capacity of feeling. Still, those two dimensions have substantial overlap.

### 3.2. Ryff's scales of Psychological Well-Being (RSPWB) and the Questionnaire about the Process of Recovery (QPR)

*Answer to RQ2: "What are the overlaps and differences between the used instruments and measurement methods in Ryff's scales of Psychological Well-Being (RSPWB) and the Questionnaire about the Process of Recovery (QPR)?"*

The QPR cannot be used interchangeably, as items did not match to specific subscales and many QPR items were recovery-related. Still, they share the same underlying values and attitudes. Regarding the set up and development of the scales the overlaps are outweighed by the differences. The general set up and approach of the QPR, as for example the inclusion of experience experts in the scale construction process, fits well to the spirit of recovery. Hence, it can be said that the QPR was developed "with" possible respondents, while the RSPWB were developed "from above" for possible respondents, as it was derived from theory and the scale was only constructed by experts.

*Comparison between the RSPWB and the QPR*

For this analysis, two tables were created, Table 5 and 6. Table 5 will be described and analyzed first, then Table 6 will be presented, followed by a description and analysis.

Table 5

*Comparison of formal characteristics between the RSPWB and the QPR*

| | RSPWB | QPR | |
|---|---|---|---|
| Assessment form | Self-report questionnaire | Self-report questionnaire | + |
| Year of construction, Country of origin | USA, 1989 | UK, 2009 | - |
| Scoring system | Higher scores indicate higher well-being | Higher scores indicative of recovery | + |
| Subscales | Six subscales: (1) Self-Acceptance (2) Positive Relations with Others (3) | Two subscales: (1) interpersonal (2) intrapersonal | - |

| | | | |
|---|---|---|---|
| | Autonomy (4) Environmental Mastery (5) Purpose in Life (6) Personal Growth | | |
| Quantity of Items | 42 | 22 | - |
| Positive and negative items | 20 positive items, 22 negative items (reversed) | 22 positive items, 0 negative items | - |
| Response format | Ordinal; Six-point Likert Scale | Ordinal; Five-point Likert Scale | + |
| Response categories | (1) strongly disagree; (2) moderately disagree; (3) slightly disagree; (4) slightly agree; (5) moderately agree; (6) strongly agree | (1) strongly disagree; (2) disagree; (3) neither agree nor disagree; (4) agree; (5) strongly agree | + |
| Shortest/Longest item regarding amount of words | 7/20 | 5/24 | + |
| Mean amount of words per item | ~14 | ~10 | - |
| Language complexity | Flesch Reading Ease: 80,19* (equals reading level in the 6th grade in the US; easy to read) | Flesch Reading Ease: 81,87* (equals reading level in the 6th grade in the US;, easy to read) | + |

*Note*. *Scores range between 0 and 100, higher scores indicate higher readability of texts. Adapted from "Beyond Ponce de Leon and life satisfaction: New directions in quest of successful ageing", by C. D. Ryff, 1989, *International Journal of Behavioral Development, 12(1)*, p. 35-55. "The Structure of Psychological Well-Being Revisited", by C. D. Ryff and C. L. M. Keyes, 1995, *Journal of Personality and Social Psychology, 69(4)*, p. 719-727. "Psychometric evaluation of the questionnaire about the process of recovery (QPR)", by J. Williams, M. Leamy, F. Pesola, V. Bird, C. Le Boutillier and M. Slade, 2015, *British Journal of Psychiatry, 207(6)*, p. 551–5. "The questionnaire about the process of recovery (QPR): A measurement tool developed in collaboration with service users", by S. T. Neil, M. Kilibride, L. Pitt, S. Nothard, M. Welford, W. Sellwood and A. P. Morrison, 2009, *Psychosis, 1(2)*, p. 145-155.

At first sight, the amount of overlaps and differences seem to be equally distributed, but the scale construction processes and validation studies are not included in the table. Taking those aspects into account, there are more differences than overlaps. Because the scale construction processes and validation studies were not included in the table, they are described in more detail after the description of the table.

The first overlap of the RSPWB and the QPR is the used assessment form and scoring system. The first major difference is that the RSPWB was developed in the US, 20 years before the QPR, which was developed in the UK. Further, the RSPWB possess six subscales

that map the six dimensions of Ryff's six-factor model of PWB, while the two subscales of the QPR developed from an exploratory factor analysis of the 22-item version of the QPR. Two factors were identified; *intrapersonal* and *interpersonal,* which constitute the subscales. Five items are interpersonal, which relate to individuals' ability to reflect on their meaning in their environment and on how external processes and relationships facilitate recovery. The other 17 items are intrapersonal and relate to tasks one is responsible for carrying out and necessary to complete in order to rebuild their life.

Moreover, the 42 items of the RSPWB are equally split into positive and negative items. In contrast, the QPR consists of 22 exclusively positively formulated items, possibly because it might be less distressing for the respondents to respond to positive than to negative items which might trigger negative emotions.

Regarding the response format and the longest and shortest sentence of items, the scales are similar. Nevertheless, the RSPWB possess a higher mean number of words per item than the QPR. However, the language complexity of both scales is similar. Language complexity was measured by applying the Flesch Reading Ease Test (Flesch, 1948), which is still popular today (Readable, 2019). Scores range between zero and 100. The higher the score, the easier a text is to read. Both, for the scales calculated, scores correspond to the US reading ability of a sixth grader and are easy to read.

*Scale construction process, item generation and validation sample study*

The scale construction process and item generation of the RSPWB and the QPR were carried out rather differently. The RSPWB are based on a theoretical model, the six-factor model of PWB. The scale was constructed to have a measurement that accesses the construct as described in the PWB model. The items were written, by three individuals, based on the descriptions of the six dimensions of the six-factor model of PWB. Due to the bipolar

dimension descriptions, half of the items for each subscale were formulated negatively. First evaluations of the items took place with respect to several criteria, such as a lack of fit of items with scale definitions or an inability of items to produce variable responses. By whom the primary evaluation was executed is not explicitly mentioned.

In contrast, the QPR was built with the aim of develop and validating a short recovery questionnaire in collaboration with service users. Two service users were part of the construction team and more were regularly consulted. For the generation of the items, in-depth-interviews into recovery were used. Afterwards, to test face validity, an independent clinical psychologist matched each item with the original themes they were derived from. Further, the items were checked again by the steering committee members and subsequently given feedback and consultation was given within the committee. Exact exclusion criteria for items are not mentioned.

With regards to the validation sample study, the two scales roughly match in their procedure, but still differ in their approach and details. The RSPWB was filled in by 321 young, middle-aged, and older adults. The young adults were recruited through an educational institution, and the middle-aged and the older adults were contacted through community and civic organizations. The QPR was completed by 126 self-selecting individuals, whose only inclusion criteria was to have personal experience with psychosis. The QPR respondents were recruited via the National Health Service (NHS) Trust and self-help organizations using convenience sampling. Further information about participants is not given in both cases.

Both questionnaires were self-reported and assessed together with other questionnaires. To provide comparative information about the validity of the RSPWB were filled in together with seven other questionnaires about psychological functioning. Those were the (1) Affect balance scale, (2) Life Satisfaction Index (3) Rosenberg's Self-Esteem Scale, (4) Moral Scale, (5) Locus of control Scale and the (6) Self-rating Depression Scale (SDS). The QPR was administered with three other questionnaires. Those scales measured

Empowerment (the Making Decisions and Empowerment Scale – MDES), quality of life (the Schizophrenia Quality of Life Scale – SQLS) and experienced psychological distress (the General Health Questionnaire – GHQ) while filling in the QPR. The reason for the inclusion of the GHQ was that the service users/experience experts involved in the development of the scale expressed concern that filling in the QPR might be distress enhancing for respondents who currently might experience already distressing symptoms of psychosis. Therefore, a distress rating scale was used to check whether the QPR might be to distressing for the individuals filling in the QPR in the validation study. It could be shown that the QPR was in generally not distressing to complete for service users, but "enjoyable, empowering and beneficial in terms of illustrating people's personal gains" (Neil, Kilibride, Pitt, Nothard, Welford, Sellwood & Morrison, 2009). This reflects the empowering spirit of the concept of recovery and is a further sign/evidence that the scale was constructed with the values and ideas, as well as for, PR.

To assess test-retest reliability the QPR was administered again two weeks after the first time. This was not done for the RSPWB.

To further validate the scales, the data of both scales were analyzed. For the RSPWB, item-to-scale correlations were calculated for all items with all of the scales. Items that correlated more highly with a scale other than their own or that showed low correlations with their total scale were deleted. By this, 20 items per scale were generated, which means 120 items in total. After that, reliability and validity were not assessed again. Similarly, the data of the QPR were factor analyzed in order to identify redundant items and determine underlying variables. The final 22-item version was then again tested for reliability and validity.

Table 6

*Overlaps of RSPWB items with QPR items*

| QPR ITEMS[a] | Overlap with items of RSPWB (item numbers including letters of subscales) | Amount of items |
|---|---|---|
| 1) I feel better about myself | G(3,4), S(1,2,4-7) | 8 |
| 2) I feel able to take chances in life | G(1,2,6,7), P5, E7 | 6 |
| 3) I am able to develop positive relationships with other people | R(2-,4,6,7) | 5 |
| 4 I feel part of society rather than isolated | R(3,5), E3 | 3 |
| 5 I am able to assert myself | A(1-5,7,), E(1,6,7), G6, P5 | 11 |
| 6) I feel that my life has a purpose | P(1-7), S5 | 8 |
| 7) My experiences have changed me for the better | G(3-5), S(1-3,5,6) | 8 |
| 8) I have been able to come to terms with things that have happened to me in the past and move on with my life. | A(4,6,7), E1, G(4-6), P(2,4,7), S(1,3,5) | 13 |
| 9) I am basically strongly motivated to get better | G(1,2,6,7), P(1-7), S2, A7, E1 | 14 |
| 10) I can recognize the positive things I have done | E7, G(3-6), S(1-3,5) | 9 |
| 11) I am able to understand myself better | G(2,4,5) | 3 |
| 12) I can take charge of my life | A(1-5,7), E(1,2,4-7), G6, P(1,2,5,6),S2 | 18 |
| 13) I am able to access independent support | E1 | 1 |
| 14) I can weigh up the pros and cons of psychiatric treatment | G(3,4) S1 | 3 |
| 15) I feel my experiences have made me more sensitive towards others | | 0 |
| 16 Meeting people who have had similar experiences makes me feel better | | 0 |
| 17 My recovery has helped challenge other people's views about getting better* | | 0 |
| 18) I am able to make sense of my distressing experiences | G(4-6) | 3 |

| | | |
|---|---|---|
| 19) I can actively engage with life | G2, E(1,6,7) G(5-7), R(1,2,4,5,7), P(2,4-7), S3 | 18 |
| 20) I realise that the views of some mental health professionals is not the only way of looking at things | A(3,4,6,7), G2 | 5 |
| 21) I can take control of aspects of my life | E(1,24-7), G6 | 7 |
| 22) I can find the time to do the things I enjoy | E(6,7), G1, R(4,5) | 5 |

*Note*. A= Autonomy, E= Environmental Mastery, R=Positive Relationships with Others, P= Purpose in Life, S=Self-Acceptance, G= Personal Growth. Adapted from "The questionnaire about the process of recovery (QPR): A measurement tool developed in collaboration with service users", by S. T. Neil, M. Kilibride, L. Pitt, S. Nothard, M. Welford, W. Sellwood and A. P. Morrison, 2009, *Psychosis, 1(2),* p. 145-155.

Unambiguously, there is a lot of overlap. Out of the 22 QPR items, 19 items did match with, on the average seven, RSPWB items. Three of the 22 QPR items did not match with any RSPWB items. Furthermore, the RSPWB items that were allocated to the QPR items, averagely matched three QPR items. Hence, 15 of the 19 QPR items matched with RSPWB items from more than two dimensions each. This means that the QPR items are not matching to particular subscales of the RSPWB.

Four items of the QPR matched remarkably more items of the RSPWM than the rest. Item 19, "I can actively engage with life." and item 12, "I can take charge of my life.", each matching 18 items of the RSPWB. Item nine matched 14 items and item eight matched 13 items of the RSPWB. Further, those four items also all matched to items from five or six dimensions of the RSPWB. The maximum of PSPWB dimensions matched by an item of the QPR, with less than 11 matches in total, was three dimensions per QPR item.

Three items of the QPR did not match any of the RSPWB items. Those items were item 15:" I feel my experiences have made me more sensitive towards others.", item 16: "Meeting people who have had similar experiences makes me feel better." and item 17: "My recovery has helped challenge other people's views about getting better.". Those three items are all highly recovery related, which might be the reason for their lack of similarity with the items of the RSPWB. Still, this cannot have been the only reason, as other recovery-related

QPR items, as for instance item 20: “I realize that the views of some mental health professionals are not the only way of looking at things”, did match items of the RSPWB. This QPR items for example, did match five items, four of them belonging to the dimension *Autonomy*, as for example “I judge myself by what I think is important, not by the values of what others think is important.”.

Another difference is that in the RSPWB, because they are split into positive and negative items, there are doubled sentences. This means that, two sentences aim at the same meaning, just and positively and one negatively formulated, as for instance, *“I am not interested in activities that will expand my horizons.*” and the item “*I think it is important to have new experiences that challenge how you think about yourself and the world.*”. However, the items that were doubled, always belonged to the same dimension and therefore naturally already should represent the same construct.

In general, the wording of the items was not similar. Therefore, the matches are based on meaning, not on explicit wording. In comparison to the formulation of the dimensions of the six-factor model of PWB, the items of the RSPWB are somewhat more explicit and refer clearly to specific behaviors, thoughts, attitudes etc. In the PWB model the dimension Self-Acceptance, for instance, is described as “Positive attitude towards self, acknowledging and accepting multiple aspects of self (good and bad) qualities, feeling good about past life”. An example item of the subscale Self-Acceptance of the RSPWB in contrast, is “When I look at the story of my life, I am pleased with how things have turned out.”. The items of the QPR were also rather clear, but a bit more generally formulated, as for instance “I can take charge of my life”. In addition to this, some QPR items were explicitly related to the recovery journey and naturally not included as such in the RSPWB.

In addition to the results of this table, results (see table in appendix D) show that all items of the RSPWB were somewhere reflected in the items of the QPR. The items that matched most with items of the QPR were item *G6* “*I gave up trying to make big*

*improvements or changes in my life a long time ago. (N)"* with nine matches and three more items with seven matches respectively. The items are all from either the dimension *Personal Growth* or *Purpose in Life*, which is in line with earlier findings. Worth mentioning is as well that the dimension *Self-acceptance* also showed a remarkable overlap, as two of its items matched six items of the QPR and one item matched five.

### 3.3. Well-Being Therapy (WBT) and the REFOCUS Intervention (RI)

*Answer to RQ3: "What are the overlaps and differences between the well-being therapy (WBT) and the REFOCUS intervention (RI)?"*

Both programmes aim at increasing self-efficacy, PWB and autonomy. Still, the WBT focuses more on the complete remission of symptoms, while the RI focuses on empowering service users despite experiencing mental illness. A crucial distinction was found in the power relations. In the WBT, individuals are still reduced to their "patient role", while in the RI the "service users" are seen as equally valuable and capable individuals of society. Concluding, the RI reflects the bottom-up thinking behind the concept of recovery, meaning that the how of treatment emanates from the individuals' needs, strengths and goals. The WBT values personal goals and self-efficacy of patients as important aspects, but still labels the patient according to DSM-5 diagnoses.

*Comparison between the WBT and the RI*

The last RQ is explored through the analysis of the descriptions of Table 7. After then giving an answer to this question, the collective results of the three parts will be summarized and evaluated in the discussion.

Table 7

*Well-Being Therapy (WBT) and the REFOCUS intervention (RI)*

| | Well-Being Therapy | REFOCUS |
|---|---|---|
| Background | Six-factor model of PWB | CHIME framework as main theoretical reference |
| Type and focus of programme | Short-term second- or third line psychotherapy<br>Not a replacement for acute therapy | Short term Intervention for workers across the mental health field, provided by recovery experts<br>Addition to standard care, not a replacement for it |
| | Strengthening well-being | Focus: make mental health care more recovery-oriented by coaching carers and workers |
| Aim of programme | To decrease the risk of relapse in the residual phase of (affectiv) disorders | To increase the extent to which workers support the recovery of mental health service users |
| | Build up well-balanced psychological functioning and to promote resilience | To increase hope, empowerment, quality of life etc. of service users, leading to improved PR |
| Targetgroup | Individuals looking for a second- or third-line therapy (with residual symptoms), especially with mood disorders<br>Target group: "Patients" | Workers in the mental health care (clinicals, nurses...)<br>Ultimate target group: "users of mental health care service" |
| Diagnosis | Clinical diagnosis + Clinical reasoning (= considering relationships of all problems and syndromes in patients' life) | Focus on the service user as a person with individual strengths, goals and abilities to cope with situation/life (clinical diagnosis not relevant) |
| Content | Self-observation of episodes of PWB through filling in a diary, create "flow experiences", implement "lifestyle modifications" | Changing care practice by working on how and on what staff works with service users through working practice training, coaching and support for practice change |
| Working mechanism | Focusing on episodes of PWB might lead to a comprehensive identification of automatic thoughts | Through the practice change that staff applies in daily practice after the intervention, the experience of the service users changes and so their final outcome changes |
| Length of programme | Normally, 8 sessions (a 40-50 minutes), every second week (=~6 h in total) | 4-4 ½ days + ongoing process of implementing REFOCUS |

Note. Adapted from "REFOCUS Trial: protocol for a cluster randomised controlled trial of a pro-recovery intervention within community based mental health teams" by M. Slade, V. Bird, C. Le Boutillier, J. Williams, P. McCrone and M. Leamy, 2011, *BMC Psychiatry, 11*, p. 185. "Well-being therapy: conceptual and technical issues" by G. A. Fava, 1999, *Psychotherapy and Psychosomatics, 68*, p. 171-179. "). Fit for purpose? Validation of a conceptual framework for personal recovery with current mental health consumers", by V. Bird, M. Leamy, J. Tew, C. Le Boutillier, J. Williams and M. Slade, 2014, *Australian & New Zealand Journal of Psychiatry, 48(7)*, p. 644-653. Adapted from *Well-Being Therapy (WBT) - Eine Kurzzeittherapie zur psychischen Stabilisierung*, by G. A. Fava, 2016, Stuttgart, Baden-Württemberg: Schattauer.

The programmes representing well-being and recovery naturally show lots of differences, since the WBT and the RI are distinct in character and form. In order to provide a comprehensible comparison between the WBT and the RI, both programmes were described in some more detail.

*Background and aim and focus of the programmes*

For both, the WBT and the RI, theoretical models are used, even though for the development of the RI a broader set of resources were incorporated. The WBT was developed as maintenance treatment in a sequential treatment approach, thus not as first line therapy or exclusive treatment, as for instance cognitive behavioral therapy or a pharmacological treatment. Originally, the aim of WBT was to decrease the risk of relapse in the residual phase of affective disorders, but through further development and clinical experience, it has become visible that the applicability of the WBT might be broader than originally anticipated. The approach of the WBT is autonomy- and self-efficacy promoting as well as growth-oriented. Individually well-balanced psychological functioning is built up and resilience promoted. The therapy focus lies on the method of self-observation. Patients are imparted that their PWB is not solely the result of external circumstances, but depends on their own exercise of influence, independent of mental illness.

The RI is a short-term intervention focusing on the creation of a more recovery-oriented approach in existing mental health care. Thus, it does not aim at being a replacement for traditional care or therapy. The RI aims at coaching mental health care workers to increase the extent to which they support mental health service users to recover. The training is provided by external recovery experts and coaches. At long last, service users should show higher levels of hope, empowerment, quality of life, well-being and satisfaction through the

behavior- and attitude change of the staff towards them. The whole RP, which the RI was part of, aimed to support mental health services to become more recovery-focused.

Hence, even though the WBT and the RI are distinct in nature, their final goals are similar. Both want to assist in achieving complete or holistic recovery, by building up, amongst other, autonomy and self-efficacy of service users.

Another common aspect is that both are not developed as exclusive treatment programmes. The WBT should be provided after at least first-line therapy, aiming at complete and holistic recovery by battling residual symptoms, as being sufficiently clinically recovered does not equal being well. Similarly, the RI is provided in addition to standard care and should be embedded in existing care systems. The RI adds on and changes how therapy and treatment take place in health care settings in a way that should lead to improved PR. In this respect, it might, if adequately implemented, in fact prevent the need of a second- or third line therapy, such as the WBT. Still, a distinction here is that the RI does not highlight the remission of all symptoms, but empowering service users and encouraging them to live well, despite current experience of symptoms. This is much in the spirit of PR, on which the REFOCUS model is based and differs from the WBT. The WBT also encourages the patient to live well and to enhance episodes of PWB, but ultimately also aims, distinct to the RI, at a complete remission of symptoms.

*Target groups and diagnosis*

Thence, another distinction are the target groups. The WBT has been developed for individuals searching maintenance treatment, when for instance only partial symptom remission has been achieved in first-line therapy or they did not respond to traditional therapy. Until now, the WBT has successfully been applied in treatment of generalized anxiety disorder, depression and cyclothymia, but potentially can be applied to other mental disorders

as well. The individuals in therapy are traditionally called “patients” in the WBT. A reason why WBT has so far only been applied to mood disorder might be that the WBT aims, amongst others, at a remission of symptoms and freeing individuals with certain (chronic) disorders from all symptoms might not be possible.

Further, a diagnosis as proposed by the DSM-5 is considered but not seen as sufficient. The dependence on listed symptoms and according diagnostic criteria are seen as limiting and restricting and would not reflect the complex decision-making process of diagnosing in clinical practice. Much more information about a person must be considered, such as stress, lifestyle, subclinical symptoms, illness behavior, PWB, interpersonal relationships and social support. Clinical reasoning should be applied for each individual again, which means that all clinical data is integrated into a broader concept and relationships between simultaneously appearing syndromes and problems are sought to be uncovered. This approach to diagnosing reflects the holistic view behind the concept of well-being, as the person is not reduced its illness and symptoms, but the whole individual in its (social) environment, circumstances etc. is considered. For the RI, the primary target group are workers in the mental health care, even though the ultimate aim is supporting the PR of mental health care users. The mental health service users are not further defined, but in contrast to WBT, they are not called “patients” but “service users”. The intervention can be provided to workers at community support organization as well as in inpatient settings or others mental health institutions.

Regarding the practice of diagnosing, the RI manual does not mention the DSM-5 or diagnoses at all and distances itself from the pathology-focused practice. The intervention aims at supporting people in their PR through workers’ behavior and support. Service users are not categorized or labeled, but their individual values are explored, personally valued goals and individual strength are identified with staff. Thus, service users are actively involved in care planning and the workers support them in striving towards their goals.

Hence, the focus lies more on the service user as an individual person than on their clinical diagnosis and according standard (dis)abilities and treatment guidelines.

Lastly, a small but crucial wording difference between the programmes should be stressed. In the WBT, individuals in therapy are called “patients”, which is in line with traditional top-down care. The term “patient” implies that the individual is dependent on professional help to treat an illness or disorder. The doctor, in this case therapist, traditionally possesses means to cure the patient’s illness, which the patient does not possess, which grants him or her power. Doctor and patient are not on a par with each other. In the RI instead, the individual in therapy is called (mental health care) service user. This is completely different, because a “service user” is not inherently dependent on and lower-ranked than the “service provider”. People are also “service users” in restaurants or public transportation, using a specific service that other people or institutions provide. Service users are usually service providers at the same time, for instance does a mother provide care to her children and provides care as a coach and at the same time receives service when she opens a bank account. Thus, by calling individuals in therapy “service users”, they are not degraded or reduced to their illness, in contrast to being called a “patient”. In the concept of recovery, people are seen as normal and capable individuals, which suffer from a mental illness, but are not reduced to it. The RI thus, is also in this regard, much in the spirit of recovery.

All in all, the RI seems to reflect the bottom-up thinking behind the approach of recovery, which entails that treatment approaches should emanate from the individual’s needs, strengths, goals etc. instead being induced top-down, i.e. from clinicians and mental health care workers. The WBT instead, although the patients’ personal goals and self-efficacy are targeted more than in pathology focused therapy should still be seen as top-down approach, with tendencies towards a bottom-up approach.

*Programme content; working mechanism and lengths*

The WBT relies mainly on the method of self-observation. Patients self-observe episodes of PWB through filling in a diary describing their behavior, thoughts/feelings as well as possible objective thoughts that might be more adequate in the respective moment than their instinctive thoughts are. Further, patients are prompted to integrate optimal or flow experiences as often as possible in their daily life or routine (e.g. search optimal working conditions that enable flow experiences) and to undertake concrete lifestyle modifications (e.g. to go for a walk in the morning to prevent back pain). Through a change of perspective, induced focusing on episodes of PWB instead of episodes of distress, the personal therapy goal is altered. The individual is encouraged to see how episodes of PWB are being interrupted and then discover how they can change this themselves. So, the aim is not primary symptom reduction, but the promotion of balanced well-being. A possible explanation why WBT works for people who did not respond to tradition therapy, might be that self-observation of episodes of PWB might lead to a more comprehensive identification of automatic thoughts than traditional self-observation of distressing episodes - as in the CBT. This might lead to a more effective cognitive restructuring.

Normally, WBT is provided in eight sessions, which should take 40-50 minutes each, although the number of sessions may variate depending on the circumstances of the patient. To give patients time in between sessions to work on themselves independently, sessions usually take place every second week or every other week.

The RI aims at changing care in two ways: 1) how staff works with service users and 2) what staff and service users discuss and do. Those two goals are implemented in four stages: 1) Recovery and REFOCUS workshop, 2) Working practices training, 3) REFOCUS Coaching for recovery training 4) Support for practice change (ongoing process, implementation plan developed by workers themselves). How change should be affecting service users in the end is demonstrated in the REFOCUS model which consists of four

phases. First, the *Intervention* takes place, which induces *Practice change*, meaning that staffs' values become more pro-recovery, more available knowledge about PR is gained and improved coaching and working skills can be applied. Third, the *Experience of service users* changes through the behavior and attitude change of the staff. Thus, service users experience more coaching, more focus on strengths, values and goal-striving which leads to more support in PR. In the fourth stage, the *Outcome for person using the service* is changed, visible in proximal outcomes as increased hope, empowerment, well-being etc., and in distal outcomes as improved PR.

Thus, the intervention takes 4 or 4,5 days, with workshops taking around one day each, depending on preferences. The time after the intervention the focus has to be on the ongoing process of implementing REFOCUS into daily practices.

Hence, even though the provided content and working mechanisms seem very different by nature, there is some overlap. In both cases, the service user or patient plays an active role. In the WBT patients have to actively cause the perspective change to happen and in the RI, service users will, after the actual intervention, be coached and guided better in their way to self-help. Goals and are planned with users, not for them. Both view the individual as capable, simply needing guidance in (re)discovering his/her strengths, self-efficacy, talents and passions.

Taken together, the results of the three research questions provided above should give an answer to the main research question "*What are the overlaps and differences between the approaches of recovery and well-being?*". Giving an answer to the main RQ through the results of the three RQs and putting it into context will be the subject of the next section.

# 4.Discussion

The aim of this research was to clearly delineate overlaps, differences and the nature of relations of the approaches of well-being and PR. Summarizing the results, it is shown that both approaches share the same underlying values and attitudes towards what it means to be well. The PR approach could be said to build upon the values of the PWB approach and applies this to people in recovery with mental illness. The found overlap was therefore more latent rather than explicit. The chosen materials, as the RSPWB and the QPR, were too different to be interchangeable. Further, the power relation between mental health care users and providers displayed in the PR approach was defined by equality, while in the PWB approach individuals were reduced to the role of the inferior patient. Hence, even though individual strength and character is highlighted in the PWB approach, a complete remission of symptoms is seen as necessary for being well. In opposition, in PR treatment approaches emanating from the people's individual needs and strengths and seeking well-being despite mental illness is promoted. When all results are taken together, one main overlap and four main differences could be derived. Those five overlaps and differences are described in detail and put into context in the next paragraphs.

The main overlap between both concepts is their shared holistic approach towards treatment of mental health care users. The approaches of PR and PWB share basic values of what it means and what one needs to be and live well. Both stand for enabling individuals to increase their levels of autonomy, self-efficacy, PWB and to recognize and build on their strengths. However, individuals in recovery might often have a higher need for support due to their illness. The PR approach reflects this for instance in the relevance of receiving help and support from others, while receiving as well as providing support to others was relevant in the PWB approach. Similarly, many aspects of the PR approach are simply not relevant for the approach of PWB, as they target special needs in recovery that are due to illness. The PR approach applies the values of PWB to people recovering from mental illness. Hence, for example do workers in recovery-oriented practice guide service users on their way to PWB and

help them figuring out how to deal with mental illness on that way.

The first difference was, as anticipated in the introduction, that the approaches of PWB and PR rose from different backgrounds, each providing various conceptualizations of general concept of well-being and recovery. The findings of this research show that the material representing the concept of well-being, i.e. the six-factor model of PWB, the RSPWB and the WBT, is solely based on theory (Ryff, 1989; Ryff, 1989a; Fava, 1999), thus emanating from professionals and experts such as researchers or clinicians. In contrast, the selected material for the approach of PR, i.e. the CHIME model, the QPR and the RI, is based on empirical research with people who experienced mental illness and recovery (Leamy, Bird, Le Boutillier, Williams & Slade, 2011; Neil, Kilibride, Pitt, Nothard, Welford, Sellwood & Morrison, 2009; Slade et al., 2017). Thence, the first fundamental difference is found in development, background and character of the two approaches. This is in line with existing research demonstrating that well-being is a concept emerging from the professional fraction in the mental health field ansd is not solely concerned with the individual person's well-being. Rather, it is often applied as concept for the measurement of well-being in populations and as indicator of progress, for example in regional, national or international comparisons (Huppert & Johnson, 2011; Huppert & So, 2013; Hone, Jarden, Schofield & Duncan, 2014). In this regard, governments and higher institutions can be seen to belong to the professional fraction, the concept of PWB emanated from.

In contrast to PWB, the concept of PR has risen independently of academic institutes. It holds personal meaning and experience as its highest good, which is reflected in used research methods. In general, knowledge is derived from inductive methods such as synthesizing narratives (Tondora & Davidson, 2006; NIMHE, 2004). An orientation toward more recovery-oriented care is just slowly starting to get embraced in policy making (e.g. Department of Health and Aging, 2009; Mental Health Commision of Canada, 2012; Department of Health Social Services and Public Safety, 2010), as treatment provided by the state needs to be sufficiently validated and proved to be efficient.

The second difference found between both approaches builds upon the first: the PWB approach applies to all people and living well with mental illness is not considered. In contrast, the approach of PR inherently focuses on how to deal and live with mental illness as well as how recovery in mental illness can best be assisted. The main goal of WBT lies on focuses and reinforces moments of experienced PWB in the patient's life. By this, residual symptoms of mental illness are battled, although they are not directly targeted. In the view of the PWB approach, one first needs "to get rid" of mental illness before being able to really be well. Therefore, it is corresponding to clinical recovery. This in line with the fact that many well-being researchers view their own work more as a complement to, and not as an alternative to, traditional standard practice (Hanlon & Carlisle, 2008), which means that they view clinical recovery as compatible with their approach. In general, mental illness does not play an important role in the well-being approach. Instead, the focus lies on the different levels of well-being and how to increase it. Hence, PWB and PR can be said to not be on the same continuum. Along the PR continuum, one end would be "Not in PR yet/No coping strategies for mental illness symptoms/Not living well with mental illness" and the other end "Far in PR/Recovered/Living well with mental illness/Being able to cope successfully". Thus, in the PR field, mental illness does not necessarily have to be eliminated to live a fulfilled life, which is in concordance with other studies (Slade, Oades & Jarden, 2017; Davidson & Strauss, 1992). Correspondingly, a study shows that people who show high levels of psychiatric symptoms do not necessarily have low levels of well-being. In turn, individuals with high levels of well-being do not always show low numbers of psychiatric symptoms. This suggests that mental illness might not determine an individual's state of well-being (Hupper & Whittington, 2003) and thus does not frame well-being and mental illness as mutually exclusive concepts. This finding confirms the beliefs of the PR approach. In opposition, on the well-being continuum, there would be "high levels of well-being" on one end, and on the other end "low levels of well-being". Mental illness does not seem relevant on this continuum. Symptoms of mental illness

are seen as interfering with the ability to live well (Fava, 1999). Nevertheless, the dual continua model of mental health (Keyes, 2005) poses as an example for a different approach in that it acknowledges a state called *struggling*. *Struggling* is defined by the simultaneous presence of mental illness and well-being (Keyes, 2002; 2005; 2007; Teng, Venning, Winefield & Crabb, 2015). In this sense, the dual continua model grants room for PR in mental health research, as PR would happen between the states of *floundering*, i.e. the presence of mental illness and absence of well-being (Keyes, 2002; 2005; 2007), and *struggling*. Hence, there might not always a clear dividing line that determines what exclusively belongs to PR, to PWB or to mental health. Rather, there are smooth transitions between the concepts. Still, the focus of PWB does not lie on mental illness, while the PR approach inherently is about living well with mental illness.

The third distinction that was found is that PR is a process, or journey, even if this process can take a life long. This in accordance with earlier research (Dawson, Rhodes & Touyz, 2014; Hay & Cho, 2013; Weaver, Wuest & Ciliska, 2005; Noordsy, Torrey, Mueser, Mead, O'Keefe & Fox, 2002). At the heart of PR lies personal experience and growth. In opposition to its antonyms, such as relapse or deterioration, PR always implies moving or aiming to move towards the better, even if the way is not linear (Cruce, Ojehagen & Nordstrom, 2012). PWB in itself is a state, even though one can improve PWB by WBT, for instance, and hence engage in a process of increasing PWB. This process is linked to an expected outcome level of PWB. In contrast, PR acknowledges the reality of relapse and chronicity, which is not considered as such in PWB practice.

The fourth distinction is the power relation between mental health care users and providers in PWB and PR approaches. In recovery-oriented practice and research, individuals searching help are called "mental health care users", while in the PWB focused practice, they are called "patients". This wording difference reflects the major divergence in power relations exhibited in the two approaches. In recovery-oriented care, the relationship between the service

user and the service provider is defined by equality and respect. The provider's aim is not to work on the individual, but with them: the person is not only seen as the source of the problem, but also the source of the solution. This is in line with the values represented by the concept of PR (Anthony, 1993; Slade, Oades & Jarden, 2017; Leamy, Bird, Le Boutillier, Williams & Slade, 2011; Leonhardt, Huling, Hamm, Roe, Hasson-Ohayon, McLeod & Lysaker, 2017). Contrary to this, in PWB approaches, the patient is naturally dependent on the therapist or carer who is therefore seen as more powerful, an inequality in power relations between the therapist or carer and the service user in traditional inpatient as well as outpatient settings that former research has already pointed to (Braga Arejano, Coelho de Souza Padilha & de Albuquerque, 2003; Szasz, 2007; Theodoridou, Schlatter, Ajdacic, Rössler & Jäger, 2012; Swartz, Wagner, Swanson, Hiday & Burns, 2002). Additionally, it was found out that in the PWB approach clinicians usually view the individual solely as a patient with certain symptoms rather than an individual like themselves. This is also reflected in the findings of another study that showed that how clinicians in the PWB approach treat patients also depends on whether they believe that the origin of illness was more biological or psychological. Their ontological beliefs affected their beliefs about the effectiveness of psychotherapy and pharmaceutical treatment, thus influencing their choice of treatment, while not actually taking into account the patients' opinion (Ahn, Proctor & Flanagan, 2009). Further, a perceived coercion by the service user has been shown to be linked to exhibiting more symptoms, worse global functioning and a more negative relationship between the service user and the carer or therapist (Theodoridou, Schlatter, Ajdacic, Rössler & Jäger, 2012; Sheehan & Burns, 2011). This is an indication for the superiority of recovery-oriented care over traditional care regarding the service user's well-being. To provide recovery-oriented care, service providers have to learn to see service users as individuals and move past exclusively seeing them through the lens of a professional. After a long history of traditional pathology-focused treatment approaches, this might be challenging for service providers but seems to be a necessary step toward PWB in PR.

All in all, despite those shared basic values, the two concepts are not interchangeable. Treatment that focuses on the enhancement of PWB does not necessarily have to be recovery-oriented. Moreover, the general approach of PWB practice is more top-down, meaning that professionals, armed with expertise, work on their patients, than bottom-up as pursued by recovery-oriented care.

### 4.1. Limitations

Despite working to the best knowledge and belief, some limitations of this study and the used materials should be mentioned. First of all, this research was conducted by one person. Despite regular feedback from two supervisors, the comparisons, analyses, and interpretations were based on one researcher's skills. Therefore, the results might be more influenced by the researcher's personal biases and idiosyncrasy than if more researchers had been included. Nevertheless, the supervisor's feedback was a valuable source for reflecting on manners of interpreting and analyzing. In addition, all steps included in the analysis and their reasoning were described in detail in the methods section, which provides maximal transparency. With regard to the selection process of the materials, the only searching platform used to choose the materials for the analysis and to show how relevant those were, was Scopus. Relying on only one platform might have narrowed the output of research. Hence, a search on two or more research platforms might have generated a greater number of studies that may have resulted in broader ground for the choice of materials. Nevertheless, Scopus is recommended as a favorable database for research in psychology (University of Twente, 2019) and articles that appeared after applying the respective search terms were carefully screened by their relevance, number of citations as well as their fit with the approaches of PWB and PR.

Moreover, this study was limited to one material per approach and comparison. Hence, using more than one material per approach and comparison, as for instance the WELLFOCUS

Positive Psychotherapy, an intervention aiming at enhancing PWB instead of ameliorating deficits (Riches, Schrank, Rashid, & Slade, 2016), might have added to the validity of results, as more diversity in materials might have decreased the risk of misinterpretation due to unique aspects of particular materials used. However, all materials were chosen to best knowledge and all were shown to adequately represent the approaches of PWB and PR as described in the methods section.

Building on this, it should be mentioned that the material for the comparisons was not always perfectly comparable and it was necessary to compromise and to accept limitations as just mentioned. Such a compromise further was the selection of the RI. It satisfyingly represents the approach of PR in practice, but simultaneously, it was not scientifically validated by external researchers, i.e. researchers who were not part of the RP. Hence, even though it was built upon empirical research, this empirical research was partly carried out by the same researchers or colleagues.

Moreover, the RSPWB has been compared to the QPR, even though the latter was constructed 20 years. This might have added to differences in theory forming, different approaches to validation processes and the view on well-being and recovery of respective time of development. Therefore, it might be of value to compare scales reflecting PR and PWB that were developed around the same time.

Lastly, the distinct character of the WBT and the RI complicated carrying out an exact comparison of different steps in the programmes and procedures. Consequently, more interpretation was needed which increased the risk of personal bias. Thus, it might have been more valuable to either compare two therapies or two interventions to each other, or both. By that, clearer overlaps and differences could have been extracted.

### 4.2. Implications and Future Directions

Due to the limited amount of material used in this study, it is suggested to replicate this study with more material to validate the findings, as described in the section above. Two or more materials per comparison and approach might uncover aspects of PWB and PR that have not been represented in this study. However, as this study has portrayed the theoretical overlaps and differences of the approaches of PWB and PR, a next step would also be to test those results by conducting empirical research. To current knowledge, no study has yet investigated the relation between both approaches by letting participants fill in questionnaires about PR and PWB, and then comparing the results. The question is how similar results would be and if or how they could complement each other. An inclusion of more items about general PWB in the assessment of PR, for example, might add to an increased representation and understanding of how well an individual is coping and living with mental illness.

Moreover, another question is whether WBT might also be applicable to people in more severe or acute states of mental illness in inpatient settings, as studies point out to the use of CBT for acute treatment of, amongst other, depression (Gregory, C. N., Rohde, P., Lewinsohn, P. M., Hops, H. & Seeley, J. R.(1999). WBT uses a similar strategy - cognitive restructuring (Fava, 1999) - and might therefore, provided together with traditional therapy, also be helpful in acute states of illness. As this has not been tested yet, this might be an option for services and researchers striving towards more recovery-oriented practice to test and try.

Besides suggestions for future research, there are possible implications for clinical practice as well. One aim of this study was to explore how the approaches of PWB and PR might be combined in practice and whether they could mutually benefit. Both approaches provide an enhancement for more holistic treatment in existing care and could approach this aim by different manners. Hence, a combination of an intervention such as the RI, that focuses on the training of mental healthcare workers towards more recovery-oriented attitudes and behaviors, and the WBT might increase positive outcomes for recovering individuals. If

therapists who are providing WBT would work with their patients in a more recovery-oriented approach, their patients might benefit from this. Recovery-oriented care only acts as a frame for the how treatment and care should take place, and consequently needs a treatment base to be integrated in, for instance WBT or other less pathology focused therapy approaches. Well-being treatment approaches such as the WBT fit better in the spirit of PR than traditional pathology focused therapies and adds the scientific expertise about mental illness and health and treatment. Further, empirical research is needed to increase the validity of recovery-oriented care. By this, more professionals can be convinced of the added value of implementing recovery-oriented practices in existing care and recovery-oriented practices could be approved and supported better by the government. To conclude, together the two approaches might build a powerful connection and promote the shift moving further away from pathology focused care in mental health care services.

Apart from (mental) illness, languishing is as prevalent as pure episodes of major depression and is also associated with severe limitations in daily activities such as work cut back (Keyes, 2002). Those individuals are not mentally ill, but they share similar experiences to those suffering from a mental illness. Hence, looking at mental health as more than the absence of illness could in this sense mean to measure PR and PWB levels in languishing people, while excluding mental illness symptoms. Therefore, it might be tested whether a combination of the QPR and the RSPWB, for instance, could be an useful tool to apply to mentally unhealthy individuals.

Concluding, well-being researchers, clinicians and professionals in mental health care service but also health care workers in general might learn from PR research and practice. The treatment of service users in recovery-oriented care might be a valuable model for a more holistic health care system and well-being service. Care providers should not forget that their patients are capable individuals that should be assisted in discovering what kind of treatment is in accordance with their individual needs, abilities, disabilities, and wishes.

## 5. Conclusion

To summarize, more differences than overlaps were found between the approaches of PWB and PR. The main overlap is their shared holistic approach toward the individual. While PWB applies to all individuals and populations, PR can be seen as an approach to PWB in relation to mental illness. Recovery-oriented practice empowers the individual in therapy or care, it encourages the individual to get back in the driver seats of their lives. This approach can add to the PWB approach, which provides the values for PR but has derived from the professionals, such as clinicians and researchers. Combining both approaches by providing more recovery-oriented care together with the empirically validated knowledge and expertise from the PWB approach, and implementing treatment practices focusing on PWB, might be a powerful fusion. As illustrated in the RI, such a change in care does not only change the role of service users but also a change in attitude and working practices with service users by the care providers is needed.

By learning from each other, the two approaches can work towards a future of mental health care that is less pathology-focused and more person-centered, one that enables all individuals to live a meaningful and enjoyable life. Till then, more research is needed to investigate how the approaches of PWB and PR can benefit best from each other. How can the aims of people demanding more holistic and recovery-oriented practice, and the practices, knowledge and guidelines of the PWB approach be integrated best in existing mental health care practices?

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being%22%29+AND+TITLE-ABS-KEY%28therapy%29%29&ss=r-f&ps=r-f&editSaveSearch=&origin=resultslist&zone=resultslist

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# Appendices

## Appendix A

All items of the QPR (Law, Neil, Dunn & Morrison, 2014)

QPR 1 I feel better about myself

QPR 2 I feel able to take chances in life

QPR 3 I am able to develop positive relationships with other people

QPR 4 I feel part of society rather than isolated

QPR 5 I am able to assert myself

QPR 6 I feel that my life has a purpose

QPR 7 My experiences have changed me for the better

QPR 8 I have been able to come to terms with things that have happened to me in the past and move on with my life.

QPR 9 I am basically strongly motivated to get better

QPR 10 I can recognise the positive things I have done

QPR 11 I am able to understand myself better

QPR 12 I can take charge of my life

QPR 13 I am able to access independent support*

QPR 14 I can weigh up the pros and cons of psychiatric treatment*

QPR 15 I feel my experiences have made me more sensitive towards others*

QPR 16 Meeting people who have had similar experiences makes me feel better*

QPR 17 My recovery has helped challenge other people's views about getting better*

QPR 18 I am able to make sense of my distressing experiences*

QPR 19 I can actively engage with life

QPR 20 I realize that the views of some mental health professionals is not the only way of looking at things*

QPR 21 I can take control of aspects of my life

QPR 22 I can find the time to do the things I enjoy

**Appendix B**

All items of the RSPWB (Ryff, Almeida, Ayanian, Carr, Cleary, Coe, … Williams, 2007; Abbott, Ploubidis, Huppert, Kuh & Croudace, 2010).

Positive items are signed by (R)

Autonomy

A1"I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people." (R)

A2"My decisions are not usually influenced by what everyone else is doing." (R)

A3"I tend to be influenced by people with strong opinions."

A4 "I have confidence in my opinions, even if they are contrary to the general consensus." (R)

A5"It's difficult for me to voice my own opinions on controversial matters."

A6"I tend to worry about what other people think of me."

A7 "I judge myself by what I think is important, not by the values of what others think is important." (R)

Environmental Mastery

E1“In general, I feel I am in charge of the situation in which I live.” (R)
E2 “The demands of everyday life often get me down.”
E3“I do not fit very well with the people and the community around me.”
E4“I am quite good at managing the many responsibilities of my daily life.” (R)
E5“I often feel overwhelmed by my responsibilities.”
E6“I have difficulty arranging my life in a way that is satisfying to me.”
E7“I have been able to build a living environment and a lifestyle for myself that is much to my liking.” (R)

Personal Growth

G1“I am not interested in activities that will expand my horizons.”
G2“I think it is important to have new experiences that challenge how you think about yourself and the world.” (R)
G3“When I think about it, I haven’t really improved much as a person over the years.”
G4“I have the sense that I have developed a lot as a person over time.” (R)
G5“For me, life has been a continuous process of learning, changing, and growth.” (R)
G6“I gave up trying to make big improvements or changes in my life a long time ago.”
G7 “I do not enjoy being in new situations that require me to change my old familiar ways of doing things.”

Positive Relations with Others

R1“Most people see me as loving and affectionate.” (R)
R2“Maintaining close relationships has been difficult and frustrating for me.”
R3“I often feel lonely because I have few close friends with whom to share my concerns.”
R4“I enjoy personal and mutual conversations with family members and friends.” (R)
R5“People would describe me as a giving person, willing to share my time with others.” (R)
R6“I have not experienced many warm and trusting relationships with others.”

R7“I know that I can trust my friends, and they know they can trust me.” (R)

Purpose in Life

P1“I live life one day at a time and don't really think about the future.”

P2“I have a sense of direction and purpose in life.” (R)

P3“I don’t have a good sense of what it is I’m trying to accomplish in life.”

P4“My daily activities often seem trivial and unimportant to me.”

P5“I enjoy making plans for the future and working to make them a reality.” (R)

P6 “Some people wander aimlessly through life, but I am not one of them.” (R)

P7“I sometimes feel as if I've done all there is to do in life.”

Self-Acceptance

S1“When I look at the story of my life, I am pleased with how things have turned out.” (R)

S2“In general, I feel confident and positive about myself.” (R)

S3“I feel like many of the people I know have gotten more out of life than I have.”

S4“I like most parts of my personality.” (R)

S5“In many ways I feel disappointed about my achievements in life.”

S6“My attitude about myself is probably not as positive as most people feel about themselves.”

S7 “When I compare myself to friends and acquaintances, it makes me feel good about who I am.” (R)

## Appendix C

Chime model components and components of 6-factor model of psychological well-being

| | CHIME model | Connectedness | Hope and Optimism about the Future | Identity | Meaning in Life | Empowerment | Aspects of six-factor model dimensions not covered in the CHIME model |
|---|---|---|---|---|---|---|---|
| Six-factor model of psychological well-being | CONTENT | Peer support & Support groups (availability and/or becoming a peer support worker or advocate), (intimate) relationships, support from others (professionals und private), being part of the community | Belief in possibility of recovery, motivation to change, hope-inspiring relationships (role models), positive thinking and valuing success, having dreams and aspirations | Dimensions of Identity (ethnic, sexual and collectivistic notions of identity, culturally specific factors), rebuilding/redefining positive sense of self (self-esteem, self-acceptance, self-belief, self-confidence), overcoming stigma (self-stigma and stigma at a societal level) | Meaning of mental illness experience (accepting or normalizing illness), spirituality, quality of life (well-being, meeting basic needs, education, work, leisure activities), meaningful life and social roles (Identification and active pursuit of previous or new roles),<br><br>Meaningful life and social goals (Identification and active pursuit of previous or new goals), | Personal responsibility (self-management: coping skills, self-help, resilience, managing symptoms, maintaining good physical health and well-being, crisis planning, goal setting), positive risk-taking Control over life (Choice; knowledge about illness and treatments, regaining independence and autonomy, Focusing on strengths, access to services and interventions | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | Rebuilding life (daily activities and routine, developing new skills) | | |
| Self-Acceptance | Positive attitude towards self, (self-acceptance,self-confidence, self-reliance) acknowledges and accepts multiple aspects of self (good and bad) qualities: feels good about past life | | Self acceptance in general (RYFF) can be related to positive thinking and valuing the process and the motivation to change (CHIME) | *Rebuilding/redefining positive sense of self (self-esteem, self-acceptance, self-belief, self-confidence), overcoming self-stigma* (CHIME) is related to *positive attitude towards self* and *feeling good about the pas*t (RYFF). Dimensions of Identity (CHIME) is related to *acknowledging multiple aspects of self (good and bad) qualities* | *Accepting or normalizing illness* (CHIME) related to *acknowledging multiple aspects of self and feeling good about/accepting the past* (RYFF). | Focusing upon strength (CHIME) related to acknowledging good aspects of self (RYFF) | *Feeling good about the past* is not explicitly mentioned in the CHIME model. The only aspect mentioned which might be interpreted as reflecting *feeling good about the pas*t is *meaning of mental illness experience (accepting and normalizing it)* |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Positive Relations with others | Warm, satisfying, trusting relationships with others; concerned about welfare of others, capable of strong empathy, affection and intimacy; understands give and take of human relationships | Both highlight all kinds of relationships with others<br><br>→ CHIME somewhat more focused on receiving and support<br><br>→ six-factor model focused on giving and taking and intrinsic motivation to help, involvement of (capacity of) feelings | Having *hope-inspiring relationships (role models)* (CHIME) might be related to *aspects of relationships with others* (RYFF) | | *Meaningful social roles* (CHIME) related to *positive relationships with others* in general (RYFF). | | The importance of *positive feelings in and towards relationships and positive and caring feelings about others* (RYFF) is not explicitly mentioned in the CHIME model. The CHIME model states *intimate relationships* as important, but does not talk about feelings and thoughts towards others. |
| Autonomy | Self-determining and independent; able to resist social pressures to think and act in certain ways; regulates behavior from within; evaluates self by personal standards | Possibly, Being part of the community, thus becoming an active citizen, membership of community organization and contributing and giving back to the community (CHIME), can be related to being self-determining and independent and being able to resist social pressures to think | Evaluating self by personal standards, being independent and self-determining (RYFF) is related to positive thinking and valuing process (CHIME) | Overcoming stigma CHIME) is related evaluating self by personal standards and resisting social pressure to think and act in certain ways (Ryff); Rebuilding and redefining sense of identity (CHIME) is related to self-determinism and being independent and evaluating self by personal standards (RYFF) | All aspects of the Meaning in Life dimension (CHIME) can be related to autonomy, as engaging in behavior that gives life real meaning has come from within the person and has to be decided independently by personal standards, needs, values | *Personal responsibility* and *control over life* (CHIME) is related to autonomy in general (RYFF).<br><br>*Involvement in decision making and access to care* (CHIME) also reflect *autonomy and independence* (RYFF). | The CHIME model does mention *independence and autonom*y as an aspect, but does not move deeper. *Regulating behavior from within; evaluating self by personal standard*s and *being able to rest social pressures to think and act in certain ways* are not covered in the CHIME model.The CHIME model mentions *overcoming stigma, managing symptoms* and *choice*, which do reflect the above mentioned aspects. |

| | | | | | |
|---|---|---|---|---|---|
| | | and act in certain ways (RYFF) | | (RYFF). | |
| Environmental Mastery | Sense of mastery and competence in managing the environment; controls complex array of external activities; makes effective use of surrounding opportunities; able to create or choose contexts suitable to personal needs and values | Creating or choosing contexts suitable to personal need and values (RYFF) is related to establishing new relationships, to being part of the community (CHIME) | Meaningful life, rebuilding life, and social goals and roles and some aspects of Quality of life(CHIME) are related to all aspects of environmental mastery (RYFF). | *Control over life and personal responsibility* (includes all aspects of *self-managemen*t) (CHIME) related to *environmental mastery* (RYFF), positive risk-taking (CHIME) is related related to making effective use of surrounding opportunities (RYFF), Focusing upon strengths and regaining independence and autonomy (CHIME) are related to being able to to create or choose contexts suitable to personal needs and values (RYFF) | All aspects of *Environmental mastery* can be found in the CHIME model, but in more concrete applications and descriptions. The CHIME can be said to miss the generality Ryff's model provides. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Purpose in Life | Goals in life and sense of directedness; feels there is meaning to present and past life; holds beliefs that give life purpose; has aims and objectives for living | Being a part of the community (=active citizen, membership community organization, contributing to community) (CHIME) can be related to a sense of directedness in life and holding beliefs that give life purpose (RYFF) | Goals in life and having a sense of directedness and seeing purpose in life and having aims and objectives for lining (RYFF) is related to having dreams and aspirations and the motivation to change (CHIME) | | Both highlight meaning in life, importance of goals in life, purpose giving beliefs or spirituality, goal-directed living | Involvement in decision-making in care planning (including goal setting etc.) and self-management, especially maintain good physical health and well-being, is related to having goals and sense of directedness and having aims and objectives for for living (RYFF) | Again, all aspects of Purpose in Life can be found in the CHIME model, but it is not that general, but links many aspects to the recovery journey. Thus, for example, instead of *having aims and objectives for living* (RYFF), the CHIME model points out to the *Identification and active pursuit of previous or new life or social goals* (CHIME). |
| Personal Growth | Feeling of continued development; sees self as growing and expanding; open to new experiences; sense of realizing his/her potential; sees improvement in self and behavior over time; is changing in ways that reflects more self-knowledge and effectiveness | Being part of the community and becoming a peer support worker or advocate (CHIME) can be related to the sense of realizing own potential and being open to new experiences (RYFF) | Personal growth in general (RYFF) is related to all aspects of hope and optimism about the future, expecept for hope-inspiring relationships (CHIME) | Overcoming stigma (CHIME) is related to related to growing personally (RYFF) → but no real overlap !! | Meaning of mental illness experience (CHIME) related to change in ways that reflect more self-knowledge and feeling of continued development (RYFF)<br><br>Spirituality (CHIME) linked to open to new experience, feeling of continued development (RYFF)<br><br>Rebuilding life and active | Positive risk-taking and focusing upon strengths (CHIME) related to being open to new experiences (RYFF) and realizing own potential, self-management and control over life (CHIME) is related to more self-knowledge and effectiveness and seeing improvement in self and behavior over time as well as the feeling of continued development (RYFF) | Again, all aspects of Personal Growth can be found in various dimensions of the CHIME model. Still, the aspects of the Personal Growth dimension are not explicitly mentioned in the CHIME model. The whole recovery journey and so the CHIME model are naturally tied to personal growth. Through relearning/refinding/identified/rebuild etc. aspects in one's life, one grows as a person. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | pursuit of social and life goals and roles (CHIME) related to realizing own potential, expanding and growing self | | |
| Aspects of CHIME model dimensions not covered in the six-factor model | The CHIME model lists many aspects of the Connectedness dimension that are explicitly tied to the recovery journey. For example, support from professionals and others enabling the journey etc. and peer support and support groups are not included in the six-factor model by Ryff. Ryff though does claim relationships and support, understanding the giving and taking in relationships and environmental mastery as important, which partly could work | The CHIME model lists many aspects of the Hope and optimism about the future dimension that are explicitly tied to the recovery journey. For example; the belief in possibility of recovery and motivation to change are tied to the recovery process and not anchored in Ryff's concept of well-being. | The CHIME model, again, is more explicit is descriptions of behaviors and more recovery-related. Overcoming Stigma is not listed in Ryff's model, but underlying characteristics and motivations needed to overcome stigma are mentioned, such as for instance: acting according to own needs and values and that own thoughts, feelings and behaviors are not dependent on societal standards. Further, in the CHIME model is more explicit in describing the dimensions of the self (sexual, cultural, ethnic), which is not | The CHIME mode, is more explicit is descriptions of behaviors and more recovery-related, such as accepting and normalizing illness. Those exact behaviors, such as resuming with daily activities and daily routine, are not explicitly mentioned in Ryff's model. Still, as in the other CHIME dimensions, the underlying motivations, feelings and characteristics are described in | The explicit activities related to recovery from mental illness, such as managing symptoms, knowledge about illness and treatments or care planning in general are naturally not explicitly described in Ryff's model. Ryff's dimensions do include the latent motivations/behavior and thought patterns behind those specific actions, such as mastery of external environment, personal growth and acting according to own needs and values for example. | SHORT CONCLUSION: Ryff's model is much more general, is applicable to access level of well-being of all people, while the CHIME model does measure well-being levels of people in mental illness recovery. The level of well-being probably would be similar to level of recovery process, because there is much overlap. The Chime model is much more specific though, naming specific behaviors in recovery that have to be relearned and are aspects of well-being, which is what recovery aims at (YES, does it??). |

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| as the the base for the explicit recovery points in the CHIME model. Still, help from professionals and peer support work are not reflected in Ryff's model. | | the case of Ryff's model. Ryff's sticks to more general terms such as accepting multiple aspects of self (good and bad qualities). | Ryff's model. Spirituality or the development of it was not mentioned in Ryff's model. |

## Appendix D

| RSPPW | |
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| A1“I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people.” (P) | 2 |
| A2“My decisions are not usually influenced by what everyone else is doing.” (P) | 2 |
| A3“I tend to be influenced by people with strong opinions.” (N) | 3 |
| A4 “I have confidence in my opinions, even if they are contrary to the general consensus.” (P) | 4 |
| A5“It’s difficult for me to voice my own opinions on controversial matters.” (N) | 2 |
| A6“I tend to worry about what other people think of me.” (N) | 2 |
| A7 “I judge myself by what I think is important, not by the values of what others think is important.” (P) | 5 |
| E1“In general, I feel I am in charge of the situation in which I live.” (P) | 7 |
| E2 “The demands of everyday life often get me down.” (N) | 2 |
| E3“I do not fit very well with the people and the community around me.” (N) | 1 |
| E4“I am quite good at managing the many responsibilities of my daily life.” (P) | 2 |
| E5“I often feel overwhelmed by my responsibilities.” (N) | 2 |
| E6“I have difficulty arranging my life in a way that is satisfying to me.” (N) | 5 |
| E7“I have been able to build a living environment and a lifestyle for myself that is much to my liking.” (P) | 7 |
| G1“I am not interested in activities that will expand my horizons.” | 3 |
| G2“I think it is important to have new experiences that challenge how you think about yourself and the world.” (P) | 5 |
| G3“When I think about it, I haven’t really improved much as a person over the years.” (N) | 4 |
| G4“I have the sense that I have developed a lot as a person over time.” (P) | 7 |
| G5“For me, life has been a continuous process of learning, changing, and growth.” (P) | 6 |
| G6“I gave up trying to make big improvements or changes in my life a long time ago.” (N) | 9 |

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| G7 “I do not enjoy being in new situations that require me to change my old familiar ways of doing things.” (N) | 3 |
| R1“Most people see me as loving and affectionate.” (P) | 1 |
| R2“Maintaining close relationships has been difficult and frustrating for me.” (N) | 2 |
| R3“I often feel lonely because I have few close friends with whom to share my concerns.” (N) | 2 |
| R4“I enjoy personal and mutual conversations with family members and friends.” (P) | 3 |
| R5“People would describe me as a giving person, willing to share my time with others.” (P) | 4 |
| R6“I have not experienced many warm and trusting relationships with others.” (N) | 1 |
| R7“I know that I can trust my friends, and they know they can trust me.” (P) | 2 |
| P1“I live life one day at a time and don't really think about the future.” (N) | 3 |
| P2“I have a sense of direction and purpose in life.” (P) | 5 |
| P3“I don’t have a good sense of what it is I’m trying to accomplish in life.” (N) | 2 |
| P4“My daily activities often seem trivial and unimportant to me.” (N) | 4 |
| P5“I enjoy making plans for the future and working to make them a reality.” (P) | 6 |
| P6 “Some people wander aimlessly through life, but I am not one of them.” (P) | 4 |
| P7“I sometimes feel as if I've done all there is to do in life.” (N) | 4 |
| S1“When I look at the story of my life, I am pleased with how things have turned out.” (P) | 6 |
| S2“In general, I feel confident and positive about myself.” (P) | 5 |
| S3“I feel like many of the people I know have gotten more out of life than I have.” (N) | 4 |
| S4“I like most parts of my personality.” (P) | 1 |
| S5“In many ways I feel disappointed about my achievements in life.” (N) | 5 |
| S6“My attitude about myself is probably not as positive as most people feel about themselves.” (N) | 2 |
| S7 “When I compare myself to friends and acquaintances, it makes me feel good about who I am.” (P) | 1 |