The Relevance of Well-Being to Clients in Primary Mental Healthcare

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Abstract

Positive Psychology is a science of well-being, studying positive emotions, traits and institutions. While treatment methods of Positive Clinical Psychology focus on enhancing well-being, research on clients' view on well-being in therapy is lacking. The present study addresses this research gap. Within the context of a research project on the Mental Health Continuum Short Form in Practice, 20 clients were observed while filling in the questionnaire. As part of the Three-Step Test-Interview, participants were interviewed on their perceived relevance of well-being, their perceived relevance of the different forms of well-being, and their perceived relevance of measuring well-being. A qualitative content analysis on half of the data (N = 10) revealed that clients in primary mental health care regard well-being relevant to their treatment. Clients appreciate a positive focus in therapy and identify aspects of well-being as part of their personal referral question. Measuring well-being showed to be relevant to clients as they gain an overview of their mental state, and are able to evaluate their treatment process. While clients consider the emotional, relational, and psychological to be relevant forms of well-being, societal well-being is regarded as least relevant. In agreement with well-being theories and findings in the related field of recovery research, the focus in clinical practice is recommended to shift towards a more balanced treatment approach. By measuring and discussing the level of well-being with each client, the therapist can adjust treatments in favour of the clients' needs.

Keywords: Well-Being, Positive Clinical Psychology, Mental Health Continuum Short Form

Introduction

After World War II, the World Health Organisation (WHO) defined health as 'a state of complete physical, mental and social well-being' (1948). Criticism followed, commonly claiming that well-being was difficult to identify and to measure (Ho, 1982). While multiple scholars turned towards these issues, it was the study of Positive Psychology (PP) which gave well-being its most prominent place. PP is a science of well-being, which studies positive emotions, traits and institutions (Seligman & Csikszentmihal, 2000). Based on theories developed in the field of PP, well-being entered clinical psychology in the form of Positive Clinical Psychology (PCP). Within PCP, interventions aim to increase well-being in clients with mental health problems. However, so far these developments are theory-based and in the field of PP and PCP little is known about client's perspective on well-being in clinical practice. The present article addresses this research gap.

Before the client's perspective will be explored, the present article turns towards theoretical knowledge on well-being and starts off by defining well-being on the basis of psychological and sociological theory and research. Two research traditions are most prominent in research on well-being, hedonism and eudemonism. Hedonism describes well-being as the presence of positive affect, life satisfaction and an absence of negative affect (see Table 1). It is also referred to as emotional

well-being and based upon the work of Diener (1984; Diener, Suh, Lucas, & Smith, 1999; Ryan & Deci, 2001). Eudemonic well-being goes back to Aristotle, who emphasized the importance of the realization of one's own potential (Westerhof & Keyes, 2010; see Table 1). Nowadays, it is referred to as psychological well-being and includes experiences like personal development and accomplishment, (Ryff, 1989; Ryff & Keyes, 1995). The current understanding of psychological well-being is based upon the theoretical review by Ryff (1989). Next to these two major traditions, with his work, Keyes (1998) called for attention to social well-being (see Table 1). He added the domain of social well-being by splitting eudemonic well-being into two levels of functioning: "positive psychological functioning" and "positive social functioning" (Keyes, 2007).

For the purpose of this present study, one further division of social well-being will be considered, as interpersonal connections are of little importance in the theories presented above. In fact, the founding father of PP, Martin Seligman (2012) emphasises the importance of positive relationships as a major component of well-being. In his original schematic overview of mental health, Keyes (2007) dedicated two out of 13 dimensions to interpersonal contacts: social integration, and positive relations. Instead, the model emphasises the social group as a whole as the functioning in the social group is represented by five out of 13 dimensions. Considering the importance Seligman (2012) ascribed to interpersonal relations, it seems justifiable to divide social well-being into two different forms of well-being: societal- and relational well-being (see Table 1). Societal well-being refers to the social well-being as brought forward by Keyes (1998); it emphasises the functioning in the social group. Relational well-being focuses on the way one relates to people close by (see Seligman, 2012; Khaw & Kern, 2015). To summarize, in the present study well-being is being defined as a composition of four components: emotional well-being, psychological well-being, societal well-being, and relational well-being, also presented in Table 1.

Table 1

Well-Being in 15 Dimensions

Hedonism/ Emotional well-being	1. Positive affect: cheerful, interested in life, in good spirits, happy, calm and peaceful, full of life 2. Avowed quality of life: mostly or highly satisfied with life overall or in domains of life
Eudemonism/ Psychological well-being	3. Self-acceptance: holds positive attitudes toward self, acknowledges, likes most parts of personality 4. Personal growth: seeks challenge, has insight into own potential, feels a sense of continued development 5. Purpose in life: finds own life has a direction and meaning 6. Environmental mastery: exercises ability to select, manage, and mold personal environs to suit needs 7. Autonomy: is guided by own, socially accepted, internal standards and values

Social well-being	8. Social acceptance: believes people, groups, and society have potential and can evolve or grow positively 9. Social actualization: believes people, groups, and society have potential and can evolve or grow positively 10. Social contribution: sees own daily activities as useful to and valued by society and others 11. Social coherence: interest in society and social life, and finds them meaningful and somewhat intelligible 12. Social integration: a sense of belonging to, and comfort and support from, a community
Relational well-being	13. Positive relations with others: has, or can form, warm, trusting personal relationships 14. Satisfaction with own social network: feels connected to others 15. Feeling supported by others: can turn to others, and ask others for help

Note. Dimensions one to 13 are adapted from "Complete Mental Health Recovery: Bridging Mental Illness with Positive Mental Health" by H. L. Provencher, and L. M. Keyes, 2007, *Journal of Public Mental Health, 10,* p. 59. Copyright 2011 by the Emerald Group Publishing.

Scientist Corey Keyes not only provided theory and research on social well-being, but his work also brought about a differentiation between high and low levels of well-being and provided means of measuring levels of well-being. There are two well-known conditions that may be identified as mental health diagnoses. Firstly, flourishing, a state of high well-being, in which someone enjoys the presence of multiple positive aspects of emotional, psychological, social, and relational well-being. Secondly, languishing, a state in which someone experiences little positive emotional, psychological, social, and relational well-being. The condition in between these states is identified as moderately mentally healthy (Keyes, 2007). In order to be diagnosed as flourishing, an individual has to show high levels on at least one measure of emotional well-being and high levels on at least six aspects of eudemonic well-being (see Keyes, 2007). A state of languishing is identified in the same way. In such a case, the levels are low on the above-mentioned criteria (see Keyes, 2007).

One well-known measurement which is used to identify the state of someone's well-being is the Mental Health Continuum Short-Form (MHC-SF, Keyes. 2005*)*, which shows good psychometric properties. It includes measures on emotional, psychological and societal well-being. Studies investigated this three-factor questionnaire in various countries among healthy samples, and found it to show good reliability and construct validity, see for example, a study in the United States (Robitschek & Keyes, 2009), in South Africa (Keyes et al., 2008), in North Korea (Lim, 2014), in Iran (Joshanloo, Wissing, Khumalo, & Lamers et al., 2013), in Argentina (Perugini, de la Iglesia, Solano, & Keyes, 2017), and in the Netherlands (Lamers, Westerhof, Bohlmeijer, Ten Klooster, & Keyes, 2011). Furthermore, in clinical populations, studies showed that the three-factor model fitted the data best and that the MHC-SF had high internal consistency for the total scale and the three subscales (Franken, Lamers, Ten Klooster, Bohlmeijer, & Westerhof, 2018; De Vos, Radstaak,

Bohlmeijer, & Westerhof, 2018). These results suggest that the MHC-SF based on the theoretically derived aspects of emotional, psychological, and social well-being form the best way of measuring well-being in the healthy and clinical population so far.

Up until now, the present article provided a definition of well-being and how it can be measured. It remains to look at the role of well-being in practice. To this aim, the focus will shift towards mental health care, and towards a model which integrates well-being and the traditional psychological approach. The status-quo in clinical psychological practice is illness-orientated (Maddux, 2009). The focus lies upon the deviant and the maladaptive. The logic behind this is the assumption that reducing the maladaptive can alleviate symptoms and suffering (see Bohlmeijer & Westerhof, 2021). Why should well-being be included in this clinical psychological approach? In fact, current findings point towards a related yet distinct relationship between well-being and psychopathology. This two-continua model includes both well-being and mental illness as two distinct phenomena. Evidence supporting this model in American, English, and Dutch populations is growing (see Keyes, 2005; Lamers et al., 2011; Schotanus- Dijkstra et al., 2016; Weich et al., 2011; Westerhof & Keyes, 2010). This suggests that the reduction of mental suffering alone will not bring about well-being. Instead, well-being needs to be promoted. Bohlmeijer and Westerhof (2021) provided the Sustainable Mental Health Model, in which they propose a way to combine the traditional clinical approach with more recent developments in positive (clinical) psychology. In their model, the traditional outcome measure (reduction of symptoms) of treatment and interventions is extended by the expressions of mental well-being. Three other major components of their model are the adaptation processes and the sources and barriers for adaptation, as the researchers claim that it is important to understand how people regulate their mental health and how these regulation processes are influenced by (dys-)functional thoughts, emotions and behaviour. Further, the model includes the component of contextual factors, which influence someone's mental health. Finally, the model of Bohlmeijer and Westerhof (2021) includes a spectrum of psychological treatments and interventions tackling either the barriers or the sources for adaptation. For all that is known about the interrelation between well-being and psychopathology (see also Bohlmeijer & Westerhof, 2021), the question may not be whether such a model should be applied in practice but when it will be applied in practice.

However, before moving too quickly, one major stakeholder in clinical practice needs yet to be considered: The clients in mental health care. While theory and research of positive psychology on well-being is abundant, the clients' perspective has not yet been explored. As a matter of fact, research in the field of positive psychology as a whole has been criticised for its lack of qualitative studies (Morgan, 2007). By making use of a qualitative approach, the current study responds to this criticism and tries to shed light on the perspectives of clients on well-being in therapy.

Fortunately, in order to explore the opinion of clients on treatment outcomes, an abundance of qualitative research from the field of recovery can be considered. Here, the patient-perspective not only changed the definition of recovery, but also the emphasis of the different components of recovery. In the early 1970s a user/survivor movement developed and criticised the pathological focus and the victimization of patients in mental health care. Back then, recovery was clinically defined as a reduction of symptoms and the absence of diseases (Macpherson et al., 2016). In contrast, the movement wanted recovery to be defined in abilities of living a valuable life (Knifton & Quinn, 2013). The result of the efforts of the movement was amongst others a great body of literature based upon narrative studies (Silverstein & Bellack, 2008) and plentiful written personal experiences (Ridgway, 2001; Spaniol & Koehler, 1994). A new definition of recovery developed.

> Recovery is [...] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/ or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993, p. 527).

The emphasis now lay upon experiences such as hope, identity, meaning and personal responsibility (Slade, 2010; Andresen, Oades, & Caputi, 2003).

In 2011, a systematic review of the above-mentioned qualitative data on patients' perspectives on recovery resulted in the theoretical CHIME framework (Leamy, Bird, le Boutillier, Williams, and Slade, 2011). In the present article, the CHIME framework will be used to compare the recovery-based theory with the theory on well-being from PP. CHIME is an abbreviation for the recovery processes identified: connectedness, hope and optimism about the future, identity, meaning in life, and empowerment. Leamy et al. (2011) propose that the CHIME framework can help practitioners to evaluate the progress of clients on these aspects in order to facilitate the process of recovery. In Table 2, the recovery processes of the CHIME model and the 15 dimensions of well-being are being compared.

Table 2

The CHIME Framework and the 15 Dimensions of Well-Being Compared

The CHIME Framework	**15 Dimensions of Well-Being**	**Form of Well-Being**
Connectedness	Social acceptance	Social
	Social integration	Social
	Positive relations	Relational
	Satisfaction with own social network	Relational
	Feeling supported by others	Relational

Hope and optimism about the future	/	/
Identity	Self-acceptance	Psychological
Meaning	Purpose in life Social contribution	Psychological Social
Empowerment	Environmental mastery Autonomy	Psychological Psychological

Interestingly, the forms of well-being resemble the elements in the CHIME model to a great extent, which was supported by a more recent study by de Vos et al. (2017). Ten dimensions of well-being show overlap with the content of the CHIME model, while five dimensions cannot be identified in the CHIME framework (see Table 2). For example, the CHIME framework does not seem to include the dimensions of hedonic well-being. The experience of positive emotions, a sense of pleasure in life and life satisfaction. The same holds true for the dimensions of personal growth, social actualization and social coherence. Looking from the side of recovery, four out of five elements of recovery are present in the dimensions of well-being (see Table 2), while the element of hope and optimism about the future is lacking. Patients' view on well-being and recovery has been investigated by de Vos et al. (2017). In a systematic review and a qualitative meta-analytic approach, the researchers explored qualitative studies on eating disorder patients' perspectives on the concept of recovery. They found that these patients regarded dimensions of psychological well-being and relational well-being as important. Translating these comparisons to the topic of investigation, one may predict that mental health care clients find the forms of relational, psychological and partly societal well-being relevant to their treatment. Yet, the theoretical model of well-being does not completely match the CHIME framework. For this reason, it is important to investigate the client perspective on well-being and explore the elements that clients find important with regard to the outcome of mental health care in measures of well-being.

This study aims to explore the views of clients on the concept of well-being as part of their therapy in primary mental health care. Especially in primary mental healthcare, positive clinical psychological approaches have gained more prominence, and clients here are acquainted with the positive approaches. In this context, the current research aims to answer the following research questions: What is the relevance of well-being to clients in primary mental health care? What is the relevance of the different well-being forms to clients? In what way is it relevant to clients that their well-being is being measured?

Method

Design

This qualitative study is part of a larger research project by Pauline Schuffelen on sustainable mental health (see Bohlmeijer & Westerhof, 2021). The research took place in the Netherlands in the setting of *Mindfit,* a primary mental health care facility working with the sustainable mental health model. Clients from Mindfit were recruited and in the context of an observational interview asked to complete the Mental Health Continuum Short-Form-Practice (MHC-SF-P). This measurement is part of the standard procedure within Mindfit before and after treatment of a client. As part of the interview, the clients were asked about their perceived relevance of well-being in the setting of primary mental health care.

Participants

The sample consisted of two men and eight women (N = 10) with a mean age of 29.6 years *(*SD = 9.37). The average time of treatment until the point of the interview was 3.8 months (SD = 2.82). The educational level varied from primary school to university level. With regard to the reason for referral, half of the clients mentioned depressive symptoms (n = 5), four clients mentioned anxiety symptoms, other reasons for referral varied from tantrums, traumata to burn-out. Notably, two clients reported a combination of depressive and anxiety symptoms. Table 3 shows a detailed overview of the characteristics of the participants, and shows that a diverse group of clients in primary mental health care was recruited. Every participant completed the interview session and all data could be included in the study.

Table 3

Sample characteristics

Participant	Gender	Age group	Educational Level	Reason for referral	Months in treatment
1	f	25-30	University	Depressive symptoms	3
2	f	25-30	Intermediate vocational education	Depressive symptoms	2
3	m	45-50	Primary school	Tantrums	2
4	f	18-20	Higher vocational education	Depressive symptoms	10
5	f	25-30	Intermediate vocational education	Depressive and anxiety symptoms	2
6	f	25-30	Intermediate vocational education	Traumata	1
7	f	35-40	Intermediate vocational education	Burn-Out	2
8	f	20-25	Pre-University education	Generalized anxiety and depressive symptoms	5
9	f	40-45	Higher vocational education	Anxiety symptoms	4

10	m	20-25	High school	Anxiety symptoms	7

Note. m = male, f = female.

Materials

Mental Health Measure

In the context of the larger research project, an adjusted version of the well-known Mental Health Continuum Short-Form (MHC-SF; Keyes, 2002) was being used. The Mental Health Continuum Short-Form Practice (MHC-SF-P) differs from the original questionnaire in three ways: Its items are formulated in a simpler manner, the time of reference is adapted from one month to one week, and items concerning interpersonal relationships are added. By this, the MHC-SF-P not only addresses social well-being as functioning in society as a whole, but also addresses interpersonal relationships, and connections to dear ones and friends. The MHC-SF-P is meant to be easy to use in practice, which is indicated by the *P*.

This self-report measurement contains 19 items and covers four subscales of well-being (social, psychological, relational, and emotional). Participants are asked to indicate how often a specific feeling was present in the previous week on a zero (*never*) to five (*almost all the time*) Likert scale. An exemplary item of relational well-being is "I feel connected to others". See Appendix B for the complete MHC-SF-P. The questionnaire is currently under investigation with regard to its psychometric properties. Yet, the original version of the MHC-SF has proven to be reliable and valid in multiple contexts and cultures (see Robitschek & Keyes, 2009; Keyes et al., 2008; Lim, 2014; Joshanloo et al., 2013; Perugini et al., 2017; Lamers et al., 2011). Furthermore, studies in clinical populations showed that the MHC-SF had high internal consistency for the total scale and the three subscales (Franken et al., 2018; De Vos et al., 2018).

Interviewing Method

As the main research project investigates how participants understand and fill in the MHC-SF-P, the Three Step Test Interview (TSTI; Hak, van de Veer, & Jansen, 2008) was used. The TSTI is an interview-strategy used to make internal thought processes observable, which take place when someone is filling in a questionnaire. The aim of this technique is to understand how questions are perceived, processed, understood, and replied to by participants (Hak et al., 2018). It consists of three steps: (a) observation of response behaviour, (b) follow-up probing aimed at remedying gaps in observational data, and (c) debriefing aimed at eliciting experiences and opinions.

For the use of the current study, the TSTI was extended with questions on participant characteristics and on the perceived relevance of well-being and the questionnaire. After participants reported on their time in treatment and reason for referral, participants practiced thinking out loud with the help of two practice questions. Afterwards, the first two steps of the TSTI followed. As part of the last

step, participants were asked to report their general opinion on the questionnaire. An example of a question asked is “how did you experience filling in the questionnaire?”. Subsequently, the interviewer provided information on the four different forms of well-being (see Appendix A). Then additional questions were asked like “how relevant are the questions on well-being to you?”, and “how relevant are the different forms of well-being to you?”. Finally, the researcher provided a metaphorical example to illustrate the relationship between well-being and psychopathological symptoms. The example consisted of a red and a blue suitcase, illustrating someone’s symptoms and someone’s sources for well-being, respectively. Then questions were asked like, “now that you received more information, how important are the questions on well-being to you and to your treatment?” See Appendix A for the complete protocol of the study.

For the purpose of this current study, the answers of clients on questions about the relevance of well-being in therapy, answers on questions about the relevance of measuring well-being in therapy, and answers on questions about the relevance of the different forms of well-being were being used in order to answer the above-mentioned research questions.

Procedure

Mindfit has multiple offices in the Netherlands. In the background of a purposive sampling method, therapists of five offices were approached and asked to recruit four clients each, ending up with a total of 20 clients. Due to time restrictions, the present study included a sub-sample of 10 clients. Participants were selected with the goal of creating a heterogeneous sample with regard to educational level and length of treatment at Mindfit.

For the one-on-one sessions, the participants were invited to the practice of Mindfit located closest to them. After they gave their informed consent and after they had time to ask questions, the researcher introduced the interview technique, the TSTI. Then, the participant was asked to fill in the MHC-SF-P, while the researcher stayed in the room to allow close observation of this process. Following, all steps of the TSTI were completed. The session took about 45-60 minutes and the participant was rewarded with an online-shop voucher with the value of 15€. Each session was audio-recorded and later transcribed and anonymised. The procedure of the research project was approved by the BMS ethics committee/*Domain Humanities and Social Sciences* (Project number 210049).

Analysis

The transcribed text data was analysed with the method of a content analysis. Three steps, were followed: (a) source description, (b) selection of the analysis method, and (c) carrying out the analysis (see Mayring, 2015). Step one, the source description consisted of making an overview of the sample characteristics (see Table 3), analysing the context in which the data was collected (see Design), and describing the knowledge and possible biases of the analyst.

Description of the Knowledge and the Possible Biases of the Analyst

Before the actual data was analysed, the analyst reflected on her role in the analysis process: *The analyst is a master student of the program Positive Clinical Psychology and Technology. The content of this program focuses on positive psychology and its application in clinical practice. Thereby, the researcher has theoretical knowledge in this field. This may facilitate a one-sided look, as the researcher is used to looking at psychology from the positive perspective. It may have influenced the probing during the interview, as she might have expected that the participants value the positive approach of the questionnaire.*

Furthermore, the analyst is an intern at the institution Mindfit. This may underscore the affiliation of the way Mindfit is working and the analyst might want to make the institution look good. Therefore, the analyst needs to be aware of her double-role relationship with the institute and let go of her role as intern during the analysis process. Furthermore, the analyst has to be cautious of the possibility of a confirmation bias (looking for confirmatory data only).

By consciously reflecting on her biases in the beginning, the analyst could stay aware of them during the analysis process and reduce interpretation biases. To this end, the analyst engaged in reflexive journaling. This entailed that the researcher kept a journal of the analysis process, describing her possible biases and thoughts after each transcript she analysed. This method was explored by Barry and O'Callaghan (2008) who concluded that it is highly useful for self-evaluation and understanding of contextual influences.

Selection of the Analysis Method

During the second step, an inductive content analysis was chosen as the method of analysis. This method was most appropriate for the data obtained, as no theories exist that could lead the coding process. The goal of this study was to get an insight into the view of the client, and this could only be accomplished with a bottom-up approach. Such a method comes with the advantage of a clean and unbiased overview of the data (Hsieh & Shannon, 2005). A risk of this method is to misinterpret and falsely represent the data and the challenge is to derive the correct key concepts (Hsieh & Shannon, 2005). Here again, reflexive journaling can help to counteract misinterpretations (Barry & O'Callaghan, 2008).

During the process of analysis, the method of Mayring's inductive content analysis (2015) was followed. His method starts with the determination of the topic of coding and the determination of selection criteria for the material to be coded. In the current study, three topics of coding were determined based on the three research questions of the present paper: (a) the relevance of well-being to clients, (b) the relevance of the four different forms of well-being to clients, and (c) the relevance of the measurement of well-being to clients. The selection criteria for the material of investigation followed, accordingly. Text would be coded if it was in the form of sentences/words/written

observations of the interviewer, which indicated either the (in-)significance of well-being to clients, or the (in-)significance of the four forms of well-being to clients, or the (in-)significance of the measurement of well-being to clients. Importantly, these topics and the selection criteria did not determine the name or the content of the codes, in contrast, they guided the selection of the relevant text data that still needed to be coded.

The coding unit was set to *one coherent thought process*, while the analysis unit was set to one whole transcript. This means that in one transcript, there could be multiple coding units. A coding unit could consist of multiple sentences or even multiple paragraphs. The coding units of each transcript were determined during the analysis process, which held the following steps. Firstly, the researcher read through all 10 transcripts and made notes to capture first impressions. Then, the researcher started with the first transcript, in which relevant text data, determined by the selection criteria, was identified. Coding units, meaning coherent thought processes were highlighted and a code was created, which resembled the content of the text as closely as possible. This process was repeated for the whole first transcript. By means of constant comparison (Parry, 2004), the researcher could identify possible contrary thought processes within one transcript. Such contradictions were highlighted and later taken into account during interpretation of the results. Similar codes were grouped and formed a category.

These steps were repeated within all transcripts. After each set of three transcripts, the researcher compared the codes, and categories created so far and grouped similar codes and categories into categories and concepts, respectively. This process is demonstrated by an example in Table 4.

Table 4

An Example of the Coding Process

Step 1	*Step 2*	*Step 3*	*Step 4*	*Step 5*
Original Text	**Code**	**Category**	**Sub-Concept**	**Concept**
R: How relevant is the society and being connected to others to your referral question? *P*: Positive feelings and being connected are relevant. *T8, p. 29*	Being connected to others is relevant	Being connected to others is relevant		
R: How relevant are these questions on well-being to you? *P*: I think very relevant, especially those about the connection to other people. *T4, p.19*	Being connected to others is relevant			

P: I am more concerned with a small group of people around me. *T2, p. 13*	Concerned with small group of people	Only close people are relevant	Connection with others	Importance of well-being
P: You know, the people close to me, those who come and visit. The others, I don't care. *T5, p. 21*	People close by are relevant			
R: Feeling at home in society is that part of your referral question? *P*: Back then, yes! Because of my anxiety disorder I didn't feel home in society. *T5, p.21*	Society is part of referral question	Society is part of referral question	Society	
P: I am not really concerned with society. *T2, p.13*	Not concerned with society	Society is less important		
P: Feeling at home in society is of little relevance to me *T4, p.20*	Society is of little relevance			
P: Questions that are less important to me are those related to society. *T7, p. 16*	Society is less important			

Note. R = researcher; *P* = participant; *T* = transcript; *p* = page. Step 1 entails: Identifying relevant thought processes according to the selection criteria; Step 2 entails: Creating the code; Step 3 entails: Comparing codes and creating categories. Step 4 entails: comparing categories and creating sub-concepts; Step 5 entails comparing sub-concepts and creating concepts.

In order to illustrate the process of coding, the last three rows of Table 4 will serve as an example. First, in the process of reading the transcript of participant two, relevant text data was identified on page 13. It was relevant as it fulfilled the selection criteria: being text data in the form of sentences, which indicated the insignificance of well-being to the client (Topic 1). The coding unit was one coherent thought process, in this example presented in one sentence. The researcher added the code "Not concerned with society" to this coding unit. Then, in the transcripts of participant four and seven, similar codes were created: "Society is of little relevance", and "Society is less important". Due to their similarities, the researcher created a category out of these codes, being: "Society is less important". In the transcript of participant five, the researcher identified one other category concerning the relevance of the society to clients: "Society is part of the referral question". Both categories form the sub-concept *Society.* The sub-concepts *Society* and *Connection with others* belong to the concept *Importance of Well-Being,* which also was identified by looking for similarities in the sub-concepts. Note that this example is not exclusive, instead all concepts, sub-concepts, and categories will be presented in the results section.

While the above-mentioned steps were followed, coding rules were created and applied. The rules applicable to the data of the present study were:

1. Include expressions of participants that are linked to a question, but which vary from the wording of the question.
2. One coding unit may hold more than one code.
3. One code may belong to more than one topic.
4. Answers on questions about the referral question are coded as belonging to coding topic one.
5. If the content is clearly related to the relevance of the items of the questionnaire, code it as belonging to coding topic three.
6. Create Dutch codes first, then translate the codes while staying as close to the meaning of the text as possible.
7. Check the newly created codes for similarities after every set of three analysed transcripts.

Carrying out the Analysis

The final step of the method by Mayring (2015) was to carry out the analysis and to proceed within the order of the steps as previously determined. The obtained results are presented below.

Results

In this study, 10 clients in primary mental health care were interviewed on their view on well-being. The analysis of the transcripts resulted in 37 categories; codes constructed as closely as possible to the raw text data, 12 sub-concepts, and six concepts. The result section is organized into the three different research questions. In order to validate the constructed (sub-) concepts, short quotations of clients are added, after they have been translated from Dutch to English.

Research Question 1

The analysis showed that in order to answer the question of how relevant clients find well-being in their treatment, one has to consider two main concepts: (a) the importance of well-being, and (b) the positive focus in therapy (see Table 5).

Table 5

Research Question 1

Sub-Concepts	Category	Code	Participants
IMPORTANCE OF WELL-BEING			

Well-Being in general	Well-Being is important	17	9
Positive feelings	Positive feelings are important	10	7
Self-Development	Self-Development is important	3	3
Connection with others	Being connected to others is relevant	5	5
	Only close people are important	2	2
Society	Society is part of referral question	1	1
	Society is less important	10	5
POSITIVE FOCUS IN THERAPY			
Positive focus	The positive focus is important to develop one's strengths and resilience	8	4
	The positive focus is important as it decreases symptoms	2	2
More information on the positive focus	The explanation on the positive focus helps the client to understand the differentiation between symptoms and well-being	13	9
	The explanation on the positive focus is needed	2	1
Referral question (RQ)	Well-being is related to the RQ	11	9
	Not all aspects of well-being are related to the RQ	2	2
Room for complaints	The client is used to focus on the negative	6	3
	The client wants room to express the negative	6	5

Note. The overarching concepts are displayed in bold upper-case letters. The sub-concepts, grouping the categories are displayed in column *Sub-Concepts.* Column *Code* shows the number of times the category was coded in all transcripts. Column *Participants* displays the number of participants' transcripts the category was coded.

1a. Importance of Well-Being

Well-Being in General. When asked whether well-being is important to them, all but one participant explicitly stated that they find well-being relevant to their therapy. The other participant did not make an explicit statement about her perceived relevance of well-being.

"I think it is really important to not only focus on the negative, because you don't always score progress with a negative approach. Maybe you can gain more strength out of the positive, the things that are already there and what you are already capable of." (P4, p.22). This statement is representative of the trend that most clients find a focus on well-being relevant and useful. Analysing the answers further, it became clear that next to a general perceived relevance, most clients differentiated which aspects of well-being they found important. In this way, four sub-concepts could be identified. These highlight the nuances in the question whether well-being is relevant to clients.

Interestingly, these sub-concepts resemble the four different forms of well-being. However, the quotes considered here arose out of the context when discussing well-being in general, and not when discussing the four forms in more detail.

Positive Feelings. Seven clients reported that they find well-being important and that especially positive feelings were an important aspect to them. This means that more than half of the clients explicitly stated that a focus on positive feelings in therapy is relevant to them. One representative quote is: *"(…) Because I think that, what we said before, that it is important to increase people's happiness and that people are feeling well." (P1, p.22).*

Self-Development. Three clients reported that they thought of self-development as a very important aspect of well-being. However, this was never exclusively the case. All of these three clients always found either positive feelings or the connection with others equally important: "*Yes, exactly [being connected to others], and being able to be yourself (…) and positive feelings. I guess all this will follow when you are happy with yourself." (P10, p.24).*

Connection With Others. Six clients reported that well-being was relevant, but that close connection with other people was either the most important element of well-being to them or was important in combination with other experiences like positive feelings. "*I think it is extremely relevant. Especially the last part which refers to other people. If you don't feel connected at all, then you are on your own, then you feel rather alone. That is such a different feeling than when you feel supported." (P4, p.19).*

Notably, two clients made the distinction that to them only their close social network was important: "*I don't bother myself with the society. I am concerned about a couple of people close to me. (…) then, I really don't see further than the end of my own nose." (P2, p.13).* This analysis shows that especially interpersonal connection is of importance to clients in therapy.

Society. A final remark made by clients when discussing the relevance of well-being was that the societal aspect was the least important part of well-being. Only one client reported that in the past it had been important to her to feel part of society again. She described how she had suffered from panic attacks and that she was unable to do her shopping on her own. For her, being able to do this meant being part of society again, which felt like freedom to her. However, after her struggles were over, being part of society was not the most pressing issue to her anymore: *"Thus, back then – yes – but not anymore. Now, I simply go to the shop. This is not an issue anymore." (P5, p.21).* Just like participant 5, most clients reported that they find the societal aspect the least important. Five clients explicitly stated that they wouldn't mind if the wider social aspects of social well-being, like society and country development, would not be covered during therapy. See for example the following quote: *"Well, as I said, the part with feeling at home in society, I wouldn't need that. It is not*

relevant for a possible diagnosis, treatment or continuation of treatment. This is not where I find my core problem to be. All of the three other aspects are more relevant to me." (P9, p.17).

1b. Positive Focus in Therapy

Positive Focus. When discussing the relevance of well-being to clients in therapy, participants also spoke of the general positive focus in therapy and how relevant this was to them. Five clients named advantages which they thought were coupled to such a positive approach. They believed that a positive approach in therapy helps the client to regain his/her strengths and to build his/her resilience. Furthermore, one client mentioned: *"When you progress in this positive development, then the red [suitcase, the problems] will decrease and will become more endurable." (P7, p.21).* Notably, by this the client drew a link between well-being and symptomology, seeing that when well-being increases her symptoms can decrease.

More Information on the Positive Focus. At the end of the interview, clients were presented with a metaphorical example, which explained the approach of positive psychology. Then, clients were asked whether they appreciated such an explanation and what they thought of such a positive focus in therapy. All participants thought that the explanation was helpful. Arguments in favour were that it was helpful to differentiate between symptoms and what is still going well, and that more information on the positive approach engages the client. *"Yes, very much so. (…) it is in fact very helpful to receive more information. This explanation is visual, especially with this figure. (…) this way of explanation makes it clear to the client that it is not only a linear relationship. There are multiple parts in these suitcases. A very nice visual form." (P6, p.30). "In this way you really get that there is a difference between those two things. You don't have to look at the negative to get rid of your symptoms. If you also look at the positive, you notice what you can rely on." (P4, p.23). "I like to receive extra information to get it myself, instead of simply hearing it from others." (P8, p.30).*

One client explicitly mentioned that she believed such an explanation was essential for the start of a therapy with a positive psychological approach: *"This explanation would have been helpful to me. (…) I think that there are many people, like me, focussed too much on the red suitcase. Then, such a positive approach really forms a contrast. So much that you might wonder: 'Are we actually going to talk about the core, here?' This would be my advice, to explain it at the beginning. Be aware that people might not be ready for [the positive] approach immediately. (…) this would be my advice; make it even more clear to clients [what the approach entails.]" (P9, p.22).*

Referral Question. At another point of the interview, the clients were asked whether they could see a relation between well-being and their personal referral question at the start of therapy. While one participant answered in the negative, the analysis showed that for nine clients the reason why they sought help was related to the concept of well-being: "*(…) as I said, the reason I came*

here, these questions are related to this. To me, this is really highly relevant, yes." (P10, p. 24). Nine clients reported that aspects of their referral questions had an overlap with aspects of well-being. *"Yes, positive feelings. In the beginning I was very negative. We worked on this quite a lot, to be more focussed on enjoying the small things, (…) back then, my feelings were turned off." (P5, p. 19).* In contrast, one participant mentioned: "*No [these questions are not related to my referral question]. My problems are my tantrums" (P3, p.32),* by which he referred back to his issues.

Notably, two of the nine clients made a distinction in the different forms of well-being and reported that to them especially the wider social aspects were not related to their referral question: *"Well, at the moment it really is about 'me'. Not so much about the things outside me. Therefore, this really doesn't feel that relevant to me at the moment." (P6, p.27). "Currently, I am busy daring to show more of myself. Thus, the first three questions on happiness, interest and being content, are somewhat related, and also the way I am dealing with my social contacts. Apart from that, I don't see much relation of the other aspects to my referral question." (P2, p.19).*

Room for Complaints. The last sub-concept identified is related to the previously discussed concepts. Next to the positive focus in therapy, clients were looking for ways to share their problems and suffering. The analysis shows the importance of room for complaints in two ways. Firstly, three participants described that a clients' state of mind at the beginning of therapy is rather negative and would need to get used to a positive approach. "*It was explained to me that we would (…) focus on my strengths. I believed that it was helpful, yet I had to get used to this approach." (P9, p."21); "You ask for help often because the negative is so pressing and [because the red suitcase is] completely full*." (*P6, p.29).*

Secondly, the clients mentioned that they needed the room to address their problems in order to clear their heads. *"Of course, you also need to address the negative (…)" (P2, p.21); "After the approach [at Mindfit] was explained to me, I thought: 'Well yes, we can do all this, but this (points at red suitcase), this is bothering me. I need to talk about this, I need to get the room, get it all out." (P9, p.21).* The analysis shows that the majority of the participants value the positive approach and perceive well-being as a relevant addition to their treatment. However, the majority also finds it important to experience support when they feel the need to talk about the negative, their problems and symptoms.

In Conclusion. Shortly summarized the findings above show that clients in primary mental health care find well-being relevant in their treatment. Of their own account, clients name aspects of well-being which they find more/less relevant than others. Positive feelings and social contacts are relevant to clients, while societal well-being is the least relevant. As for the positive focus in therapy, clients see such a positive approach as relevant, as they see advantages of such an approach.

Participants also appreciate additional information on the approach of therapy and would like to have the room to talk about their problems as well.

Research Question 2

In order to answer the research question regarding the relevance of the four different forms of well-being, the participants were introduced to the four forms during the interview. The analysis shows that clients made statements on two main aspects regarding the four forms of well-being: (a) the relationship between these forms, and (b) the relevance of the forms. These two concepts resulted from the grouping of multiple categories and sub-concepts (see Table 6).

Table 6

Research Question 2

Sub-Concepts	Category	Code	Participants
RELATION BETWEEN THE FORMS			
Interrelation	The forms are interrelated and form well-being	15	9
Distinction	The forms stand alone	4	4
IMPORTANCE OF THE FOUR FORMS			
Importance in general	All forms are equally important	3	3
	The importance of the forms depends on one's symptoms	3	2
The four forms	Positive feelings are important	9	6
	Being- and developing yourself is important	12	8
	Social contacts are important	16	8
	Feeling part of society is important	2	2
	The society is least important	12	7

Note. The overarching concepts are displayed in bold upper-case letters. The sub-concepts, grouping the categories are displayed in column *Sub-Concepts.* Column *Code* shows the number of times the category was coded in all transcripts. Column *Participants* displays the number of participants' transcripts the category was coded.

2a. The Relation Between the Four Forms

Interrelation. During the interview, the clients shared their view on the relationship between the four forms of well-being. All but one participant explicitly reported that to them the forms were interrelated and that a combination of all forms determined the level of well-being. The other client did not mention his view on the relationship of the forms. Note, that the category - *The forms are*

interrelated and form well-being - was applied to clients mentioning two to four forms being interrelated. While some clients could see an overall relationship between all four forms of well-being, others merely saw two or three forms being interconnected and pointed out their interdependence: *"Yes, I understand how all of these four parts form you as a complete person. The outside as well as your inside, each can positively influence each other. And then, the people close to you, and of course how you look at your own life and how you rate your life. Thus, all pieces form one." (P6, p.24); "[Positive Feelings] shares the TOP 1 with being able to develop yourself. I think those two are closely related. If you can be yourself and if you can develop yourself, you may experience positive feelings about these developments." (P2, p.19).*

Distinction. As opposed to seeing an interrelation between the different forms of well-being, four clients remarked that the forms were unconnected and were standing alone: *"They are all different. Thus, you are talking about four very different experiences." (P2, p.17).* Interestingly, the two opinions on the relationship of the forms co-existed within participants. The last quotes were taken from one transcript (participant 2). This tendency recurred in the interviews of a couple of participants. Two observations could be made. Firstly, some clients held overlapping opinions on this matter. See participant 5: *"All of the four [forms] stand alone. Well, of course they are partly connected. Yet, I think that they can stand alone and that you can experience the one but not the other." (P5, p. 18).*

A second observation was that some participants adjusted their opinion after having received more information on the four forms of well-being. See participant 6 as an example: *"That is, now that I know this, it all makes more sense also why the society is included. At first, this really felt unrelated, but after you explained it like this, I think: 'yes, all is interrelated. Now, I get why it is included in the whole." (P6, p.23).* She adjusted her opinion after having received information on the four forms of well-being.

Altogether, it can be said that the majority of the participants viewed the four forms of well-being as interrelated and viewed them as logical and important parts of well-being. Some clients see the forms as distinct yet related.

2b. The Importance of the Four Forms

Importance in General. Next to the relation, the analysis showed how relevant each form of well-being was to the clients. Only three participants mentioned that to them all forms were equally important. Others were more exclusive about the importance of one or two forms of well-being. Furthermore, two clients remarked that the relevance of the forms to someone were dependent on one's symptoms, suggesting, that individual opinions may not be generalized to each client. However, the analysis resulted in a clear trend regarding clients' perceived relevance of the different forms of well-being. Each form will be discussed in detail below.

The Four Forms.

Positive Feelings. Six participants mentioned that to them positive feelings were the most important form of well-being. Suggesting that more than half of the participants valued especially dimensions of hedonic well-being. *"I felt negative for a long time, thinking negative as well. Thus, I think that the positive feelings are really important." (P4, p. 20). "For well-being, you just need to be like you are. You got to know: 'This is me; this is how I fit in society.' And, yes, you need to develop and be happy and feel positive. I think that those two are the two most important in order to have high levels of well-being." (P10, p.21).*

Being- and Developing Yourself is Important. Eight clients reported that being able to be themselves and their personal development were the most or one of the most important forms of well-being: *"Very much the part of being able to be yourself and to develop yourself. This part feels most important." (P7, p.17).* Notably, some clients valued personal development as in their view it would bring about more positive feelings: *"(...) if you are still mentally challenged to grow, this supports positive feelings." (P9, p.18).* This suggests that at least the dimensions, self-acceptance and personal growth, of psychological well-being are relevant to clients.

Interpersonal Connection. Eight clients rated interpersonal connection as the most or one of the most important form(s) of well-being. Here, one participant explicitly states that her insecurities decreased through the social contacts she enjoyed: *"The insecurity is for example related to less social contacts, when you share less with others, you receive less recognition. Recognition would lead to less insecurity, because you know that you are not alone in your experiences" (P2, p.26); "I think that the social aspect of feeling connected to other people is really important. I felt rather lonely when I didn't have much social contact." (P1, p22).* This points towards the trend that clients see relational well-being as highly relevant.

Society. Only two participants thought that being part of society is an important aspect of well-being, while seven clients thought that society is the least important form of well-being and one participant didn't say anything on this matter. One of the two clients was discussed in the section on research question one. Participant five described that societal well-being was important to her only while her symptoms were pressing. One other client, who thought that the societal aspect was important, mentioned: *"Again, it is related. In the end, all other aspects make that you find your place in society and that you can feel well and function well in society" (P1, p.24).* Here, the client shared the view that the forms are related and one follows from the other.

The majority of clients felt that the societal aspect was less or even least important to them: *"Feeling home in society is not yet relevant to me." (P4, p.20); "If I had to choose one that I find least important, I would say: feeling at home in society." (P8, p.26).*

In Conclusion. Clients in primary mental health care see the forms of well-being as being interrelated, yet distinct. This shows that the concept of well-being and its different forms is complex and that an opinion on the forms is influenced by the view of their relationship towards each other. When explicitly discussed, clients name positive feelings, social contacts, and personal development as important aspects of well-being. Societal well-being is seen as the least important form of well-being.

Research Question 3

With the aim of answering the last research question – In what way is it relevant to clients that their well-being is being measured during treatment? – the clients have been posed questions on this matter during the interview. The analysis shows that the answers of clients can be categorized into two main concepts: (a) the relevance of the questionnaire as a whole, and (b) the relevance of single questions. The first concept is related to participants' overall opinion on the MHC-SF-P, while the second concept encompasses clients' comments on the content of the questions (see Table 7).

Table 7

Research Question 3

Sub-Concepts	Category	Code	Participants
RELEVANCE OF THE QUESTIONNAIRE			
General opinion on the questionnaire	The questionnaire gives a good overview	6	4
	The questionnaire is one-sided	3	1
	The questionnaire is not needed at the end of therapy	6	3
Relevance for therapist	The results of the questionnaire are relevant for the therapist	15	9
	It is relevant for the choice of interventions	4	3
	A questionnaire is answered honestly	2	2
Relevance for clients	It is not relevant for the individual	1	1
	The process of filling in the questionnaire is insightful	15	4
Relevance for therapist and client	It is relevant for the evaluation of therapy	19	9
THE RELEVANCE OF SINGLE QUESTIONS			

Questions in general	The questions on well-being are relevant	16	10
Questions on society	Clients unable to relate to questions on society	12	6
	Questions should address personal interests	13	5
	The questions are unrelated	4	3
	The relevance of the questions depends on the person and one's struggles	1	1

Note. The overarching concepts are displayed in bold upper-case letters. The sub-concepts, grouping the categories are displayed in column *Sub-Concepts.* Column *Code* shows the number of times the category was coded in all transcripts. Column *Participants* displays the number of participants' transcripts the category was coded.

34. Relevance of the Questionnaire

General opinion on the questionnaire. Seven clients explicitly reported their opinion on the questionnaire as a whole. Four clients described that to them the questionnaire was helpful in creating a good overview of their state of well-being: *"Yes, for sure, it creates structure in the presented problems and in their causes." (P9, p.9); "It is very important, because you need to know where you are at." (P5, p.18).*

Next to this positive view on the use of the questionnaire, clients also reported that they found it less relevant to fill in the questionnaire at the end of therapy: *"I receive feedback from work, they can tell me whether it is going better (…). I don't need a questionnaire to tell me that." (P3, p.31); "If it would be offered, I would make use of it, that is for sure. Yet, if it wouldn't be offered to me, I wouldn't mind." (P8, p.28).* In total, three clients reported that they would not need a measurement at the end of treatment. Notably, the analysis shows that two of these three clients do see a use in comparing pre- and post-measures (see *Relevance for the Therapist and Client).*

A final remark mentioned by a client was that the questionnaire was one-sided, and that she missed questions on psychopathology: *"Thus, it is purely focussed on well-being. This questionnaire fits well to this part, but I am wondering: 'Hey, what about the reasons why I am not feeling well?' So, it [the questionnaire] fits well, but I am experiencing a sort of one-sidedness."* An interesting remark, which is connected to clients' wish to make room for sharing their difficult experiences (see *Positive Focus in Therapy*).

Relevance for the Therapist. Interestingly, all of the clients made a remark on the relevance of the questionnaire to therapists. Two representative quotes are: *"I don't know, I think that I personally really don't mind that much. Yet, for you [the therapists] it may provide a lot of answers." (P3, p.27); "You may also be able to do a lot with the information you gained from the intake conversation, but it seems very relevant to have such a questionnaire with the answers directly from the client. You can always come back to these answers." (P8, p.25).* Other clients mentioned that the outcome of a questionnaire could help the therapist in setting-up a treatment plan and in

choosing the right treatment methods. Still others mentioned that they assumed that clients were more honest in such a questionnaire than when asked personally by a therapist. *"I believe that one can get information from this questionnaire, information that is especially relevant for the treatment plan." (P8, p.25), "I think that it is relevant for the therapist, as (…) I would always hold something back. I would fill in a questionnaire more honestly." (P2, p.18).*

Relevance for the Individual. Next to the relevance for therapists, clients also discussed the relevance of such a questionnaire to the individual. One aspect that made the questionnaire relevant to the clients was that already the process of filling in the questionnaire was insightful to them. This was mentioned by four clients, see this representative quote: *"Very relevant, in fact. It is like a mirror, then you understand how others may look at you. If you are not able to present yourself in such a questionnaire, how would others be able to understand you? That part is also very important, yes, I actually like that these questions make me reflect upon where I am, who I am and how I think about these things. This [process] creates some kind of self-view." (P7, p.18).* In contrast, one participant mentioned that to him the questionnaire was not relevant: *"I don't know. I think that to me personally all of this really doesn't matter much." (P3, p.26).*

Relevance for the Therapist and Client. One category which was applied in all but one transcript could be matched to both, the relevance for the therapist and the relevance for the client: *Relevant for evaluation.* Here, the analysis shows a clear trend that clients find it useful to complete the questionnaire at the beginning of a treatment and afterwards in order to be able to see the progress they made. *"Very important, because then you can compare where you are at the start and at the end." (P4, p.20); "It is also very relevant for you as a person, it is nice to see that change has happened." (P6, p.30).*

3b. The Relevance of the Single Questions

All participants reported that to them questions on well-being in general were relevant. One representative quote is as follows: *"Yes, of course it is relevant to know: how are you with regard to your well-being at the beginning of therapy. Especially if you would want to compare it after the treatment in order to evaluate whether there is change to be reported (…)." (P6, p.25).*

Notably, nine clients made a distinction between the relevance of all questions and the questions on societal well-being. Here, the analysis shows that clients find these particular questions less relevant. Analysing the categories, various reasons could be identified why societal questions were evaluated as being less important. Some clients could not relate to the society as a whole: *"Well, the part I personally can't relate to is the part on society." (P7, p.14); "The thing with society is that I am just not busy with this part. (…) This is because I think that I don't contribute much to society. Whether I drop my garbage bag or not, that really doesn't make a difference." (P2, pp.13-17).* Instead, clients thought that it was more relevant that the questions focussed on personal issues

than on the bigger picture. *"Important to me – Some of the questions. Especially those that ask about me personally, and the questions on my close social environment. Society (…) to me personally this is really not that relevant." (P6, p.22).*

Others reported that the questions on society were unrelated to the rest of the questions, and they therefore thought that these questions were less relevant to them: *"In my view, they [the questions] were very divergent. Things like whether our country is developing well… This is more related to the big picture and questions like 'I am happy' really are about the person" (P1, p.16).* One client specifically stated that she believed that the relevance of the questions depended on the issues someone experiences: *"Well, you never know, everyone comes here for different reasons and these questions might be less relevant to one than to the other. I could imagine that someone who comes here with totally different problems might not find these questions relevant." (P10, p.23).*

In Conclusion. In general clients' opinion on the questionnaire is positive, as it provides a good overview. Measuring well-being during treatment is seen as relevant as it helps therapists to set up a treatment plan, and provides insights to the client. Especially relevant is the possibility of treatment evaluation. While questions on well-being in general were seen as relevant, questions on societal well-being are irrelevant to clients as they are too impersonal.

Discussion

The field of PP is dominated by theoretical research, while qualitative data and along with that, research on clients' perspective on well-being in therapy is lacking. This study addressed this research gap by interviewing 10 clients of a Dutch primary mental health care facility, which works with the Sustainable Mental Health Model (Bohlmeijer & Westerhof, 2021). With the help of the obtained results, the research questions will be answered. The questions included how relevant well-being and its four forms are to clients of primary mental health care, and whether clients find it relevant to measure well-being during treatment.

In a nutshell, the results of this study showed that clients consider well-being to be of relevance to their treatment. This means that clients not only ask for help to reduce their psychopathological symptoms but also to increase their well-being. Regarding the different forms of well-being, the results indicated that clients find positive feelings, social contacts and to some extent psychological well-being relevant to their treatment, while societal well-being was regarded as the least relevant. Interestingly, as mentioned by the clients, their perceived importance of the different forms of well-being depended on their symptoms and complaints. While someone with depressive symptoms may regard hedonic well-being as most important, someone with anxiety symptoms may find psychological well-being more important than hedonic well-being.

Finally, the results showed that clients view measuring well-being during therapy as relevant. Clients noted that when questions address the individual's personal interests, a questionnaire on well-being can give a good overview of their mental state, can help the therapist to set up a treatment plan, and can be used to evaluate the treatment process. Notably, such statements on the measurement hold true for any psychological measurement. When asked to fill in a measure of psychopathology, clients would also gain an overview of their mental health state, the therapist would be able to set up a fitting treatment plan, and the process of the client could also be evaluated. Consequently, the question arises whether *measuring well-being* is relevant to clients, or whether *measuring in general* is relevant to clients? This question and the major findings of the present study will be discussed in detail and analysed in the background of relevant literature.

Importance of Well-Being in General

This study is the first research in the field of Positive Psychology to show that clients in primary mental health care value the focus on well-being in treatment. This finding on clients' perspective on well-being supports the need for a transition in clinical psychological practice towards a more balanced approach, as introduced by Bohlmeijer and Westerhof (2021). While traditionally the focus lies upon the reduction of symptoms (Maddux, 2009), the findings of the present study showed that clients' referral question is not only about reducing complaints but also about increasing well-being. Both aspects are included in the Sustainable Mental Health Model by Bohlmeijer and Westerhof (2021). Notably, the participants in the current study clearly mentioned that they would need room to discuss their complaints, next to focussing on increasing their well-being. These findings indicate that clients would not want to solemnly focus on the positive. Therefore, the Sustainable Mental Health Model seems to be a perfect fit. The model is based upon research on the two continua-model of psychopathology and well-being (see for example Keyes, 2005), and integrates both continua in one balanced treatment approach. For this purpose, the model introduces the way people regulate their mental health (adaptation processes) as a key mechanism for well-being and symptomatology. By focussing on these adaptation processes, clinical psychological practitioners could apply valuable treatment methodology, which would help the client to reduce mental suffering and to increase well-being.

Importance of the Different Forms of Well-Being

The present findings indicated which forms of well-being were relevant to clients in primary mental health care. Strikingly, clients more often than not viewed the forms of well-being as being interrelated, which might have made it more difficult for them to evaluate the relevance of the single forms of well-being. The finding that clients viewed the forms as being interrelated, supports the

theoretical view that the concept of well-being is a combination of the four different forms of well-being. However, in the discussion of the relevance of the single forms, clients' view on the interrelation of the forms needs to be considered. If the participants were not able to distinguish the different forms of well-being, they may not have been able to form an accurate opinion on the single forms of well-being.

Notwithstanding, a few trends stood out. Firstly, clients considered the forms of hedonic well-being and psychological well-being relevant to their treatment in primary mental health care. These findings support previous research traditions and fit to more recent studies in the area of recovery. Clients mentioned spontaneously as well as when actively discussed that positive emotions were relevant to their treatment. This supports the importance of the research tradition on hedonic well-being (see Diener, 1984). With regard to psychological well-being, the present findings also support the importance of the research tradition on eudemonic well-being (Diener, 1984), yet clients mentioned specific aspects of psychological well-being as being relevant to them. Clients regarded being able to be oneself and being able to develop oneself as especially relevant to their treatment. These aspects of psychological well-being resemble the dimensions of *self-acceptance* and *personal growth* (see Table 8). While psychological well-being theoretically is made up out of more dimensions, those were not mentioned by clients to be of importance to them (*autonomy, environmental mastery,* and *purpose in life*). Notably, these trends partly overlap with the results the study by de Vos et al. (2017). Here, patients recovering from eating disorders considered *self-acceptance, personal growth,* and *autonomy* as important criteria for recovery. While two dimensions were also identified in the present study, *autonomy* was not mentioned by the participants of the current study as an important aspect of psychological well-being. A discussion of the differences in results and in population between the two studies will follow.

Table 8

Comparison of the Present Findings with Theories on Well-Being and Recovery

Results of the Present Study	**15 Dimensions of Well-Being**	**The CHIME Framework**
EMOTIONAL WELL-BEING		
Positive feelings are important	Positive affect	/
PSYCHOLOGICAL WELL-BEING		
Being yourself and personal development is important	Self-acceptance & Personal growth	Identity
RELATIONAL WELL-BEING		

Feeling connected to (close) others is important	Positive relations, Social integration, Feeling supported, & Satisfied with social network	Connectedness
SOCIETAL WELL-BEING		
Society is less important	/	/

Note. The first column displays the four main findings of the present study. The second column shows which of the15 dimensions of well-being could be identified when compared to column one. The third column shows which elements of the recovery framework CHIME (Leamy et al., 2011) overlap with the present findings.

A second major trend, discovered in the present study, was that clients indicated that social contacts, especially to dear-ones, were highly relevant to them, while societal matters were seen as the least important. These findings relate to earlier theoretical research and to recent insights of recovery studies. The relevance of positive close relationships has been pointed out by Seligman (2012) and is supported by the current results. Clients clearly value the connection to others while being in treatment. The dimensions of the theoretical models on societal (Keyes, 2007) and relational well-being that could be identified are *positive relations, social integration, feeling supported,* and *feeling satisfied with one's social network* (see Table 8). Again, overlap with the findings by de Vos et al. (2017) can be found. Eating disorder patients identified *positive relationships with others* as an important criterion for recovery and regarded societal aspects as less important criteria to recovery. In this study, clients repeatedly regarded societal well-being as the least important form of well-being, too. Clients in primary mental health care as well as patients recovering from eating disorders are more concerned with their close social contacts than with the larger society as a whole. By this, the findings discussed support the distinction of social well-being into societal well-being and relational well-being. Herewith, Keyes' (2007) emphasis on societal well-being is not supported. In fact, four out of five dimensions of social well-being cannot be identified in the accounts of the participants in this study (see Table 8). Only social integration seems to fit the accounts of the participants in the present study.

The question remains, whether these findings hold true for other populations in clinical practice? Interestingly, one participant of the current study mentioned that to her the societal aspect had been relevant in the past, due to her past complaints. After the complaints were dealt with, the relevance of social well-being declined. Furthermore, clients themselves mentioned that their perceived relevance of the forms depended on their complaints. This points towards the assumption that the relevance of social well-being to a client depends on his/her complaints and life circumstances. For example, when the question of the perceived relevance of societal well-being would be asked to U.S. military veterans, suffering from PTSD, the results might be very different. As Blakey et al. (2021) discovered, in this population especially social well-being is of importance

for the veterans' functioning in life. Similarly, a study with Korean immigrants showed that their well-being was linked to social connectedness only when the participant valued social integration (Yoon & Lee, 2010). Such studies suggest that personal preferences and circumstances influence how much someone values societal connectedness.

While differences in clients' perspectives on well-being can arise from differences in client populations, another possibility is that different research methodologies yield different results. As mentioned above, when comparing the study of de Vos et al. (2017) with the current study, multiple similarities can be identified in the accounts of recovering eating disorder patients and primary mental health care patients. However, a couple of differences also stand out. For example, de Vos et al. (2017) found substantial to moderate evidence that recovering eating disorder patients considered social contribution, autonomy, purpose and meaning in life, and spiritual integration as important criteria for recovery. These aspects were not identified in the current sample of primary mental heatlh care clients. While the study of de Vos et al. (2017) is based upon the method of a qualitative meta-analysis, the current study made use of a qualitative content analysis of 10 clients in primary mental health care. This comparison indicates that a difference in the findings on clients'/patients' perspectives on well-being may occur due to differences in population characteristics or due to the methodology of the researchers.

This is also true when comparing the present results with the CHIME framework (Leamy et al., 2011). Here again, similarities and differences can be identified, and the differences might be the cause of a variation in population characteristics or the cause of differences in the methodology of the studies. The accounts of the participants in the present study resemble the elements of *identity* and *connectedness* of the CHIME framework (see Table 8). In contrast, *hope*, *engagement* and *meaning* were not mentioned by the clients of the current study as being relevant aspects to their treatment. Looking from the other side of the coin, the CHIME framework does not include aspects related to positive emotions, which has been an important part of well-being to clients in the present study. However, one important difference between the populations of the CHIME study and the present study is the severity and complexity of the patients'/clients' complaints. While the present sample consisted of 10 clients with mild to moderate mental complaints, taken care of in primary mental health care, the personal accounts on recovery originated from patients with chronic complaints (Leamy et al., 2011). This difference in experienced mental struggles might explain the difference of the importance of elements in recovery and well-being. Furthermore, the methodology of the two studies differed. The CHIME study used a systematic review and a modified narrative synthesis on various types of literature on recovery, including primary and secondary sources. While they made use of inductive open coding techniques to arrive at the recovery themes relevant for patients, the final CHIME elements were named by the researchers themselves. In contrast, the

method applied in the current study was applied to the original accounts of clients only, inductive coding was used in order to let the clients' phrasing guide the coding process. These differences in methodology should be considered when comparing two sources presented as bottom-up approaches. Possibly, the actual content of the recovery literature and the reports of clients on well-being show even more similarities.

Finally, turning towards the third research question on the relevance of measuring well-being, the accounts of the participants indicated that clients in primary mental health care regard measuring well-being in therapy as relevant. However, the arguments of the participants need to be reviewed in the larger context of psychological measurements in treatment. Most clients agreed upon the value of being able to evaluate one's treatment process. Others saw advantages for therapists, such as selecting therapeutic methods and setting up treatment plans based on the individual needs. Yet other clients mentioned that they had gained insight even while filling in the questionnaire and that they had a good overview of their own mental state after filling in the MHC-SF-P. However, the relevance of measuring well-being should be interpreted with caution, as the above-mentioned arguments apply to measurements assessing psychopathological symptoms as well. Notwithstanding, considering the overall high relevance of well-being to clients in treatment, it can be concluded that measuring well-being at the beginning and at the end of clients is valuable. By measuring well-being at the start of a treatment process, therapist and client can identify the aspects of well-being that need to be addressed during therapy. Measuring well-being at the end of the treatment, allows the therapist and the client to evaluate the treatment process, and again take the level of well-being into account. A psychopathological measure could additionally be applied to also make room for the clients' complaints. By this, therapist and client work together with a treatment plan that fits the clients' needs and which focuses on both well-being and psychopathological symptoms.

Strengths and Limitations of the Present Study

The current study is the first study to investigate the view of primary mental health clients on well-being. By this the present paper contributes to the qualitative research lacking in the field of positive psychology (see Morgan, 2007). Furthermore, the methodology of the present study has been carried out with great caution and the steps are explained in detail, which enables other researchers to replicate the present findings and to apply the method presented here within different populations or different study contexts. Finally, the presented results bring about major implications for clinical psychologists in practice. These implications will follow.

Nevertheless, two limitations of the present study need to be addressed. These are limitations with regard to the sample of this study, 10 clients of a primary health care facility, which is already using the Sustainable Mental Health Model. Due to the conditions of this research project, saturation was not reached during code creation. Within each interview of the participants, at least one code

was newly created. Therefore, the results of this study should be generalized with caution. Future research could apply the current method to a group of clients in primary mental health care to support the outcomes of the current study. Related to this, a second limitation regarding the generalizability of the current findings is the setting in which the clients were selected. As previously mentioned, practitioners at Mindfit apply the Sustainable Mental Health Model and therefore make use of positive psychological methods. This implies that the sample of the current study was at least to some extent acquainted with the concept of well-being. This might have influenced their responses and thereby might have influenced the code creation and finally the conclusions drawn from the data obtained. In order to investigate this, future studies should include samples from various institutions with different approaches and various clinical populations. In the end, this study was the first to investigate clients' perspective on well-being in clinical practice. The results suggest that similar studies are needed in order to adapt the clinical psychological approach according to the clients wishes and needs.

Implications

The majority of the clients in this study reported that their referral question was related to well-being. Dependent on the individual complaints, clients distinguished between the different forms of well-being and which of these was relevant to their referral question. In fact, clients suggested that they believed the subjective relevance of a form of well-being was dependent on the complaints a client experienced. These findings call for a therapeutic approach, which includes well-being and which is adjusted to those aspects of well-being which are valued the most by the individual client. Note that the present results also suggest that clients see all forms of well-being as being interrelated. In order to specify which form of well-being is most relevant to a client, and in order to determine one's treatment approach, a therapist should start by explaining the relationships and differences between the forms of well-being. As an additional step, therapists are encouraged to use measurements like the MHC-SF-P in order to determine together with the client the focus of the collaborative work. In fact, measuring well-being in therapy is regarded as relevant by clients in primary mental health care. By including measures like the MHC-SF-P, therapists can make sure to include the positive approach into their treatment. Yet, most important to clients is the ability to evaluate their progress by the measurement before and after the treatment took place. In the end, the usage of a well-being measurement is highly supported by clients and should be included in clinical practice. Additionally, clients mentioned that they valued detailed information on the measurement and the forms of well-being. This results in yet another suggestion for therapists in practice: take the time and explain the positive psychological approach to a client. By this, therapists can establish a therapeutic relationship which is dominated by active engagement and decision making of the client (Bannink, 2012).

One last, yet not least important implication can be drawn from the data of the current study. Clients clearly stated that they wish to have room to express their complaints. Meaning, even though clients value the positive approach and focus on well-being, they need to feel room to talk about their symptoms. If therapists are not aware of this and simply introduce their positive approach, the client may feel misunderstood and not taken seriously. This calls for an approach in which clients are involved in the structure and content of the therapy sessions. Therapists should take care to include the client in the process of establishing a treatment plan and together decide when it is time to shift the focus towards the positive. These findings lead back to the Sustainable Mental Health Model (Bohlmeijer & Westerhof, 2021).

Conclusion

Altogether, it can be said that the development of positive psychology and its introduction into the clinical field is in line with the wishes and needs of clients in primary mental health care. Well-being is highly relevant to clients. The present study entails multiple practical implications for practitioners on what to consider when wanting to use a positively oriented approach. By this, the current research not only contributes to positive psychological research alone, but also contributes to the clinical psychological practice.

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Appendix A

Protocol of the Study Procedure

Protocol Three Step Test Interview MHC-SF-R

Doel: Het onderzoeken van de inhoudsvaliditeit van de Mental Health Continuum-Short Form-Revised (MHC-SF-R). We willen weten in hoeverre de MHC-SF-R begrijpelijk is en hoe relevant de MHC-SF-R is voor de behandeling van mensen met milde tot matige psychische klachten in de BGGZ.

Instrument: de MHC-SF-R is een aangepaste versie van de Mental Health Continuum – Short Form (MHC-SF; Keyes et al., 2008; Lamers, Westerhof, Bohlmeijer, ten Klooster, & Keyes, 2011). De MHC-SF meet de mate van positieve mentale gezondheid door middel van 14 items en drie subschalen. De eerste subschaal *Emotioneel Welbevinden* (EW) meet positieve emoties en levenstevredenheid. De tweede subschaal *Psychologisch Welbevinden* (PWB) omvat zelfrealisatie en het optimaal functioneren van een individu. Tot slot de subschaal *sociaal welbevinden* (SW) die meet in hoeverre een individu optimaal functioneert in de maatschappij. In de MHC-SF-R is deze laatste schaal opgedeeld in sociaal maatschappelijk welbevinden (SMW) en sociaal-relationeel welbevinden (SRW). Hierbij focust de SMW schaal zich op het functioneren van het individu in de samenleving terwijl de SRW schaal zich richt op het functioneren van het individu in de directe contactenkring. De MHC-SF-R bevat om deze reden 19 items. Op alle items moet aangegeven worden hoe de respondent zich heeft gevoeld gedurende de afgelopen week. Dit kan op een zes-puntsschaal lopend van nooit tot (bijna) altijd.

Methode: Om de inhoudsvaliditeit te onderzoeken wordt er binnen dit protocol gebruik gemaakt van het Three Step Test Interview (TSTI; Hak, van der Veer, & Jansen, 2008). Dit is een cognitief interview waarin de interactie tussen een instrument en respondent wordt onderzocht. Dit interactieproces bestaat uit vier stappen namelijk: (1) *begrijpen*, de respondent maakt een interpretatie van de betekenis van een vraag (2) *ophalen*, de respondent probeert relevante informatie op te halen uit zijn/haar geheugen (3) *beoordeling* de respondent maakt een beoordeling in hoeverre de opgehaalde informatie relevant is voor de betekenis van de vraag (4) *communicatie*, de respondent geeft een antwoord op de vraag (Tourangeau, 1984). Gedurende dit gehele proces kunnen zich problemen voordoen die kunnen leiden tot meetfouten. Om structurele meetfouten te identificeren kan gebruikt gemaakt worden van de TSTI. De TSTI bestaat uit drie stappen namelijk;

1. *Hardop denken:* Omdat het zojuist genoemde interactieproces voornamelijk bestaat uit ‘denken’ wordt er binnen de TSTI in de eerste stap gebruik gemaakt van het *hardop denken*. De respondent wordt gevraagd de vragenlijst volledig in te vullen terwijl hij/zij hardop zegt wat hij/zij denkt. Hierbij wordt er door de onderzoeker middels observatie zoveel mogelijk informatie verzameld over moeilijkheden bij het beantwoorden van de items. Belangrijk is dat hierbij zowel non-verbale (zoals: overslaan van vragen; corrigeren van het gegeven antwoord;

twijfel; zenuwachtigheid) als verbale observaties worden genoteerd. Er mogen tijdens deze stap GEEN vragen worden gesteld door de onderzoeker.

2. *Focus interview:* in stap twee heeft de onderzoeker de mogelijkheid om verduidelijking over gemaakte observaties te vragen. Voorbeeldvragen zijn: hoorde ik je dit zeggen?; je stopte daar hoe kwam dit? Etc.). Belangrijk is dat deze vragen worden beantwoord zoals de respondent het op het moment van invullen ervoer en dus niet nu hij/zij de vragenlijst af heeft. Het gaat erom dat de onderzoeker het denkproces helder in beeld kan brengen.
3. *Semigestructureerd interview:* in deze stap mag de respondent vrijuit praten over zijn ervaring met de vragenlijst. Belangrijke aspecten zijn allereerst dat de respondent zijn gedrag en moeilijkheden kan uitleggen. Daarnaast kan er gevraagd worden om items uit te leggen zodat er gekeken kan worden hoe de respondent een item heeft geïnterpreteerd. Tot slot kan er gevraagd worden naar onderwerpen gerelateerd aan de vragenlijst en hoe deze relevant zijn voor de respondent.

Uit eerder onderzoek met de TSTI blijkt dat na 16 interviews saturatie plaatsvindt. Met een slag om de arm worden er binnen dit onderzoek 20 respondenten geïnterviewd.

Respondenten selectie: Om een beeld te krijgen van de content validiteit voor de gehele populatie van volwassenen in de BGGZ wordt er een zo heterogeen mogelijke groep samengesteld. Respondenten zullen verschillen in klachten, leeftijd, opleidingsniveau en de hoeveelheid behandeling die ze al hebben ontvangen.

Setting: Belangrijk bij een TSTI is dat de respondent zich bij het invullen bevindt op de plek waar hij/zij de vragenlijst normaal ook in zou vullen. Om ecologische validiteit te waarborgen zullen de interviews gedaan worden op de locatie waar de behandeling van de respondent ook plaatsvindt. Er zal een audio-opname gemaakt worden van het interview.

Informed consent: Voordat de opname begint moet het toestemmingsformulier ondertekend zijn (zie bijlage 1). Hierbij moet nogmaals een mondelinge toelichting gegeven worden van de implicaties van deelname aan het onderzoek.

Interview-instructies:

Introductie

Zoals je in het toestemmingsformulier hebt gelezen zullen we vandaag een interview hebben van 45 minuten tot een uur. Hierin willen we een meer cliëntvriendelijke versie van de vragenlijst de MHC-SF onderzoeken. MHC-SF staat voor Mental Health Continuum Short Form. Dit is een vragenlijst die inzicht geeft in hoeverre iemand zich goed voelt, dit noemen we ook wel welbevinden.

Er zijn een aantal zaken belangrijk om te weten voordat we starten. Allereerst onderzoeken wij de vragenlijst en niet jou persoonlijk. We zullen het interview opnemen en naderhand uittypen. De opname wordt daarna verwijderd en de uitgetypte versie is anoniem en niet naar jou te herleiden. We bewaren de gegevens 15 jaar waarna ze worden vernietigd. Je mag te allen tijde aangeven als je wilt stoppen. Voel je daarnaast vrij om vragen te stellen. Als je hiermee akkoord gaat wil ik je nu vragen het toestemmingsformulier te ondertekenen.

Voordat we beginnen heb ik enkele vragen vooraf:

1. *Wat is je geboortedatum?*
2. *Wat is je geboorteland?*
3. *Wat doe je in het dagelijks leven?*
4. *Welke opleiding heb je gedaan?*
5. *Hoe lang ben je in behandeling bij Mindfit?*
6. *Waarvoor ben je in behandeling bij Mindfit?*

Instructie

Om de vragenlijst te onderzoeken maken we gebruik van een interview in drie stappen. In de eerste stap vragen we u hardop te denken terwijl u de vragenlijst invult. In de tweede stap zal ik aanvullende vragen stellen om eventuele onduidelijkheden voor mij te verhelderen. Tot slot geef ik je in de derde stap de gelegenheid jouw ervaring met de vragenlijst toe te lichten en heb ik nog enkele vragen over de relevantie van de vragenlijst. Ik ga zo stap voor stap uitleggen wat we gaan doen maar heb je tot nu toe vragen?

Stap 1

We starten met stap 1. Het beantwoorden van een vragenlijst gebeurt gewoonlijk volledig in je hoofd en is dan ook niet zichtbaar. Om voor mij zichtbaar te maken hoe mensen de vragenlijst invullen en tegen welke problemen zij aanlopen wil ik zien wat er in het hoofd van mensen gebeurt. Ik wil je dan ook vragen om hardop te zeggen wat je denkt op het moment dat je het denkt terwijl je de vragenlijst invult. Dit is best moeilijk omdat we veel sneller denken dan praten. Het is dan ook goed dit even te oefenen. Let op je hoeft geen uitleg te geven van je gedachtes. Je hoeft daarnaast ook geen gedachtes te verzinnen er mag best een stilte vallen. Tot slot wil ik je vragen om in deze eerste stap nog geen vragen aan mij te stellen of je mening te geven over het instrument.

De eerste oefening is als volgt:

1. *Probeer in je hoofd voor je te zien waar je woont en hoeveel ramen jouw woning heeft. Vertel mij wat je ziet en denkt terwijl je de ramen in je huis telt.*
2. *Wanneer was de laatste keer dat je hebt gefietst? Vertel alsjeblieft hardop wat je denkt terwijl je in je hoofd teruggaat naar de datum.*

Als we het zometeen in het echt gaan doen zal je mij zien schrijven. Ik maak notities van wat ik zie en van jouw gedachten zodat ik ze goed kan begrijpen. Jij hoeft niet op mij te letten. **Voor de instructeur**: leg nu de vragenlijst voor de respondent en laat hem/haar van start gaan.

Let op: geef tussentijds feedback: *je doet het goed; ga zo door; blijf alstublieft zeggen wat je denkt; zeg alleen wat je denkt je hoeft nog geen commentaar te geven op wat je denkt; doe maar alsof ik er niet ben; je mag straks aangeven wat je ervan vindt.*

Stap 2

Bedankt voor het invullen van de vragenlijst. Je hebt het heel goed gedaan. Nu heb ik enkele vragen over jouw denkproces.

Voor de instructeur: stel hier alleen vragen over datgene wat zich heeft voorgedaan. Denk aan verduidelijking rondom een observatie of de gedachten van de respondent. Bijv. 'je stopte bij item X, hoe kwam dit? Of hoorde ik je dit zeggen? Of je stopte nadat je dit zei ….. wat dacht je hierna? Let op het gaat hier om verheldering van het denkproces nog niet om een interpretatie hiervan.

Stap 3

Nu we stap 1 en 2 hebben gedaan ben ik benieuwd naar jouw ervaring met deze vragenlijst. Hiervoor heb ik een aantal vragen voor je op papier gezet. Zullen we deze doorlopen?

Algemeen

1. *Hoe was het voor je om deze vragenlijst in te vullen?*
2. *Wat vond je van de vragen? Waren de vragen duidelijk voor jou?*
3. *Wat vond je van de antwoordmogelijkheden? Waren die duidelijk voor je?*
4. *Kan jij in jouw woorden vertellen wat je denkt dat we van jou willen weten met deze vragenlijst?*
5. *Vind jij dit soort vragen belangrijk voor je behandeling?*

Relevantie

De vragen die je hebt ingevuld gaan over jouw welbevinden. Ik leg je hier kort iets over uit. Er zijn meerdere vormen van welbevinden, dit is allereerst 'het ervaren van positieve gevoelens' zoals gevoelens van tevredenheid, geluk, interesse en plezier. Ten tweede gaat welbevinden ook over hoe je functioneert in het dagelijks leven, dus of je tevreden bent met wie je bent, of je warme relaties hebt, het gevoel hebt dat je zelf keuzes kunt maken en wordt uitgedaagd om te groeien. Daarnaast gaat welbevinden over je thuis voelen in de samenleving. Heb je het gevoel dat je deel uit maakt van een groep en ben je tevreden met jouw bijdrage aan de samenleving. Tot slot kan welbevinden ook gaan over persoonlijke relaties. Je tevreden voelen met je sociale contact en verbonden voelen met andere mensen. Maar ook het gevoel dat je bij de ander terecht kunt.

1. *Hoe relevant vind je deze vragen over welbevinden?*
2. *Hoe relevant vind je de verschillende vormen van welbevinden?*
3. *In hoeverre vind jij het relevant dat deze vragen aan je gesteld worden **voor** een behandeling van psychische klachten?*
4. *In hoeverre vind jij het relevant dat deze vragen aan je gesteld worden **na** een behandeling van psychische klachten?*
5. *Hoe hangen deze vragen samen met jouw hulpvraag?*

Positieve gevoelens	*Jezelf kunnen zijn en je kunnen ontwikkelen*
Je thuis voelen in de samenleving	*Je verbonden voelen met andere mensen*

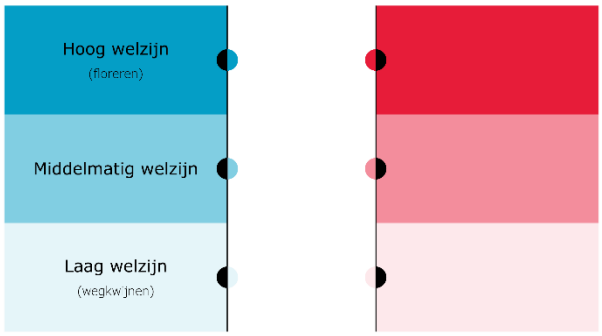
Metafoor koffers

We hebben nu heel wat vragen gehad. Waarschijnlijk vind je het ook interessant om te horen wat we nou eigenlijk meten met deze vragenlijst. Zoals eerder gezegd meet de vragenlijst welbevinden. Ieder mens draagt eigenlijk altijd twee koffers met zich mee. Op dit plaatje zie je twee blokken deze staan voor de koffers.

De eerste koffer, het rode plaatje, is de koffer van wanhoop. Deze koffer bevat onze moeilijke gebeurtenissen, ervaringen, verdriet en pijn, en onze lastige eigenschappen en negatieve denkpatronen. Soms is het nodig om deze koffer te openen en uit te pakken: dan verwerk je moeilijke ervaringen, leer je negatieve denkpatronen te veranderen en leer je om te gaan met je kwetsbaarheden en lastige eigenschappen. Daar is veel moed voor nodig. Een therapie kan je helpen om de koffer wat lichter te maken en de inhoud te ordenen. Maar de koffer zal nooit leeg worden. Er blijven kwetsbaarheden in aanwezig. Het is onderdeel van jouw leven en van wie je bent. Deze koffer van kwetsbaarheid hoort bij je.

Maar hoe zit het met de andere koffer? Het blauwe blok. Wat zit daarin? Dit is de koffer van hoop en kracht. Deze koffer bevat jouw potentie en bronnen voor welzijn. Jouw mogelijkheden en talenten, jouw vermogen tot plezier, positieve ervaringen en fijne relaties, doelen in het leven en de liefde voor jezelf en anderen. Voor onze mentale gezondheid is het ook belangrijk dat we deze koffer openmaken en onderzoeken wat we kunnen doen met de inhoud. En ook daar is moed voor nodig!

Het kan zijn dat klachten niet zozeer voortkomen uit problemen in de eerste koffer, maar vooral uit het feit dat je de tweede koffer nog onvoldoende hebt uitgepakt en er nog niet voldoende aandacht aan hebt gegeven.



Eigenlijk meten we dus met deze vragenlijst jouw tweede koffer en dus het blauwe blok. We willen graag weten in hoeverre jij je goed voelt en hoop en kracht ervaart of dat we dit nog kunnen uitbouwen met een behandeling. Zoals gezegd gaat dat over de mate van welbevinden.

1. *Nu je dit weet hoe belangrijk vind jij het dat we de vragen over welbevinden stellen bij jouw behandeling?*
2. *Helpt het jou om deze uitleg te krijgen en zo ja hoe?*

Afsluiten

Tot slot wil ik je vragen of je nog op of aanmerkingen hebt voor zowel de vragenlijst als dit interview. Uiteraard hartelijk dank voor jouw medewerking. Je ontvangt van ons de €15,- cadeaubon. Mocht je willen weten wat er uit het onderzoek is gekomen kan je contact opnemen met Pauline Schuffelen via pauline.schuffelen@mindfit.nl of 06-12506168.

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Betreft Toestemming onderzoek: 'werken aan duurzame mentale gezondheid

Beste meneer/mevrouw,

Je bent gevraagd om deel te nemen aan een interview voor het onderzoek 'werken aan duurzame mentale gezondheid' bij Mindfit. Je beslist zelf of je wilt meedoen. Voordat je de beslissing neemt, is het goed om meer te weten over het onderzoek. Lees deze informatiebrief rustig door en heb je na het lezen van de informatie nog vragen? Dan kunt je terecht bij de onderzoeker, die onderaan deze brief vermeld is.

Mindfit wil graag samen met cliënten werken aan duurzame mentale gezondheid. Dit wil zeggen dat er in de behandeling niet alleen gewerkt wordt aan het verminderen van jouw klachten maar ook gericht wordt op het leiden van een plezierig, betekenisvol en betrokken bestaan. Dit laatste noemen we ook wel welbevinden. Om meer inzicht te krijgen in het welbevinden van onze cliënten zetten wij al lange tijd een vragenlijst in, deze heet: the Mental health – continuüm – Short Form (MHCS-F). In de praktijk blijkt echter dat cliënten moeilijkheden hebben bij het invullen van de vragenlijst. Om deze reden hebben we de vragenlijst aangepast. Met hulp van jou willen we erachter komen of deze aanpassingen voldoende geholpen hebben en of je de vragenlijst belangrijk vindt.

Tijdens een interview van maximaal 45 minuten vragen we je om de vragenlijst hardop nadenkend in te vullen zodat wij inzicht krijgen in hoe je de vragenlijst ervaart. Daarnaast zullen we je persoonlijk vragen naar je mening en ervaring met de vragen. Op basis van jouw gegevens en die van anderen kunnen we bepalen welke aanpassingen er nog gedaan moeten worden. We zullen het interview opnemen op een voice-recorder en uiteindelijk uittypen op papier. Zodra het uitgetypt is zullen we de opname direct verwijderen. Je gegevens zullen vertrouwelijk en anoniem behandeld worden volgens (inter-) nationale regels en wetten, waaronder de Wet Bescherming Persoonsgegevens. Van de onderzoeksresultaten zal een rapport gemaakt worden.

Jouw onderzoeksgegevens worden tot vijftien jaar na het einde van het onderzoek bewaard. Hierna zullen ze worden vernietigd. Indien je besluit deel te nemen aan dit onderzoek geef je toestemming voor het volgende:

- Bepaalde personen zijn gerechtigd jouw medische onderzoeksgegevens in te zien. Deze personen zijn bevoegde medewerkers van dit onderzoek, de Inspectie voor de Gezondheidszorg en controleurs van de Raad van Bestuur van de instelling waar het onderzoek wordt uitgevoerd. Al deze personen zijn verplicht jouw persoonsgegevens geheim te houden.
- Indien je zou beslissen om jouw deelname aan het onderzoek stop te zetten, mogen jouw gegevens die verzameld werden voor deze beslissing nog steeds verwerkt worden, samen met andere gegevens, verzameld als onderdeel van het wetenschappelijk onderzoek.

Door onderstaand toestemmingsformulier te tekenen, ga je akkoord met het gebruik van de onderzoeksgegevens door de onderzoeker. Je maakt geen extra kosten voor het onderzoek. Je krijgt een cadeaubon van 15 euro voor deelname aan de studie.

De Raad van Bestuur en directie van Dimence Groep en Mindfit hebben goedkeuring gegeven om dit onderzoek uit te voeren. Indien u na zorgvuldige overweging besluit deel te nemen aan dit wetenschappelijk onderzoek, dan vragen we je om het toestemmingsformulier te ondertekenen en van een datum te voorzien.

Met vriendelijke groet,

Pauline Schuffelen,
Psycholoog en onderzoeker

Email: pauline.schuffelen@mindfit.nl
Telefoonnummer: 06-12506168

Toestemmingsformulier

☐ Ik heb de informatiebrief voor deelname aan het onderzoek gelezen. Ik kon aanvullende vragen stellen. Mijn vragen zijn genoeg beantwoord. Ik had genoeg tijd om te beslissen of ik meedoe.

☐ Ik weet dat meedoen helemaal vrijwillig is. Ik weet dat ik op ieder moment kan beslissen om toch niet mee te doen. Daarvoor hoef ik geen reden te geven.

☐ Ik weet dat sommige mensen mijn gegevens kunnen zien. Die mensen staan vermeld in de informatiebrief.

☐ Ik geef toestemming om mijn gegevens te gebruiken, voor de doelen die in de informatiebrief staan.

☐ Ik geef toestemming om mijn onderzoeksgegevens 5 jaar na afloop van dit onderzoek te bewaren.

☐ Ik geef toestemming om mijn gegevens 5 jaar na afloop van dit onderzoek te bewaren, zodat dit in de toekomst misschien gebruikt kan worden voor een nieuw onderzoek.

☐ Ik geef toestemming voor deelname aan de interview studie behorende bij het onderzoek.

☐ Ik wil meedoen aan dit onderzoek.

Datum :
Handtekening deelnemer:

*De onderzoeker Pauline Schuffelen verklaart hierbij de deelnemer volledig te hebben geïnformeerd over het genoemde onderzoek. Als er tijdens het onderzoek informatie bekend wordt die de toestemming van de deelnemer zou kunnen beïnvloeden, dan brengt Pauline Schuffelen hem/haar daarvan tijdig op de hoogte.

Appendix B

The MHC-SF-R

The following questions describe feelings people experience. Read through each statement carefully and check the number that represents how often you experienced that particular feeling THE PAST WEEK.

	Never	Rarely	Sometimes	Regularly	Often	(Almost) Always
I am happy.	0	1	2	3	4	5
I am interested in life.	0	1	2	3	4	5
I am satisfied with life.	0	1	2	3	4	5
I have something important to contribute to society.	0	1	2	3	4	5
I think that our country is developing in a positive direction.	0	1	2	3	4	5
I accept people as they are.	0	1	2	3	4	5
I belong to a community (like social group, school, neighbourhood, etc.).	0	1	2	3	4	5
The way our society works makes sense to me.	0	1	2	3	4	5
I like most parts of my personality.	0	1	2	3	4	5
I am good at managing the responsibilities of my daily life.	0	1	2	3	4	5
I have warm and trusting relationships with others.	0	1	2	3	4	5
I have experiences that challenge me to grow and become a better person.	0	1	2	3	4	5
I am confident to think or express my own ideas and opinions.	0	1	2	3	4	5
My life has a sense of direction or meaning to it.	0	1	2	3	4	5
I can be of value to others.	0	1	2	3	4	5
I am satisfied with my social network.	0	1	2	3	4	5
I feel connected to others.	0	1	2	3	4	5
I have contacts I can turn to for help.	0	1	2	3	4	5
I find my way in society.	0	1	2	3	4	5