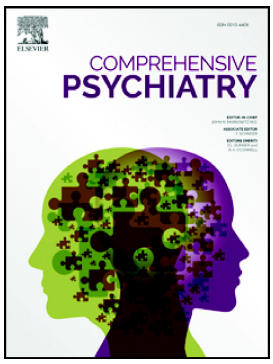

Exploring the meaning of well-being in severe mental disorder: Insights from patients, relatives and mental health professionals

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Exploring the meaning of well-being in severe mental disorder: Insights from patients, relatives and mental health professionals

Well-Being Perspectives in Severe Mental Disorders

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We are deeply grateful to the service users with severe mental disorders, their relatives, and the professionals who generously shared their perspectives, which have been invaluable in advancing the understanding of well-being as a key dimension of recovery. We also thank the Spanish public mental health system, and particularly the psychiatric rehabilitation centers, for their generous, engaged, and supportive collaboration, always marked by kindness and gratitude. Special thanks go to the professionals, patients, relatives, and friends attending the rehabilitation centers for people affected by severe mental disorders in the Community of Madrid and Castilla-La Mancha, whose contributions have been essential for this work.

Abstract

Background: Well-being is a central dimension of recovery in severe mental disorders (SMD), underscoring that mental health extends beyond the absence of illness. However, well-being may not hold the same meaning for patients, relatives, and professionals, raising key questions about its assessment in clinical practice. Moreover, the perception of well-being is a decisive outcome that can guide clinical decision-making, reinforcing its role as a critical indicator in psychiatric care.

Methods: This sequential mixed-methods study examined agreement between 186 patients with SMD (self-informants) and 186 external informants (family, friends, or therapists) on the Warwick-Edinburgh Mental Well-being Scale (WEMWBS). Quantitative analyses assessed concordance and tested whether age, gender, relationship type, or relationship duration predicted discrepancies. Complementary qualitative interviews explored how each group conceptualizes well-being.

Results: Quantitative analyses showed moderate concordance between self- and external informants (69%), with professionals tending to rate well-being higher than relatives and patients. Relationship type explained only a small proportion of variance. Qualitative findings indicated that patients primarily linked well-being to experiential recovery processes such as empowerment, freedom, and acceptance, whereas external informants, particularly professionals, focused on observable and behavioral aspects, including self-efficacy and help-seeking.

Conclusions: Well-being is understood differently by stakeholders. Patients emphasize internal, subjective dimensions, while relatives and professionals prioritize behavioral indicators. These complementary but divergent perspectives highlight that self-reports capture unique aspects of well-being not reflected in proxy assessments. Clarifying what well-being means for each agent is essential for individualized rehabilitation planning and ensuring clinical decisions align with patients' recovery goals.

Keywords: Well-being, severe mental disorder, Person-centered care, decision-making, agreement, mixed methods.

Exploring the meaning of well-being in severe mental disorder: Insights from patients, relatives, and mental health professionals

1. Introduction

The assessment of well-being in individuals with severe mental disorders (SMD) is essential for guiding and evaluating their personal recovery process [1]. SMD includes psychiatric disorders such as schizophrenia spectrum disorders or bipolar disorders, characterized by significant functional impairment and a duration exceeding two years [2]. Mental health goes beyond the absence of illness, yet stigma keeps many professionals focused on dysfunction and distress, limiting person-centered, recovery-oriented approaches [3–5]. In this context, personal recovery is related to mental health and is defined by the patient's subjective experience of connection, hope, identity, meaning, and empowerment (CHIME) [6]. Recovery from an SMD is a complex and individual process, where well-being is more than just the absence of mental illness [7]. In this sense, well-being can be divided into three main components: 1) Psychological well-being refers to having meaning in life and the agency to actualize one's potential [8]; 2) Emotional well-being is the subjective sense of happiness and satisfaction experienced by individuals [9], and lastly, 3) social well-being focuses on the quality of relationships with others and connections within them [10]. Accordingly, previous studies have shown that a sense of purpose in life is strongly associated with psychological well-being and recovery processes in individuals with serious mental health conditions [11]. More recent research has also linked the Japanese concept of 'ikigai' to the development of eudaimonic well-being, which is achieved through engaging in meaningful interests and activities [12].

Notably, most patients with SMD can reliably complete self-assessment scales, making well-being evaluations a valuable and practical tool in clinical settings [13]. They even describe in their narratives their desire to be listened to, to participate in life based on their goals and strengths, and to find meaning and purpose by constructing a valid identity and social roles [1,14]. Shared Decision-Making (SDM) fosters equal collaboration between patients and clinicians by aligning treatment with patient values, strengthening trust, and improving engagement, satisfaction, and outcomes, while the evaluation of well-being supports a person-centred approach that promotes recovery-oriented strategies and further enhances SDM [15,16]. However, clinicians often view patients with psychotic disorders as having limited decision-making capacity, sharing little information, or fearing to give them decision power [17]. As a

result, they prioritize their observations or input from others (such as family members or other professionals) over the patient's self-assessment [18]. Therefore, the subjective nature of well-being makes it crucial to evaluate the level of concordance between a patient's self-assessment and that of an external informant (e.g., family, friends, or professionals) to determine if they align appropriately.

Remarkably, research in the general population shows moderate agreement between self-reports and informant assessments of well-being, with higher concordance for positive affect [19] and little variation by informant type [20]. However, in SMD populations, this concordance is far more limited, as research reveals marked discrepancies between patient and external ratings of symptoms, personality traits, and well-being [21–24]. Similar results have been found in depression, as psychiatrists prioritize behavioral and functional indicators, while patients focus on emotional aspects, leading to differences in ratings [25]. Yet, it remains unclear whether differences arise between relatives and professionals or whether other factors such as gender may play a role, making it crucial to investigate the concordance between patients and external raters in well-being and to identify the determinants of these discrepancies, particularly in severe mental disorders [24].

This study examines the consistency of well-being assessments between individuals with SMD and their selected external informants. First, the degree of concordance between the two informants (self-reporters with SMD and an external informant) will be assessed. Secondly, possible predictors of concordance, such as age, gender, duration of the relationship, and type of relationship (family/friend vs. professional), will be investigated. Finally, qualitative interviews will explore the factors associated with well-being of people with SMD, from the perspective of service users, family members/friends, and professionals.

Methods

2.1 Study 1: Quantitative study.

2.1.1 Participants:

This study analyses a subset of participants enrolled in a randomized controlled trial (RCT), (Evaluation of the Efficacy of the "Think and Cope Positively" Program (TC+), registered at ClinicalTrials.gov (NCT06054061), recruited through the NHS psychiatric rehabilitation network in Madrid, Spain. The initial sampling frame comprised 792 individuals: 418 service users with severe mental disorder (SMD) and 374 accompanying informants (family members or friends) nominated by the users. Both service users and their nominated supporters were enrolled in the RCT protocol; external informants additionally provided collateral evaluations of the users' well-being.

Participants were consecutively recruited through outpatient psychiatric rehabilitation services within the NHS network in Madrid, Spain. All participants voluntarily agreed to take part in the in-depth interviews and were deemed by their therapists to be in an appropriate clinical condition to participate at the time of the interview. With respect to the self-informants, inclusion criteria for this study required participants to: (1) be between 18 and 65 years old, (2) have a primary diagnosis of severe mental disorder (SMD), specifically schizophrenia or bipolar disorder, (3) have a complete evaluation dataset available, and (4) be currently receiving outpatient psychiatric rehabilitation while providing informed consent. Exclusion criteria were defined as incomplete evaluation protocols and diagnostic categories with insufficient sample size to allow for meaningful statistical analyses. The final included sample consisted of 186 self-informants with SMD, diagnosed with either schizophrenia (86%) or bipolar disorder (14%), who met all inclusion and exclusion criteria. Most were single (72%), unemployed (97%), and had a primary or secondary education level (80%), with a mean age of 50.1 years.

Regarding the external informants, participants were selected according to their significance to the service user, either as close personal contacts (family, friends, or partners) or as professionals with a strong therapeutic relationship. Inclusion criteria for external informants required (1) a long-standing and meaningful relationship with the patient, and (2) the ability to complete the assessment protocol. Exclusion was applied when the relationship was too recent or too weak to provide reliable information. The final supporter sample comprised 186 external informants, predominantly female (74%), with a mean age of 51.8~~2~~ years, and mostly family members (69%), while 31% were professionals. The average relationship duration between patients and supporters was 24.6~~3~~ years.

2.1.2 Procedure

We informed the NHS adult rehabilitation network for individuals with SMD (e.g., schizophrenia or bipolar disorder diagnosed by the referring psychiatrist) about the study's aim. Ethical approval was obtained in compliance with the Declaration of Helsinki. The study received ethical approval from two independent Research Ethics Committees: The Internal University Ethics Committee of Universidad Pontificia Comillas, Faculty of Human and Social Sciences (Registration code: 7-22/23; Approval date: 28th November 2022), and the External Hospital Ethics Committee of Hospital Clínico San Carlos (Registration code: 23/518-EC_X; Approval date: 10th August 2023). Service users and a significant external informant with a personal or therapeutic bond gave consent and completed well-being assessment protocol at the rehabilitation center, which lasted about 10 minutes. The database is publicly available at 10.6084/m9.figshare.29467925. This work was embedded within a larger competitive research project funded by La Caixa Foundation (CX22-00110), conducted during the period from September 2022 to March 2026.

2.1.3 Measures

- Sociodemographic and Clinical Characteristics

Information on both the self-informant and external informant included gender and age. For the self-informant (SMD), additional data were collected on marital status, education, employment, living arrangement, disability, primary diagnosis, and the type and duration of their relationship with the external informant or supporter.

- Well-being measure

Well-being was measured by the Warwick Edinburgh Mental Well-being Scale - short form (WEMWBS; [26]). The WEMWBS is a 7-item on a 5-point scale ranging from 1 (none of the time) to 5 (all of the time). Examples of items include 'I have been feeling optimistic about the future', 'I have been feeling useful', and 'I have been able to make up my own mind about things', creating a total score ranging from 7 to 35, with higher scores indicating greater well-being. This instrument is feasible, reliable, and sensitive to well-being changes in people with various mental health problems [27,28]. The WEMWBS showed high internal consistency in self-informants ($\alpha = 0.89$) and external informants ($\alpha = 0.85$).

2.1.4 Data analysis:

First, a quantitative analysis was conducted to examine the degree of agreement in assessing the user's well-being between the self-informant and the external informant and identify variables that may predict this agreement. All data were analysed using R [29] and Jamovi software [30]. The code to conduct the analyses is publicly available at 10.6084/m9.figshare.29468240.

- *Discrepancy Index of* well-being*:*

The agreement between WEMWBS scores from self-informants and external informants was analysed using three methods: 1) Intraclass Correlation Coefficients (ICCs), a common statistic to assess the consistency of quantitative measurements made on the same topic by multiple raters. In this case, we used it to measure the agreement on both the individual items and the overall WEMWBS score. 2) Categorical Discrepancy Index (CDI) to assess the degree of agreement between the self and the external informant. CDI has been based on previous work conducted by Caballero et al. [24], who classified differences into Negative Discrepancy (D-), where the external informant rated well-being lower than the self-informant; Concordance (C), where both ratings were similar; and Positive Discrepancy (D+), where the external informant rated well-being higher than the self-informant. The CDI was derived using standard deviation (SD) thresholds: D- (< -1 SD), C (between -1 and +1 SD), and D+ (> +1 SD). 3) Quantitative

Discrepancy Index (QDI), calculated by Z-transforming WEMWBS scores and subtracting the external informant's rating from the self- informant's score.

- *Analytical plan.*

We first tested whether the two groups of self-informants and external informants (with schizophrenia and bipolar patients) differed in their WEMWBS ratings using independent-sample t-tests, to ensure that further comparisons between self-informants and external informants were not confounded by diagnostic category. We then assessed inter-rater agreement using the ICC and the CDI. Finally, we examined whether demographic and relational factors were associated with rating discrepancies, using both categorical and continuous approaches as described below.

- *Predictor variables:*

For the categorical outcome, multinomial logistic regressions were fitted with the Categorical Discrepancy Index (CDI) as the dependent variable, comprising three levels: negative discrepancy (D-), concordance (C), and positive discrepancy (D+). For the continuous outcome, linear regressions were fitted with the Quantitative Discrepancy Index (QDI) as the dependent variable. In both sets of models, independent predictors included age, sex, relationship duration, and relationship type (family/friend vs. professional).

2.2 Study 2: Qualitative study.

2.2.1 Participants:

The data were collected from 21 self-informants aged 34 to 67 years (M_{age}= 54.0 years), primarily diagnosed with schizophrenia (76%) or bipolar disorder (24%). Most were men (76%). In parallel, 16 external informants participated: 11 (69%) were family members or close friends, and 5 (31%) were professionals (some accompanied more than one user). Among them, 60% were women. In total, 18 matched user-companion dyads were formed. No external informant data were available for four self-informants, and information about the associated self-informant was missing for two external informants.

2.2.2. Procedure

Subsequently, two female researchers conducted 21 semi-structured interviews (see Appendix A). Participants were informed about the aims of the study and the interviewers' affiliations prior to participating. The interviews were conducted in person or by telephone, at the participants' preference. They were audio-recorded with consent and supplemented by field notes. Participants did not review interview transcripts or study findings.

2.2.3 Measures

It was designed to examine the semantic agreement between the self-reported and the responses provided by external informants, focusing on the degree of semantic consistency between both sources for each of the seven items of the WEMWBS questionnaire [26]. The semi-structured interview guide (Appendix A) was organized around the seven items of the WEMWBS [26]. Each item statement (e.g., "I have been feeling optimistic about the future") was presented to participants as a thematic prompt, followed by two types of open-ended questions: (a) a definitional question (e.g., "How would you define feeling optimistic about the future?") and (b) an experiential question inviting concrete examples (e.g., "Could you share a recent experience in which you felt useful?"). This structure was systematically applied to all seven WEMWBS items to explore the subjective meanings participants attributed to each well-being domain. Two parallel versions of the interview guide were developed: one for self-informants, focusing on their own experiences, and one for external informants, focusing on their perceptions of the service user's well-being. Both versions followed the same item-by-item structure to enable systematic comparison of semantic agreement between self-reported and externally reported well-being definitions.

2.2.4 Data analysis

Data coding and analysis were conducted using ATLAS.ti [31] software, following a qualitative content analysis approach that integrates both deductive coding (assigning data to a pre-existing framework, here, the seven WEMWBS items) and inductive coding (deriving new codes directly from participants' responses) [32] (see Appendix D). Since deductive coding may overlook data that do not align with existing theoretical frameworks or predefined categories, it was considered essential to complement this approach with inductive strategies and an iterative coding process.

To clarify the levels of analysis, the following terms are used throughout: the three theoretical components of well-being (psychological, emotional, and social) refer to the constructs introduced above; the seven WEMWBS items denote the specific scale statements, each assessing one well-being domain; qualitative codes are the labels that emerged within each domain during analysis; and these codes were subsequently grouped into broader overarching categories.

The initial coding scheme is informed by the existing literature and guided by the recommendations of Braun and Clarke [33], including familiarisation with the data, systematic code generation, and iterative refinement of categories. A structured codebook approach with independent double-coding was adopted to enhance the reliability of the analytic process (see

Appendix B). Disagreements were resolved through systematic discussion until consensus was reached.

Each domain of well-being was initially segmented into distinct codes. As the iterative process progressed, new codes emerged and were incorporated into the final coding manual. Subsequently, similar codes were merged into broader category constructs. For example, within the domain of 'feeling useful' (item: 'I've been feeling useful'), codes related to autonomy and freedom were merged, reflecting a shared understanding of being able to determine one's sense of usefulness. Similarly, in the coping domain (item: 'I've been dealing with problems well'), codes such as planning and reinterpretation were grouped to represent cognitive coping strategies.

Finally, all codes across domains were reviewed and categorized into four overarching categories (cognitive, behavioral, emotional, and mixed) (see Figure 1), allowing a systematic comparison of the frequency with which each type of code was reported by different groups of informants (self-informants, external informants: family/friends, and professionals). Using contingency tables (Table 3), we compared the frequency distributions of well-being codes across three groups (self-informants, family/friends, and professionals). Overall, the global distributions for Items 1 (Optimism), 2 (Feeling Useful), 3 (Feeling Relaxed), 5 (Thinking Clearly), and 6 (Feeling Close to Others) revealed no significant group differences (all Fisher $p \geq 0.25$).

Figure 1. *Four Overarching Categories of* well-being *Components*

_____Insert figure 1 here_____

Rigour was further enhanced through prolonged engagement with the data, persistent observation, and methodological triangulation. Credibility was enhanced through an extended and iterative coding and theme refinement process. This included participant validation (member checking), as Campbell et al. [34] recommended, whereby clarifying questions were used to confirm individual data interpretations and broader analytic insights. Dependability was sought by double-coding all data and creating a codebook that was used for double-coding [34]. The codebook is available in Appendix B. Regular meetings were held to review emerging codes and maintain consistency, and data saturation was continuously assessed until no new codes or themes emerged [35].

Reflexive memos were used throughout data collection and analysis to manage potential researcher bias, capturing interpretative insights, analytic decisions, thematic development, and links to existing literature and participant patterns [36].

Quantitative analyses were performed using Jamovi software [30]. We employed a two-step quantitative approach to examine the coded responses to the definitional questions concerning each well-being domain across the three informant groups (self-informants, relatives, and professionals).

First, we used contingency tables to compare the frequency distributions of well-being codes for each WEMWBS item (Optimism, Feeling Useful, Feeling Relaxed, Coping, Thinking, Feeling Close to Others, and Ability to Make Decisions). For each individual code within an item, data were dichotomized into “Code” (observed frequency) and “Remainder” (the total domain frequency minus the component frequency), yielding a 2×3 table for group comparisons. Because several cells had expected frequencies below 5, including cells with zero counts (e.g., "Acceptance" in the Coping item), the chi-square approximation was unreliable; Fisher's exact test was therefore used as the test of reference and is the only test reported (Table 3).

Second, all individual codes were aggregated into four overarching categories (cognitive, emotional, behavioral, and mixed), and their percentage distributions across the three informant groups were examined descriptively (Table 4).The rationale for collapsing individual codes into these categories was informed by well-established theoretical frameworks in the well-being literature: the cognitive and emotional categories align with the hedonic and evaluative dimensions described by Diener [9], while behavioral components reflect the functional and agentic aspects emphasized in eudaimonic models of well-being [8]. The mixed category was retained as a descriptive label for codes that could not be unambiguously assigned to a single dimension (i.e., codes that simultaneously reflected elements from two or more categories). This categorization was developed iteratively through team discussion and reviewed for face validity. These aggregated distributions are reported as descriptive indicators of broad tendencies rather than as inferential tests.

The Consolidated Criteria for Reporting Qualitative Research (COREQ) were followed to ensure transparency in reporting [39].

2.2.5. Researcher reflexivity:

The research team approached this study from the premise that well-being in severe mental disorder is a multifaceted construct that cannot be fully captured through a single evaluative perspective (hence the multi-informant, mixed-methods design). This theoretical orientation, grounded in personal recovery frameworks [1,6], may have sensitised the researchers to

interpretations that prioritise patients' subjective experiences over external assessments. To manage this potential bias, reflexive memos were maintained throughout data collection and analysis [34], and regular team meetings were held to systematically challenge emerging interpretations and to ensure that the analytic process remained grounded in the data.

2. Results

3.1 Quantitative results

- *Discrepancy Index of* well-being*:*

No significant differences were found in WEMWBS scores between the schizophrenia and bipolar disorder groups, either in patients' scores (self-informants, t = -1.91, p = .065) or external informants (t = -1.63, p = .111). These results suggest that WEMBWS scores from patients suffering from schizophrenia and bipolar disorders are indistinguishable statistically. The same can also be said of their reference to external informants' scores. Hence, diagnostic group differences will not introduce bias into subsequent analyses, and it is legitimate to analyze both diagnostic groups together to maximize sample size. As shown in Table 1, the global ICC indicates low agreement between self-informant and external-informant ratings (0.22; 95% CI: 0.08-0.35), highlighting the variability in how patients and their external reference informants perceive well-being. While the average item scores tend to converge, their correlations remain low, with negative (D-) and positive (D+) discrepancies ranging from 11% to 32%. This variability suggests potential differences in the interpretation of well-being or divergent priorities in its assessment.

- *Predictor variables:*

The data met the assumptions for parametric tests (Shapiro-Wilk = 0.99; p = .346). Age, gender, and relationship duration did not significantly predict discrepancy. However, the type of relationship (family/friend vs. professional) was a significant predictor of the Quantitative Discrepancy Index (QDI) in a simple linear regression model (R = 0.233, R^2 = .054; F(1, 184) = 10.60, p = .001; see Table A5 in Appendix C). On average, professional informants showed 0.47 more discrepancies than family members or friends (B = 0.472, SE = 0.145, 95% CI [0.186, 0.758]). A positive discrepancy (D+) indicates that external informants rated patients' well-being higher than self-informants.

Regarding the distribution of categorical discrepancy (see Table A6 in Appendix C), among family/friend informants (n = 128), 12.5% of assessments showed positive discrepancy (D+), 67.2% showed concordance (C), and 20.3% showed negative discrepancy (D−). Among professional informants (n = 58), D+ was notably more frequent (24.1%) and D− considerably less so (8.6%), with concordance rates being identical across groups (67.2%). These patterns are

consistent with the linear regression finding: professionals tend to rate patients' well-being higher than they themselves report, while family/friends are more likely to rate it lower.

To further examine potential predictors of categorical discrepancy, three separate multinomial logistic regression models were fitted with the CDI (D+, D−, or Concordance as reference) as the outcome variable (see Tables A1–A4 in Appendix C). Neither relationship duration (Model 1), nor the age of either informant (Model 2), nor the type of relationship (Model 3) significantly predicted membership in the D+ or D− categories relative to concordance at the individual coefficient level (all $p > .10$). The overall fit of Model 3 was marginally significant ($\chi^2(2) = 6.83$, $p = .033$, R^2McF = .021), yet neither regression coefficient reached significance (Professional vs. family/friend for D+ vs. C: OR = 1.93, 95% CI [0.87, 4.32], $p = .110$; for D− vs. C: OR = 0.42, 95% CI [0.15, 1.20], $p = .103$). Across all models, the intercepts were significant and negative (Models 1 and 3: $p < .001$), confirming that concordance was the predominant baseline outcome regardless of the predictor examined. Taken together, these findings indicate that although professionals tend to assign marginally higher well-being scores on the continuous scale, this difference does not translate into a systematic shift from concordance to positive discrepancy at the categorical level.

3.2 Qualitative results.

The qualitative sample comprised 21 self-informants and 16 external informants with diverse sociodemographic and clinical profiles (Table 2). Their characteristics and the composition of the informant dyads are summarized below.

_____Insert table 2 here_____

Using contingency tables (Table 3), we compared the frequency distributions of well-being codes across three groups, self-informants, and external informants (family/friends and professionals), reporting both Chi-square and Fisher's exact tests for transparency. Overall, the global distributions for Items 1 (Optimism), 2 (Feeling Useful), 3 (Feeling Relaxed), 5 (Thinking Clearly), and 6 (Feeling Close to Others) revealed no significant group differences (all $p \geq 0.25$).

In contrast, significant differences emerged for specific codes in Item 4 (Coping) and Item 7 (Ability to Make Decisions). For Item 4, which comprises four codes (Active Behavioral Coping, Cognitive Coping, Help-seeking, and Acceptance), significant differences were observed in the Acceptance and Help-seeking codes. In the Acceptance code, self-informants

reported nine instances (29%), whereas both external groups reported zero (Fisher p=0.03). As one participant (SI-10) explained:

> "*To face them (problems) properly, maybe confront them directly*. *Instead of using all the energy at that moment to complain and say, 'Poor me,' do the opposite, find out what you can do now*."

Another stated, "*As the English say, accept life, endure it*.' (SI-9)

The Help-seeking code also approached significance (Fisher p=0.03) and was more frequently noted by external informants than self-informants. For instance, a family companion remarked:

> "*That he asks for help, that he expresses himself-in essence, he asks for help at the right moment"* (EI- 11).

A professional companion commented:

> "(*When he wants to deal with something), he consults you about it, even if he already has a solution or does not have one, so he does not keep it to himself, you know?*" (EI-1)

Finally, Item 7 (Ability to Make Decisions) includes three codes: Self-efficacy, Self-determination, and Freedom or Empowerment. Here, self-efficacy was rated significantly higher by family/friends (53%) than by self-informants (10%) (Fisher p=0.05). One family companion (EI-9) noted:

> "*For example, when faced with a health issue, she had to decide about undergoing a test; although she was scared, she knew it had to be done and managed her health care*. *Similarly, when lacking clothing or food, she can handle it alone*."

Moreover, Freedom or Empowerment was significantly higher among self-informants (73%) compared to family/friends (35%) (Fisher p = 0.02), as one self-informant explained:

> "*To participate in an activity, to do something, to buy something—something I have declared: 'I decided this myself.*" (SI-13)

_____Insert table 3 here_____

When individual codes were aggregated into the four overarching categories described in the Methods section (Table 4), their percentage distributions suggested that the three informant groups placed differential emphasis on the types of well-being codes they reported.

The most notable tendency concerned the behavioural category, which was reported proportionally more often by family/friends (36%) than by self-informants (22%) or professionals (26%); conversely, self-informants showed a comparatively higher proportion of cognitive and emotional responses. These descriptive tendencies are consistent with the component-level findings reported above (Table 3), in which service users emphasised internal processes such as acceptance and empowerment, whereas external informants more often referred to observable behaviours and help-seeking.

_____Insert table 4 here_____

4. Discussion

First, this study aims to examine the level of agreement in well-being between the assessments of an external informant chosen by the patient (with a personal or therapeutic relationship) and the SMD's own well-being, assessed with the same measure. Quantitative results showed moderate to high levels of agreement (51-72%) between self-reporters with SMD and their external informants. These findings are consistent with Schneider & Schimmack's [20] meta-analysis of a large sample, which reported moderate agreement between self-reports and informant ratings of well-being in the general population, and with Lieberman et al.'s [40] study in clinical samples with anxiety and depression, where agreement was also moderate but lower in depressed patients, likely due to reduced behavioural expression that biases informant assessments [41]. However, our findings contrast with a previous study by Caballero et al. [24], who reported low agreement (35-50%) between patients with SMD and their key professionals when assessing well-being. These differences may be due to methodological issues, since their study compared semantically similar items from different questionnaires, whereas ours used the same instrument for both informants [20].

Secondly, our study revealed high variability in self-informant agreement, suggesting heterogeneous perspectives in well-being evaluation [42]. A regression analysis showed that only the type of relationship modestly predicted discrepancies (≈5% of variance), underscoring the need for a qualitative component to better understand their underlying causes [43]. In this regard, the observed tendency of professionals to rate well-being higher than close personal contacts (i.e., family members or friends) may reflect differences in how clinical training and ongoing therapeutic interaction shape the perception and assessment of patients' well-being. Even though this effect was modest, relying on a single informant perspective in clinical

decision-making could introduce systematic biases that do not adequately capture the patient's subjective experience.

Third, this finding prompted the qualitative study, which found differences between self-informants and external informants in their understanding of which coping strategies and ability to make decisions were associated with well-being. Regarding coping, the interviews revealed a tendency for service users to view acceptance as a key pathway to achieving well-being, whereas external informants emphasized help-seeking as the most effective strategy for enhancing the patient's well-being. These findings align with literature showing that service users and professionals differ in how they view well-being and patient needs, with users often prioritizing acceptance as a key strategy to manage uncertainty and maintain psychological well-being [44,45]. In contrast, professionals tend to prioritize intervention for help-seeking behaviors as the primary mechanism to support recovery [46,47]. This divergence is evident in the therapeutic relationship, where professionals' protective or paternalistic roles may unintentionally restrict patient autonomy and hinder shared decision-making and personalized goal setting [44,46]. These differing frameworks not only shape how well-being is evaluated but also reflect broader systemic challenges in aligning recovery-oriented care with patients' lived experiences and values [47].

Also, our study reveals that service users associate well-being with empowerment and freedom, key elements of personal recovery (CHIME) [1,6]. In contrast, external informants, mainly family and friends, more often highlight self-efficacy. However, professionals may unintentionally limit these experiences by adopting overprotective or deficit-based approaches, focusing more on symptom management, daily functioning, and self-efficacy than on supporting autonomy [46]. This divergence underscores the need to align clinical practice with personal recovery-oriented models that prioritize user-defined goals and strengths, facilitating well-being not merely as the absence of illness but as the presence of agency and purpose [1]. In this regard, patient-led and community-based approaches may promote autonomy and meaningful participation by encouraging socially valued roles, self-determination, and engagement in personally meaningful activities. These factors have been associated with eudaimonic well-being and recovery in people with serious mental illness [12,48].

Moreover, a notable pattern was the divergence in focus between external informants and service users: informants emphasized observable behavioural aspects of well-being, while service users prioritized a combination of emotional, behavioural, and cognitive processes, especially acceptance, as more meaningful paths to well-being. This contrast likely stems from the greater visibility of behavioural indicators for informants versus the subjective nature of emotional and cognitive experiences, which are more accessible to service users. This pattern

aligns with previous research highlighting similar perspective differences in clinical populations [25,49,50].

4.1 Clinical implications:

Our findings highlight the need to incorporate well-being as a core component in individualized rehabilitation plans for patients with SMD. This recommendation is supported by the observed tendency among service users to associate well-being with key recovery-related processes such as acceptance, empowerment, and a sense of freedom. Considering these findings, it is essential to directly engage patients in conversations about their needs and how they believe their well-being can be achieved. Similarly, Gunnmo et al. [51] found that individuals with schizophrenia express a strong desire for autonomy and active participation in decisions that affect their lives, elements they view as central to their well-being. In the same line, Hamm et al. [52] emphasize that self-directed recovery fosters a sense of agency essential for long-term and meaningful recovery, where the client's goals and values shape the therapeutic agenda. Therefore, these findings underscore the importance of clinical practices that include service users in defining their goals, preferences, and strategies for achieving well-being within the recovery process.

4.2 Strengths of this study:

First, the study employed a rigorous mixed-methods design, combining quantitative and qualitative approaches to provide a more comprehensive understanding of well-being assessments. This design enabled not only the examination of concordance between informants through statistical indicators, but also the exploration of the subjective meanings, interpretations, and contextual factors underlying those assessments, which would not have been captured by quantitative data alone. Second, it included a large and representative sample, enhancing the generalizability of the findings. Third, using the same standardized global well-being questionnaire for both self- and external informants ensured consistency in the data collection process. Finally, the study demonstrated strong internal reliability, as evidenced by a high Cronbach’s alpha, supporting the robustness of the measurement tool used.

4.3 Limitations:

First, the study could have included a psychological assessment of the external informants, such as their emotional state, which may have helped to further clarify the heterogeneity observed in the results, as Carnovale et al. [22] did in their study. Additionally, the WEMWBS scale measurement tool may have had limitations in capturing specific dimensions of well-being. Regarding the qualitative component, two professionals evaluated six service users, which may have introduced a potential bias associated. Furthermore, while

theoretical saturation was achieved, the relatively small and context-specific sample may limit the transferability of findings to broader populations or settings.

It is important to note that the quantitative analysis of qualitative code frequencies (i.e., using the number of times a code was mentioned as a score in contingency tables and exact tests involves an inherent epistemological tension. While this approach helped to identify the most prominent patterns of divergence between informant groups and to systematically select the key findings for further discussion, it inevitably reduces the richness and contextual nuances of qualitative data to numerical summaries. As such, the statistical results derived from code frequencies should be interpreted as complementary indicators that highlight broad distributional patterns, rather than as definitive tests of qualitative meaning. The qualitative excerpts and thematic interpretations presented throughout the Results section are intended to preserve the depth and specificity that numerical comparisons alone cannot capture.

4.4 Conclusion:

This study highlights the importance of incorporating both self- and proxy perspectives in assessing well-being in severe mental disorder. Using a mixed-methods design, we found modest concordance on the WEMWBS. Qualitative findings showed that service users emphasized empowerment, freedom, and acceptance, while proxies focused on behavioural indicators, underscoring that self-reports capture unique experiential aspects of recovery. These results support integrating well-being into individualized rehabilitation and promoting person-centred, recovery-oriented care through shared decision-making. Although limited by its cross-sectional, single-region sample, the study advances understanding of well-being assessment and calls for longitudinal research to reduce self-proxy discrepancies and improve recovery outcomes.

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Table 1.

Degree of agreement in the assessment of SWB in individuals with SMD between self-informant and external informant (supporter).

Item	*M (SD)* self-informant N = 186	*M (SD*) external informant N = 186	ICC	D- (%)	C (%)	D+ (%)
Item 1	3.23 (1.13)	3.32 (1.02)	0.36	11.29	72.04	16.67
Item 2	3.36 (1.12)	3.51 (0.98)	0.25	15.05	59.14	25.81
Item 3	3.26 (1.02)	3.35 (0.98)	0.16	14.52	54.84	30.65
Item 4	3.45 (1.02)	3.35 (0.97)	0.12	31.72	51.61	16.67
Item 5	3.40 (0.99)	3.53 (1)	0.1	14.52	55.38	30.11
Item 6	3.47 (1)	3.63 (1.16)	0.24	15.59	61.29	23.12
Item 7	3.72 (0.98)	3.56 (1.07)	0.11	32.26	51.61	16.13
Global score	3.41 (0.81)	3.46 (0.75)	0.22	14.52	69.89	15.59

Note: Item 1 = I've been feeling optimistic about the future; Item 2 = I've been feeling useful; Item 3 = I've been feeling relaxed; Item 4 = I've been dealing with problems well; Item 5= I've been thinking clearly; Item 6 = I've been feeling close to other people; Item 7 = I've been able to make up my mind about things; ICC = Intra-class correlation, D- = negative discrepancy, C = concordance, D+ = positive discrepancy.

Table 2.

Self-informant and external-informants characteristics

Self-informant (N = 21)				External Informant (N = 16)		
	Age	Sex	Diagnosis	Code	Sex	Type
SI-1	48	Male	Schizophrenia	EI-1	Female	Professional
SI-2	55	Male	Schizophrenia	EI-1	Female	Professional
SI-3	67	Female	Bipolar Disorder	EI-2	Female	Professional
SI-4	61	Male	Schizophrenia	EI-2	Female	Professional
SI-5	66	Male	Schizophrenia	EI-2	Female	Professional
SI-6	62	Female	Schizophrenia	EI-2	Female	Professional
SI-7	61	Male	Schizophrenia	EI-3	Male	Friend
-	55	Female	Bipolar Disorder	EI-4	Female	Family
-	55	Male	Schizophrenia	EI-5	Male	Family
SI-8	42	Female	Schizophrenia	EI-6	Female	Friend
SI-9	34	Female	Schizophrenia	EI-7	Female	Professional
SI-10	48	Female	Bipolar Disorder	EI-8	Female	Family
SI-11	57	Male	Bipolar Disorder	EI-9	Female	Professional
SI-12	56	Male	Schizophrenia	-	-	-
SI-13	51	Male	Schizophrenia	-	-	-
SI-14	47	Male	Schizophrenia	EI-10	Female	Family
SI-15	43	Male	Schizophrenia	EI-11	Female	Family
SI-16	49	Male	Schizophrenia	EI-12	Male	Family
SI-17	49	Male	Bipolar Disorder	EI-13	Female	Family
SI-18	51	Male	Schizophrenia	EI-14	Male	Professional
SI-19	62	Male	Bipolar Disorder	EI-15	Female	Family
SI-20	63	Male	Schizophrenia	EI-16	Female	Family
SI-21	61	Male	Schizophrenia	-	-	-

Table 3.

Degree of agreement between self-informant and external informant in the definition of SWB

Item / Codes	Self-Informant (N = 21)	Family /friends Accompanies (N=11)	Professional Accompanies (N=5)	Fisher's exact test (p)
Item 1: Optimism: "I've been feeling optimistic about the future."	25 (100%)	16 (100%)	12 (100%)	p= 1.00
Cognitive	11 (44%)	5 (31.3%)	4 (33.3%)	p = 0.71
Motivational	6 (24%)	7 (43.8%)	6 (50%)	p = 0.25
Hope	8 (32%)	4 (25%)	2 (16.7%)	p = 0.61
Item 2: Feeling Useful: "I've been feeling useful"	28 (100%)	13 (100%)	8 (100%)	p = 1.00
Self-acceptance	5 (17.86%)	2 (15.38%)	0 (0%)	p = 0.73
Autonomy and Freedom	5 (17.86%)	2 (15.38%)	2 (25%)	p = 0.77
Environmental Mastery	12 (42.86%)	8 (61.54%)	5 (62.5%)	p = 0.45
Personal Growth	6 (21.43%)	1 (7.69%)	1 (12.5%)	p = 0.66
Item 3: Feeling Relaxed: "I've been feeling relaxed"	19 (100%)	18 (100%)	7 (100%)	p = 1.00
Absence of Stress	5 (26.32%)	1 (5.55%)	2 (28.57%)	p = 0.18
Affective Balance	3 (15.79%)	5 (27.78%)	2 (28.57%)	p = 0.63
Physical Calm	9 (47.37%)	5 (27.78%)	1 (14.29%)	p = 0.25
Security	2 (10.53%)	7 (38.89%)	2 (28.57%)	p = 0.13
Item 4: Coping: "I've been coping effectively"	31 (100%)	14 (100%)	6 (100%)	p = 1.00
Acceptance	9 (29.03%)	0 (0%)	0 (0%)	**p = 0.03**
Active Behavioral Coping	16 (51.61%)	9 (64.29%)	3 (50%)	p = 0.71
Cognitive	5 (16.13%)	2 (14.29%)	1 (16.67%)	p = 1.00
Help-seeking	1 (3.23%)	3 (21.43%)	2 (33.33%)	**p = 0.03**

Item / Codes	Self-Informant (N = 21)	Family /friends Accompanies (N=11)	Professional Accompanies (N=5)	Fisher's exact test (p)
Item 5: Thinking Clearly: "I've been thinking clearly"	33 (100%)	16 (100%)	5 (100%)	p = 1
Having a Purpose in Life	10 (30.30%)	6 (37.5%)	2 (40%)	p = 0.75
Mental Calm	23 (69.70%)	10 (62.5%)	3 (60%)	p = 0.75
Item 6: Feeling Close to Others: "I've been feeling close to other people."	42 (100%)	21 (100%)	7 (100%)	p = 1.00
Positive Relationships	33 (78.57%)	15 (71.43%)	7 (100%)	p = 0.35
Sharing Activities	9 (21.43%)	6 (28.57%)	0 (0%)	p = 0.35
Item 7: Ability to Make Decisions: "I've been able to make up my mind about things."	30 (100%)	17 (100%)	3 (100%)	p = 1.00
Self-efficacy	3 (10%)	9 (52.94%)	1 (33.33%)	**p = 0.05**
Self-determination	5 (16.67%)	2 (11.76%)	0 (0%)	p = 1.00
Freedom or Empowerment	22 (73.33%)	6 (35.29%)	2 (66.67%)	**p = 0.02**

Note. Only Fisher's exact test is reported, as expected cell frequencies were below 5 in most comparisons, making the chi-square approximation unreliable. Bold indicates $p \leq .05$.

Table 4.

Agreement Between Service Users and External Informants in SWB Definitions

Overarching Category	Self-informants N (%)	External Informants Family/Friends N (%)	Professionals N (%)	Total N (%)
Cognitive	68 (25.9%)	29 (21.2%)	10 (23.8%)	107 (24.2%)
Emotional	122 (46.4%)	57 (41.6%)	21 (50.0%)	200 (45.2%)
Behavioural	58 (22.1%)	49 (35.8%)	11 (26.2%)	118 (26.7%)
Mixed	15 (5.7%)	2 (1.5%)	0 (0.0%)	17 (3.8%)
Total	263 (100.0%)	137 (100.0%)	42 (100.0%)	442 (100.0%)

Note. Values are observed frequencies with column percentages in parentheses. Distributions are presented descriptively to illustrate broad tendencies across informant groups; a global Fisher's exact test indicated an overall association between category and group (p = .03). The "mixed" category denotes codes reflecting more than one dimension and is included as a descriptive label only.

Data Statement_availability

The database is publicly available at 10.6084/m9.figshare.29467925.

Highlights

- Moderate agreement exists between informants regarding well-being in SMD.
- Self-informants or Patients link well-being to empowerment, freedom, and acceptance
- External-informants, especially professionals, stress self-efficacy, help-seeking
- Combining views supports shared decision-making in treatment

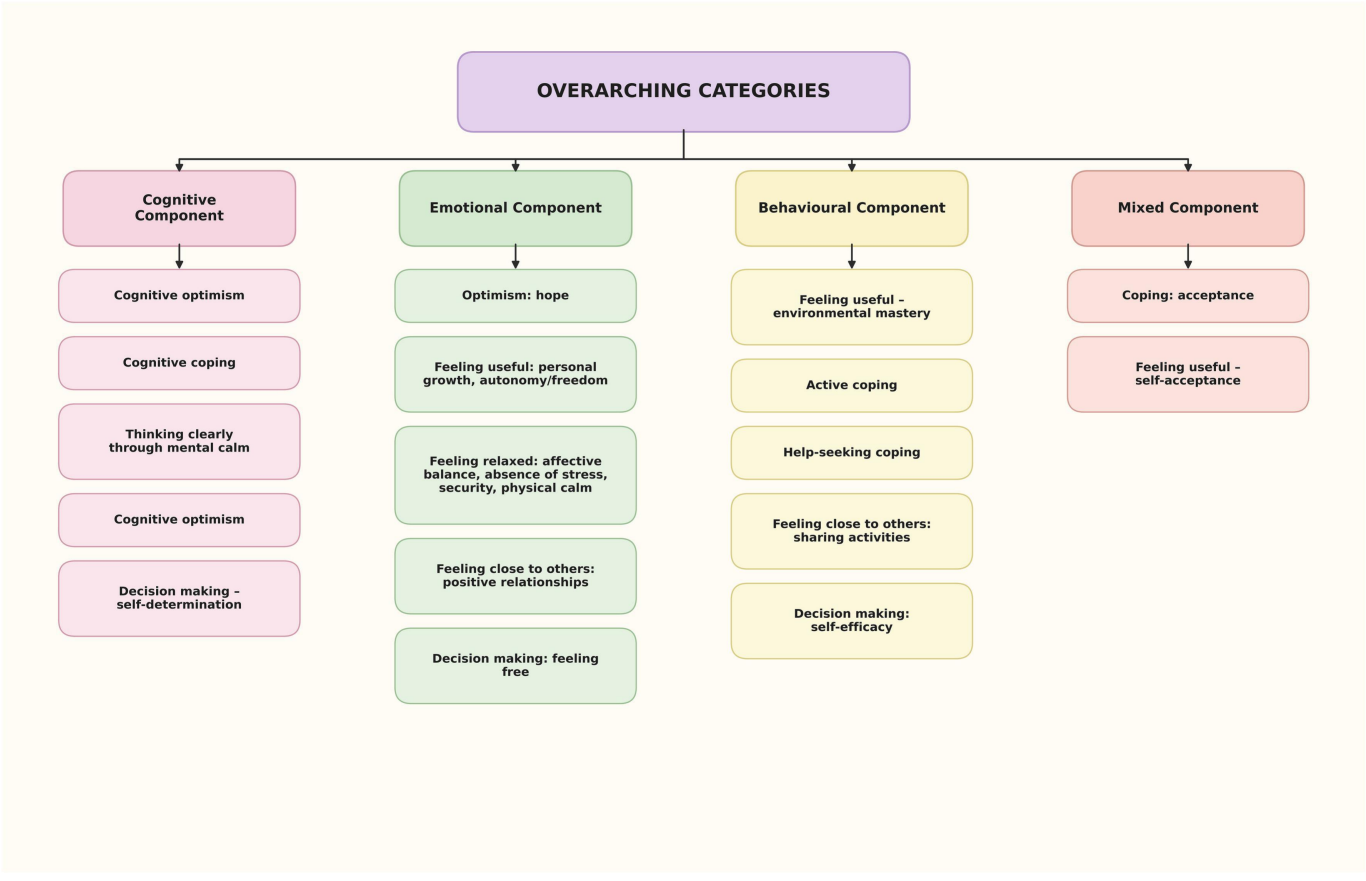
OVERARCHING CATEGORIES
Cognitive Component
Cognitive optimism
Cognitive coping
Thinking clearly through mental calm
Cognitive optimism
Decision making – self-determination
Emotional Component
Optimism: hope
Feeling useful: personal growth, autonomy/freedom
Feeling relaxed: affective balance, absence of stress, security, physical calm
Feeling close to others: positive relationships
Decision making: feeling free
Behavioural Component
Feeling useful – environmental mastery
Active coping
Help-seeking coping
Feeling close to others: sharing activities
Decision making: self-efficacy
Mixed Component
Coping: acceptance
Feeling useful – self-acceptance

Figure 1