



Community Members Prioritise Indicators of Both Mental Health and Wellbeing to Define Flourishing and Quality of Life: Towards *The Total Psychological Health Framework*

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Abstract

Current frameworks define flourishing in terms of wellbeing alone. This paper examines whether community members similarly define flourishing in terms of wellbeing or whether they prioritise both wellbeing and mental health. We also compare whether those indicators of wellbeing and mental health prioritised to define flourishing are similarly important for community members' definition of quality of life. Results are from 2 surveys of community respondents (Survey 1 $n=359$; Survey 2 $n=287$) aged between 18 and 84 years. Participants were asked to identify 5 indicators of wellbeing or mental health which best reflected 'Quality of Life' (Survey 1), and Flourishing (Survey 2). Eleven indicators of wellbeing were from the European Social Survey (ESS) Wellbeing module and nine indicators of mental health were from the Diagnostic Statistical Manual of Disorders V.5 (DSM 5) diagnoses for Major Depressive Disorder and Generalised Anxiety Disorder. Respondents defined flourishing and quality of life in similar ways and in terms of a combination of mental health and wellbeing indicators. Importantly respondents rated both wellbeing and absence of mental illness as reflecting flourishing. There was no single indicator that was endorsed by all participants; instead a range of wellbeing and mental health indicators were endorsed by participants as reflecting flourishing and quality of life. Contrary to current flourishing frameworks, community respondents defined flourishing in terms of both the presence of wellbeing and absence of mental illness. We propose a new model of psychological health that is informed by both wellbeing and mental health/illness and where flourishing is defined in terms of both wellbeing and mental health.

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Introduction

The current paper seeks to examine the extent to which community members define flourishing and quality of life in terms of wellbeing, mental health, or a combination of wellbeing and mental health. Whilst mental health is commonly and formally defined in terms of clinical dysfunction (e.g. the Diagnostic and Statistical Manual of Mental Disorders (DSM (American Psychiatric Association, 2013)); the International Statistical Classification of Diseases and Related Health Problems (ICD-10 (World Health Organization, 2004)), definitions of wellbeing focus on positive dimensions of psychological health that include perceptions of hedonic (i.e., focus on psychological feeling (e.g. affect states) and cognitive judgements of satisfaction) and eudaimonic (i.e., psychological functioning that relates to possessing a sense of purpose, mastery, acceptance of self, etc..) wellbeing (Huppert & So, 2013; Keyes, 2002; Ryff, 1989a, b). And social wellbeing dimensions emphasise connectedness with community and family, altruism and volunteerism, and have also been posited as important for individuals' wellbeing (Gallagher et al., 2009; Huppert & So, 2013; Keyes, 2002; Marsh et al., 2020). There is substantive support for a multi-dimensional and hierarchical model of wellbeing by which indicators are grouped into hedonic, eudaimonic and social factors (Burns & Machin, 2009; Compton et al., 1996; Gallagher et al., 2009; Hervás & Vázquez, 2013; Huppert et al., 2009; Keyes, 1998; Linley et al., 2009), although there is a growing body of evidence to suggest that individuals generally score consistently across multiple wellbeing indicators (Bhullar et al., 2014; Burns & Crisp, 2021; Goodman et al., 2017; Morin et al., 2016). That is, generally there is limited evidence for well-being complexity, instead derived mixture groups identify stability in how groups of individuals score across multiple wellbeing indicators. Currently, most theoretical frameworks define flourishing in terms of these broad wellbeing indicators only—although some researchers have continued to discuss such concepts in Jahoda's (1958) terms of positive mental health, (Huppert & So, 2013; Keyes, 2002, 2007), and there is a need to confirm that community similarly conceptualise in terms of wellbeing, or possibly a combination of both wellbeing and mental health.

Following Jahoda's (1958) well cited 'call to arms' to focus on concepts of positive mental health, flourishing has been defined as the experience of life going well, where individuals experience a sense of wellbeing, feel good about themselves and their lives, and function effectively in their daily lives (Huppert & So, 2013; Keyes, 2002). An individual's flourishing status is therefore defined in terms of wellbeing (or positive mental health) only and not really informed by their mental health, at least not in terms of clinically relevant symptomology. One of the first systematic attempts to present a quantifiable operational definition of flourishing was proposed by Keyes (Keyes, 2002, 2005) who advocated for transforming individual wellbeing dimensions onto a standardized metric and then dividing each scale into 3 tertile groups; those in the top tertile on at least one emotional wellbeing and 6 eudaimonic dimensions were defined as flourishing. Upon what basis these criteria were

formulated to define flourishing is not explicit; why 6 eudaimonic dimensions and not 5 or 7? And of course, one of the issues in making comparisons between different populations from a cut-point on a standardized scale is that the distribution changes and the mean for the standardized scale is meaningful only for that particular sample. In contrast, Huppert and So (2013) proposed approaching flourishing definitions in terms of the extent to which individual experienced multiple positive feelings and functioning. For Huppert and So (2013), participants had to indicate 'agree' to 'strongly agree' on 5-point scales for Competence, Meaning, Optimism, Resilience, Self-Esteem, and Positive Relationships, 'most of the time' to 'all or almost all of the time' on 4-point scales for Vitality and Emotional Stability, and rate their Positive Emotion as 8 and above on a 0–10 scale bounded by 'extremely unhappy' to 'extremely happy'. A similar method was also adopted by Keyes (2007) who abandoned the earlier standardization approach and proposed that flourishers report experiencing wellbeing 'everyday' or 'almost everyday', for at least 1 of 3 emotional wellbeing indicators (Happy, Interested, Satisfied), and at least 6 of eleven indicators of psychological (Self-Acceptance, Mastery, Personal Growth, Autonomy, Purpose in Life, Positive Relations with others) and social wellbeing (Social Contribution, Social Integration, Social Actualisation, Social Acceptance, Social Coherence).

The issue for developing a standard definition of flourishing is that unlike diagnostic classification systems (e.g. DSM 5 (American Psychiatric Association, 2013); ICD-10 (World Health Organization, 2004)) for mental illnesses like depression and anxiety, there is no real consensus in the wellbeing literature regarding what wellbeing dimensions are most important and how to use these models to develop a consistent operational definition of flourishing. In an important review, Hone and colleagues (Hone et al., 2014) examined the concordance between different models of flourishing and demonstrated that changing the operationalisation or definition of flourishing can result in quite different prevalence rates of flourishing. Furthermore, concordance in status varied, such that the likelihood of being defined as flourishing depended on the definition applied. Hone et al. (2014) found substantial difference in prevalence rates of flourishing depending upon the operationalization employed, from 24 to 47%. Also, the concordance of flourishing status ranged from 74 to 81%. That is, even in the best-case scenario, 1 in 5 persons defined as flourishing on one scale were NOT defined as flourishing on another scale. A final and gold-standard flourishing definition is therefore not established. It is important to understand broader community perceptions of flourishing as many questions remain to be answered. For example, it is unclear whether community members define flourishing in terms of wellbeing only. And just what do community members prioritise as important for flourishing?

Relatedly, it would be important to compare the extent to which community members differ in their operationalisation of flourishing with quality of life (QoL). In contrast to flourishing, QoL is perhaps more ubiquitous within the biomedical and health science literature. QoL is a broader concept that generally reflects how well individuals are living their lives, with or without disease. QoL can relate specifically to physical, social, and emotional functional capacities or a general outlook on life (Spitzer et al., 1981). A significant portion of what constitutes QoL can be

defined by those things that constitute wellbeing within the psychological (Dijkers, 2003, 2005) and mental health (Cella et al., 2007) literature.

Another question then to be explored is the extent to which these terms are defined differently or similarly by community members. It may well be that definitions of flourishing and quality of life suffer from Jingle-Jangle fallacies (Marsh et al., 2019, 2020) to an extent, where constructs named similarly are qualitatively different (Jingle) and similar constructs are named differently (Jangles). Members of the community may define terms like flourishing and quality of life synonymously. Therefore, the existing substantive knowledge-base regarding quality of life, may be directly relevant to flourishing researchers. Further, since mental health and wellbeing is such an integral components of these constructs, a key question is whether individuals emphasise the absence of psychopathology or the presence of wellbeing as most important for reflecting flourishing and QoL. It is important to ensure that the ways in which researchers define, and government policy is then designed around, these constructs, recognises those facets of psychological health the community values and are reflected in current models.

Current models of flourishing (Diener et al., 2010; Huppert & So, 2013; Keyes, 2007), with their emphasis on wellbeing, ignore the extent to which community members prioritise the absence of psychopathology as reflective of flourishing. In some respects Keyes addressed this by further developing a concept of “complete mental health” (absence of psychopathology and presence of wellbeing), although at times even discussion of this model is often conflated by Jingle-Jangles. In one sense flourishing can be defined solely in terms of positive mental health (i.e. wellbeing) (Keyes, 2007), but othertimes, even in the same study (Keyes, 2004), flourishing can be defined both as high wellbeing in one instance, and high well-being and lack of psychopathology (i.e. complete mental health) in another instance. In contrast, languishing is solely defined as low wellbeing (e.g. languishing vs. languishing with major depressive episode) (Keyes, 2004). And so the argument remains whether flourishing itself, in the eyes of community members themselves, is indeed reflective of well-being only, BUT also the absence of psychopathology. We would propose, based on a combination of research, clinical and public engagement with community, that community members prioritise both presence of wellbeing and absence of psychopathology as reflective of flourishing. The issue is that the most widely cited flourishing models either ignore the role of psychopathology, or conflate terms, sometimes within the same research paper! The development of a clearly defined nosological/salutogenic model of flourishing, that is informed by dimensions of wellbeing and psychopathology, is needed. Researchers and policy advocates need to ask community members what they think is important to flourish and experience quality of life, to inform their own practice.

The current paper therefore seeks to examine whether lay community members prioritise indicators of wellbeing and/or mental health as reflecting flourishing and QoL. In contrast to established flourishing models (Huppert & So, 2013; Keyes, 2007), it may be that community members define flourishing (and QoL) in terms of a combination of both mental health and wellbeing. We will answer this by providing community members with validated indicators of wellbeing and mental health, and asking respondents to identify and rank 5 mental health and wellbeing

indicators that best reflect flourishing and QoL. It is important to determine whether community members define flourishing and QoL synonymously and if community members define these constructs in terms of wellbeing or mental health.

Research Hypothesis 1: We hypothesise that for lay community members, there will be no differences in

- a) those indicators chosen by community members as reflecting flourishing and QoL, and
- b) the rank order of chosen indicators between flourishing and QoL contexts.

Finally, we then examine whether the indicators of QoL and flourishing chosen by community members are related to several key socio-demographic and health characteristics. For instance, we know that there are sex differences in mental health and wellbeing (Burns et al., n.d.; Eid et al., 2019), and similarly that people prioritise different aspects of mental health and wellbeing across the life course (Burns, 2020; Charles et al., 2001; Keyes et al., 2002; Ryff, 1989b, 2014). It will be important to know whether these same socio-demographic characteristics manifest in different perceptions of QoL and flourishing indicators so that we can understand whether those aspects which reflect psychological health to community members are consistent between sex and age, for example. Further, we will also examine whether a range of health characteristics, including personal mental health stigma, degree of contact with mental illness, and current level of mental health and wellbeing, moderate which indicators community members prioritise as reflecting QoL and flourishing. It is important to consider how community members' responses may be moderated by aspects of their own mental health and wellbeing. There are several possible associations which are worth examining. For example, it may be that those with higher stigma and lower degree of contact with mental illness prioritise wellbeing indicators. Conversely, those with poorer mental health and wellbeing may prioritise mental health indicators. And the level of contact individuals have with those living with mental ill-health is strongly related to their levels of stigma (Couture & Penn, 2003).

Research Hypothesis 2: We hypothesise that the items chosen to reflect flourishing and QoL (Hypothesis 1a) will be moderated by key socio-demographic (sex, age, partner status, level of contact with mental illness) and health characteristics (psychological distress, wellbeing and mental health stigma). We can make no definitive statement about which items will be more or less likely endorsed.

Methods

To be eligible for the study, participants had to consent to participate, be aged 18 and older, and reside in Australia. Over 1120 potential participants responded to a Facebook advert to complete a survey of mental health and well-being literacy hosted on Qualtrics. Of these, 646 participants met our eligibility criteria completed questions about defining QoL and flourishing.

QoL and Flourishing Surveys

Participants completed one of two surveys. In both surveys, participants were provided a list of 20 indicators of wellbeing and mental health. In the first survey, participants ($n=359$ (55.6%)) were asked to choose 5 indicators which best reflected “Quality of Life”. Specifically, participants were asked “we would like to know which of the following statements you think best reflect a good Quality of Life.” In the second survey, participants ($n=287$ (44.4%)) were asked to choose 5 indicators which best reflected “Flourishing”. Specifically, participants were asked “we would like to know which of the following statements you think best reflect whether you are flourishing in life.” In both surveys, participants were then asked to rank their 5 indicators in order of importance.

Mental Health and Wellbeing Indicators:

Eleven indicators of wellbeing were drawn from the European Social Survey Well-being Module (Huppert et al., 2009; Huppert & So, 2013) and encompass dimensions of social, psychological and subjective wellbeing, and included items: "Feeling close to community and people in the local area"; "Having a lot of energy"; "Feeling very positive about oneself"; "Being able to bounce back when things go wrong"; "Having people around who really care about me"; "Taking all things together, generally feeling happy most of the time"; "Being optimistic about the future"; "Having a sense of accomplishment"; "Feeling that what you do in your life is valuable and worthwhile"; "Being interested in learning new things"; "Feeling calm and peaceful".

Nine indicators of mental health were drawn from DSM 5 diagnoses for Major Depressive Disorder and Generalised Anxiety Disorder (American Psychiatric Association, 2013). Recurrent thoughts of death, which is a symptom of Major Depressive Disorder, was excluded as it was deemed to be an obvious symptom of mental health disorder. Owing to the inherent negative valence of mental health indicators and the positive valence of the wellbeing indicators, the authors rephrased the mental health indicators with a positive valence. For example, DSM criterion for the presence of depressed mood (e.g. Major Depression, Dysthymia) and/or excessive worries and anxiety (e.g. Generalized Anxiety Disorder) were rephrased as “Being free of depressed mood” and “Being free of excessive worries and anxieties that are difficult to control” respectively.

Socio-demographic, Health and Mental Health Covariates:

Participants’ self-reported sex, marital status and age were asked. For the purposes of this paper, participants were either male or female; $n=2$ reported ‘other’ sex status and were removed from the analysis. Marital status was coded

as either currently partnered or not currently partnered. Age was reported in terms of chronological age in years.

Participants completed the Level-of-Contact Report (LCR). The LCR presents 12 situations to measure one's familiarity towards mental illness. These situations were generated based on adaptations from other scales measuring stigma and ranked by three experts in severe mental illness and psychiatric rehabilitation (Holmes et al., 1999). Participants' scores range from 1, indicating the lowest level of familiarity towards mental illness, to 12, reflecting the highest level of familiarity towards mental illness. For this study, one item relating to 'working with someone with mental illness' was excluded as not all participants were employed. Therefore, the highest score of 11 reflects the highest level of familiarity towards mental illness. The interrater reliability for the correlation of the mean rank order was reported to be 0.83 (Holmes et al., 1999).

Participants completed the Kessler Psychological Distress Scale (K-10). The K10 is a 10-item questionnaire which measures non-specific psychological distress of an individual in the last 30 days. Items are scored on a scale from one (none of the time) to five (all the time) with higher scores indicative of higher distress (Kessler et al., 2002). Both surveys reported Cronbach's alphas = 0.93, reflecting high internal consistency.

Participants completed the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) The WEMWBS has 14 items which measures both the hedonic and eudaimonic aspects of well-being (Deary et al., 2013; Tennant et al., 2007). Higher total score reflects higher level of individual well-being. Cronbach's alpha values of 0.94 and 0.95 were reported for Surveys 1 and 2 respectively, reflecting high internal consistency.

Participants completed the Personal Stigma Subscale (PSS) of the Depression Stigma Scale. The PSS consists of 9 items measuring participant's attitudes towards depression (Griffiths et al., 2004). Each item is measured on a 5-point Likert scale from 0 (strongly disagree) to 4 (strongly agree), with higher scores indicating higher levels of stigma towards depression. Cronbach's alpha values of 0.81 and 0.82 were reported for Surveys 1 and 2 respectively.

Results

Socio-demographic and health characteristics of the participants are reported in Table 1. Overall, the sample was predominantly female sex and partnered. Participants were aged from 18 to 84 years with a mean (M) age of 49.7 (SD = 16.0) years. The mean level of contact score suggests that a large number of participants had moderate contact with people with mental illness, and a low level of stigma was reported on average. Overall, K-10 and Wellbeing scores suggest the sample is generally moderate in psychological distress and wellbeing. There were no substantive differences between the two samples.

Table 1 Socio-demographic and health characteristics of the participants

	Whole Sample (n = 646)	Survey 1 (QoL) (n = 359)	Survey 2 (Flourishing) (n = 287)	QoL vs. Flourishing
	M (SD)	M (SD)	M (SD)	
Male, N (%)	117 (18.1)	67 (18.7)	50 (17.4)	$\chi^2=0.17$; $P=0.684$
Partnered, N (%)	378 (58.6)	211 (58.8)	167 (58.4)	$\chi^2=0.01$; $P=0.922$
Age	49.7 (16.0)	48.7 (16.4)	50.9 (15.4)	$t=1.68$; $P=0.093$
Level of Contact	9.5 (2.1)	9.4 (2.2)	9.6 (1.8)	$t=1.73$; $P=0.083$
Perceived Stigma	6.0 (5.0)	6.4 (4.9)	5.5 (5.0)	$t=1.98$; $P=0.048$
K10	21.9 (8.6)	21.7 (8.5)	22.1 (8.7)	$t=0.62$; $P=0.538$
Wellbeing	41.2 (10.4)	41.4 (10.4)	41.0 (10.3)	$t=0.54$; $P=0.586$

Indicators of Quality of Life (QoL) and Flourishing

The proportion of participants who reported each of the indicators as important for QoL or Flourishing are provided in Fig. 1. We can observe that the wellbeing indicators (rather than mental health) were most frequently selected by participants as reflective of QoL or Flourishing. It appears that members of the community report ‘having people around who care’, ‘having a sense of worth’, ‘a sense that one’s life is valuable’, ‘being able to bounce back when things go wrong’, and ‘generally feeling positively about oneself’ are markers of flourishing and QoL.

We also compared whether different indicators were endorsed for defining QoL versus Flourishing (see Table 2). Overall there were few differences in the

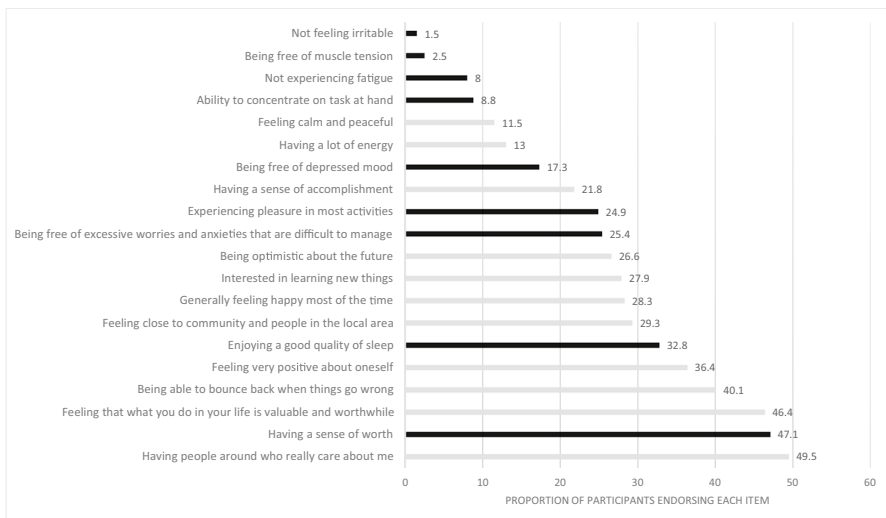


Fig. 1 Proportion of respondents endorsing wellbeing and mental health items in both Survey 1 and Survey 2. Note: Black bar graphs reflect Mental Health Indicators; Gray bar graphs reflect wellbeing indicators

Table 2 Differences in the proportions reporting indicators as their top 5 reflecting QoL and Flourishing

	QoL % (SE)	Flourishing % (SE)	QoL vs. Flourish χ^2
Having people around who really care about me	54.0 (2.6)	43.9 (2.9)	$\chi^2 = 6.56; P = 0.010$
Having a sense of worth	49.3 (2.6)	44.3 (2.9)	$\chi^2 = 1.63; P = 0.201$
Feeling that what you do in your life is valuable and worthwhile	46.5 (2.6)	46.3 (2.9)	$\chi^2 = 0.01; P = 0.964$
Being able to bounce back when things go wrong	38.7 (2.6)	41.8 (2.9)	$\chi^2 = 0.64; P = 0.425$
Feeling very positive about oneself	36.8 (2.5)	35.9 (2.8)	$\chi^2 = 0.05; P = 0.817$
Enjoying a good quality of sleep	35.9 (2.5)	28.9 (2.7)	$\chi^2 = 3.56; P = 0.059$
Feeling close to community and people in the local area	29.2 (2.4)	29.3 (2.7)	$\chi^2 = 0.01; P = 0.995$
Generally feeling happy most of the time	30.6 (2.4)	25.4 (2.6)	$\chi^2 = 2.13; P = 0.145$
Interested in learning new things	26.4 (2.3)	29.6 (2.7)	$\chi^2 = 0.79; P = 0.374$
Being optimistic about the future	26.2 (2.3)	27.2 (2.6)	$\chi^2 = 0.08; P = 0.776$
Being free of excessive worries and anxieties that are difficult to manage	29.2 (2.4)	20.6 (2.4)	$\chi^2 = 6.36; P = 0.012$
Experiencing pleasure in most activities	22.0 (2.2)	28.6 (2.7)	$\chi^2 = 3.67; P = 0.055$
Having a sense of accomplishment	17.8 (2.0)	26.8 (2.6)	$\chi^2 = 7.57; P = 0.006$
Being free of depressed mood	17.5 (2.0)	17.1 (2.2)	$\chi^2 = 0.25; P = 0.874$
Having a lot of energy	11.7 (1.7)	14.6 (2.1)	$\chi^2 = 1.21; P = 0.270$
Feeling calm and peaceful	10.0 (1.6)	13.2 (2.0)	$\chi^2 = 1.62; P = 0.203$
Ability to concentrate on task at hand	7.5 (1.4)	10.5 (1.8)	$\chi^2 = 1.70; P = 0.192$
Not experiencing fatigue	7.5 (1.4)	8.7 (1.7)	$\chi^2 = 0.31; P = 0.581$
Being free of muscle tension	1.1 (0.6)	4.2 (1.2)	$\chi^2 = 6.21; P = 0.013$
Not feeling irritable	1.7 (0.7)	1.4 (0.7)	$\chi^2 = 0.08; P = 0.776$

Bolded items reflect Mental Health Indicators

proportions reporting a particular indicator as reflective of either QoL or Flourishing. The wellbeing indicator *'Having a sense of accomplishment'* was more frequently endorsed as an indicator of Flourishing (26.8% (SE=2.6)) than QoL (17.8% (SE=2.0)). In contrast, *'having people around me who really care about me'* was more frequently endorsed as an indicator of QoL (54.0% (SE=2.6)) than Flourishing (43.9% (SE=2.9)). It is important to note that despite these differences, *'having people around me who really care about me'* was still strongly endorsed for both Flourishing and QoL. Notably, *'being free of muscle tension'* was more frequently endorsed as an indicator of Flourishing (4.2% (SE=1.2)) than QoL (1.1% (SE=0.6)), though the relative magnitude of this is low for both Flourishing and QoL Life. Otherwise, there were few differences between the surveys suggesting a degree of similarity with how individuals define flourishing and QoL in terms of wellbeing and mental health.

The mean rank order of the indicators in order of importance for all participants are displayed in Table 3. Unlike the results indicating a predominance of wellbeing indicators as being prioritised most frequently for reflecting QoL and Flourishing, we can see that when asked to rank their top 5 selections, mental health and wellbeing indicators were more evenly distributed amongst the top-ranked indicators. So, wellbeing indicators were more likely to be selected into the top 5 indicators of QoL and Flourishing, but then there appears to be no particular emphasis for wellbeing or mental health indicators in the rank order. The mental health indicator *'having a sense of worth'* was rated as the most important indicator of QoL and Flourishing, and along with *'being free of depressed mood'*, were among 2 of the top 5 indicators. Being *'free of excessive worries and anxieties'* and *'not experiencing fatigue'* were other highly ranked mental health indicators of both QoL or Flourishing. In terms of wellbeing indicators, *'social connection'*, *'feeling happy'*, *'positive about oneself'* and *'feeling one's life is valuable'* were the leading indicators ranked. Comparison of the mean rank order between the QoL and Flourishing surveys generally revealed no substantive differences in the rank orders of the individual indicators (Table 3).

Further comparison of the top-5 rank order between QoL and Flourishing in terms of the proportion of participants who endorsed each indicator are displayed in Figs. 2 and 3 for both Surveys (Stated % in Supplementary Table 1). There were no substantive differences in the proportions between surveys in terms of the top-5 rank. There was one difference in the rank order for the item *'Feeling that what you do in your life is valuable and worthwhile'* although on inspection the differences appear to be driven only by the extent to which the item was ranked 4th or 5th between QoL and Flourishing surveys. Overall, these results suggest that community members define QoL and Flourishing with the same set of wellbeing and mental health indicators.

Socio-Demographic and Health Characteristics that Drive Perceptions of QoL and Flourishing

Finally we examined whether the socio-demographic and health characteristics of participants were related to which indicators were selected. Since the differences in

Table 3 Mean rank scores for the wellbeing and mental health indicators

	Combined Sample M (SD)	QoL M (SD)	Flourish M (SD)	QoL vs. Flourish t (df) P
Having a sense of worth	2.10 (1.13)	2.11 (1.11)	2.09 (1.16)	t=0.21 (287); P=0.837
Having people around who really care about me	2.42 (1.30)	2.45 (1.31)	2.39 (1.29)	t=0.37 (304); P=0.709
Feeling that what you do in your life is valuable and worthwhile	2.60 (1.35)	2.57 (1.29)	2.63 (1.44)	t=0.36 (280); P=0.717
Being free of depressed mood	2.67 (1.48)	2.90 (1.54)	2.33 (1.34)	t=1.93 (100); P=0.056
Feeling very positive about oneself	2.76 (1.28)	2.89 (1.29)	2.58 (1.26)	t=1.79 (217); P=0.075
Generally feeling happy most of the time	2.77 (1.63)	2.61 (1.63)	3.05 (1.60)	t=1.71 (171); P=0.088
Free of excessive worries and anxieties that are difficult to manage	3.15 (1.47)	3.14 (1.46)	3.16 (1.50)	t=0.08 (156); P=0.937
Not experiencing fatigue	3.21 (1.40)	3.56 (1.42)	2.75 (1.25)	t=2.02 (45); P=0.050
Feeling close to community and people in the local area	3.24 (1.47)	3.22 (1.52)	3.27 (1.41)	t=0.21 (173); P=0.836
Being able to bounce back when things go wrong	3.28 (1.30)	3.39 (1.30)	3.15 (1.28)	t=1.39 (243); P=0.166
Feeling calm and peaceful	3.33 (1.44)	3.31 (1.59)	3.35 (1.30)	t=0.11 (67); P=0.912
Having a sense of accomplishment	3.35 (1.19)	3.30 (1.14)	3.39 (1.23)	t=0.43 (133); P=0.671
Having a lot of energy	3.36 (1.44)	3.45 (1.31)	3.26 (1.58)	t=0.61 (79); P=0.545
Enjoying a good quality of sleep	3.43 (1.33)	3.29 (1.38)	3.67 (1.21)	t=1.91 (196); P=0.058
Experiencing pleasure in most activities	3.45 (1.39)	3.50 (1.31)	3.40 (1.46)	t=0.43 (151); P=0.665
Ability to concentrate on task at hand	3.54 (1.24)	3.48 (1.28)	3.59 (1.21)	t=0.21 (54); P=0.754
Being free of muscle tension	3.60 (0.99)	3.75 (0.96)	3.55 (1.04)	t=0.34 (13); P=0.736
Being optimistic about the future	3.67 (1.20)	3.76 (1.13)	3.54 (1.30)	t=1.11 (157); P=0.269
Interested in learning new things	3.76 (1.11)	3.77 (1.12)	3.76 (1.12)	t=0.04 (156); P=0.964
Not feeling irritable	4.00 (1.33)	4.17 (1.33)	3.75 (1.50)	t=0.46 (8); P=0.656

Bolded items reflect Mental Health Indicators

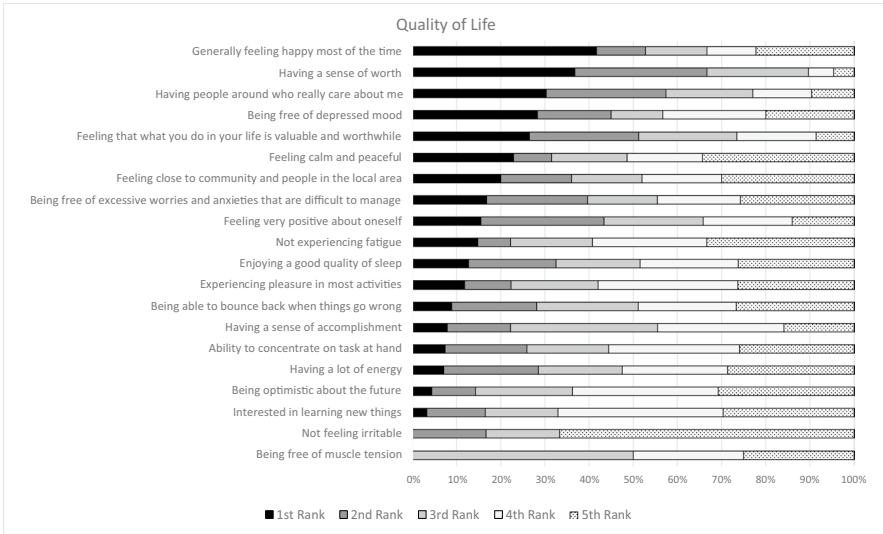


Fig. 2 The proportion to which each item was ranked in Survey 1

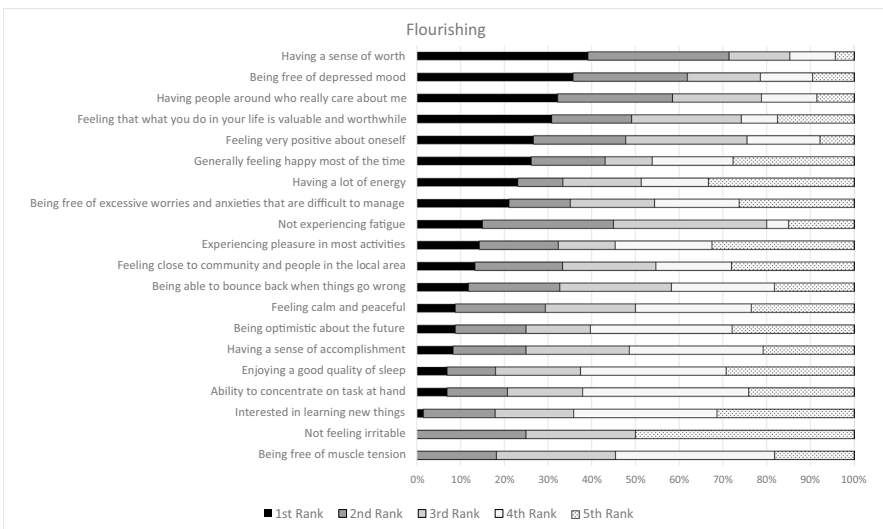


Fig. 3 The proportion to which each item was ranked in Survey 2

the indicators chosen and their rank order did not substantially differ between the QoL and flourishing surveys, these analyses combined the 2 samples. Bi-variate associations between each wellbeing and mental health indicator with age, sex, partner status, level of contact with prior mental illness, psychological distress, wellbeing, and personal stigma of mental illness are reported in Table 4. There were few moderate to strong associations that were reported with very high level of probability

Table 4 Correlations between socio-demographic variables and selecting indicators of mental health and wellbeing as important

	Age	Male	Part	Cont	K10	WB	Stigma
Wellbeing Indicators							
Feeling close to community and people in the local area	0.09	0.06	0.02	0.03	-0.06	0.04	-0.06
Having a lot of energy	-0.01	0.02	0.00	0.01	0.04	-0.05	0.06
Not experiencing fatigue	-0.03	-0.04	-0.01	0.13*	0.23*	-0.20*	0.04
Having a sense of accomplishment	0.02	0.09	-0.03	-0.04	-0.02	0.00	-0.01
Feeling very positive about oneself	-0.01	0.00	-0.06	-0.07	-0.01	0.02	0.03
Interested in learning new things	0.12	0.07	-0.01	-0.07	-0.01	0.06	0.03
Having people around who really care about me	-0.09	-0.14*	-0.08	0.04	-0.03	0.03	-0.07
Being able to bounce back when things go wrong	-0.11	-0.11	-0.05	0.04	-0.08	0.11	-0.07
Generally feeling happy most of the time	0.03	0.03	0.08	-0.13	-0.11	0.09	0.07
Being optimistic about the future	0.07	-0.01	0.06	-0.05	-0.09	0.12	0.04
Feeling what you do in life is valuable and worthwhile	0.01	-0.02	-0.02	-0.01	-0.07	0.08	-0.07
Feeling calm and peaceful	0.03	0.08	-0.01	-0.09	-0.01	-0.02	0.04
Mental Health Indicators							
Having a sense of worth	-0.06	-0.05	0.04	0.06	-0.01	0.00	-0.05
Ability to concentrate on task at hand	0.02	0.07	-0.04	-0.04	0.05	-0.04	0.08
Being free of muscle tension	0.03	0.00	0.03	-0.01	0.06	-0.14*	0.05
Being free of depressed mood	0.01	0.01	-0.10	0.07	0.16*	-0.18*	0.04
Enjoying a good quality of sleep	0.03	0.04	0.05	0.00	0.06	-0.09	0.08
Experiencing pleasure in most activities	-0.02	0.00	0.02	0.04	0.02	0.02	-0.05
Not feeling irritable	0.05	0.04	0.05	0.02	0.01	-0.03	0.03
Free of excessive anxieties that are difficult to manage	-0.08	-0.03	0.07	0.09	0.09	-0.07	-0.06

* $p < 0.001$. *Part*, Partnered; *Cont*, Prior contact with mental illness; *K10*, Kessler psychological distress scale; *WB*, Warwick Edinburgh wellbeing scale; *Stigma*, Personal stigma scale

($p < 0.001$). For example, psychological distress was positively associated with likelihood of selecting 'not experiencing fatigue' and 'being free of depressed mood' as indicative of QoL or flourishing. Conversely, wellbeing was negatively associated with likelihood of selecting these indicators and 'being free of muscle tension'.

Multi-variate logistic regression analysis examined the likelihood of reporting each wellbeing and mental health indicator as reflective of either QoL or flourishing associated with sex, partner status, level of contact with prior mental illness, psychological distress, wellbeing and personal stigma of mental illness. Estimates are reported in Table 5. As with the bivariate analyses, there were few moderate to strong associations which were reported with a high level of probability ($p < 0.001$), therefore we report those associations with $p < 0.05$. For example, higher wellbeing was associated with lower likelihood of reporting 'being free of muscle tension'

Table 5 Estimates from multi-variate regression analyses between socio-demographic variables and selecting indicators of mental health and wellbeing as important

	Age		Male		Partner Status		Level of Contact		Psychological Distress		Wellbeing		Personal Stigma	
	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p
Wellbeing Indicators														
Feeling close to community and people in the local area	1.01 (1.03)	0.036	1.52 (2.36)	0.063	1.06 (1.52)	0.739	1.09 (1.21)	0.092	0.98 (1.01)	0.220	0.99 (1.02)	0.620	0.98 (1.02)	0.337
Having a lot of energy	1.00 (1.01)	0.857	1.16 (2.09)	0.628	1.08 (1.75)	0.759	1.03 (1.18)	0.653	1.00 (1.05)	0.993	0.99 (1.03)	0.550	1.04 (1.09)	0.162
Not experiencing fatigue	1.01 (1.03)	0.258	0.60 (1.49)	0.274	1.18 (2.17)	0.599	1.25 (1.63)	0.096	1.06 (1.12)	0.050	0.97 (1.02)	0.252	1.01 (1.07)	0.799
Having a sense of accomplishment	0.99 (1.00)	0.095	0.85 (1.29)	0.444	1.24 (1.72)	0.194	1.07 (1.17)	0.145	0.98 (1.01)	0.248	0.99 (1.02)	0.506	0.99 (1.02)	0.544
Feeling very positive about oneself	1.00 (1.01)	0.580	0.91 (1.40)	0.672	0.75 (1.05)	0.091	0.92 (1.01)	0.071	1.01 (1.04)	0.578	1.01 (1.04)	0.467	1.01 (1.05)	0.567
Interested in learning new things	1.02 (1.03)	0.004	1.32 (2.08)	0.221	0.87 (1.26)	0.467	0.94 (1.04)	0.227	1.05 (1.09)	0.011	1.03 (1.06)	0.023	1.00 (1.04)	0.852

Table 5 (continued)

	Age		Male		Partner Status		Level of Contact		Psychological Distress		Wellbeing		Personal Stigma	
	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p
Having people around who really care about me	0.99 (0.0.98; 1.00)	0.041	0.51 (0.033; 0.79)	0.002	0.73 (0.53; 1.01)	0.058	1.00 (0.91; 1.10)	0.956	0.98 (0.95; 1.01)	0.224	1.00 (0.97; 1.02)	0.905	0.98 (0.95; 1.02)	0.316
Being able to bounce back when things go wrong	0.98 (0.97; 0.99)	0.001	0.62 (0.40; 0.97)	0.038	0.83 (0.59; 1.16)	0.271	1.04 (0.94; 1.14)	0.454	0.99 (0.95; 1.02)	0.430	1.03 (1.00; 1.05)	0.064	0.99 (0.95; 1.02)	0.512
Generally feeling happy most of the time	0.99 (0.98; 1.01)	0.393	1.11 (0.71; 1.75)	0.647	1.32 (0.91; 1.89)	0.141	0.93 (0.84; 1.02)	0.123	0.98 (0.95; 1.02)	0.304	1.00 (0.98; 1.03)	0.784	1.03 (0.99; 1.07)	0.147
Being optimistic about the future	1.01 (0.99; 1.02)	0.344	0.92 (0.57; 1.47)	0.722	1.20 (0.83; 1.74)	0.325	1.01 (0.91; 1.12)	0.836	1.01 (0.97; 1.05)	0.602	1.03 (1.00; 1.06)	0.026	1.03 (0.99; 1.07)	0.188
Feeling what you do in life is valuable and worthwhile	1.00 (0.99; 1.01)	0.931	0.96 (0.64; 1.46)	0.864	0.87 (0.63; 1.20)	0.401	0.99 (0.91; 1.08)	0.846	0.99 (0.96; 1.02)	0.585	1.01 (0.98; 1.03)	0.540	0.97 (0.94; 1.01)	0.191

Table 5 (continued)

	Age		Male		Partner Status		Level of Contact		Psychological Distress		Wellbeing		Personal Stigma		
	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	
Feeling calm and peaceful	1.00 (0.98; 1.02)	0.879	1.58 (0.88; 2.86)	0.129	0.90 (0.54; 1.50)	0.691	0.89 (0.79; 1.01)	0.078	1.00 (0.96; 1.06)	0.847	0.98 (0.95; 1.02)	0.390	1.00 (0.94; 1.05)	0.866	
Mental Health Indicators															
Having a sense of worth	0.99 (0.98; 1.00)	0.095	0.85 (0.56; 1.29)	0.444	1.24 (0.90; 1.72)	0.194	1.07 (0.98; 1.17)	0.145	0.98 (0.95; 1.01)	0.248	0.99 (0.97; 1.02)	0.506	0.99 (0.96; 1.02)	0.544	
Ability to concentrate on task at hand	1.01 (0.99; 1.03)	0.495	1.45 (0.75; 2.82)	0.271	0.73 (0.41; 1.28)	0.270	0.92 (0.80; 1.06)	0.260	1.02 (0.97; 1.08)	0.429	1.00 (0.96; 1.05)	0.886	1.03 (0.97; 1.09)	0.332	
Being free of muscle tension	1.02 (0.98; 1.06)	0.261	0.63 (0.13; 3.09)	0.571	1.31 (0.42; 4.05)	0.643	0.89 (0.68; 1.18)	0.425	0.95 (0.87; 1.04)	0.249	0.89 (0.83; 0.95)	0.001	0.94 (0.83; 1.06)	0.282	
Being free of depressed mood	1.01 (1.00; 1.03)	0.073	0.99 (0.57; 1.72)	0.981	0.66 (0.43; 1.01)	0.054	1.05 (0.92; 1.20)	0.440	1.01 (0.97; 1.06)	0.501	0.96 (0.93; 0.99)	0.018	1.01 (0.97; 1.06)	0.640	
Enjoying a good quality of sleep	1.01 (1.00; 1.02)	0.202	1.14 (0.74; 1.77)	0.548	1.26 (0.89; 1.79)	0.197	1.00 (0.91; 1.10)	0.977	1.00 (0.96; 1.03)	0.874	0.98 (0.95; 1.01)	0.112	1.03 (0.99; 1.07)	0.165	

Table 5 (continued)

	Age		Male		Partner Status		Level of Contact		Psychological Distress		Wellbeing		Personal Stigma	
	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p	OR (95% CI)	p
Experiencing pleasure in most activities	1.00 (0.99; 1.02)	0.974	1.07 (0.67; 1.73)	0.770	1.11 (0.76; 1.62)	0.581	1.02 (0.92; 1.14)	0.712	1.01 (0.98; 1.05)	0.448	1.02 (0.99; 1.03)	0.286	0.99 (0.95; 1.03)	0.578
Not feeling irritable	1.03 (0.98; 1.09)	0.218	2.15 (0.52; 8.97)	0.294	3.41 (0.69; 16.86)	0.132	1.29 (0.83; 2.00)	0.262	0.97 (0.85; 1.10)	0.599	0.95 (0.86; 1.05)	0.325	1.06 (0.94; 1.19)	0.356
Free of excessive anxieties that are difficult to manage	0.99 (0.98; 1.00)	0.164	0.88 (0.53; 1.43)	0.597	1.62 (1.10; 2.37)	0.014	1.07 (0.96; 1.21)	0.221	1.01 (0.98; 1.05)	0.429	1.00 (0.97; 1.03)	0.776	0.97 (0.93; 1.01)	0.195

(OR=0.89 (95% CI: 0.84; 0.95) $p=0.001$) and *'being free of depressed mood'* (OR=0.96 (95% CI: 0.93; 0.99) $p=0.018$), but higher likelihood of reporting *'interested in learning new things'* (OR=1.03 (95% CI: 1.00; 1.06) $p=0.024$) and *'being optimistic about the future'* (OR=1.03 (95% CI: 1.00; 1.06) $p=0.022$). Higher psychological distress was associated with higher likelihood of reporting *'interested in learning new things'* (OR=1.04 (95% CI: 1.00; 1.07) $p=0.042$). Being male was associated with higher likelihood of reporting *'having a sense of accomplishment'* (OR=1.67 (95% CI: 1.05; 2.65) $p=0.030$), but lower likelihood of reporting *'having people around who really care about me'* (OR=0.50 (95% CI: 0.33; 0.77) $p=0.001$) and *'being able to bounce back when things go wrong'* (OR 0.60 (95% CI 0.38; 0.94) $p=0.25$). Being partnered was associated with lower likelihood of reporting *'having people around who really care about me'* (OR=0.70 (95% CI: 0.51; 0.97) $p=0.033$) but higher likelihood of reporting *'being free of excessive worries and anxieties that are difficult to manage'* (OR=1 0.56 (95% CI: 1.07; 2.27) $p=0.021$). We note that many of these effects are of marginal substantive difference and the extent of any statistical significance need to be considered in the light of the combined sample size. Notably level of contact with mental health was not associated with endorsement of mental health or wellbeing indicators.

Discussion

The primary aim of the current paper was to examine whether community members prioritised indicators of wellbeing, mental health, or both mental health and wellbeing to define flourishing. Further we compared whether those indicators chosen to reflect flourishing differed from those indicators prioritised as reflecting QoL; just how much do flourishing and QoL overlap? Finally, we considered the extent socio-demographic and health characteristics were associated with definitions of quality of life and flourishing.

There are a number of important findings to elucidate. First, it was highlighted that participants defined 'flourishing' and 'a good quality of life' in terms of a combination of both mental health and wellbeing. Based on the responses of our 646 survey participants, we note that most (13) of the indicators were selected as reflective of QoL and flourishing by more than 20% of the sample. This suggests that there is no consistency between community members in how either flourishing or QoL are defined. Further, it is important to highlight that greater proportions of items selected were derived from the wellbeing indicators, (e.g. *'having people around who really care about me'*, *'feeling that what you do in your life is valuable and worthwhile'*, *'being able to bounce back when things go wrong'*). Although some mental health indicators, namely *'having a sense of worth'*, *'enjoying a good quality sleep'*, *'being free of excessive worries/anxieties that are difficult to manage'*, and *'experiencing pleasure in most activities'*, were also selected by at least 20% of the respondents. Conversely, only 4 indicators, specifically mental health indicators with a somatic element, including *'ability to concentrate on task at hand'*, *'not experiencing fatigue'*, *'being free of muscle tension'*, and *'not feeling irritable'*, were selected by less than 10% of the sample. Indeed, the latter 2 indicators were selected

by only 2.5% and 1.5% of the sample respectively. This suggests that wellbeing indicators appear to hold slightly more weight for individuals in describing flourishing and QoL, at least for those respondents in this study. However, when asked to rank those items selected, the differences in the extent to which mental health or wellbeing indicators were ranked was less substantive.

Second, we can conclude that the chosen indicators of both QoL and Flourishing are highly comparable. Overall, there were few differences between the two surveys in the proportions of respondents identifying each indicator as indicative of QoL or Flourishing. Any notable differences were for low prevalence indicators. For example, more respondents in the Flourishing survey (4.2%) were likely to select *'being free of muscle tension'* in comparison with the QoL survey (1.1%); however, the overall rate of selection was very low < 5%. There were notable differences in terms of the wellbeing indicators *'having people around who really care about me'* and *'having a sense of accomplishment'* with 43.9% and 26.8% of respondents in the Flourishing survey (Survey 2) selecting these items in comparison with 54.0% and 17.8% of respondents in the QoL survey (Survey 1). There also was a notable difference in terms of the mental health indicator *'being free of excessive worries and anxieties that are difficult to manage'* with 29.2% of respondents in the QoL survey selecting this item in comparison with 20.6% of respondents in the Flourishing survey. Otherwise, there were no other substantive differences between surveys in the proportions of participants selecting the mental health and wellbeing indicators. This suggests that, at a measurement level, QoL and Flourishing may be conceptually highly similar to members of the community.

Third, and perhaps of most importance, is that no one indicator was endorsed by more than 50% of the sample. Although 54.0% of the QoL sample endorsed *'having people around who really care about me'* (vs. 43.9% in the Flourishing sample), these findings suggest that there is no particular feature of wellbeing or mental health which unanimously captures Flourishing or QoL. Instead, respondents endorsed a large number of the available indicators. These similarities were also noted in the rank order of items between the QoL and Flourishing samples. Perhaps of particular interest for wellbeing researchers was that strongly endorsed wellbeing indicators reflected social, psychological and subjective wellbeing suggesting all three dimensions are perceived as equally important. That there was no dominant feature for defining Flourishing is similar to results on happiness, where happiness has been defined in terms of family (29%), relationships (26.9%), a sense of harmony (25.4%), with no single factor reported by a majority of respondents (Delle Fave et al., 2011).

Finally, we examined whether the indicators of quality of life and flourishing were related to socio-demographic participant characteristics. Several associations were reported. First, individuals with higher wellbeing were less likely to endorse indicators associated with anxiety (e.g. *'being free of muscle tension'*) and depression (e.g. *'being free of depressed mood'*). This suggests that the immediate salience of indicators may be important in community conceptualisations of what it means to flourish or have a good quality of life. For example, for those with poorer wellbeing, the importance of being free of depression may be vital, whereas for those already experiencing positive wellbeing they instead emphasise indicators that may

elevate positive wellbeing further such as being *'interested in learning new thing'* and *'being optimistic about the future'*. Being male was associated with higher likelihood of reporting *'having a sense of accomplishment'*, but lower likelihood of reporting *'having people around who really care about me'* and *'being able to bounce back when things go wrong'*. This is consistent with research examining gender differences in value priorities and definitions such that females prioritise social connection and personal relationships where material success and accomplishment are reported by males (Dyke & Murphy, 2006).

Other notable socio-demographic characteristics were partner status and level of contact. Surprisingly, being partnered was associated with lower likelihood of reporting *'having people around who really care about me'*. It is possible that this may be because individuals that are partnered take the support benefits for granted and don't see it as something that drives their wellbeing. Being partnered was also associated with higher likelihood of reporting *'being free of excessive worries and anxieties that are difficult to manage'* which is in line with existing literature which highlights that those in good quality relationships report better wellbeing and mental health (Umberson & Montez, 2010; Williams, 2003). Level of contact with mental health was not associated with endorsement of mental health or wellbeing indicators.

Together these findings may inform clinical practice and health policy. On one hand it is useful to know that community conceptualisations of flourishing and QoL are largely the same regardless of the terminology they were presented. However, the finding that only approximately 50% of the sample endorse one item, at most – most items ranged from 17 to 45%, highlights the diverse ways in which the community values and understands flourishing or quality of life to mean. Whilst some may prioritise social connections, others value having a sense of worth, resilience, positive experiences or mastery. This implies that measurement of community and individuals' wellbeing must consider the breadth and multi-dimensional (and to an extent the hierarchical structure) nature of wellbeing. Otherwise, purported differences between individuals or groups of individuals, may otherwise be simply an artifact of underlying measurement issues.

The endorsement of a combination of mental health and wellbeing indicators adds complexity to the flourishing literature. Common definitions of flourishing are defined in terms of wellbeing or positive mental health only (Diener et al., 2010; Hone et al., 2014; Huppert & So, 2013; Keyes, 2002). Whilst wellbeing indicators were generally more frequently endorsed in our study, a review of the mental health indicators still shows that 5 of the 9 mental health indicators were endorsed as indicators of flourishing by 17.1% to 44.3% of respondents. This is a substantial number who define flourishing in terms of mental health or specifically the lack of psychopathology. Further, a comparison of the rank order of items endorsed reveals that respondents ranked 2 mental health indicators (*'sense of worth'*; *'free of depressed mood'*) in the top 5, and 2 more (*'free of excessive worries and anxiety'*; *'not experiencing fatigue'*) in the top 10 of ranked indicators. We therefore believe there is an argument to reconcile current theoretical frameworks of Flourishing (and consequently Languishing) which are informed by wellbeing, or positive mental health, only (Diener et al., 2010; Hone et al., 2014; Huppert & So, 2013; Keyes, 2002) following the results of our community

surveys. That is, researchers define flourishing in terms of the presence of wellbeing, and languishing in terms of the absence wellbeing. There may be significant limitations for current flourishing frameworks where existing flourishing definitions are based on wellbeing (note, the term positive mental health is often used synonymously), as the results from our community survey suggest a number of mental health indicators, in addition to wellbeing, reflect community members' perceptions of this construct.

Consequently, we propose a conceptual model, *The Total Psychological Health Framework of Flourishing and Languishing* (See Fig. 4) which incorporates existing theoretical frameworks of flourishing and languishing, and the dual continua of mental health and wellbeing (Diener et al., 2010; Huppert & So, 2013; Keyes, 2002, 2005, 2007). First, individuals are placed on scales of mental health (high vs. low levels of symptomology/distress) and wellbeing (low vs. high levels of wellbeing) independently. Generally we would expect at least small to moderate negative correlations between where individuals may sit on these dimensions. Second, in contrast to current definitions of flourishing and languishing which are identified on the figure, and reflected by level of wellbeing only, we propose defining flourishing in terms of the concordance of both wellbeing and mental health. Flourishing therefore reflects the presence of both high mental health (i.e. low psychological distress/symptomology) and high wellbeing. Conversely, languishing is defined as the presence of both low mental health (i.e. high psychological distress/symptomology) and low wellbeing. Our proposed definitions of flourishing and languishing are described by the dotted lines that encircle both ends of the mental health and wellbeing axes. This proposition is supported by the results of our community participants who prioritised both dimensions of wellbeing and mental health as reflecting flourishing. Conversely, we hypothesize

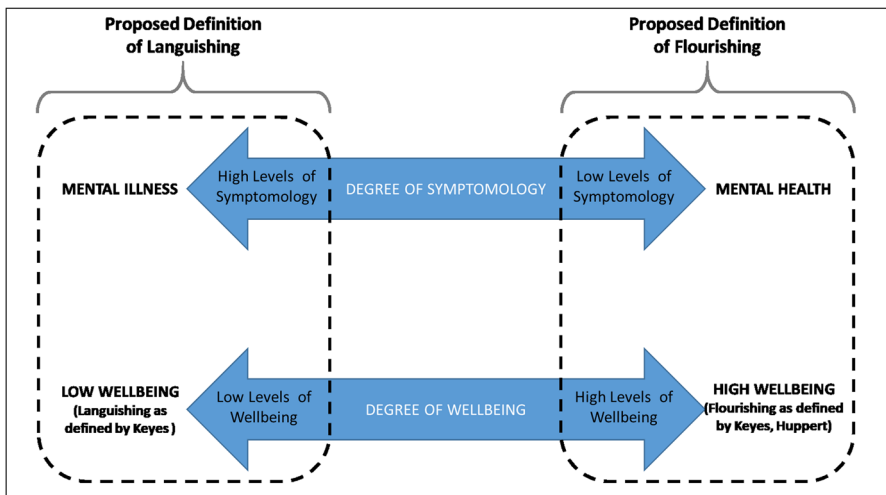


Fig. 4 The Total Psychological Health Framework: A new conceptual model of Flourishing and Languishing

that Languishing, can be defined as the absence of wellbeing and presence of mental illness symptoms. Our current study did not examine languishing specifically, and clearly this is a hypothesis that needs to be tested.

We note that in some instances defining flourishing as the concordance of wellbeing and psychopathology (high well-being + low psychopathology) has been proposed (Keyes, 2004), but the extent to which this model is applied is inconsistent. And a corresponding definition of languishing (in terms of the concordance of wellbeing and psychopathology) has not been made, as far as we are aware. We therefore consider it important that a clear and declarative model outlines unambiguously how flourishing and languishing are defined in terms of both dimensions of wellbeing and mental health.

We recognise that much of this discussion is around the concordance participants may experience (i.e. high mental health and wellbeing; low mental health and wellbeing), but other combinations of wellbeing and mental health may be possible (see Keyes (2002)) where individuals may report moderate on one dimension, and high, or low, on another dimension. However, we believe it is also important to caution over-interpreting some of these findings, specifically that individuals can experience high wellbeing whilst reporting mental illness. Indeed, we note that Keyes' (2002) mental illness was based on a binary indicator drawn from 12-month CIDI diagnosis – whereas wellbeing was defined on current state. Whilst we strongly advocate that those who experience periods of mental illness can still experience wellbeing throughout their lives, and hence capacity to flourish, we believe it is highly unlikely that individuals with current high wellbeing can experience concurrent psychological distress that would be sufficient to inhibit individuals' daily functional capacity. Indeed, Criteria B for MDD, for example, would most likely specifically preclude this. At this stage, we would emphasise here a need to distinguish between ever and current diagnosis, and specifically treated vs. non-treated current ill-health. Simply, if someone is symptomatic (i.e. currently experiencing symptoms of mental illness or is currently unwell), it is unlikely that they would report high levels of flourishing across multiple wellbeing dimensions, including mood. But that person, when managing their illness (e.g. in receipt of treatment), has potential to flourish. It is highly feasible for the individual in remission or not experiencing an episode, to be afforded the capacity to flourish. Indeed, we would highlight that several indicators of major depressive disorder (e.g. presence of depressed mood, lack of positive mood, feelings of worthlessness) directly contrast with wellbeing indicators (e.g. lack of negative affect, presence of positive mood, a sense of worth) and so the likelihood of individuals being able to 'flourish' within existing frameworks AND experiencing significant psychological disturbance is problematic. We therefore argue here, in line with our community participants' responses, that having positive mental health or wellbeing alone does not reflect a flourishing state. Rather we posit that experiencing both wellbeing and mental health reflects a flourishing status; the converse reflects languishing.

The main argument we make here is based on the results from our community members who appear to rank mental health as an important indicator of flourishing. There is clearly scope for further research to consider how and in what ways complexity in wellbeing and mental health co-occur. However, while individuals with

psychiatric illness may experience flourishing in periods of their lives, it is questionable to suggest that individuals can be flourishing when reporting a psychiatric disorder as identified by current flourishing definitions (Diener et al., 2010; Huppert & So, 2013; Keyes, 2002, 2005, 2007). Importantly, it is unclear the extent to which current flourishing models identify individuals at-risk. We believe it is important for both clinical practice and public health policy to clearly distinguish between wellbeing and mental health dimensions, since wellbeing is itself a risk for future mental health outcomes (Burns et al., 2011, 2022; Fava et al., 2001, 2011; Lamers et al., 2015; Ruini & Fava, 2009; Weich et al., 2011; Wood & Joseph, 2010), and consequently that definitions of personal flourishing should be based in terms of lives being lived well, with a sense of emotional, psychological and social wellbeing, AND the absence of CURRENT psychopathology/mental illness which inhibit daily functioning. We believe such a clear distinction has important implications for emphasising differences in promoting positive wellbeing and addressing mental illness in the community. We propose that our model proposed here may be an avenue for structuring further research in the area which examines the nexus between wellbeing and mental health.

Limitations and Future Directions

While the current study provides important insight into the way in which community members identify wellbeing and mental health indicators as important in reflecting Flourishing and a Quality of Life, several limitations should be acknowledged. First, it is important to note that even when considering the 10 most endorsed indicators, they were only endorsed between approximately 25% and 50% of the sample. This highlights the difficulties in defining and establishing clear differentiation between QoL and Flourishing constructs. Second, we note that many of the socio-demographic predictors found to be related to perceptions of QoL and Flourishing are of marginal substantive difference. Therefore, the extent of any statistical significance identified needs to be considered with caution in light of the sample size. Generally, there was consistency in the way individuals emphasised mental health and wellbeing indicators for both QoL and Flourishing. However, we note that there were some differences in socio-demographic and health characteristics between the surveys which assessed Quality of Life (Survey 1) and Flourishing (Survey 2) separately and we recognise that these between-person factors may account for the study findings.

There are several areas for future consideration. First, despite the large sample size, the study needs to be replicated with other community samples. Also, we make no assertion that the findings from our community sample would reflect specific populations, particularly those at greater risk for poor mental health (e.g. university students, older adults in residential care, those with particular chronic illnesses). Relatedly, owing to the broad age range of our sample (age 18–84 years), we have not examined age differences in the results presented here. Study designs which utilise multiple narrow age-cohorts (e.g. 20–25; 40–45; 60–65; 80–85 years) would be best for eliciting whether there are age-related differences in the indicator elicited as reflective of flourishing and quality of life. Relatedly, studies need to consider

longitudinal stability in participant responses in order to discriminate between-person and within-person differences, where within-person differences may reflect ageing related (or other external contextual factors) changes in indicator preferences. Finally, we have focused on eliciting from respondents which indicators they prioritise as the most important for describing flourishing and quality of life. We need to replicate these findings in terms of how community persons define languishing. As the current findings implicate both the absence of mental illness symptoms and the presence of positive wellbeing indicators in defining flourishing/quality of life, it will be important to determine whether the presence of mental illness symptoms and absence of wellbeing indicators are similarly related to perceptions of languishing or whether it is primarily the presence of mental illness symptoms or absence of wellbeing indicators that are prioritised in defining languishing. We recognise that in order to control for the valence of the DSM and ESS indicators, DSM mental health symptoms were rephrased to reflect a positive state or absence of symptom. It would be important to extend this method and examine whether managing mental illness symptoms; in that respects, some individuals may define their flourishing as being able to manage mental illness symptoms as well as prioritising wellbeing. Relatedly latent class/mixture analysis of wellbeing and mental health symptoms could identify relatively homogenous groups of individuals who have particular combinations of wellbeing and mental health symptoms; for example, are there groups of individuals who have active symptoms of mental illness and have positive well-being?

Conclusion

To conclude, we have sought to explore whether community members define Flourishing and QoL in terms of mental health symptoms or personal wellbeing. Generally, findings between Flourishing and QoL were consistent; that is those indicators reported by Survey 1 as reflecting QoL were reported by participants in Survey 2 as reflecting Flourishing. Notably, contrary to current conceptual models that define Flourishing in terms of wellbeing, our community respondents emphasised both indicators of mental health and wellbeing as reflecting Flourishing and QoL. There is a need for Flourishing researchers to address limitations with existing Flourishing theoretical models and acknowledge community perceptions. We therefore propose a new conceptual approach to defining Flourishing and Wellbeing which incorporates the dual continua model of wellbeing and mental health to define Flourishing and Languishing in terms of both mental health and wellbeing, which can guide further research in this important area.

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Declarations

Compliance of Ethical Standard Statement The Australian National University Human Research Ethics Committee approved the research study (Protocol 2019/945). All procedures performed in this study involving human participants were in accordance with the ethical standards of the institution, the National Statement on Ethical Conduct in Human Research 2007 and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent As part of the ethics approval, participants needed to consent to participate and were able to withdraw from the study at any time during data collection.

Conflict of Interest Statement The authors declare that there are no disclosures to report.

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