Towards a Taxonomy of Positive Mental Health: A Delphi Consensus Study

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Abstract

Inconsistent conceptualisation of terms such as positive mental health, flourishing, and mental wellbeing across disciplines hinders reliable measurement, intervention design, and policy. This study sought expert consensus on a preliminary taxonomy of positive mental health dimensions to standardize conceptualization using the Delphi method. We surveyed experts (n=122) across 11 disciplines relevant to positive mental health via three iterative rounds. The first round invited experts to rate the suitability of 26 initial dimensions (identified in prior reviews) on relevance for a taxonomy, while subsequent rounds invited expert-suggested dimensions and rating of dimensions as drivers or outcomes of positive mental health. Nineteen dimensions achieved consensus (≥75% agreement) for inclusion in the preliminary taxonomy of positive mental health. Six dimensions exceeded 90% agreement, including Meaning and Purpose, Life Satisfaction, Self-Acceptance, Connection, Autonomy, and Happiness. This taxonomy promotes standardized conceptualisation and cross-disciplinary collaboration, addressing fragmentation to enhance interventions and policy.

Introduction

There is growing recognition of positive mental health, both as an intrinsic asset and a protective factor for physical and mental health outcomes(1, 2). Positive mental health is associated with reduced risk of chronic disease, improved recovery from stressful events, longevity, and a range of personal, community, and societal benefits(3, 4).

As the promotion and assessment of positive mental health attracts greater attention in research, practice, and public policy(5-7), there is a pressing need to clarify how positive mental health is conceptualized(8, 9). Currently, there is a multiplicity of terms – for example, mental wellbeing, flourishing, thriving, coping, and quality of life – which are conflated across disciplines such as psychology, sociology, philosophy, public health, and medicine. Inconsistent terminology has resulted in fragmented efforts in measurement, intervention design, policy, and cross-disciplinary collaboration(10).

While major theories of positive mental health, mental wellbeing, or flourishing (here used synonymously) contain some degree of overlap, there is limited consistency in what a measure for positive mental health may contain, or what an intervention designed to improve positive mental health will target. Reviews of measures of positive mental health and related terms have found a wide degree of variability in dimensions included in the scales(11-13). Similarly, interventions to improve mental wellbeing can include any combination of psychological, social, cultural/environmental, or physical components(14). This diversity makes comparison between measures and interventions difficult, which in turn undermines data synthesis and recommendations for policy and practice.

Positive mental health has become a topic of significant academic interest, yet it is not contained within a single discipline, and each discipline defines positive mental health differently, using partially overlapping combinations of indicators or dimensions to operationalize the concept(10). For example, entire disciplines or individual researchers will use Life Satisfaction as *the* dimension of positive mental

health, whereas others broaden to include a composite of life satisfaction with positive and negative affect, and some broaden further to include indicators of purpose, optimism, growth, belonging, and so on. This list of possible dimensions to include in a model or composite of positive mental health continues to expand, with an umbrella review of measures identifying 21 different dimensions that are commonly used to define positive mental health[12]. This review of measures identified key dimensions of positive mental health, but simultaneously underscored the interdisciplinary nature of the challenge, with divergent approaches across fields complicating consensus.

There have been calls for greater consistency in the use of definitions and dimensions of positive mental health to prevent further conceptual confusion[15-17]. While it is commonly agreed that positive mental health is more than happiness and life satisfaction[18], there is no upper limit to how many dimensions might be considered. This conceptual confusion, perpetuated by limited inter-disciplinary crosstalk, prevents governments, researchers, and funders from knowing which dimensions of mental health should be assessed, monitored, and targeted to best promote positive mental health and prevent future physical and mental illness. We used the Delphi method to develop expert consensus on the constituent dimensions of positive mental health, engaging a large and multidisciplinary panel of scholars from relevant academic fields.

Results

A total of 1,650 authors were identified from the literature review and additional 99 authors from the World Happiness Report. From this combined list, valid emails addresses were obtained for 1,349 active academics. When the survey was administered, there were approximately 160 automatic replies (e.g. notices of retirement or leave, delivery failure notices, mailbox bounce-backs). In total, 122 participants consented and completed the first round the of survey, resulting in an approximate 10.3% response rate (122/1189). The respondents were highly accomplished scholars, with an average of approximately 16,748 citations per person according to Google Scholar (median citation count: 8,027). Participant demographics, reported in Table 1, demonstrated that the panel of experts was balanced by gender, highly educated, and had an average of nearly 20 years of experience in the field. The majority identified as primarily ethnically Caucasian/European. Participants came from mostly Clinical and Positive Psychology, though several opted to self-describe their discipline. Participants lived in 26 countries, predominantly from Western nations. One participant reported insufficient expertise and was excluded from the analyses.

Table 2: Demographics of Expert Panel (n=122)

Demographics		Count (%)
Age		53.42 (13.30)
Gender	Male	56 (45.9%)
	Female	65 (53.3%)
	Non-binary	1 (0.8%)
Education	Doctoral Degree Level	118 (96.7%)
	Master Degree Level	3 (2.5%)
	Other	1 (0.8%)
Ethnicity	Aboriginal/Torres Strait Islander	1 (0.8%)
	Asian/Indian	8 (6.6%)
	Caucasian/European	102 (83.6%)
	Latin American/Hispanic	1 (0.8%)
	Middle Eastern	2 (1.6%)
	Other	5 (4.1%)
	Prefer not to answer	3 (2.5%)
Country	United States of America	37 (30.3%)
	United Kingdom	20 (16.4%)
	Australia	16 (13.1%)
	Netherlands	8 (6.6%)
	Canada	7 (5.7%)
	Italy	4 (3.3%)
	Spain	4 (3.3%)
	Belgium	2 (1.6%)
	China	2 (1.6%)
	Germany	2 (1.6%)
	Ireland	2 (1.6%)
	Portugal	2 (1.6%)

	Sweden	2 (1.6%)
	Switzerland	2 (1.6%)
Discipline	Economics	7 (5.7%)
	Medicine	10 (8.2%)
	Nursing	4 (3.3%)
	Other	19 (15.6%)
	Philosophy	2 (1.6%)
	Psychiatry	4 (3.3%)
	Psychology (clinical)	19 (15.6%)
	Psychology (health)	14 (11.5%)
	Psychology (positive)	17 (13.9%)
	Public Health	14 (11.5%)
	Sociology	9 (7.4%)
	Theology	3 (2.5%)
Years in Field, Mean (SD) [Median]		19.39 (11.5) [15.0]

Note: Only countries with at least two participants are listed. Countries with one participant included: Algeria, Austria, Denmark, France, Israel, Japan, Kazakhstan, South Korea, New Zealand, Singapore, South Africa, Turkey.

The results of the expert panel votes across the three rounds are reported in Table 2 (we report the aggregated votes, that is, important and essential are merged into included). Experts reached consensus on 19 dimensions (bold) across the three rounds, with only Avoidant coping reaching consensus for exclusion. In Round 2, the expert-suggested dimensions were included in the survey, and the dimension of Sense of Community (which did reach agreement in round 1) was divided into four dimensions that were suggested by experts. The complete aggregate scores along with the list of dimensions that were expert-suggested are included in Appendix Table A2-3.

Table 2: Expert panel votes on whether dimensions should be included in a taxonomy of positive mental health. Bolded results indicate dimensions that met the threshold for consensus.

	Agreement for inclusion or exclusion (%)		
	R1 (n=122)	R2 (n=95)	R3 (n=89)
Meaning and purpose	**95.9%**	rc1	rc1
Life satisfaction	**94.3%**	rc1	rc1
Self-acceptance	**94.2%**	rc1	rc1
Connection	**93.4%**	rc1	rc1
Autonomy	**90.9%**	rc1	rc1
Happiness	**90.1%**	rc1	rc1
Acceptance	**84.3%**	rc1	rc1
Competence	**84.2%**	rc1	rc1
Sense of community	82.6%	d	d
Belonging	-	**87.2%**	rc2
Positive view of people & society	-	46.2%	na
Social contribution	-	71.0%	69.1%
Engagement	**82.4%**	rc1	rc1
Development	**81.1%**	rc1	rc1
Optimism	**81.0%**	rc1	rc1
Self-congruence	**80.2%**	rc1	rc1
Fun	**78.3%**	rc1	rc1
Vitality	**75.0%**	rc1	rc1
Activities and Functioning	**75.0%**	rc1	rc1
Achievement	73.1%	**81.7%**	rc2
Accepting of others	68.6%	66.7%	na
Calmness	68.4%	**75.5%**	rc2
Emotion-focused coping	65.2%	66.0%	na
Problem-focused coping	64.2%	60.2%	na
Physical health	62.8%	61.1%	na
Personal Circumstance	62.5%	57.9%	na
Spirituality	54.7%	45.2%	na

Novelty	36.8%	26.9%	na
Avoidant coping	20.4%	rc1	Rc1
Sense of safety	-	**75.5%**	rc2

Note: R1 – Round 1; R2 – round 3; R3 – round 3; rc1 – not assessed because consensus was reached as 'included' in R1; rc2 – not assessed because consensus was reached as 'included' in R2; d – not assessed because it was divided into four separate dimensions; na – not assessed because consensus was reached as 'not include'. Bolded numbers indicate a final decision of inclusion.

In round 3, experts were asked to consider whether each of the included dimensions were considered '100=mostly an outcome' or '0=mostly a driver' of positive mental health. The mean and median responses of experts is reported in Table 3. Happiness and Life satisfaction were the most commonly considered 'mostly an outcome', whereas Sense of Safety and Autonomy were considered 'mostly a driver'.

Table 3: Beliefs in whether a dimension is a driver or outcome of positive mental health (n=89).

	Mean (SD)	Median
Happiness	74.74 (27.92)	90
Life Satisfaction	72.46 (28.60)	85
Calmness	64.39 (33.37)	74
Vitality	58.01 (30.62)	52
Meaning and Purpose	53.7 (33.78)	52
Fun	53.37 (32.34)	52
Self-acceptance	49.60 (32.71)	51
Development	46.27 (31.38)	50
Optimism	46.01 (30.97)	50
Activities and functioning	45.4 (31.34)	51
Achievement	44.18 (33.55)	50
Engagement	43.92 (32.93)	50
Competence	39.51 (31.43)	48
Connection	39.04 (25.65)	50
Self-congruence	39.00 (32.61)	47
Acceptance	38.16 (30.08)	49
Belonging	35.95 (27.35)	48
Sense of Safety	32.47 (28.72)	23
Autonomy	29.10 (26.90)	17

Note: These responses are to the question 'to what extent do you consider this dimension to be mostly a driver of positive mental health (0), both (50), or mostly a positive mental health outcome (100).

Round 1 also included an opportunity for experts to provide feedback on the formation of a taxonomy. A number of concerns were raised, which have been thematically summarised. These included: cultural

and contextual variability; the distinction between dimensions, causes, outcomes; challenges associated with defining positive mental health; inclusion of diverse perspectives and stakeholders; developmental considerations, comments on the purpose and application of the taxonomy, and missing dimensions. Descriptions of each theme and representative quotes are available in Appendix Table A4.

Finally, the experts in round 3 were presented with a working definition of positive mental health, which was developed by the authors in a previous project, based on existing definitions in the literature. The original definition is included in Appendix Table A5.

There were a range of suggested modifications to the definition, and commentary around the definition was summarised into major themes, including: concerns related to the overemphasis on 'subjectivity' which could be confused with being overly individualistic or transient; conflating defining features with antecedents (as the original definition included some but not all dimensions), support for the notion of separating positive mental health from mental health conditions (i.e., positive mental health is possible for those who experience a mental health condition). The original definition and full set of themes are outlined in Appendix Table A5 with representative quotes. The authors adopted the recommendations and have created a modified definition:

"Positive mental health is a personal and subjective experience, where we are content with our lives, feel good, function well, and view ourselves favourably.

Our level of positive mental health can vary over time, and is influenced by the way we adapt to the problems and opportunities we face. It's impacted by many factors such as our environment, life experiences, cultural background, biology, and behaviours.

Many people have some level of positive mental health, and we can improve it by taking action using a variety of means, even when we experience a mental health condition."

Discussion

This Delphi study established academic consensus on 19 dimensions for inclusion in a taxonomy of positive mental health. Rather than proposing a new model, the development of the first version of a taxonomy aims to serve as a foundation for consistent conceptualization, measurement, and application of positive mental health constructs, addressing the need for a unified approach in a fragmented field[19]. The development of the current taxonomy parallels the process involved to form the high-impact behaviour change technique (BCT) taxonomy[20], which standardized partially overlapping behaviour change models to synthesize the distinct BCTs in the literature. Like Michie et al. [23], our ambition is for this taxonomy to continue to develop with academic discourse, maturing evidence, and multi-disciplinary collaboration.

Notably, six dimensions (Meaning and Purpose, Life Satisfaction, Self-Acceptance, Connection, Autonomy, and Happiness) achieved exceptional consensus, exceeding 90% agreement among experts

as either essential or important for aspects of positive mental health. These dimensions align closely with established frameworks, including Diener's subjective wellbeing model, which emphasizes life satisfaction and positive affect(21), Self-Determination Theory, which prioritizes autonomy and relatedness (akin to social connection) as a core psychological needs(22), and Ryff's model of psychological wellbeing, which integrates meaning, self-acceptance and relationships(23). The high degree of consensus likely reflects experts' familiarity with these influential frameworks, suggesting both their conceptual robustness across disciplines, but also a potential bias toward widely recognized constructs from prominent theories.

We anticipate healthy discourse on the various dimensions included in this preliminary taxonomy, with suggestions for dimensions to be merged, separated or added. For example, meaning and purpose has a strong academic tradition of involving the subdimensions of coherence, purpose, and significance and could arguably constitute their own distinct dimensions(24). Further, some may consider the absence of spirituality in the taxonomy controversial, as its relevance to positive mental health has recently been debated(25, 26). Similarly, the blurred boundary between the psychological and the physical will likely need to be addressed, as the expert panel did not reach consensus to include dimensions of physical health and personal circumstances. This possibly indicates the trend to prioritize psychological indicators over physical or sociological ones when conceptualizing positive mental health(27). Such discourse will raise an important consideration for future refinement of the taxonomy; what criteria are required to justify future modifications to the list of dimensions. Established frameworks in the literature may serve as useful models. For example, the basic psychological need theory requires that the satisfaction of a given dimension must be essential for optimal functioning, whereas its frustration leads to negative psychological outcomes (16). Further, there is a need to understand the relationship between dimensions and develop an organising structure for the taxonomy, which may assist in clarifying interrelationships as well as facets contained within each dimension(15).

A significant challenge reported by participants related to distinguishing between drivers and outcomes of positive mental health, a tension also reflected in broader academic discourse. Despite explicit instructions to focus on constitutive dimensions of positive mental health, qualitative feedback revealed the difficulty of separating drivers from outcomes, given that these differences are often subtle, contextual and dynamically interactive(28). For example, autonomy may foster happiness, which enhances life satisfaction, which in turn reinforces autonomy(29). When experts were asked to indicate whether each dimension is primarily an outcome, primarily a driver, or both, Happiness and Life Satisfaction were predominantly viewed as outcomes, consistent with Diener's (21) subjective wellbeing framework, which has guided much interdisciplinary research. In contrast, Autonomy and Safety, were closer to being considered 'mostly drivers', prompting questions about their inclusion, and again reinforcing the need for clear criteria for future versions of the taxonomy.

Qualitative expert feedback highlighted several critical themes related to the development of the taxonomy which related to discourse in the literature. The inherent complexity of positive mental health poses challenges for taxonomy development, as its multifaceted nature resists reduction to discrete

categories(30). Cultural and contextual variability emerged as a prominent concern, with experts advocating for the inclusion of non-Western, indigenous, and linguistically diverse perspectives to address the Western bias in existing models(31). One respondent noted, "the concepts seem very much related to a Western concept of wellbeing," echoing critiques of WEIRD (Western, Educated, Industrialised, Rich, Democratic) bias in psychological research(32). There was also a call to incorporate the lived experiences of marginalised groups when considering the constitutive dimensions of positive mental health, such as those facing chronic illness or discrimination, to ensure inclusivity(33).

The study was impacted by several limitations that likely influenced the results. These include the inherent complexity of defining an undefined topic, the fact that the dimensions originated from Western concepts of mental wellbeing, the primarily English-speaking and Western composition of the expert panel, and the relatively low participation rate among invited experts. In spite of the challenges in recruiting a multicultural panel, there was a significant awareness among participants of potential Western-bias, and the high average citation count of experts suggests a reliable degree of scholarly expertise in the panel to overweigh some of these limitations.

This preliminary taxonomy marks an important step toward standardising positive mental health research by providing a shared language for researchers, clinicians, and policymakers. To build on this foundation, future work should validate the relevance of the 19 dimensions across diverse cultural and contextual settings. Engaging lay perspectives and the lived experiences of marginalised groups will enhance inclusivity and relevance. Establishing clear criteria for including new dimensions, whether through expert consensus, theoretical frameworks, or empirical validation, is essential for the taxonomy's evolution. Similarly, considerations of an organising hierarchy (e.g., Feeling, Thinking, Doing; Lomas(17)) may help to arrange the dimensions. Further testing and refinement of measures developed in prior work based on these dimensions and exploring their potential hierarchical organisation will further strengthen its utility(34). Additionally, integrating insights from cross-cultural wellbeing research (35) could help address identified gaps, identify 'universally' relevant dimensions(36), and promote a more comprehensive and globally applicable framework. There is also future work required to map how these dimensions map against dimensions of psychopathology(37), which may help to identify constructs that are clinically relevant, either as targets for prevention, management, intervention, or recovery from mental illness (38). By pursuing these directions, the taxonomy can advance the science and practice of positive mental health, fostering greater alignment across disciplines and cultures.

Methods

The design of the study was guided by all authors, who have expertise across a range of disciplines relevant to positive mental health. The study employed a three-round Delphi method to achieve expert consensus on the dimensions to include in a taxonomy of positive mental health. The study was conducted from March - August 2024 with ethical approval from Flinders University (7019), funded by the Victorian Department of Health in Australia.

Our study aimed to recruit experts from 11 major disciplines where wellbeing science is prevalent, corresponding to a bibliometric analysis of the term 'flourishing'(39). These included Economics, Medicine, Nursing, Philosophy, Psychiatry, Psychology (clinical), Psychology (health), Psychology (positive), Public Health, Sociology and Theology (10). Experts were identified via two approaches: The primary approach was to identify first or last authors of the highest cited peer-reviewed journal articles in the past 10 years for each of the above disciplines. The research team searched in Scopus and Web of Science (WoS) (February 2024) using the following keywords: wellbeing OR well-being OR positive mental health, and [discipline] (as 'topic' in WoS, or 'all fields' in Scopus). Search results were then sorted by citation count. This list was supplemented with the first and last authors of each chapter of the World Happiness Report [https://www.worldhappiness.report]. These authors were selected as the World Happiness Report is considered the world's foremost publication of global wellbeing, and consistently invites reputable and leading, multi-disciplinary authors. Combined, the systematic search ensured that the most widely appreciated scholars based on their work were identified, and the World Happiness Report authors ensured that high impact scientists who influenced the field but are not high on the singular metric of citations are included.

Experts were invited to participate via their institutional email. It was anticipated that there would be a low response rate, due to a range of factors such as retirement or limited availability of very senior academics, and approximately 150 experts were invited per discipline. Participants were later able to self-describe their discipline, acknowledging that our recruitment approach across disciplines could not be exact.

The Delphi study was conducted over three iterative rounds, via an online survey in English. The maximum number of rounds was determined a priori to maximize expert input while minimizing participant burden and attrition, consistent with previous studies(40). Experts were presented with 26 dimensions of positive mental health, identified via previous review of wellbeing measures (12) and item bank development(34). These previous studies provided some empirical foundation for the Expert panel to consider. For each dimension, panelists were provided a working definition along with two representative items. The following wording was used for each assessment: How important do you think [dimension] is as a dimension of positive mental health? [Dimension] was defined as: "[Definition]". Some characteristic items included: "[Item 1 from Item bank], [Item 2 from item bank]. A full list of dimensions, their definitions, and representative items are available in Appendix Table A1. Panelists were invited to rate the importance of each dimension on a 4-point scale (1 = irrelevant, 2 = peripheral, 3 = important, 4 = essential). This allowed for dichotomization into agreement (important/essential) or disagreement (irrelevant/peripheral). An "I don't know" response option was also available.

The survey included a video introduction, which included the following script: "Knowing there is discourse of whether something is a cause, a consequence, or a part of positive mental health itself, we ask you to consider whether each dimension is a part of positive mental health *itself*."

Expert consensus on whether a dimension should be considered for the taxonomy was defined a priori as ≥75% agreement or disagreement on each dimension as per previous recommendations(41). Dimensions that did not reach consensus were re-presented to expert panel, along with the results from the previous round, for further consideration.

In Round 1, the survey collected demographic information including: age, gender, country of residence, education, ethnicity, academic discipline, years of experience in field of positive mental health, and self-rated topic expertise. An open-text box was provided for experts to suggest additional dimensions that they believed could be considered for inclusion in the taxonomy but had not been part of the original list. Expert-suggested dimensions were considered by the authors to determine whether they were conceptually unique, not overly multi-dimensional, and not overlapping with existing dimensions. Those meeting these criteria were included in Rounds 2 and 3 of the Delphi process.

Round 1 also asked participants to vote on a name for the taxonomy, acknowledging the use of many terms synonymously in the literature. Options included Mental Health, Mental Wellbeing, Positive Functioning, Positive Mental Health, Wellbeing, Wellness, Other. In this round, experts were offered an opportunity to provide feedback on the formation of a taxonomy.

In Round 3, experts were invited to indicate the degree to which each of the included dimensions represented an outcome or driver of Positive Mental Health. For each of the dimensions that reached consensus for inclusion in the taxonomy, experts rated their assessment using a visual analogue scale ranging from 0 (Mostly a driver), 50 (Both), to 100 (Mostly an outcome). Finally, the survey presented a working definition for Positive Mental Health, originally drafted by authors in previous work(42). Open-text fields were available for experts to offer spontaneous, unprompted comments or reflections on the proposed definition.

Declarations

Statement on participant consent: All participants consented to participate in the study.

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