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EVALUATING EFFECTIVENESS OF THE SELF-MANAGEMENT OF WELL-BEING INTERVENTION FOR SOCIAL ASSISTANCE RECIPIENTS

EVALUATIE VAN DE EFFECTIVITEIT VAN DE GRIP&GLANS INTERVENTIE VOOR BIJSTANDSGERECHTIGDEN

AMBER VELLINGA-DINGS, NARDI STEVERINK, BAŞAK BILECEN

ABSTRACT

Background. Strengthening the agency of social assistance recipients facing vulnerability may be crucial for improving their well-being. This study evaluates the effectiveness of the Self-Management of Well-being (SMW) group intervention among benefit recipients in the Netherlands.
Methods. A one-group pretest-posttest design was used to evaluate self-management ability (SMA), well-being, loneliness, and stress in 87 intervention participants using validated questionnaire scales. Outcomes were measured pre-intervention (T_0), immediately after the final session (T_1, N=64) and three months later (T_2, N=54). Repeated measures ANOVA with repeated contrasts, and sequential regression analyses tested intervention effects.
Results. Significant short-term improvements were found in SMA and well-being, alongside significant reductions in loneliness and stress. Repeated measures ANOVA indicated that these intervention effects were maintained over time. Sequential regression analyses revealed that improvements in well-being, loneliness, and stress were partially explained by improved SMA.
Discussion. The SMW group intervention enhanced SMA and overall well-being while reducing loneliness and stress among benefit recipients, suggesting that it is a valuable tool for strengthening agency and well-being in this population.

KEYWORDS

Pretest-Posttest Design, Self-Management of Well-being Intervention, Benefit Recipients, Long-term Unemployment, Agency, Well-being, Loneliness, Stress

SAMENVATTING

Achtergrond. Het versterken van de zelfredzaamheid van bijstandsgerechtigden in kwetsbaarmakende omstandigheden kan een belangrijke bijdrage leveren aan hun welbevinden. In dit onderzoek werd de effectiviteit van de GRIP&GLANS groepscursus onder uitkeringsgerechtigden onderzocht.
Methoden. In dit onderzoek werd een pretest-posttest design toegepast. Bij 87 deelnemers werden zelfmanagementvaardigheden, welbevinden, eenzaamheid en stress gemeten met gevalideerde vragenlijsten. De metingen vonden plaats vóór de interventie (T_0), direct na afloop van de laatste bijeenkomst (T_1) en drie maanden later (T_2). De effecten van de interventie werden geanalyseerd met repeated meaures ANOVA en sequentiële regressieanalyses.

Resultaten. Op korte termijn werden significante verbeteringen gevonden in zelfmanagementvaardigheden en welbevinden. Gevoelens van eenzaamheid en stress namen significant af. De repeated measures ANOVA liet zien dat deze effecten over langere tijd behouden bleven. Uit de sequentiële regressieanalyses bleek bovendien dat de verbeteringen in welbevinden, eenzaamheid en stress deels konden worden verklaard door de toename in zelfmanagementvaardigheden.
Discussie. De GRIP&GLANS groepscursus droeg bij aan grotere zelfredzaamheid en een beter welbevinden onder bijstandsgerechtigden. Tegelijkertijd verminderden gevoelens van eenzaamheid en stress. De resultaten suggereren dat deze interventie een waardevol middel kan zijn om het welbevinden en de zelfredzaamheid van deze doelgroep te versterken.

TREFWOORDEN

Pretest-Posttest Design, GRIP&GLANS-interventie, Zelf-Management-van-Welbevinden interventie, Bijstandsgerechtigden, Langdurige werkloosheid, Eenzaamheid, Stress

INTRODUCTION

As of July 2025, the Netherlands had approximately 410 thousand individuals receiving social assistance (CBS, 2025a). Social assistance (SA) serves as a last-resort safety net, designed to secure a minimum standard of living for those who cannot meet their basic needs and are ineligible for other benefits, such as unemployment or sickness assistance (Rijksoverheid, 2025a). Because the contributory benefits are limited to two years, individuals facing long-term unemployment or illness often transition to social assistance. Over the past two years, the number of social assistance recipients (SARs) has continued to rise, with inflows exceeding outflows. Notably, the number of recipients aged 45 and under has increased (CBS, 2025b). Since 2015, the number of individuals receiving SA for five years or longer has been continuously increasing (Van Gerwen et al., 2025). This increase can be partly attributed to the implementation of the Participation Act (PA) introduced in the same year. The PA broadened the SA eligibility criteria to include groups previously covered by disability-specific schemes, such as young people with partial work capacity and individuals with physical, mental, or psychological impairments requiring support in obtaining or maintaining employment (Ministerie Van SZW, 2024).

Many SARs struggle to find employment due to complex, multifaceted problems that extend beyond work and income, affecting various aspects of their lives (Kuiper, 2022). These problems

include administrative challenges, limited social networks, difficulties with performing daily tasks or household duties, and family-related stressors (Doove et al., 2018; FNV, 2021). More than half of the SARs face three or more of the aforementioned issues simultaneously (Van Echtelt et al., 2023). The accumulation of adversity leads to increased stress, which in turn negatively affects physical and mental health (Vellinga-Dings et al., 2025). As a result, SARs report lower satisfaction with their financial situation, social relationships, daily activities, and they experience loneliness two to three times more frequently than people earning their own income (Van Echtelt et al., 2023). Given that paid employment is often not a realistic outcome for this target group (e.g., Kromhout et al., 2020; Van Echtelt et al., 2019), this article focuses on an intervention that emphasizes well-being and self-management ability rather than employment outcomes.

The precarious situation of SARs stems not only from the numerous problems they encounter, but also from a certain lack of ability to cope with these problems. Those with the least resources tend to experience the most problems, highlighting an imbalance between their burden and coping capacity (Klerk et al., 2023). Previous research has shown that SARs possess not only fewer economic resources but also fewer personal resources, such as lower levels of resilience and perceived control. Approximately 50% of SARs report low levels of perceived control, compared to only 10% among non-SARs (Van Echtelt et al., 2023). Moreover, studies indicate that their life circumstances improve when personal resources and skills, such as self-management ability, are strengthened (Den Ridder et al., 2020). Consequently, support strategies for SARs should prioritize strengthening their resources and capacities rather than focusing solely on problem alleviation (Klerk et al., 2023). Although structural reforms at the macro level are crucial for improving the well-being of SARs, such changes are often slow to materialize and difficult to implement. Therefore, this article focuses on an individual-level intervention, which offers a more immediate and actionable avenue for support within the constraints of existing policy frameworks. Drawing on evidence regarding the impact of scarcity on cognitive capacity (e.g., Mullainathan & Shafir, 2013) and the notion that individuals' "capacity to act" may be constrained for various reasons (Bovens et al., 2017), an intervention targeting this capacity appears to be a promising approach. This paper specifically examines an intervention designed to enhance self-management of overall well-being among SARs and other benefit recipients.

To our knowledge, no effective interventions currently exist that specifically target these goals for this population. However, Self-Management of Well-being (SMW) theory provides a strong theoretical basis for addressing them, as it explains the role of self-management skills in achieving and maintaining both physical and social well-being (Steverink, 2014; Steverink et al., 2005). SMW

theory builds on the theory of Social Production Function theory (SPF; Lindenberg, 1996), which posits that individuals strive to improve their subjective well-being by fulfilling five basic physical and social human needs (comfort, stimulation, affection, behavioral confirmation, and status), which constitute the main domains of physical and social well-being. SMW extends this framework by identifying six core self-management abilities (SMA) necessary for attaining and maintaining the resources required to meet these five fundamental needs. The six SMA are *self-efficacy beliefs* and a *positive frame of mind* (as cognitive abilities), *taking the initiative* and *investment behavior* (as active-motivational abilities), and *multifunctionality of resources* and *variety in resources* (as resource-combining abilities) (Steverink, 2014; Steverink et al., 2005).

Based on the theoretical framework of SMW theory, the SMW intervention aims to improve SMA, and by doing so, improve overall well-being. The SMW intervention is a group intervention consisting of 6 weekly sessions lasting around two hours, and involving 8 to 12 participants. This intervention has already proven to be effective for women aged 50 years and older who suffer from mild psychosocial problems, loneliness, and a lack of control to improve their situation (e.g. Goedendorp et al., 2017; Kremers et al., 2006). In addition, preliminary evidence suggests positive effects of the SMW intervention among benefit recipients (Steverink & Kamminga, 2023), with findings from a recent process evaluation further indicating its potential effectiveness (Vellinga-Dings et al., 2024). Building on this evidence, we expect that the SMW intervention enhances SMA and overall well-being of SARs. We further expect the intervention to reduce feelings of loneliness and stress, as key well-being indicators particularly relevant for SARs (Vellinga-Dings et al., 2025). Finally, in line with the proposed theoretical mechanism, we expect that improvements in SMA contribute to enhanced well-being and reductions in both loneliness and stress.

METHODS

Study design

This study employed a one-group pretest-posttest design to evaluate participants' SMA, well-being, loneliness, and stress across three time points using validated questionnaire scales. This design was selected instead of an RCT because it is particularly suitable for the early stages of intervention development, where the primary aim is to establish feasibility and obtain preliminary evidence of effectiveness. In addition, non-randomized designs are often perceived as more acceptable and less intrusive, an important consideration when working with populations that may exhibit low levels of trust in research and institutional settings, such as benefit recipients (Edzes

et al., 2021). Finally, withholding a potentially beneficial intervention from eligible participants was considered ethically inappropriate. The study received ethical approval from the Ethics Committee of the Department of Sociology at the University of Groningen (SOC-2223-S-0004).

Sample and recruitment

The sample comprised benefit recipients aged between 21 and 67 years old. While our primary focus was on social assistance recipients, individuals receiving sickness, disability, or unemployment benefits were also included. This broader inclusion was partly pragmatic, facilitating the formation of participant groups, but it also reflected a commitment to an inclusive recruitment strategy. It was further informed by the assumption that these groups share broadly comparable life circumstances and challenges, particularly regarding health, well-being, and limited coping capacity. Moreover, as sickness and unemployment benefits are temporary (Rijksoverheid, 2025b, c), while many recipients eventually transition to social assistance.

Participants were recruited between March 2023 and June 2025 in two neighboring municipalities in the Northeastern part of the Netherlands. We used two recruitment approaches: a personal approach by stakeholders such as work coaches, social workers, social activators, and welfare coaches, and a formal approach using flyers and advertisements in local newspapers. To ensure stakeholders were well-informed, information sessions were organized, and detailed documentation and flyers were distributed. Potential participants were invited for an intake interview or a group information session with the intervention teachers. During these meetings, potential participants were informed about the intervention, and were given the possibility to ask questions. Furthermore, exclusion criteria were verified, including inadequate language skills, lack of motivation, insufficient availability of time, severity of symptoms (e.g., severe grief or depression), and incapacity to engage in a group setting. Finally, mutual expectations between teachers and participants were discussed, and the information letter, informed consent form, and pretest questionnaire were distributed among the participants.

Intervention

The SMW intervention consists of six weekly group sessions, each lasting two hours and ideally involving 8 to 12 participants, followed by a booster session three months later. Guided by SMW theory, all sessions emphasize the five core domains of well-being, while each meeting also highlights one or more of the six SMA. During the sessions, the six SMAs are covered both

in theory and in practice. Participants learn how to apply the SMAs by setting goals during the sessions that they achieve outside of the sessions, in their daily lives. They always apply the SMAs in relation to one or more of the domains of well-being. Each session, except the first, follows the same structure, consisting of several topics and exercises. Sessions begin with discussing the homework followed by an introduction to the session's theme. Topics are diverse, with some being more theoretical in nature and other more practical and interactive. Participants receive a workbook with session summaries and at-home assignments. Each group is led by two social workers who are certified SMW teachers, having completed a two-day training conducted by qualified SMW trainers. During each session, teachers use a very detailed teacher's manual in order to assure that all groups receive the same content. For a detailed description of the SMW intervention, see https://www.movisie.nl/interventie/grip-glans-groepscursus.

Measures

We applied validated scales that were also used in previous research on the SMW intervention (e.g., Frieswijk et al., 2006; Goedendorp & Steverink, 2017; Kremers et al., 2006; Schuurmans, 2004; Steverink & Kamminga, 2023) to assess the effectiveness of the SMW intervention in terms of self-management ability, well-being, loneliness, and stress.

Self-management ability (SMA)

SMA was measured with the short version (SMA-S, Cramm et al., 2012) of the SMA Scale (SMAS-30, Schuurmans et al., 2005). It consists of 18 items covering the six SMA. Example items are: 'Are you able to let others know that you care about them?' (self-efficacy); 'The activities I enjoy, I do together with others' (multifunctionality); 'Do you have different occasions on which you have friendly contacts with others?' (variety). The original scale demonstrates strong psychometric properties (Schuurmans et al., 2005), and the shortened version (SMA-S) has also been found to be both reliable and valid (Cramm et al., 2012). Some sub-scales are scored on a five-point Likert scale, and other on a six-point scale. All scores were transformed to a 100-point scale. Cronbach's α was .93.

Well-being

The short version of the Social Production Function Index Level Scale (SPF-Ils; Nieboer et al., 2005) was used to assess well-being and its dimensions. It consists of 15 items covering the five dimensions of well-being. Examples are: 'Are your activities challenging to you?' (stimulation); 'Do

you feel useful to others?' (behavioural confirmation); 'Are you known for the things you have accomplished?' (status). The scale has been found to have good psychometric properties (Nieboer et al., 2005), and is being used widely to measure subjective well-being. Each sub-scale is rated on a four-point Likert scale, and the total sum score was used to calculate overall well-being. Cronbach's α was .97.

Loneliness

The six-item scale De Jong Gierveld Loneliness Scale was used as a reliable and valid instrument for measuring loneliness (De Jong Gierveld & Van Tilburg, 2006). It measures social and emotional loneliness. The three social loneliness items refer to a sense of closeness and lack of discrepancy in desired relationships (e.g., 'There are enough people I feel close to'). The three emotional loneliness items capture feelings of rejection and emptiness (e.g., 'I miss people around me'). Following the guidelines, the three answer categories ('yes', 'more or less', and 'no') were dichotomized into 0 and 1, and summed up to get a total score (De Jong Gierveld & Van Tilburg, 2023). Cronbach's α was .95.

Stress

The reliable and valid four-item version of the Perceived Stress Scale (PSS-4) was used to measure the degree to which an individual finds circumstances in their life to be stressful, unpredictable, or uncontrollable (Cohen & Williamson, 1988; Cohen et al., 1983). An example item is: 'In the last month, how often have you felt confident about your ability to handle your personal problems?'. We made a minor modification to the answer categories, expanding them from five options to six to obtain more nuanced answers. Reverse coded items were recoded and scores of each of the four items were summed up to get a total score. Cronbach's α was .89.

Other variables

In the sequential regression analysis, gender and age were added as control variables.

Data collection

The pretest (T_0) questionnaires were distributed by the teachers before the start of the group intervention, the first posttest (T_1) right after the group intervention has finished, and the second posttest (T_2) three months after the end of the group intervention. Participants were asked

to complete the questionnaire on-site, as the intervention locations provided sufficient space to ensure privacy during completion. If necessary, participants were allowed to complete the questionnaires at home, for example, if they lacked time during the session, preferred to complete it in their own environment, or were occasionally absent. In cases of absence, the teacher sent the questionnaire to the participant's home address, accompanied by a return envelope.

Data analysis

Repeated measures ANOVAs were performed to analyze changes in SMA, well-being, loneliness, and stress across three time points: pre-intervention, post-intervention, and follow-up three months later. In addition, repeated contrasts were used to analyze participants' scores between two time points (T_0-T_1 and T_1-T_2). Finally, sequential regression analyses were conducted to assess whether improvements in well-being, loneliness, and stress are explained by changes in SMA.

RESULTS

Participants

The pretest (T_0) was completed by 87 participants, of whom 22 stopped participating in the intervention at some point during the six sessions. The most frequently reported reason for dropout was health-related issues, although personal circumstances and scheduling difficulties also contributed. For a few participants, reasons were unknown. One participant completed the sessions but declined to fill out the posttest questionnaire. The remaining 64 completed the first (T_1) posttest. Another ten participants did not attend the 3-months booster session nor filled out the second posttest, leaving 54 participants who completed the second (T_2) posttest questionnaire. The majority of participants attended all sessions, although some missed one or two. Participants who missed more than two sessions were invited to discuss with the teacher whether continued participation was feasible. If continuation was deemed unfeasible, they were encouraged to join a new round of the SMW intervention later on.

Potential attrition bias, defined as the selective dropout of participants who systematically differ from those who complete a study (Nunan et al., 2018), was assessed by comparing dropouts (N=33) and non-dropouts (N=54) on the primary intervention measures (e.g., SMA, well-being, loneliness, and stress). As presented in the Appendix (Table A1), independent samples *t*-tests indicated no significant differences, suggesting that attrition did not systematically bias the results.

The majority of participants (N=87) identified as female (69%), while 29% identified as male, and 2% as "other". Their age ranged from 21 to 66 years (M = 41.7, SD = 13.7). Most were single (58%) or divorced (13%), while 23% were in a relationship, either cohabiting or living apart. Educational backgrounds varied considerably. In total, 65 participants received social assistance benefits, for an average of five years, while the remaining 22 participants received other types of benefits (e.g., sickness, disability, or unemployment). More detailed information about the participant group, divided into complete cases (N=54) and dropouts (N=33), is presented in Table 1.

Repeated measures ANOVA

One-way repeated measures analyses of variance (ANOVA) were used to investigate the impact of the intervention on participants' SMA, well-being, loneliness, and stress across the pretest (T_0) and posttest questionnaires (T_1 and T_2). Prior to conducting the main analyses, descriptive statistics were examined, and statistical assumptions were evaluated. The assumption of homogeneity of variance was confirmed, with F_{max} values ranging from 1.15 to 1.52 across all scales. Mauchly's test indicated that the assumption of sphericity was violated for SMA and stress; therefore, Huynh-Feldt corrections were applied. For well-being and loneliness, Mauchly's test was non-significant, indicating that the sphericity assumption was met.

The repeated measures ANOVA results indicated a significant improvement in SMA over time, $F(1.5, 71.1) = 32.47$, $p < .001$, $\eta_p^2 = .41$. Also well-being improved significantly after intervention participation, $F(2, 90) = 21.27$, $p < .001$, $\eta_p^2 = .32$. Moreover, we found that loneliness decreased significantly, $F(2, 94) = 17.41$, $p < .001$, $\eta_p^2 = .27$. Lastly, the results indicated that stress decreased significantly as well, $F(1.8, 84.4) = 26.16$, $p < .001$, $\eta_p^2 = .36$. The partial eta-squared values, which ranged from .27 to .41, indicate large effect sizes across all components, with the largest effects observed for SMA and the smallest for loneliness.

To further examine changes across different time points, repeated contrasts were conducted comparing outcomes from T_0 to T_1 and from T_1 to T_2. These analyses showed significant improvements from T_0 to T_1 for all variables, whereas changes from T_1 to T_2, although in the expected directions, were non-significant. The partial-eta squared values for the T_0 to T_1 comparisons ranged from .36 to .58, reflecting large effect sizes for all components. Full results of the repeated contrasts are presented in Table 2, together with descriptive statistics.

Table 1: Demographic information about complete cases and dropouts.

	Complete cases (N=54)		Dropouts (N=33)	
	Abs.	%	Abs.	%
Age groups				
21-35 years	23	42.6	11	33.3
36-50 years	14	25.9	11	33.3
51-66 years	17	31.5	11	33.3
Gender				
Male	17	31.5	8	24.2
Female	35	64.8	25	75.8
Other	2	3.7	0	0
Marital status				
Partnered	10	18.5	10	30.3
Divorced	7	13.0	4	12.1
Widowed	3	5.5	0	0
Single	33	61.1	17	51.5
Other	1	1.9	2	6.1
Education				
Lower education	15	27.8	7	21.3
Middle education	21	38.9	11	33.3
Higher education	18	35.3	15	45.4
Benefit receipt				
Social assistance	41	75.9	24	72.7
Disability benefits	1	1.9	7	21.2
Sickness benefits	3	5.5	2	6.1
Unemployment benefits	3	5.5	0	0
Unknown*	6	11.1	0	0

Table 1: Continued

	Complete cases (N=54)		Dropouts (N=33)	
	Abs.	%	Abs.	%
Household income				
Less than €1350	31	57.4	24	72.7
€1351-€1800	4	7.4	4	12.1
€1801-€2500	4	7.4	1	3.0
€2501 or more	2	3.7	2	6.1
Do not know or do not want to share	13	24.1	2	6.1

*Six participants did not report benefit receipt, possibly because they did not want to mention it or they relied on alternative income sources such as partner's earnings, alimony, or savings.

Multiple regression analysis

Sequential multiple regression analyses were performed to assess whether changes in SMA, as stated by SMW theory, accounted for improvements in well-being, loneliness and stress from T_0 to T_1. Prior to conducting the main analyses, bivariate analyses were examined and regression assumptions were tested and met. The bivariate analyses, as presented in the Appendix (Table A2), showed the strongest associations between pre-intervention and post-intervention SMA (r =.77), pre-intervention and post-intervention well-being (r =.71), and post-intervention SMA and post-intervention well-being (r =.73). The significant correlations between SMA and well-being, loneliness, and stress underscore the rationale for further investigating the effect of SMA on these outcomes.

Linear regression analyses were performed to assess whether improvements in SMA accounted for improvements in well-being, loneliness, and stress at post-intervention. For each outcome, two regression models were estimated. In the first set of models, baseline outcomes served as the independent variables (*X*), baseline SMA as the covariate (*Z*), and post-intervention SMA as the dependent variable (*Y*). In the second set of models, baseline outcomes were entered as the independent variables (*X*), baseline SMA as the covariate (*Z*), post-intervention SMA as the mediator (*M*), and post-intervention outcomes as the dependent variables (*Y*). Age and gender

Table 2: Descriptive statistics and repeated contrasts.

	Descriptive results						Repeated contrasts			
	T_0 (N=83-86)		T_1 (N=63-64)		T_2 (N=54)		T_0-T_1		T_1-T_2	
	M	SD	M	SD	M	SD	*F* (df1, df2)	η_p^2	*F* (df1, df2)	η_p^2
SMA (range 0-100)	52.39	13.62	58.05	11.36	60.67	13.23	64.28*** (1,46)	.58	.76 (1, 46)	.02
Well-being (range 1-4)	2.20	.38	2.36	.36	2.39	.32	31.26*** (1, 45)	.41	.14 (1, 45)	.03
Loneliness (range 1-6)	4.33	1.81	3.70	1.91	3.55	1.93	26.44*** (1, 47)	.36	.34 (1, 45)	.01
Stress (range 0-20)	11.84	3.61	9.67	2.93	9.28	2.98	40.06*** (1, 47)	.46	.92 (1, 47)	.02

***p<.001.

were included as control variables in all analyses. Standardized regression coefficients (β) describing the associations between X, Z, M, and Y are presented in Figure 1. These outcomes show that post-intervention SMA significantly impacts post-intervention well-being (β = .667, p<.001), post-intervention loneliness (β = –.301, p = .047), and post-intervention stress (β = –.654, p<.001). *p<.05 ***p<.001.

Post-intervention well-being

In step 1 of the sequential model, gender, age, and pre-intervention well-being accounted for 52% of the variance in post-intervention well-being, R^2 = .52, F(3, 55) = 20.07, p <.001. In step 2, pre-intervention SMA was added, which contributed an additional 2% of the variance, ΔR^2 = .02, *F Change*(1, 54) = 2.37, p = .130. In step 3, post-intervention SMA was added, accounting for an additional 15% of the variance in post-intervention well-being ΔR^2 = .15, *F Change*(1, 53) = 26.29, p < .001. Overall, the full model explained 69% of the variance in post-intervention well-being, indicating that the predictors collectively explain a substantial portion of the variance, with post-intervention SMA contributing a medium effect.

Post-intervention loneliness

In step 1 of the sequential model, gender, age, and pre-intervention loneliness accounted for 51% of the variance in post-intervention loneliness, R^2 = .51, F(3, 56) = 19.08, p <.001. In step 2,

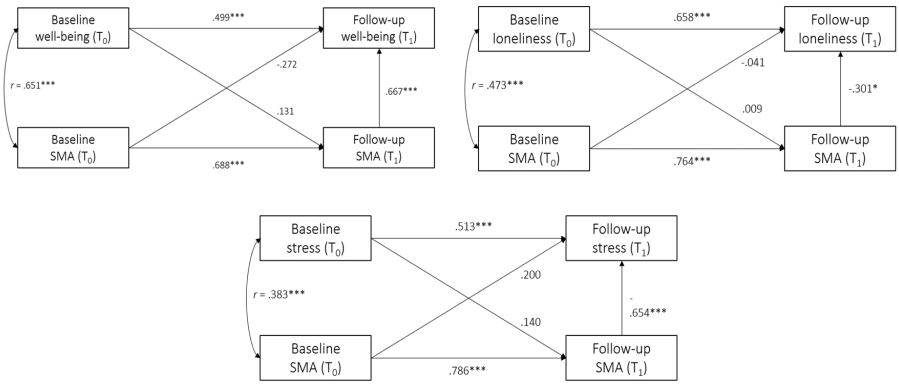

Figure 1: Standardized regression coefficients with gender and age as control variables. ***p<.001; *p<.05.

pre-intervention SMA was added, which contributed an additional 3% of the variance, $\Delta R^2 = .03$, *F Change*(1, 55) = 3.63, $p = .062$. In step 3, post-intervention SMA was added, accounting for an additional 3% of the variance in post-intervention loneliness, $\Delta R^2 = .03$, *F Change*(1, 54) = 4.14, $p = .047$. Overall, the full model explained 57% of the variance in post-intervention loneliness, indicating that the predictors collectively explain a substantial portion of the variance, with post-intervention SMA contributing a small effect.

Post-intervention stress

In step 1 of the sequential model, gender, age, and pre-intervention stress accounted for 31% of the variance in post-intervention stress, $R^2 = .31$, $F(3, 57) = 8.40$, $p < .001$. In step 2, pre-intervention SMA was added, which contributed an additional 9% of the variance, $\Delta R^2 = .09$, *F Change*(1, 56) = 8.72, $p = .005$. In step 3, post-intervention SMA was added, accounting for an additional 15% of the variance in post-intervention stress, $\Delta R^2 = .15$, *F Change*(1, 55) = 17.91, $p < .001$. Overall, the full model explained 55% of the variance in post-intervention stress, indicating that the predictors collectively explain a substantial portion of the variance, with post-intervention SMA contributing a medium effect.

Concluding, SMA explained significant parts of the variance in post-intervention well-being, loneliness, and stress, thereby supporting the theoretical underpinnings of the SMW intervention. Detailed results of the sequential regression analyses can be found in the Appendix (Tables A3–A5).

Subjective evaluation of the intervention

At the first posttest, administered immediately after the six intervention sessions, participants were asked to answer several evaluative questions regarding their experience with the sessions. Approximately 90% indicated that they had enjoyed the intervention, and 80% said that they would recommend the intervention to others. Participants were also given the opportunity to provide open-ended comments, in which they expressed enthusiasm about what they had learned. For example, one participant noted, "I have learned to start and end the day positively and to make a plan for the next day(s) or week more often" (woman, single, 32 years), while others stated, "I feel like I'm starting to find myself back again" (male, married, 60 years) and "It makes you more aware of what you already have and what you can invest in" (woman, divorced, 37 years).

The group-based format of the intervention was also widely appreciated. Participants described it as supportive and motivating. As one noted: "It was a pleasant intervention, and in particular the group setting did me well" (woman, partnered, 37 years) and another reflected, "I had heard or read a lot of the material before, but it worked better because you engage with it as a group" (woman, divorced, 54 years). Several participants emphasized the value of regular weekly meetings and the friendly atmosphere which contributed positively to their well-being. Many also expressed appreciation for the competence and warmth of the intervention teachers. Some participants suggested extending the duration of the intervention or offering a follow-up program.

DISCUSSION

The main aim of our study was to investigate whether benefit recipients showed improvements in SMA and well-being, and reductions in loneliness and stress, after having participated in the SMW group intervention, based on the SMW theory. As expected, we observed overall improvements in SMA and well-being, alongside declines in feelings of loneliness and stress. These findings are in line with earlier SMW intervention studies targeting other populations such as single women aged 50 years and older (e.g., Frieswijk et al., 2006; Goedendorp & Steverink, 2017; Kremers et al., 2006; Schuurmans, 2004). Although the most substantial change occurred between T_0 and T_1, the effects were maintained at the 3-month follow-up, with all measures even showing a slight further improvement. These lasting effects suggest that participants not only benefited in the short term but also carried the intervention's principles into their daily lives, sustaining the positive changes over time. Taken together, the findings point to both immediate and enduring improvements in SMA, well-being, loneliness, and stress.

In line with SMW theory, it was expected that the improvements in well-being are induced by increases in SMA. This hypothesized effect was confirmed, as SMA accounted for 15% of the variance in well-being after controlling for gender, age, pre-intervention well-being and pre-intervention SMA. The importance of SMA is further highlighted by its effect on post-intervention loneliness and stress. These findings indicate that intervention participants not only showed significant improvements in SMA but also effectively applied these skills to improve their overall well-being, which is in line with previous research on SMW intervention effects (e.g., Goedendorp & Steverink, 2017). Our results align with previous research showing that personal resources, such as control and agency, can enhance life circumstances, such as better health and reduced feelings of loneliness (e.g., Den Ridder et al., 2020; Van Echtelt et al., 2023). These findings reinforce earlier policy recommendations that support for benefit recipients should emphasize the strengthening of

individual capacities and resources, rather than focusing solely on problem reduction (Klerk et al., 2023; Van Echtelt et al., 2023).

Strengths, limitations and future directions

A key strength of the SMW intervention lies in its theory-driven design, which clarifies the underlying mechanisms through which it aims to improve well-being. This theoretical foundation adds to the understanding of why and how the intervention works, and it facilitates the evaluation of its effects, as demonstrated in this study. Furthermore, the use of measurement scales that closely reflect the intervention's theoretical underpinnings, specifically the SMA-S and SPF-IL, further strengthens the validity of the findings.

Next to its strengths, this study has some limitations. First, the use of purposive sampling without a control group limits generalizability of the findings and raises the possibility of sampling bias. Future research could include a control group to more rigorously assess intervention effects, although the aforementioned ethical concerns would need to be carefully considered. Second, the voluntary nature of participation may have introduced a certain amount of self-selection bias, as those who participated are likely to have already a certain amount of self-management ability (agency), showing a motivation to improve their situation and well-being. Those who lack this minimum amount of self-management ability, probably also lack the motivation to apply for an intervention that could change their situation, although they might need such an intervention most. Making the SMW intervention mandatory would not be desirable, but finding ways to reach also the most vulnerable benefit recipients, could provide valuable insights into the broader usefulness of the intervention. Finally, although effects of the intervention remained at the follow-up period of three months, longer-term assessments may show to what extent these effects are sustained over longer periods of time.

CONCLUSION

In many countries, long-term benefit recipients often face precarious life circumstances, which may also undermine their coping capacity, increasing the risk of a negative spiral. Although these problems are widely acknowledged, effective and evidence-based support options remain scarce. This study examined the SMW group intervention as a potential strategy to improve their situation and well-being. Our findings show that the SMW intervention provides both short-term benefits and sustained improvements in SMA, well-being, loneliness, and stress, with effects

observed three months after completion. The lasting impact suggests that participants internalized and applied the intervention's principles and applied them in their daily lives. Our findings also reinforce core assumptions of SMW theory, emphasizing the crucial role of SMA in achieving and maintaining well-being over time. Overall, these findings highlight the potential of the SMW group intervention as an evidence-based approach to fostering lasting improvements in self-management abilities and well-being among benefit recipients. Because our participants already had relatively high levels of self-management and motivation, the results mainly apply to this group; future research needs to determine if they are generalizable to the broader population of social assistance recipients.

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APPENDICES

Table A1: Independent t-sample complete cases versus dropouts.

	Complete cases (N=51-53)		Dropouts (N=31-33)					
	M	*SD*	*M*	*SD*	*t*	*df*	*p*	*Cohen's d*
SMA	51.50	13.08	53.89	14.59	.77	81	.44	.18
Well-being	2.16	.34	2.26	.43	1.18	80	.25	.27
Loneliness	4.36	1.84	4.27	1.79	–.21	84	.83	.05
Stress	12.11	3.47	11.39	3.83	–.89	84	.37	.20

Table A2: Bivariate correlations pre-intervention (T_0) and post-intervention (T_1).

	Age	Gender	SMA T_0	SMA T_1	Well-being T_0	Well-being T_1	Loneliness T_0	Loneliness T_1	Stress T_0	Stress T_1
Age	1									
Gender	–.08	1								
SMA T_0	–.03	.15	1							
SMA T_1	.07	.24	.77***	1						
Well-being T_0	–.12	.04	.65***	.53***	1					
Well-being T_1	–.02	.21	.59***	.73***	.71***	1				
Loneliness T_0	.18	.03	–.47***	–.23	–.53***	–.31*	1			
Loneliness T_1	.17	–.02	–.41***	–.42***	–.32*	–.39**	.70***	1		
Stress T_0	–.14	–.06	–.38**	–.02	–.48***	–.21	.49***	.21	1	
Stress T_1	–.27*	–.06	–.37**	–.50***	–.42***	–.50***	.28*	.39**	.53***	1

*p<.05, **p<.01, ***p<.001.

Table A3: Sequential regression analysis with post-intervention well-being as dependent variable.

	Model 1		Model 2		Model 3[a]		Model 4	
	b (SE)	*p*	*b (SE)*	*p*	*b (SE)*	*p*	*b (SE)*	*p*
Constant	.48 (.27)	.084	.49 (.27)	.076	3.71 (9.83)	.618	.41 (.22)	.072
Age	.00 (.00)	.607	.00 (.00)	.616	.11 (.07)	.118	.00 (.00)	.630
Gender	.11 (.07)	.101	.10 (.07)	.141	3.66 (1.81)	.048	.02 (.06)	.701
Pre-intervention well-being (X)	.76 (.10)	<.001	.63 (.13)	<.001	4.45 (3.54)	.214	.54 (.11)	<.001
Pre-intervention SMA (Z)			.01 (.00)	.130	.68 (.10)	<.001	.00 (.00)	.048
Post-intervention SMA (M)							.02 (.00)	<.001
R^2	.52		.54		.66		.69	
R^2 change	.52		.02				.15	
F change	20.07	<.001	2.37	.130	43.14	<.001	26.29	<.001

[a]Model 3 has post-intervention SMA (M) as dependent variable.

Table A4: Sequential regression analysis with post-intervention loneliness as dependent variable.

	Model 1		Model 2		Model 3[a]		Model 4	
	b (SE)	*p*	*b (SE)*	*p*	*b (SE)*	*p*	*b (SE)*	*p*
Constant	.12 (.90)	.892	1.79 (1.24)	155	9.96 (6.72)	.144	2.29 (1.23)	.069
Age	−.01 (.01)	.686	−.01 (.01)	.695	.12 (.07)	.086	.00 (.01)	.960
Gender	−.07 (34)	.838	.03 (.33)	.932	3.22 (1.80)	.079	.19 (.33)	.572
Pre-intervention loneliness (X)	.85 (.12)	<.001	.77 (.12)	<.001	.07 (.65)	.919	.78 (12)	<.001
Pre-intervention SMA (Z)			−.03 (.02)	.062	.75 (.09)	<.001	.01 (.02)	.783
Post-intervention SMA (M)							−.05 (0.2)	.047
R^2	.51		.54		.64		.57	
R^2 change	.51		.03				.03	
F change	19.08	<.001	3.63	.062	77.93	<.001	4.14	.047

[a]Model 3 has post-intervention SMA (M) as dependent variable.

Table A5: Sequential regression analysis with post-intervention stress as dependent variable.

	Model 1		Model 2		Model 3[a]		Model 4	
	b (SE)	*p*	*b (SE)*	*p*	*b (SE)*	*p*	*b (SE)*	*p*
Constant	6.49 (2.20)	.003	10.82 (2.46)	<.001	1.86 (7.39)	.802	11.13 (2.15)	<.001
Age	−.04 (.02)	.071	−.05 (.02)	.030	.14 (.07)	.035	−.03 (.02)	.213
Gender	−.16 (.62)	.793	.06 (.58)	.919	3.31 (1.76)	.064	.61 (.53)	.255
Pre-intervention stress (X)	.44 (.10)	<.001	.39 (.09)	<.001	.51 (29)	.089	.47 (.09)	<.001
Pre-intervention SMA (Z)			−.08 (.03)	.005	.77 (.08)	<.001	.05 (.04)	.197
Post-intervention SMA (M)							−.17 (.04)	<.001
R^2	.31		.40		.65		.55	
R^2 change	.31		.09				.15	
F change	8.40	<.001	8.72	.005	95.08	<.001	17.91	<.001

[a]Model 3 has post-intervention SMA (M) as dependent variable.