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Positive Psychology: applied to clinical populations

"Build what is strong rather than fix what is wrong"

-Seligman

Overview

Introduction

Positive psychology is a newly founded branch which aims at raising positivity above baseline mental well-being. It has been mainly applied to non-clinical populations, but recently it has also been applied to clinical populations. As such, it is being debated whether it should remain an independent branch or be integrated into mainstream psychology. Results suggest that overall Positive Psychology Interventions are successful in achieving this goal in relation to several clinical populations including depression and anxiety disorders. However, there are many methodological issues that need be addressed, and these interventions should also be tested independently of the usual treatments (e.g. CBT), thus clarifying their individual effects.

Theory

Positive psychology is applied in clinical settings through a strengths-based approach: it encourages an equal focus on both negative and positive aspects when dealing with clinical disorders, and especially in treating distress (Duckworth, Steen & Seligman, 2005). It is believed that developing interventions which promote one's inner strengths, positive emotions and behaviours – not dwelling on the adverse effects of the disorder, such as dysfunctional behaviours – can be equally effective as other approaches commonly used in traditional psychology such as cognitive behavioural therapy (CBT) (Seligman, Steen & Peterson, 2005; Sin & Lyubomirsky, 2009).

Positive interventions used to treat clinical symptoms usually consist of brief, self-administered exercises intended to enhance positive cognitions and behaviours (Krentzman, 2012), by targeting feelings of well-being, happiness, optimism, and quality of life; all of these emotions combined give us a sense of purpose and life satisfaction. Techniques, which involve the mindfulness component of meditation, are aimed at bringing attention to the here-and-now in a non-judgemental manner, which allows the individual to identify and accept emotions and circumstances, which cannot be changed. The aim of positive interventions is not just to change people's emotional state so as to reach the non-negative baseline, but to over-exceed this 'average' level altogether.

''Building a strength, in this case, optimism, and teaching people when to use it, rather than repairing damage, effectively prevents depression and anxiety…If we wish to prevent schizophrenia in a young person at genetic risk, I would propose that the repairing of damage is not going to work. Rather, I suggest that a young person who learns effective interpersonal skills, who has a strong work ethic, and who has learned persistence under adversity is at lessened risk for schizophrenia.''

(Seligman & Csikszentmihalyi, 2000).

If positive psychology is indeed more focused on preventing rather than repairing what is broken, *then why are positive psychology based interventions even used in clinical populations*? Maybe it should only focus on non-clinical populations?

Other interventions, such as cognitive-behavioural therapy (CBT), psychoanalysis and medication, have been shown to be efficient in clinical populations. However, research suggests that a successful outcome of the intervention is more dependent on the therapist, and the client-therapist relationship, than the chosen therapy (reference). If this is the case, then why is it important at all to examine the efficacy of positive psychology interventions in clinical populations?

If optimism and happiness are traits that are beneficial to have, it is important to understand if these mental states can even be acquired or if our internal programming (genetic happiness and optimism levels) constrict the extent to which our mental well-being can be modified. A few studies suggest that *some* change is possible (Segerstrom, 2006), but this change is limited and it is still questionable how permanent it is. Thus, the potential inability to permanently change our mental states challenges the entire notion of positive psychology interventions being applied in clinical settings.

After reading everything, reflect on the information and take a few minutes to think about this quote of Seligman:

Food for thought:

'I predict that in this new century positive psychology will come to understand and build those factors that allow individuals, communities, and societies to flourish'' (Seligman, 2002).

a. Based on what you have now learned, do you agree with Seligman's quote?

b. After reading about all these positive psychology-based interventions, think about which ones do you think would be more effective on you and why? Do you think they are all equally effective?

Summary points

- Positive psychology focuses on positive emotions and personal strengths.
- It can complement rather than replace traditional psychotherapy.
- Studies evaluating outcomes of interventions using positive psychology have mostly been small and short term.
- If I only had to read 4 papers, which ones would they be?

1. **http://www.ncbi.nlm.nih.gov/pubmed/18230223**
2. **http://www.ppc.sas.upenn.edu/ppclinicalpractice.pdf** (for a general introduction to the topic)
3. **http://socs.berkeley.edu/~akring/JCP%20Johnson.et.al.2009.pdf**
4. **http://www.ncbi.nlm.nih.gov/pubmed/16045394**

Clinical Application - Are there any?

Practical Exercises

Criticisms of Positive Psychology - In General

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Clinical Application - Are there any?

Clinical Applications - Are there any?

In recent years several studies have tested interventions which are part of the Positive Psychology school of thought. From Seligman et al's (2005) package of Positive Psychology Intervention (PPI) exercises, to mindfulness-based meditation, some empirical research suggests that such treatments may be effectively applied to various clinical populations. However, much of the research is exploratory and qualitative. As such, more rigorous randomised control studies are needed. The following are examples from the literature of Positive Psychology applied to clinical populations.

Overview -
Positive Psychology Interventions
- Well-Being Therapy
- Interventions derived from mindfulness meditation

Positive Psychology Interventions (PPIs)

Table 1: PPIs covered in this section include:

PPI	Increases
Identifying signature strengths	Well-being and life-satisfaction
Three blessings/good things	Happiness
Writing a positive obituary	Positive emotions
Gratitude	Happiness
Best Future self	Optimism

Signature Strengths – ***Increase general well-being and life-satisfaction***
Patients are asked to consider their various strengths and try to identify the top five in their repertoire using the **Values in Action Inventory of Strengths (VIA-IS)**, which identifies 24 strengths that can be divided into six core traits (see Farmer, 2011) for the complete explanation of each strength):Wisdom; Courage; Humanity; Justice; Temperance; Transcendence.

As such, patients can learn which strengths work in specific situations and learn to better incorporate them into their daily lives, both creatively and industriously, improving daily functioning. This intervention could teach individuals to associate the usual stress of daily tasks with their strengths allowing them to feel a sense of control and agency. Over time, stress might become connected with these feelings of agency, which is assumed to be a key determinant of physiological toughness.

Three Blessings/Good Things – ***Increases happiness levels and well-being***
The patient should write down three things that have gone well each day and why, in the evening for a week.

It's easy to ruminate on the things that didn't go well; we are usually much more unpracticed at remembering the good things and savoring them. Therefore, taking the time to think about what has gone well, shifts our cognitions from negative to positive.

Writing a positive obituary – ***Promotes positive emotions***
The newly developed Broad Minded Affective Coping (BMAC) technique (Tarrier, 2010a) is designed to promote

positive emotions through the recall of positive autobiographical memories, as happiness and hope expand thought-action repertoires and support the building of resources and resilience to a variety of psychological disorders.

***Gratitude* – Increases happiness levels**
This exercise involves the patient thinking of someone to whom they are very grateful but have never properly thanked. They are directed to write a letter describing their gratitude and are urged to give it to the person. This is because when we are grateful for what is good in our lives, we appreciate them more.

Empirical Results for these PPIs

Using PPIs in group therapy

Other Interventions: Well-Being Therapy

Interventions using mindfulness developed from meditation

These interventions are different from PPIs as they are derived from the mindfulness component of meditiation.

Meta-analysis

However, both of these studies combined PPIs with CBT-thus, how can one be confident that the beneficial gains were the result of the PPIs and not of the CBT which is a more traditional and well-established intervention (Fava *et al*., 2005; Zautra, Davis, Reich, *et al*., 2008). In order to substantiate and ascertain the significance of PPIs when applied to clinical populations, studies have to be carried out where PPIs are compared against other types of interventions such as psychoanalysis, CBT, and medication.

A meta-analysis showed that the positive-psychology interventions are less effective when compared against the *control groups* than when compared to the *no-treatment groups*, which suggests that part of the effectiveness of the interventions is due to demand effects or the general therapeutic expectations of taking part in any intervention (Wampold, 2007).

Whilst the studies discussed above provide evidence of successful clinical application of PPIs in a variety of cases, Sin *et al.*'s (2009) meta-analysis provides an excellent quantitative picture of how effective PPIs have been in enhancing well-being and alleviating depressive symptoms, compared with traditional interventions.

Results: Essentially the study showed that PPIs were more successful than control interventions both in alleviating depressive symptoms and in enhancing well-being. Furthermore, clinical populations experienced a larger effect size than non-clinical populations, which goes some way to dispelling the notion that PPIs are more suited to non-clinical populations.

It was noted, however, that the efficacy of PPIs was reduced in patients who scored low on motivation and so one way to maximise the gains of PPIs would be for the therapist to work on increasing the client's motivation to be treated this way, prior to the beginning of therapy.

General conclusion of the effectiveness of Positive Psychology Interventions in clinical populations

*See **Table 2** for a Summary of the different Positive Psychology Interventions.*

Overall, the empirical evidence seems to support the usefulness of PPIs. However, is it important to remember that the field of positive psychology is at a rather immature stage in its development and thus not many long-term follow-up studies have been carried out.

Although there is supportive empirical evidence, many studies can be criticised on the grounds of methodological issues - the empirical nature of the field can be enhanced if the subjective self-report measures of happiness are replaced by neuropsychological, behavioural and experimental measures, which are more objective and indisputable.

From the studies described above it is evident that PPIs have been applied in a variety of clinical settings and, in at least some cases their efficacy matches or exceeds that of the traditional interventions. Given such findings Woods and Tarrier (2010) recommend that Positive Psychology is integrated into mainstream clinical psychology so that clinicians have a wider range of intervention techniques to offer patients. Further rigorous evaluation of PPIs should be carried out, but initial findings suggest that such treatments have strong potential for clinical application.

Table 2: Summary of the Interventions

	What kind of intervention is it?	What does it do?	Evidence?	Limitations?	Compared to other interventions?	Improvements

Three blessings	PPI	Increases well-being and happiness	Seligman et al. (2006) *Decreased BDI points in moderately depressed, which was maintained over a 12-month follow-up.* *64% remission for severely depressed vs. 11% for TAU and 9% for TAUMED.*	PPIs need to be used in combination with traditional interventions (e.g. CBT) rather than on their own.	PPIs are shown to be better than TAU and TAUMED.	These PPIs need to be tested against other interventions such as psychoanalysis. The individual usefulness of PPIs needs to be tested. More studies need to test the usefulness of PPIs in clinical populations.
Writing a positive obituary (BMAC)		Promotes positive emotions				
Signature strengths		Increases life-satisfaction				
Gratitude		Increases happiness				
Best future self		Increases optimism	Shapira & Mongrain (2010)			More studies need to test the usefulness of PPIs in clinical populations.
Loving-kindness meditation (LKM)	Meditation	Develops love and acceptance	Qualitative	No quantitative research.	No other interventions - this study was exploratory.	Quantitative research needs to be done.
Mindfulness based stress reduction (MBSR)	Meditation	Develops awareness and acceptance	Grossman et al. (2007) *Reduced pain in rheuatoid arthritis* Zautra et al. (2008) *Reduced pain in fibromyalgia*	MBSR needs to be used in combination with traditional interventions. Zautra et al. (2008)'s study did not test MBSR alone, but only in combination with CBT.	There are many variations of mindfulness-based interventions e.g. *Acceptance and Commitment therapy (ACT), mindfulness-based cognitive therapy (MBCT), Dialectical Behaviour therapy.* These are all commonly grouped under the term 'Third Wave therapies'.	Studies should examine whether it is actually an increase in concentration (rather than the mindfulness) that has a positive impact on people.
Well-Being Therapy (WBT)	PPI	Improves well-being and life quality and reduced risk of relapse	Fava et al. (2005) *Useful as a supplementary intervention to CBT in reducing symptoms (anxiety) in GAD more than CBT alone.*	Studies have only examined the use of WBT as a compliment to traditional interventions (e.g. CBT)	Should be a compliment to traditional interventions.	Studies need to examine if WBT can be used on its own.
Positive Psychology Couples Therapy	PPI	Improves openness in relationships, sexual fulfillment and general relationship satisfaction.	Kaufmann et al. (2009) *Exploratory qualitative case study.*	No quantitative research done. Study does not compare results to traditional couples therapy.	Study does not compare to regular couples therapy.	Quantitative research is needed.

Criticisms of Positive Psychology - In General

Criticisms of Positive Psychology - In General

The field of positive psychology has given rise to many wild, uncritical claims. Perhaps the most notable area for this type of claim is in the self-help literature now widely available, which has lead to many non-clinical “interventions”. However, in the clinical application of positive psychology, the uncritical claims are somewhat more difficult to identify. A place to begin investigating these wild claims may be in the definitions of some terms widely used in positive psychology, such as “happiness”, “optimism” and “gratitude”. These concepts are difficult to define, and so, clinical application of positive psychology is seeking to promote states of being which are fluid, changeable and difficult to quantify.

A measure for positive psychology which has been widely criticized is Michael Argyle’s “Oxford Happiness Questionnaire” (2002) as the approach does not demonstrate a theoretical model of happiness, and also for too much overlap with the related fields of self-esteem, sense of humour, social interest, kindness and aesthetic pleasure (Todd, 2004). This questionnaire therefore attempts to measure happiness without actually defining same, which renders it an extremely poor tool to determine how to raise those suffering from mental illness from below normal to more than normal, that is, happy.

The evolutionary perspective of positive psychology offers an alternative approach to understanding what happiness or quality of life is about. It focuses on the questions “What features are included in the brain that allow humans to distinguish between positive and negative states of mind?” and “How do these features improve humans’ ability to survive and reproduce?”. It claims that answering these questions points towards an understanding of what happiness is about and how best to exploit the capacities of the brain with which humans are endowed (Grinde, 2002). However, it seems unreasonable to determine what happiness is about without being able to give a definitive account of what happiness is. Raising people from negative states of mind towards happiness is quite a feat, particularly if there are no clear standards by which to measure success or achievement.

Researcher Dianne Hales described a person who is *emotionally healthy* as someone who exhibited flexibility and adaptability to different circumstances, had a sense of meaning and affirmation in life as well as an "understanding that the self is not the center of the universe", had compassion and the ability to be unselfish, along with increased depth and satisfaction in intimate relationships, and who had a sense of control over the mind and body (2010). When applying this type of criteria to clinical populations, it seems unreasonable to speak of emotional health, when neuroimaging has found differences in the brain structures of, for example, schizophrenics.

Lazarus is openly critical of the positive psychology movement in his 2003 paper entitled “Does the Positive Psychology Movement Have Legs?” in which he claims that positive psychology is simply a new ideological movement, supporting the opinion that positive psychology is merely rebranding of components from other areas of psychology. He states that the goal of positive psychology is to engage individuals in a more positive way of thinking in order to reduce or escape from their “preoccupation” with the negative and stressful aspects of life, thus allowing them to generate higher levels of health and well-being. While this may be the case for the “normal” population, clinical populations differ from the normal population in several crucial ways. One way that the clinical population differs from the normal population is that, in the case of depression, there may be problems with neurotransmitters such as dopamine and serotonin, thus, it seems unreasonable to define a hormonal deficiency as a “preoccupation with negativity”. Although this view would be supported by Beck, who posited the theory of the Negative Cognitive Triad, wherein he states that negative thoughts are about the self, the world and the future. Additionally, it seems unreasonable to accuse clinical populations of dwelling on negative circumstances, as the nature of the disorders in question do make it extremely difficult to gain perspective, or “turn off” the unhelpful thoughts. It may even be that unhelpful thoughts are not recognised as such, and this technique must be taught through psychological interventions.

In terms of literature in the movement of positive psychology, as early as 2002 the Handbook of Positive Psychology was published by Snyder & Lopez. For a field which is universally regarded as in infancy, this adds to the uncritical claims made by positive psychology in that there is a lack of a well-established field with solid theory and empirical foundations. This is perhaps unsurprising, when considering the aforementioned concepts such as happiness. While there are claims of reliable and valid measures of such notions, it seems inconceivable, as happiness most certainly means different things from one individual to another.

How much lasting change is possible based on genetic influence on happiness and hedonic adaptation? According to Lyubomirsky, Sheldon & Schkade (2005) we can affect up to 40% of our happiness through intentional activity. Selgiman (2005) posits three distinct routes to happiness, namely positive emotion and pleasure, engagement, and meaning, suggesting that engagement and meaning are the largest contributors to happiness, and therefore would be the most suitable targets for interventions. Some of the more interesting efforts and their drawbacks are summarised:

Burton & King (2004) created a writing-based intervention, where participants were asked to write about positive experiences to see the effect this had on mood and health. While results were promising, participants were only followed up for 3 days for mood ratings, something corrected in their later study (2008), where follow-ups were carried out at 4-6 weeks with similarly positive results.

Seligman, Steen, Park & Peterson (2005) carried out a study testing 5 potential interventions for depression, and found that 3 of them, namely a gratitude visit, a writing exercise similar to Burton & King’s (2004; 2008) and ways to put their measured “signature strengths” to better use. The biggest (but shortest, lasting only 1 month) effect came

from the gratitude visit, in which time was spent thanking a person from their past for their input, encouragement or support, with the other 2 interventions having effects lasting around 6 months. Analysis suggests that the reason the interventions were efficacious was due to participants' continued participation. Thought the results obtained are promising, the sample was not representative in terms of socio-demographics or mood of participants.

Lyubomirsky *et al*. (2005) asked participants to perform 5 acts of kindness each week for 6 weeks, either 1 per day, or all 5 on one day. Both groups showed improvements, with the 5 in one day group's well-being significantly out-performing the 1 per day group, suggesting a possible dose-response or threshold effect. In another of their studies (carried out in 2005) which asked participants to count their blessings either once or three times per week, only those who counted their blessings once a week were happier after 6 weeks, suggesting a larger time between exercises prevented habituation.

Seligman, Rashid & Parks (2006) carried out a series of therapist-led interventions for depression against 2 treatment-as-usual groups and found that 6 – 12 weeks of positive therapy plus homework had significantly more positive outcomes and good maintenance (determined during a 1 year follow-up). However, these trials have numerous methodological issues, including the representativeness and size of the sample utilised, non-matched skill levels of therapists, and questions as to the choice (and effect) of therapy in the treatment groups.

Certainly these trials are intriguing, even with the various methodological and sampling issues, but a key question that remains largely unanswered is whether the effects are long lasting, or whether hedonic adaptation and our genetic happiness set-points will mean that the effects will fade over a relatively short time-frame. Longitudinal studies with regular follow-ups will help address and answer this. Additionally, the issue of the subjectivity of self-report measures of happiness could be to some extent addressed with neuropsychological, behavioural and experimental measures, which would enhance the empirical nature of the field.

According to Wampold (2007), specific techniques of a particular psychotherapy only contribute 15% to its efficacy, with extra-therapeutic (40%) and common factors (30%) accounting for the vast majority of the explained variance. However, it has been suggested by Duckworth, *et al*. (2005) that many positive psychology strategies can be found within non-specific therapeutic factors, including developing "buffering strengths" and instilling hope. If this is confirmed, and those factors can, through specific trails, be optimised, positive psychology could contribute much more to psychotherapy at large.

Partly because of the immaturity of the field, positive psychology interventions using specific ordering and combinations of techniques have not yet been trialled, but it will be interesting to see if effects over and above the sum of the parts are achieved. Additionally, elements could be combined with pharmacological and/or already mature, evidence based interventions such as Cognitive Behavioural Therapy. There is clearly much research to be conducted, and until studies of higher quality are implemented, one should be sceptical as to positive psychology's longevity, both in terms of intervention outcomes and the movement itself. However, given the early positive results, it seems likely positive psychology's efforts will be redoubled in order to try to catch up with more established therapies.

Additionally, from reviewing some of the literature, positive psychology does not appear to mean the same thing to all psychologists. To some, it is about positive versus negative emotions. To others, it is about the personality resources and virtues that help people not only to survive but to flourish. Seligman & Csikszentmihalyi (2000), pioneers in the positive psychology movement, advise that psychology has little understanding of what makes life worth living. They concede that much research has been carried out and theories formulated detailing how people can survive and endure adversity, but as a field we know little of what allows non-clinical populations to flourish in normal conditions. Seligman & Csikszentmihalyi acknowledge that since the Second World War psychology has become a discipline preoccupied with the disease model of human functioning, striving to heal and to return those in need to a baseline of non-negative emotion, but not necessarily positive emotion. They state that this almost exclusive attention to pathology neglects the fulfilled individual and the thriving community, however, what need for psychology or intervention does said fulfilled individual or thriving community really need? While it may further clinical application of psychology to understand how these states and baseline levels of, for want of a better word, happiness occur and are maintained, how does this really apply to clinical populations, for whom baseline would be a significant improvement? Perhaps it is important for the psychological community to embrace positive psychology and its attempt to catalyse a change in focus from merely repairing the worst things in life to also building positive qualities, and educating people in how do achieve this. It is important to challenge the view that positive and negative should be separated and isolated. Aside from uncertainties and misunderstandings about what defines positive and negative, this polarity represents two sides of the same coin, and is perhaps better understood on a sliding scale, such as is the case for stress and coping. Perhaps one cannot exist without the other: negativity is required in some situations, even if only considered in the sense of being able to recognise danger and escape from it, and perhaps it also required in order that the bad parts of life allow the appreciation of the good aspects. Whenever the focus of attention is narrowed too much to one side or the other, there is the danger of losing perspective.

In their 2010 paper, Joseph & Wood support this view that positive and negative functioning should be assessed on a single continuum (such as on bipolar dimensions from happiness to depression, and from anxiety to relaxation). They also posit that specific measures of positive functioning could be used in conjunction with existing clinical scales. Additionally, they point out that different measures are required depending on whether well-being is defined as emotional or medical functioning, or as humanistically oriented growth (in line with Seligman's (2005) proposition that there are three distinct routes to happiness, namely positive emotion and pleasure, engagement, and meaning). It is important that clinical psychologists introduce positive functioning into their research and practice in order to widen their armoury of therapeutic interventions, but in doing so researchers and practitioners must also

be aware that they may be shifting the agenda of clinical psychology by incorporating the findings of a discipline still considered by many to be in its infancy and potentially a fad.

Cultural origins

Cultural Origins

The origins of positive psychology stem from many different branches of psychology. With regards to clinical applications of positive psychology, the ancient Greek philosophy has a prominent part to play. Particularly, the Stoics developed spiritual exercises which are incorporated in cognitive behavioural therapy and other aspects of Positive Psychology today. The Stoics focussed their attention on realistic and objective techniques to uplift themselves.

Religious Roots

Positive Psychology has taken inspiration from a variety of religions, such as Christianity. Christianity is the most popular religion throughout the world therefore it is relevant to look at the potential links between the Christian beliefs and the dynamics of Positive Psychology and how it can be applied globally. Barbara Enhreich believed that Positive Psychology was developed as an opposing side to Calvinism; an extreme form of Christianity in which any aspect of pleasure or indulgence are forbidden. Lewis and Cruise (2006) highlighted key discrepancies in the methodology used to test the connection between religion and happiness. It was noted that using the Oxford Happiness Inventory, Christians reported higher rates of happiness than non-religious individuals however, using the Depression-Happiness Scale, no difference in happiness levels were reported. Uplifting techniques used by Buddhists have been adopted by Positive Psychology which offers some explanation as to why there is not such a prominent demand for Positive Psychology in Buddhist regions (Marlatt, 2002). This study showed that addictive behaviour (such as substance abuse, gambling and alcohol addiction) could be treated using techniques shared by Buddhists and Positive Psychology.

Whatever the weather...

The benefits of Positive Psychology will naturally vary from place to place across the globe. There is ongoing debate as to whether the weather has a role in bringing happiness to people's lives. If this was to be true, individuals who lived in sunnier places would rate happier than those who don't receive as much sunlight. Shkade and Kahneman (1998) investigated whether people living in the 'sunshine state' of California rated themselves as happier than individuals living in the Midwest states of North America. It was reported that weather was listed at the bottom of factors influencing a person's happiness and also that individual's living in California were no happier than those living in states where there was more rainfall and wind annually. Seasonal Affective Disorder (Rosenthal, 1984) is a clinical issue in which individuals feel low and less energetic, and is thought to be due to a lack of sunlight. This was discovered on Rosenthal's move from Johannesburg to New York where he experienced these symptoms. SAD is still existent in today's society, with around 7% of Britain suffering from the disorder. Furthermore, it was noted that only individuals living in the states in the Northern Hemisphere of the United States suffer from SAD. Interestingly, arguments have been put forward for a condition named reverse-SAD in which individuals experience feelings of sadness and low energy in the summer time. Treatment for SAD has been offered in the form of light boxes from the NHS which appear to be effective in lifting people's spirits in days where there is a lack of sunlight. However, SAD is not commonly treated as a separate disorder but rather a symptom of another depressive disorder.

Example of a SAD lamp.

Individualistic vs Collectivist cultures

Suh and Osihi investigated a potential link between culture and happiness by gathering 6000 students from 43 nations to rank their happiness scale. In this particular study, Chinese students rated lowest of their life satisfaction scale and the Dutch individuals rated the highest. It was therefore concluded that individuals in individualistic cultures rate their happiness better than those living in collectivist cultures. Positive Psychology revolves around the shifting of attention from negativity to positive thoughts and emotions (Kauffman, 2006). Cross-cultural studies (Masuda and Nisbett, 2008; Rosinski & Abbott, 2006) have shown that inhabitants of Eastern and Western cultures attend to information differently. Therefore, this should be considered when practicing Positive Psychology across the globe.

Empirical Results for these PPIs

Seligman et al (2005) conducted 2 studies comparing the efficacy of PPIs used as packages which they termed Positive Psychotherapy with traditional treatments, for both moderate and severe depression. Both studies found significant reduction of depressive symptoms and increases in well-beng which were, importantly, of greater magnitude than those of traditional treatments.

The effects were particularly striking for the severely depressed group, with 64% being in remission of their Major Depressive DIsorder one year after receiving Positive Psychotherapy, compared to just 8% of the traditional treatment group. This type of long-term effect is unusual in severe depression and so suggests that Positive Psychotherapy could become the gold standard for severe depression if such results are consistently replicated.

Empirical Results for these PPIs:

Seligman et al (2006) conducted two studies, which found the above PPIs (Positive Psychotherapy) to be more effective than traditional control interventions in treating both mild and severe depression.

Study 1: Randomly assigned moderately depressed participants (as measured by the Beck Depression Inventory (BDI)) to either a 6 week course of group Positive Psychotherapy, or a no-treatment control condition. The treatment group engaged in exercises such as:

Using signature strengths, Thinking of 3 blessings, Writing a positive obituary and Gratitude

Both groups were followed up at 3-, 6- and 12-month intervals to assess long-term effects.

- Results: It was found that the treatment group experienced an average drop of 0.96 BDI points per week, which was maintained across all follow-ups. This degree of sustained long-term improvement is greater than seen in traditional psychotherapy suggesting that the self-maintaining practices which are involved in PPI exercises play a role here.

Study 2: Severely depressed patients (diagnosed with Major Depressive Disorder) were assigned to undertake either individual Positive Psychotherapy, treatment as usual (TAU) or treatment as usual plus antidepressant medication (TAUMED).

- Results: After a course of 12 weeks 64% of the PPI group was in remission of their Major Depressive Disorder, compared with 11% of the TAU group and 9% of the TAUMED group.

Best future self – Increases optimism

Shapira and Mongrain's (2010) procedure.

Study: patients are asked to envision a positive future, 1-10 years from now, in various areas of their life: e.g. family, relationship and work, each day for a week, if everything unfolds exactly the way they want it to. They are asked to write about these positive possibilities and consider existing issues that had to solve in this future and haw they could best solve these problems from the perspective of this future self.

- Results: Relative to the control condition, this optimism condition increased happiness over the next six months. This intervention diminished depression over the next three months.

Across these two studies it is demonstrated that PPIs are flexible interventions, which can be tailored for use in a one-to-one or group setting. Most importantly however, it is shown to be generally more effective than (a) no treatment and (b) traditional treatment/ antidepressants, in the samples. It should be noted however that the sample sizes of these two studies was small

For other studies see:

- Seligman, Steen, Park, and Peterson (2005).

- Wood, Linley, Maltby, Kashdan, and Hurling (2010
- Littman-Ovadia and Steger (2010).
- Peters, Flink, and Boersma, and Linton (2010).

General criticisms of Positive psychology

General Criticisms of Positive Psychology

The field of positive psychology has given rise to many wild, uncritical claims. Perhaps the most notable area for this type of claim is in the self-help literature now widely available, which has lead to many non-clinical “interventions”. However, in the clinical application of positive psychology, the uncritical claims are somewhat more difficult to identify. A place to begin investigating these wild claims may be in the definitions of some terms widely used in positive psychology, such as “happiness”, “optimism” and “gratitude”. These concepts are difficult to define, and so, clinical application of positive psychology is seeking to promote states of being which are fluid, changeable and difficult to quantify.

A measure for positive psychology which has been widely criticized is Michael Argyle’s “Oxford Happiness Questionnaire” (2002) as the approach does not demonstrate a theoretical model of happiness, and also for too much overlap with the related fields of self-esteem, sense of humour, social interest, kindness and aesthetic pleasure (Todd, 2004). This questionnaire therefore attempts to measure happiness without actually defining same, which renders it an extremely poor tool to determine how to raise those suffering from mental illness from below normal to more than normal, that is, happy.

The evolutionary perspective of positive psychology offers an alternative approach to understanding what happiness or quality of life is about. It focuses on the questions “What features are included in the brain that allow humans to distinguish between positive and negative states of mind?” and “How do these features improve humans’ ability to survive and reproduce?”. It claims that answering these questions points towards an understanding of what happiness is about and how best to exploit the capacities of the brain with which humans are endowed (Grinde, 2002). However, it seems unreasonable to determine what happiness is about without being able to give a definitive account of what happiness *is*. Raising people from negative states of mind towards happiness is quite a feat, particularly if there are no clear standards by which to measure success or achievement.

Researcher Dianne Hales described a person who is *emotionally healthy* as someone who exhibited flexibility and adaptability to different circumstances, had a sense of meaning and affirmation in life as well as an "understanding that the self is not the center of the universe", had compassion and the ability to be unselfish, along with increased depth and satisfaction in intimate relationships, and who had a sense of control over the mind and body (2010).

When applying this type of criteria to clinical populations, it seems unreasonable to speak of emotional health, when neuroimaging has found differences in the brain structures of, for example, schizophrenics.

Lazarus is openly critical of the positive psychology movement in his 2003 paper entitled "Does the Positive Psychology Movement Have Legs?" in which he claims that positive psychology is simply a new ideological movement, supporting the opinion that positive psychology is merely rebranding of components from other areas of psychology. He states that the goal of positive psychology is to engage individuals in a more positive way of thinking in order to reduce or escape from their "preoccupation" with the negative and stressful aspects of life, thus allowing them to generate higher levels of health and well-being. While this may be the case for the "normal" population, clinical populations differ from the normal population in several crucial ways. One way that the clinical population differs from the normal population is that, in the case of depression, there may be problems with neurotransmitters such as dopamine and serotonin, thus, it seems unreasonable to define a hormonal deficiency as a "preoccupation with negativity". Although this view would be supported by Beck, who posited the theory of the Negative Cognitive Triad, wherein he states that negative thoughts are about the self, the world and the future. Additionally, it seems unreasonable to accuse clinical populations of dwelling on negative circumstances, as the nature of the disorders in question do make it extremely difficult to gain perspective, or "turn off" the unhelpful thoughts. It may even be that unhelpful thoughts are not recognised as such, and this technique must be taught through psychological interventions.

In terms of literature in the movement of positive psychology, as early as 2002 the Handbook of Positive Psychology was published by Snyder & Lopez. For a field which is universally regarded as in it's infancy, this adds to the uncritical claims made by positive psychology in that there is a lack of a well-established field with solid theory and empirical foundations. This is perhaps unsurprising, when considering the aforementioned concepts such as happiness. While there are claims of reliable and valid measures of such notions, it seems inconceivable, as happiness almost certainly means different things from one individual to another.

How much lasting change is possible based on genetic influence on happiness and hedonic adaptation? According to Lyubomirsky, Sheldon & Schkade (2005) we can affect up to 40% of our happiness through intentional activity. Selgiman (2005) posits three distinct routes to happiness, namely positive emotion and pleasure, engagement, and meaning, suggesting that engagement and meaning are the largest contributors to happiness, and therefore would be the most suitable targets for interventions. Some of the more interesting efforts and their drawbacks are summarised:

Burton & King (2004) created a writing-based intervention, where participants were asked to write about positive experiences to see the effect this had on mood and health. While results were promising, participants were only followed up for 3 days for mood ratings, something corrected in their later study (2008), where follow-ups were carried out at 4-6 weeks with similarly positive results.

Seligman, Steen, Park & Peterson (2005) carried out a study testing 5 potential interventions for depression, and found that 3 of them, namely a gratitude visit, a writing exercise similar to Burton & King's (2004; 2008) and ways to put their measured "signature strengths" to better use. The biggest (but shortest, lasting only 1 month) effect came from the gratitude visit, in which time was spent thanking a person from their past for their input, encouragement or support, with the other 2 interventions having effects lasting around 6 months. Analysis suggests that the reason the interventions were efficacious was due to participants' continued participation. Though the results obtained are promising, the sample was not representative in terms of socio-demographics or mood of participants.

Lyubomirsky *et al*. (2005) asked participants to perform 5 acts of kindness each week for 6 weeks, either 1 per day, or all 5 on one day. Both groups showed improvements, with the 5 in one day group's well-being significantly out-performing the 1 per day group, suggesting a possible dose-response or threshold effect. In another of their studies (carried out in 2005) which asked participants to count their blessings either once or three times per week, only those who counted their blessings once a week were happier after 6 weeks, suggesting a larger time between exercises prevented habituation.

Seligman, Rashid & Parks (2006) carried out a series of therapist-led interventions for depression against 2 treatment-as-usual groups and found that 6 – 12 weeks of positive therapy plus homework had significantly more positive outcomes and good maintenance (determined during a 1 year follow-up). However, these trials have numerous methodological issues, including the representativeness and size of the samples utilised, non-matched skill levels of therapists, and questions as to the choice (and effect) of therapy in the treatment groups.

Certainly these trials are intriguing, even with the various methodological and sampling issues, but a key question that remains largely unanswered is whether the effects are long lasting, or whether hedonic adaptation and our genetic happiness set-points will mean that the effects will fade over a relatively short time-frame. Longitudinal studies with regular follow-ups will help address and answer this. Additionally, the issue of the subjectivity of self-report measures of happiness could be to some extent addressed with neuropsychological, behavioural and experimental measures, which would enhance the empirical nature of the field.

According to Wampold (2007), specific techniques of a particular psychotherapy only contribute 15% to its efficacy, with extra-therapeutic (40%) and common factors (30%) accounting for the vast majority of the explained variance. However, it has been suggested by Duckworth, *et al*. (2005) that many positive psychology strategies can be found within non-specific therapeutic factors, including developing "buffering strengths" and instilling hope. If this is confirmed, and those factors can, through specific trials, be optimised, positive psychology could contribute much more to psychotherapy at large.

Partly because of the immaturity of the field, positive psychology interventions using specific ordering and

combinations of techniques have not yet been trialled, but it will be interesting to see if effects over and above the sum of the parts are achieved. Additionally, elements could be combined with pharmacological and/or already mature, evidence based interventions such as Cognitive Behavioural Therapy. There is clearly much research to be conducted, and until studies of higher quality are implemented, one should be sceptical as to positive psychology's longevity, both in terms of intervention outcomes and the movement itself. However, given the early positive results, it seems likely positive psychology's efforts will be redoubled in order to try to catch up with more established therapies.

Additionally, from reviewing some of the literature, positive psychology does not appear to mean the same thing to all psychologists. To some, it is about positive versus negative emotions. To others, it is about the personality resources and virtues that help people not only to survive but to flourish. Seligman & Csikszentmihalyi (2000), pioneers in the positive psychology movement, advise that psychology has little understanding of what makes life worth living. They concede that much research has been carried out and theories formulated detailing how people can survive and endure adversity, but as a field we know little of what allows non-clinical populations to flourish in normal conditions. Seligman & Csikszentmihalyi acknowledge that since the Second World War psychology has become a discipline preoccupied with the disease model of human functioning, striving to heal and to return those in need to a baseline of non-negative emotion, but not necessarily positive emotion. They state that this almost exclusive attention to pathology neglects the fulfilled individual and the thriving community, however, what need for psychology or intervention does said fulfilled individual or thriving community actually have? While it may further clinical application of psychology to understand how these states and baseline levels of, for want of a better word, happiness occur and are maintained, how does this really apply to clinical populations, for whom baseline would be a significant improvement? Perhaps it is important for the psychological community to embrace positive psychology and its attempt to catalyse a change in focus from merely repairing the worst things in life to also building positive qualities, and educating people in how do achieve this. It is important to challenge the view that positive and negative should be separated and isolated. Aside from uncertainties and misunderstandings about what defines positive and negative, this polarity represents two sides of the same coin, and is perhaps better understood on a sliding scale, such as is the case for stress and coping. Perhaps one cannot exist without the other: negativity is required in some situations, even if only considered in the sense of being able to recognise danger and escape from it, and perhaps it is also required in order that the bad parts of life allow the appreciation of the good aspects. Whenever the focus of attention is narrowed too much to one side or the other, there is the danger of losing perspective.

In their 2010 paper, Joseph & Wood support this view that positive and negative functioning should be assessed on a single continuum (such as on bipolar dimensions from happiness to depression, and from anxiety to relaxation). They also posit that specific measures of positive functioning could be used in conjunction with existing clinical scales. Additionally, they point out that different measures are required depending on whether well-being is defined as emotional or medical functioning, or as humanistically oriented growth (in line with Seligman's (2005) proposition that there are three distinct routes to happiness, namely positive emotion and pleasure, engagement, and meaning). It is important that clinical psychologists introduce positive functioning into their research and practice in order to widen their armoury of therapeutic interventions, but in doing so researchers and practitioners must also be aware that they may be shifting the agenda of clinical psychology by incorporating the findings of a discipline still considered by many to be in its infancy and potentially a fad.

History of Positive Psychology

History of Positive Psychology Interventions

History of Positive Psychology Interventions

The development of positive psychology was shaped in the 1990's by the considerable efforts of Seligman and Csikszentimihalyi (2000). These two researchers, particularly Seligman (also known as the father of positive psychology), provided major research funding into the clinical benefits of positive psychology.

Seligman attributes the movement of positive psychology to a conversation he had with his 5 year old daughter. From this conversation Seligman realised that psychology should not be aimed at reducing weakness but should promote, identify and nurture an individuals strongest qualities (Seligman, 2002). He believed that in order to cope with psychological disorders such as depression, schizophrenia and anorexia you should look at the disorder in its broader context so you can fully understand it and use your strengths to respond to this disorder rather than illuminating or suppressing the disorder. This technique of coping with psychological disorders is known as positive psychotherapy.

However, it has been argued that positive psychotherapy was developed well before Seligman and in actual fact derived from humanistic psychology. Humanistic psychology was intentionally launched by James, Maslow (1958) and Rogers (1961) to counter the negativity and pessimism of Freud and Skinner. This movement in psychology was based on the study of healthy, creative and self-actualised individuals. Rogers (1961) used humanistic psychology to develop client-centred therapy/psychotherapy. Rogers believed that through psychotherapy individuals could learn to fully understand themselves. They would then be able to use this understanding of themselves and their strongest qualitites to solve their problems. Maslow (1958) also believed that in order for any therapy to be successful in coping with a disorder it should promote the client to realise their full potential. Therefore humanistic psychology used positive psychotherapy and client-centred therapy to deal with clinical populations in the early 90's which suggests that Seligman did not actually develop positive psychology but instead he used the previous work of Maslow and Rogers and established it as his own.

Mindfulness is another area of positive psychology that originated from another source (Buddhism). This concept is defined as the intentionally focused awareness of your immediate experience. Mindfulness meditation gets an individual not to judge their experience, related thoughts, draw conclusions or try and change anything about it, but instead just to enjoy the experience in the moment. By focusing on the experience at the time an individual can reduces stress, anxiety, depression and chronic pain. However mindfulness was not developed through positive psychology, instead it originated from Buddhist practices. Western psychologists incorporated these practices in positive psychotherapy as they share core principles on how to cope with personal suffering. Buddhists for thousands of years have used mindfulness meditation techniques to cope with psychological disorders. The Mindfulness Based Stress Reduction (MBSR) therapy is used by Buddhists to reduce stress by getting an individual to focus on moment-to-moment experiences and so this promotes the attitude of owning each experience whether it is good or bad. This helps individuals to cope with and reduce depression and anxiety disorders. Buddhists have also used mindfulness meditation to restructure their negative cognitive thoughts into positive ones. For example the way Buddhists would cope with anger is to produce loving thoughts instead which helps reduce the anger. Therefore Buddhist practices have helped shape and develop techniques used in positive psychology for clinical benefits.

If you would like to try out mindfulness meditation here is a link to a short video showing you how you can do it.

Interventions using mindfulness developed from meditation

The following studies investigated the benefits of developing mindfulness through meditation and other exercises for a variety of clinical populations.

1) Loving Kindness Meditation: Applied to Schizophrenic population

2) Mindfulness Based Stress Reduction: Applied to chronic pain sufferers

Loving Kindness Meditation: background

Loving-kindness is a meditation practice, which brings about positive attitudinal changes as it systematically develops the quality of 'loving-acceptance'. The patient is asked to sit quietly and use devices such as visualisations, reflections or the repetition of loving-kindness mantra to help them arouse positive feelings of loving-kindness. If the mind strays, the patient is encourage to bring it back to the device, and re-elicit the feeling of loving-kindness. The practice always begins with developing a loving acceptance of oneself. Then by sending loving-kindness in the following order: a respected person, a dearly beloved, a neutral person, and then a hostile person, will have the effect of breaking down the barriers between the four types of people and the patient, and the divisions within their mind, the source of much of the conflict they experience. This also allows the individual to think a more flexible way, thus fostering more personal resources such as resilience and motivation which are more enduring than the positive emotion itself (Frederickson, 2001).

Empirical results for Loving Kindness Meditiation

Johnson et al (2009) performed an explorative qualitative study which found that using a course of Loving Kindness Meditation (LKM) was effective in reducing the problems associated with the negative symptoms of schizophrenia.

Case study 1: Samantha – tried several treatments for schizophrenia and GAD and rated LKM as the most enjoyable and most useful. Massively reduced anxiety, increased motivation, joined college courses, made friends. She related this to the feelings of positive emotion she had, from LKM, consistent with the broaden-and-build theory.

Case study 2: Kerry - meditating lead to improved mood which lead to enhanced thought and behavioural flexibility, allowing her to pursue recreational interests which she previously hadn't felt able to due to her negative emotions

Case study 3: Henry – LKM had little or no effect on his negative symptoms of mood. However, he reports the meditation was successful in alleviating anxiety. Thus brief exposure to LKM may not be enough to reduce negative symptoms of schizophrenia but may be useful in reducing positive symptoms such as stress/anxiety.

In summary this paper provides preliminary qualitative evidence that a LKM intervention can be effective in managing the effects associated with the negative symptoms of schizophrenia via the route of generating positive emotion, in line with the values of Positive Psychology.

Criticism: As this study is an exploratory qualitative study there is no quantitative data to further generalizability and validity to the findings. Future research needs to examine this type of intervention using a quantitative methods also applying to other clinical populations.

Mindfulness-based Interventions: Background

Mindfulness Based Stress Reduction (MBSR) is a structured complimentary program that uses mindfulness in an approach that focuses on alleviating pain and on improving physical and emotional well-being for individuals suffering from a variety of diseases and disorders. It as a moment-to-moment non-judgmental awareness. The focus of this particular type of meditation is for the individual to figure out the things that cause stress in their life - and respond to them in such a way that he or she feels empowered rather than overwhelmed.

To practice mindfulness, focus on the body starting at one end and moving all the way through to the other while noting breathing and any areas of discomfort. Pay attention to what is going on at that moment. When a thought about the past or future does come to mind, acknowledge but don't dwell on it, and just let it go.

Empirical results for Mindfullness-based interventions

Grossman et al (2007):

Zautra et al (2008):

Two studies have found that interventions which develop 'mindfulness', can help clients manage the physical pain associated with 1) Fibromyalgia (an intractable pain disorder) and 2) Rheumatoid arthritis.

Study 1: Grossman et al (2007) explored the immediate and long-term effects of a course of Mindfulness-Based Stress Reduction (MBSR) on a group of fibromyalgia sufferers. The MBSR programme involved such techniques as developing mental awareness and physical yoga exercises and was undertaken for a course of 8 weeks.

- Results: The results showed significant benefits in pain intensity, depressive symptoms, anxiety, competence and sense of belonging. Furthermore these benefits were significantly higher than a control group, and were maintained at a 3 year follow up.

Study 2: Zautra et al. (2008) also used a mindfulness-based intervention (Mindfulness meditation and emotion regulation therapy) compared and combined with the traditional CBT intervention, to assess the extent to which each improves the quality of life of sufferers of rheumatoid arthritis.

- Results: Similarly this study found significant gains in pain-coping and life satisfaction for the mindfulness based intervention group alone, and in combination with CBT.

From these two studies it is clear that interventions which develop mindfulness have potential clinical application to physical conditions which are characterised by physical pain. It may be the case that this type of intervention offers the patients with skills and perspectives not available from traditional behavioural interventions. Mindfulness based interventions may also be successful due to their focus on the tolerance, rather than the actual reduction, of physical symptoms.

Criticisms:

Since the above study (Zautra, Davis, Reich, et al., 2008) combined a PPI with CBT, how can one be confident that the beneficial gains were the result of the PPIs and not of the CBT which is a more traditional and a well-established intervention? In order to substantiate and ascertain the significance of PPIs when applied to clinical populations, studies have to be carried out where PPIs are compared against other types of interventions such as psychoanalysis, CBT, and medication.

Other Interventions: Well-Being Therapy

Well-Being Therapy - *Improves well-being and quality of life*
In practical terms, well-being therapy (WBT) is much like cognitive behavioral therapy. A patient keeps a journal to keep track of and recognize the positive events that occur each day. Next the patient starts recognizing negative thoughts and beliefs that distract from or disrupt positive events. The ultimate goal is to challenge and eventually change negative ways of thinking, to enable positive events to have more of an impact on the patient's life.

The therapy is a highly structured, short-term strategy, designed to be completed in 8 weekly sessions, though that could run to 12 in more difficult cases. Through a diary recording positive feelings and development of awareness of negative triggers the patient can be helped to break the habit of interpreting experiences in a consistently negative way. When an individual is depressed, it takes practice to learn how to shift their attention to the positive side of an event. The therapy can also help limit the expectation of failure, that nothing will work out well for them.

Empirical results for Well-Being Therapy

Fava et al. (2005)

Study: Fava et al (2005) found that WBT was useful as a supplementary intervention to the classic gold-standard treatment for Generalised Anxiety Disorder (GAD): CBT.

20 patients diagnosed with GAD were randomly assigned to receive either the traditional therapy of CBT, or a combination of CBT and WBT.

- Results: Both treatments were significantly associated with reduced anxiety. However the CBT+WBT group experienced significantly greater symptom reduction and well-being improvement. These gains were maintained at a 1 year follow up.

The authors interpret that the gains made on the dimensions of well-being facilitate a reduction in the pessimistic cognitive distortions associated with GAD. As such it appears that WBT has useful clinical application as a supplementary therapy to the traditional treatment for GAD of CBT.

Criticisms:

This study combined PPIs with CBT-thus, how can one be confident that the beneficial gains were the result of the PPIs and not of the CBT which is a more traditional and a well-established intervention (Fava et al., 2005). In order to substantiate and ascertain the significance of PPIs when applied to clinical populations, studies have to be carried out where PPIs are compared against other types of interventions such as psychoanalysis, CBT, and medication.

Practical Exercises

Practical Exercises for the Reader

Exercise 1:

'Identify 3 Good things' exercise: Identify three good things that have happened during the day and write them down. E.g. That you stumbled across some flowers that reminded you that spring is just around the corner.

Exercise 2

Try to fill out the table on your own to make your own study 'cheat sheet' for an exam question on the use of Positive psychology to treat clinical populations.

	What kind of intervention is it?	What does it do?	Why it works	Evidence	Limitations	Compared to other interventions?	Improvements that can be made?
Three blessings							
Writing a positive obituary							
Signature strengths							
Gratitude							
Best future self							
Loving-kindness meditation							
Mindfulness based stress reduction							

Well-being therapy							
Positive psychology couples therapy							

Exercise 3:

To prepare for the practical exam try to design an experiment which asses the use of any of the above interventions in a clinical population

Example: Design of experiment

Intervention to be assessed	**Well-being therapy** Aimed at reducing relapse rates (important for well-being in clinical populations).
Clinical population	**Obsessive Compulsive Disorder (OCD)**
Assessed against	**Cogntive Behavioural Therapy (CBT)** Chosen as CBT has been shown to be effective in the treatment of all anxiety disorders.
Hypothesis	Both WBT and CBT will reduce residual symptoms in the patients, but only WBT will increase PWB scores after treatment.
Participants	30 participants in each group (central limit theorem) *Participants must meet the following criteria:* 1. A current DSM-IV (APA, 1994) diagnosis of any anxiety disorder; 2. No history of active drug or alcohol abuse or dependence or personality disorder according to criteria; 3. No history of bipolar illness or antecedent dysthymia; 4. No active medical illness; and 5. Successful response to treatment administered by two psychiatrists/psychologists. Only the patients rated as 'better' or 'much better' according to Kellner's global scale of improvement (1972) will be included in the study.
Design	
Between subjects design	Patients will be randomly assigned to one of two treatment groups: 1. WBT; 2. CBT of residual symptoms
Measures	**Residual symptoms measured by Ryff's (1989) Scales of Psychological Well-Being (PWB)** (self-report). an 84-item inventory that covers six areas of well-being. Subjects respond with a six-point format ranging from strongly disagree to strongly agree.
Independent variable (IV)	**Treatment type** - 1 Factor 2 levels - (WBT & CBT)
Dependent variable (DV)	PWB score
Treatment	In both cases treatment will consist of eight 40 min sessions once every other week for 3-5 months. The same psychiatrist will be involved in both treatment groups. WBT patients will be asked to report only the episodes of well-being, rated on a

	0-100 scale, in a diary. The initial 2 sessions will be concerned with identifying and setting into a situational context such episodes, not matter how short lived they were. CBT will be conducted as described by BECK et al. (1979). Its focus, however, will be on psychological distress, and identifying and modifying negative automatic thoughts and beliefs underlying it. After treatment, all patients will be assessed on the PWB by the same clinical psychologist who evaluated them on intake, but who did not take part in the treatment and was blind as to treatment assigned (double-blind study). Follow-up studies will be conducted at 3-, 6-, and 12-month intervals.
Statistics	A non-parametric method, the permutation test, adapted by Pesarin (1990), will be used to evaluate differences between groups. This test is analogue of two-tailed student's t test and parametric analysis of variance and covariance, without, however, being conditioned by normal distrubition hypotheses. The method is based on a simulation or resampling procedure, conditional on the data, which provides a simulated estimate of the permutation distribution of any statistic. It is particularly suitable for multi-dimensional (multivariate and/or multiparametric) cases, since it allows a combination procedure to control for multiple testing.
Implication of results	Assuming that the results demonstrate a decrease in residual symptoms in both treatments at the second assessment, but only a significant effect in increase of PWB well-being for WBT but not CBT then WBT can be used to to reduce residual symptoms in patients with anxiety disorders. It has been suggested that treatments that are effective in the acute phase of anxiety disorders may not be the most suitable for their residual stage or for preventive purposes (Fava, 1996). Modifications of current cognitive-behavioural strategies with WBT may target just such issues.
Validity, reliability, etc.	The PWB has been extensively validated in non-clinical populations (Ryff & Singer, 1996) and this study has ecological validity.
Limitations	Preliminary study. The characteristics of the simple are quite heterogeneous. Semi-naturalistic design, since patients were initially treated with the of different, even though standardised, methods.

Exercise 4:

As a therapist, which of the intervention(s) would you pick to treat patient X? Justify your reasoning.

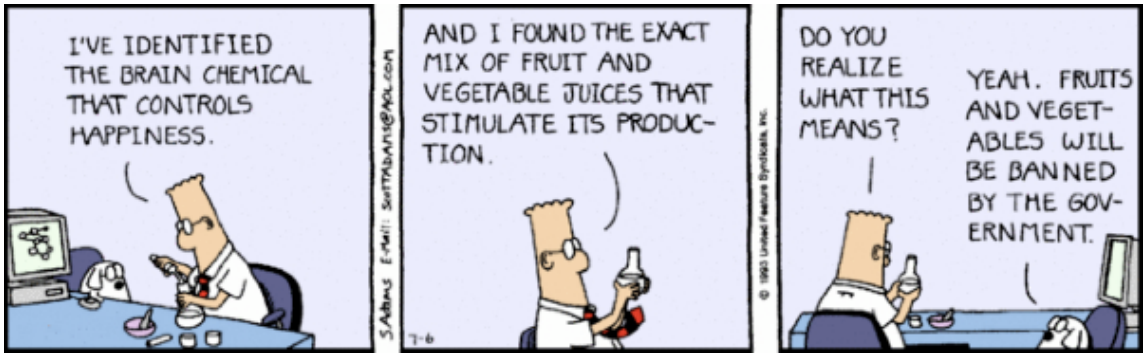
Case history:

A 16-year-old female presented with a 3-year diagnosis of Anorexia Nervosa. At age 13, the client began to diet because she was slightly overweight and dissatisfied with her body, immediately assuming hypo-caloric eating behavior ("*Being thin makes me happy*"). She has constant doubt about her intellectual ability, self-deprecating thoughts about her image, and a desire to die or leave school (*"It is too late, it is very difficult"; "Therapy cannot help"; "I want to die"*). she dwells on painful family and personal matters, past and present. she devotes 15 hrs daily to homework, and expects everything to be perfect. She receives constant criticism and no sign of affection from her parents.

Example: The author's choice and reasoning:

As PPIs have been found to be useful in combination with tradition treatments I would choose to use the Positive Psychotherapies (signature strengths, 3 blessings and best future self) along with CBT and Loving Kindness Meditation (LKM	
3 blessings	Increases patient X's general well-being and happiness by making her think of the positive events in her life rather than focusing on the negative aspects (e.g. "*It is too late, it is very difficult*" and "*Therapy cannot help*"). Can also help her to remove the focus from the personal and family matters that she spends so much time dwelling on, helping her to remember good time that they have spent together.
Best future self	Increases her optimism, targeting her negative thoughts, such as "*I want to die*". This exercise can allow her to understand that there is more to live for than her grades. Similarly, it should help her come to terms with her family situation and that things will not stay the same forever. By identifying coping strategies for future issues, she may learn how to identify ones that may be useful for dealing with current difficult situations. Importantly, this may also allow her to view herself in a future without the pathology (excess fear of weight gain), where her desire to die or leave school no longer exist and understand how the 'future' alternative is much more appealing than her current contemplations.
Loving Kindness Meditation	Develop love and kind thoughts towards herself, targeting her self-doubt and body-image dissatisfaction as well as the irrational fear of gaining weight. The acceptance component of LKM allows her to accept these negative thoughts from a position of safety (distanced observation of the mind) and not to become obsessed with solutions that are ineffective. She is on principle, not urged to modify and control negative events so as to free her mental state from them. This mindfulness component, central to all the 'third wave therapies', would not necessarily seek relaxation or a state of happiness in and of itself; rather, it allows a form of freedom, that is, of being able to act more comfortably in difficult situations. This is not as directly experienced in LKM as it is in e.g. MBSR so this should be taken into consideration when applying the interventions. As LKM also directs love and acceptance towards others and as such should increase positive emotions or at least tolerance towards her parents, despite their criticisms.

Along this line of thought, these exercises and the Socratic dialogue around them, rather than being "a correct way of thinking," are therapeutic activities that could enable the patient's thinking to become more flexible, enabling her to focus on the content of her thoughts from the necessary objective distance, thereby reducing cognitive diffusion, as well as emphasising more positive cognitions.



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Uplifting music to increase positive feelings

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Using PPIs in group therapy

Kaufmann et al (2009):

Again demonstrating that PPIs are flexible and adaptable clinical tools, Kaufmann et al (2002) tailored some of the classic PPIs to be used in the context of couples' therapy. They document their findings in a qualitative case-study of the couple John and Jane who are suffering severe marital problems.

Study: In this intervention the emphasis of the exercises in generating positive affect and experience shifts from the individual, to the partner and the relationship in general. For example, the 'three good things' exercise is adapted so that the partners identify their relative strengths, and then assess how these can be utilised to make the relationship work. This allowed John and Jane to tackle each negative situation they encountered from their strongest angle.

- Results: Ultimately the couples' relationship improved in terms of positive emotion, openness, sexual fulfilment and general satisfaction. Although negative events still occurred, the techniques they had learned allowed John and Jane to prevent these from descending into negative spirals which made for a much more stable relationship.
- From this exploratory work it appears the flexibility of PPIs make them useful tools in couples therapy – another clinical application of positive psychology.

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