

## POSITIVE CLINICAL INTERVENTIONS: WHY ARE THEY IMPORTANT AND HOW DO THEY WORK?

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*En el presente artículo se discute la Psicología Clínica Positiva como un campo emergente en la Psicología clínica. La Psicología Positiva Clínica se basa en la investigación demostrando que la salud mental es más que la ausencia de la enfermedad mental, que el bienestar tiene efectos amortiguadores sobre la incidencia de la psicopatología y de la enfermedad mental y en estudios que demuestran que las características positivas, tales como las emociones positivas y la gratitud, pueden predecir la patología más allá que el poder predictivo de las características negativas. En este trabajo, se presentan tres formas diferentes de bienestar: emocional, psicológico y social. Además, se revisan tres tipos de intervenciones clínicas positivas: terapia del bienestar, psicoterapia positiva y terapia de la aceptación y del compromiso. El trabajo finaliza con una llamada a la transformación del cuidado de la salud mental en el que los tratamientos orientados a la enfermedad se complementan con los tratamientos orientados al bienestar.*

**Palabras clave:** Psicología positiva clínica, Bienestar, Intervenciones clínicas positivas, Salud mental.

*In this paper we discuss positive clinical psychology as an emerging field within clinical psychology. Positive clinical psychology is based on research demonstrating that mental health is more than the absence of mental illness, on research showing that well-being has buffering effects on the incidence of psychopathology and mental illnesses and on studies demonstrating that positive characteristics, such as positive emotions and gratitude, can predict pathology beyond the predictive power of negative characteristics. In this paper we present three distinct forms of well-being: emotional, psychological and social. In addition we review three types of positive clinical interventions: well-being therapy, positive psychotherapy and acceptance and commitment therapy. The paper ends with a call for a transformation of mental health care in which illness oriented treatments are complemented with well-being oriented treatments.*

**Key words:** Positive clinical psychology, Well-being, Positive clinical interventions, Mental health.

It has been discussed that the practice and research of clinical psychology have been predominantly based on the medical model. In the twentieth century the focus of clinical psychology has been mainly on what is deviant, abnormal or maladaptive (Maddux, 2009). On the one hand, this focus has yielded numerous valuable and effective treatments of mental disorders. However, on the other hand, there is growing recognition that positive aspects of mental health have been neglected (Seligman & Csikszentmihaly, 2000) and deserve more attention in clinical psychology (e.g., Fava et al., 1998; Slade, 2010). Recently, the concept of positive clinical psychology was introduced (e.g., Wood & Tarrrier, 2010). One approach within positive clinical psychology is to study how positive characteristics and functioning are related to disorders. Wood & Tarrrier (2010) review various studies that demonstrate that positive characteristics, such as positive emotions and gratitude, can predict pathology beyond the predictive power of negative characteristics. A second approach is to focus on promoting mental health or well-being as an important outcome of mental

health care in addition to treatment of disorders. In this paper we focus on this second approach. We start with introducing the concept and operationalization of well-being. We then review recent studies that demonstrate that well-being and mental illness can best be seen as two related but different dimensions of mental health and we present initial evidence of the longitudinal impact of well-being on pathology. In the second part of this paper we introduce some positive clinical interventions that typically aim for promoting well-being in addition to reducing distress and pathology and review the current evidence of the effectiveness of these interventions.

### WHAT IS WELL-BEING?

The World Health Organization (WHO) emphasizes to define mental health not only as the absence of mental disorder. The WHO describes mental health from a positive perspective as 'a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community' (WHO, 2005, p.2).

This definition by the WHO comprises three components: 1) well-being; 2) effective functioning of the individual by self-realization; and 3) effective functioning in the society. As functioning is usually studied by self-report, these three components can be referred to

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as components of well-being: emotional well-being, psychological well-being, and social well-being (Keyes, 2005). These three components are theoretically and empirically interrelated, but distinguishable components of well-being. Below, we will describe the three components of well-being and the association between well-being and psychopathology.

**Emotional well-being**

Studies on emotional well-being derive from a fifty year long tradition of research on quality of life. In addition to more objective indicators such as income, education and health, since the 1960's subjective indicators are studied in large-scale population studies (e.g., Campbell, Converse, & Rogers, 1976). The aim of these studies was and still is monitoring the social change and improving political policies.

Since an important publication of Diener (1984) there is a consensus that emotional well-being comprises three aspects: the presence of positive affect, the absence of negative affect, and being satisfied with one's life. Sociologist Ruut Veenhoven has played a prominent role in research on happiness. His *World Database of Happiness* is a bibliography of more than 6,000 publications in this field, in which many studies on happiness in different countries are included. The database shows that in countries with a higher Gross Domestic Product, more respect for human rights, more social equality, and more individualism and freedom of choice, there is a higher level of emotional well-being (Veenhoven, 1999). Finally, individual differences play an important role. In a meta-analysis, Steel, Schmidt, & Schulz (2008) come to the conclusion that neuroticism is the strongest negative correlate to life satisfaction, and extraversion to positive affect.

In recent years, it has become clear that emotional well-being is highly important for the functioning of people. For example, Diener and Chan (2011) conclude that people with a higher emotional well-being (mainly the presence of positive affect) are healthier and live longer. Lamers et al. (2012) show in a meta-analysis of seventeen studies that emotional well-being has a positive effect on recovery and survival in people with physical diseases.

Although research on emotional well-being has a long tradition and much is known about its causes and consequences, there is also criticism on the narrow view of this ('hedonic') approach to well-being. The indicators of happiness and life satisfaction give little information on how a person develops or participates in a larger societal context (Huppert & So, 2013; Ryff, 1989). Because of these reasons, there has been considerable attention to another ('eudaimonic') approach of well-being.

**Psychological well-being**

The WHO definition of mental health refers to self-realization as a second important component of mental health. Self-

realization is about the functioning of an individual according to normative psychological standards. It is not about having a pleasant life, but about having a meaningful and good life from a psychological point of view.

Pioneer in operationalizing this approach of mental health from a psychological perspective was Carol Ryff (Ryff, 1989; Ryff & Singer, 1996). She extensively studied the work of life span, humanistic, and clinical psychologists, searching for the core dimensions in their descriptions of optimally developed and functioning individuals. Ryff has extracted six criteria that are essential in the striving for realizing one's potential (see Table 1).

As the classical works that Ryff studied were primarily theoretical descriptions or therapeutic insights, she developed a questionnaire to measure the six dimensions of psychological well-being. Population studies using this questionnaire show that psychological well-being is systematically related to age, sex, socioeconomic status, and ethnicity (e.g., Ryff & Singer, 2008). That is, older adults on average score higher on autonomy and environmental mastery, but lower on personal growth and purpose in life than younger adults. And although there are few sex differences in psychological well-being, women score somewhat higher on positive relations with others and lower on environmental mastery than men. A higher socioeconomic status, measured as the level of education, is associated with a higher psychological well-being on all six dimensions, but mainly on purpose in life and personal growth.

**TABLE 1**  
**THE SIX DIMENSIONS OF PSYCHOLOGICAL WELL-BEING**

Psychological well-being	
<i>Self-acceptance</i>	Holding positive attitudes towards oneself and past life and conceding and accepting varied aspects of self.
<i>Environmental mastery</i>	Exhibiting the capability to manage a complex environment, and the ability to choose or manage and mould environments to one's needs.
<i>Positive relations with others</i>	Having warm, satisfying, trusting personal relationships and being capable of empathy and intimacy.
<i>Personal growth</i>	Showing insight into one's own potential, having a sense of development, and being open to new and challenging experiences.
<i>Autonomy</i>	Exhibiting a self-direction that is often guided by one's own socially accepted and conventional internal standards and resisting unsavory social pressures.
<i>Purpose in life</i>	Holding goals and beliefs that affirm one's sense of direction in life and feeling that life had a purpose and meaning.



In a recent comprehensive paper Ryff (2014) reviews many studies that support the health protective features of psychological well-being in reducing risk for disease and promoting length of life.

### **Social well-being**

In addition to psychological well-being, social well-being is distinguished as a third well-being component. Where psychological well-being refers to the evaluation of optimal individual functioning, social well-being involves an evaluation of optimal social functioning in the society.

Corey Keyes applied a similar approach as Ryff, focusing on the work of classical sociologists and social psychologists. Keyes (1998) distinguishes five dimensions that together constitute our social well-being. These dimensions describe a person who has a positive view on other people and believes in societal progression, who understands society and participates in it, and who feels at home in society and the social groups around him or her. Similarly, Keyes developed a questionnaire to measure this component of well-being. Socioeconomic status and social-societal activities are the strongest correlates of social well-being (Keyes, 1998; Cicognani et al., 2008).

### **WELL-BEING AND PSYCHOPATHOLOGY**

In sum, new views on well-being contain the core components of experiencing happiness, personal growth, and societal involvement. This perspective evokes the question of how well-being is related to psychological symptoms, dysfunctioning, and disorders. To measure the three components of well-being a short questionnaire, the mental health continuum – short form (MHC-SF), was developed to measure all 14 dimensions of mental health with one question per dimension (Keyes, 2002). The psychometric properties of this instrument have been found to be excellent (e.g., Lamers et al., 2011). This instrument also allowed for developing a classification model of mental health (Keyes, 2007) that distinguishes between people who are flourishing, people with moderate mental health and people who are languishing. When individuals score high on at least one dimension of emotional well-being and at least six dimensions of psychological and social well-being, they are classified as “flourishing.” When individuals score low on at least one dimension of emotional well-being and at least six dimensions of psychological or social well-being, they are classified as “languishing.” People who do not fit the criteria for either flourishing or languishing are classified as “moderately mentally healthy”.

Keyes (2005) conducted a study on well-being and psychopathology based on the MIDUS-study (*Midlife Development in the United States*). In this study, over 3,000 Americans between the ages of 25 and 75 years filled out questionnaires on emotional, psychological, and social well-

being. In addition, the presence of four of the most common mental disorders was determined with a diagnostic interview: affective disorder, generalized anxiety disorder, panic disorder, and alcohol dependence.

Based on confirmative factor analyses, the so-called ‘two continua model’ fitted best to the data. In this model, well-being and psychopathology are two related yet distinguishable factors. Although a higher score on well-being is related to less psychopathological symptoms, and vice versa, this relation is far from perfect. Keyes (2005) showed that ten percent of the people did not have a disorder but experienced low well-being, and that people with a disorder more often had a moderate than a low well-being.

In recent years this model has been replicated in other populations, such as American adolescents (Keyes, 2006) and Dutch adults (Lamers et al., 2011). Additional studies showed that levels of well-being are related to health care use and productivity at work, even when controlling for levels of psychopathology (Keyes, 2005; 2007). As this study was cross-sectional using one measurement occasion, no causal conclusions can be drawn.

In a study in a representative sample of the Dutch population, well-being and psychopathology were measured four times in nine months (Lamers et al., 2015). Emotional, psychological, and social well-being were measured by the MHC-SF and psychopathological symptoms were measured by the Brief Symptom Inventory (BSI; De Beurs, 2006). Both scales were moderately negatively correlated ( $r = -.33$ ). In the same study, the reciprocal relation between well-being and psychopathological symptoms over time was investigated. The change in well-being in the three-month period between the measurements, was a significant predictor of psychopathological symptoms. The change in well-being was even a stronger predictor of psychopathology than the baseline level of well-being (Lamers et al., 2015). These findings corroborate the hypothesis that well-being buffers the impact of negative life-events and prevents the development of psychopathology and disorders (Keyes et al., 2011; Wood & Joseph, 2010).

### **POSITIVE CLINICAL INTERVENTIONS**

The two-continua model, the buffering effects of well-being in general, and the adaptive impact of specific positive characteristics such as positive emotions (Garland et al., 2010), kindness (Alden & Trew, 2013), optimism (Carver et al., 2010) and gratitude (Wood et al., 2010) have important implications for clinical psychology and mental health care. A more balanced model of research and clinical practice is warranted (see also Rashid, 2009; Wood & Tarrier, 2010). Recovery should be defined as the absence of or coping with disorders and the presence of well-being (Fava et al. 2007;



Slade 2010). Clinical interventions should aim at reducing symptoms and at promoting well-being. But what positive clinical interventions are available and what is the current evidence that they work? We introduce three types of interventions: well-being therapy, positive psychotherapy and acceptance and commitment therapy.

### **Well-being therapy**

One of the first positive clinical interventions was well-being therapy (WBT, Fava, 1999). Fava argued that recovery in treatment should not only be defined in terms of absence of symptomatology but in terms of presence of well-being as well (Fava et al., 1998). Several studies showed that clients who had been treated but relapsed and needed new treatment for depression or anxiety had substantially lower levels of psychological well-being than matched health groups (Rafanelli et al, 2000; Fava et al, 2001). The absence of psychological well-being can thus be considered a risk factor for relapse that a large group of clients experiences in the years following treatment (Labbate & Doyle, 1997; Ramana et al, 1995).

WBT consists of eight sessions of thirty to fifty minutes. It uses self-observations, journaling, and techniques from cognitive behavioural therapy and solution-focused therapy. There are three phases: monitoring periods of well-being, analysis of reasons why these periods end and intervening in these reasons. During the first phase of treatment the client is instructed to daily monitor periods of well-being and write them down in a journal, no matter how short they were. The client rates on a scale from 0 to 100 how strong the feelings of well-being were (0 = completely absent to 100 = completely present). Many clients believe that such periods are completely absent in their lives, but it often shows that they are actually there. This phase takes on average two weeks.

In the second phase, the client is asked to assess cognitions and beliefs that may stop a positive period. Fava (2003) gives the example of a client who visited his two nephews who very much liked that he came by. He felt good when he noticed that they really liked him. The cognition that disturbed this was that this was only the case because he brought presents for them. The therapist gains insight during the first two phases in which aspects of psychological well-being are mainly threatened by irrational beliefs. He or she may use the Socratic method to confront the client how irrational these beliefs are and search for more rational beliefs instead. The second phase takes about two to three weeks.

In the third phase, the therapist explores with the client how components of psychological well-being can be strengthened. The first phases have generally shown in which domains this is most desirable. The psychological well-being questionnaire (Ryff, 1989; Ryff & Keyes, 1995) may be filled out to complete the picture. Examples are planning pleasant activities,

strengthening solution-focused competencies by remembering earlier successful solutions, identifying and challenging undermining beliefs, or training assertiveness.

Several, mostly smaller studies have been carried out on the effects of WBT. For example, Fava and colleagues (1998) conducted an RCT with twenty clients who were successfully treated for mood or anxiety disorders. Ten clients received WBT and 10 clients received additional cognitive behavioural therapy (CBT). After this additional treatment, clients who received WBT had higher scores on psychological well-being (in particular on personal growth) and lower scores on depressive symptoms than clients who received additional CBT.

Fava et al. (2005) studied the effectiveness of WBT among 20 clients with generalized anxiety disorders. These clients were randomized to either four sessions CBT and four sessions WBT or to eight sessions CBT. After treatment, psychological well-being was significantly higher and psychological complaints (depression, anxiety, somatisation, hostility) were significantly lower among those who received the combination of CBT and WBT than among those who only received CBT.

WBT has recently been adapted in the Netherlands (Meulenbeek, Christenhusz & Bohlmeijer, 2015). In the adapted protocol the third phase of well-being therapy is more structured. This adapted well-being therapy is currently studied in various populations.

### **Positive psychotherapy**

A second group of positive clinical interventions could be defined as positive psychotherapy. These interventions typically are aimed at enhancing well-being and flourishing by promoting positive characteristics and behaviour, such as positive emotions, using strengths, optimism, kindness and gratitude (Linley & Joseph, 2004).

Seligman and colleagues Seligman developed a package of short positive psychological exercises which they called 'positive psychotherapy' (Seligman e.a., 2006). These interventions are aimed at the improvement of an enjoyable, engaged and meaningful life.

Examples of these interventions are:

*Using your strengths.* The participant is encouraged to assess his or her personal qualities and talents with a validated strengths questionnaire. The assignment is to utilize these strengths more into daily life.

*Three positive things.* People are assigned to write down three positive things at the end of the day and the reason why these things happened to them.

*The death notice.* The participant is asked to imagine that he or she has died after a fruitful and enjoyable life. What would the relatives and people around say on the death notice? People are assigned to write a short essay on how they would like to be remembered.



*Gratitude visit.* In this intervention, a participant thinks of a person to whom he or she is very grateful but who was never properly thanked. The assignment is to write a letter to this person in which the gratitude is described and read this letter by phone or face-to-face.

*Active/constructive responding.* Participants are asked to respond at least once a day in a constructive and active way to good news from an acquaintance.

*Savouring.* The participant is assigned to enjoy a daily activity that he or she does normally in a hasty manner, for example eating breakfast or walking to work or school. After that, the person is asked to write what they did, how it felt and how it was different compared to doing things in a hurry.

Seligman and colleagues examined the effectiveness of positive psychotherapy in a group of students presenting mild to moderate depressive symptoms. The students were randomized across a PPT group ( $n = 19$ ) and a no-treatment control group ( $n = 21$ ). Students in the PPT group followed a 6-week group course. Overall, the PPT was more effective in reducing depressive symptoms and in increasing life satisfaction compared to the control group, up to the follow-up of 1 year. The effect in life satisfaction was less pronounced than the effect in depressive symptoms, as life satisfaction increased in both groups over time. The sustained effects for depression might suggest that important relapse preventive factors are imbedded in the positive exercises.

In another study, individual PPT in a format of 14 sessions was offered to students diagnosed with a major depressive disorder. The students were randomized across the PPT group and a treatment-as-usual control group. There was a third matched non-randomized group who received treatment as usual and antidepressant medication. PPT was effective in reducing depression and in enhancing happiness (but not in enhancing life satisfaction) as compared to the control groups. Effect sizes were large. However, attrition rates in the control groups were quite large, therefore these results should be considered cautiously.

Trew & Alden (2013) demonstrated that an intervention focusing on increasing acts of kindness in people with social anxiety was effective in enhancing positive affect in comparison with a group that conducted behavioral experiments or got a monitoring assignment. Santos et al (2009) reviewed several intervention studies and found that there is initial evidence that positive interventions reduce depressive symptomatology in various populations.

Positive psychotherapy has also been adapted for people with severe psychiatric disorders. The feasibility of an adapted version of group PPT for people with schizophrenia (called 'Positive Living') was examined in a small pre-post study of 16 patients (Meyer, Johnson, Parks, Iwanski, & Penn, 2012). The intervention was well accepted by the patients and associated

with improvements in psychological well-being, psychological recovery, self-esteem, and psychiatric symptoms. Recently, PPT was evaluated in a randomized controlled trial for people with psychosis (Schrang et al., 2014). In an iterative process with experts an adapted version of PPT was developed, called WELLFOCUS PPT (Riches, Schrang, Rashid, & Slade, 2015). In comparison to the control group ( $n = 41$ ), people in the PPT group ( $n = 43$ ) showed significant psychiatric symptom reduction and well-being enhancement (on one of two measures). However, on several other measures such as self-esteem and hope (Schrang et al., 2015) no significant effects were found. The authors therefore concluded that improvements of the intervention have to be made to improve the effectiveness.

Another pre post study assessed the feasibility of positive psychological exercises in a population of patients ( $n = 61$ ) hospitalized for suicidal thoughts and behaviors (Huffman et al., 2014). Significant effects were found on optimism and hopelessness, especially for a gratitude exercise, counting blessings and a personal strengths exercise (and not for a forgiveness letter). The intervention seemed quite acceptable as 85% of the participants completed at least one exercise; on the other hand a substantial number of people ( $n = 8$ ) were overwhelmed by participation.

Overall, to deliver positive psychological interventions to people with severe mental disorders requires a careful and co-productive process of adaptation to their needs and preferences.

Another new development is to offer positive interventions in an online format as a public mental health strategy. In different randomized controlled trials significant effects on both well-being and distress have been found (e.g., Mitchell et al., 2009; Bolier et al., 2014). Bolier et al (2013) also conducted a rigorous meta-analysis to assess the effects of positive psychology interventions on emotional and psychological well-being and depression. The interventions included self-help, group and individual therapeutic formats. Small but significant overall effect-sizes were found across the studies for all three outcomes.

### ***Acceptance and commitment therapy***

A third therapeutic approach that fits well with a mental health promotion framework is Acceptance and Commitment Therapy (ACT). ACT has been defined as a distinctive model of behavioral and cognitive therapy with a strong focus on the context of behavior (Hayes et al., 2013). It is based on a relational frame model that links behavioral principles to both pathology and flourishing (Ciarrochi & Kashdan, 2013; Hayes et al., 2013). "The aim of ACT is, quite simply, to maximize human potential for a rich, full and meaningful life" (Ciarrochi & Kashdan, p. 2). Experiential acceptance or mindfulness is a core process within ACT and has been found to relate to well-being (Carmody & Baer, 2008). Additionally, promoting



valued or engaged living is a primary focus of ACT. Commitment to choices and goals based upon intrinsic values and motivations has been found to predict well-being (Ryan & Deci, 2000; Steger et al., 2013). The capacity to live mindfully or accept present experiences and to act in accordance with one's core values has been defined as psychological flexibility (Ciarrochi & Kashdan, 2013; Hayes et al., 2013). Randomized controlled trials have shown the efficacy of ACT as a treatment of distress (e.g., Bohlmeijer et al., 2010; Trompeter et al., 2014) and as an intervention that enhances well-being (Fledderus et al., 2011, 2012). Bohlmeijer et al (2015) conducted a post-analysis on an earlier randomized controlled trial of a sample of adults with depressive symptomatology who participated in a guided self-help ACT intervention. This post-analysis showed a 5% to 28% increase of flourishing by the participants. In addition, the effects on flourishing were maintained at the three-month follow-up. The participants in the waiting-list control group, increased from 5% to about 14% flourishing after nine weeks.

## CONCLUSION

We conclude that positive clinical psychology is an interesting and promising new approach for both practice and research. We have presented research that underscores the need for a redesign of mental health care. A more balanced mental health care is warranted in which illness oriented treatments and assessments are complemented with well-being oriented treatments and assessments. A good step forward would be to implement a well-being measure in the routine outcome monitoring of mental health care. At the same time we must recognize that positive clinical psychology still is a new field. Epidemiological studies investigating the relationship between psychopathology and well-being over time are still scarce. More high quality studies on the effects of positive clinical interventions are needed. For the practitioner the complete mental health model broadens the scope of interventions. In our collaboration with psychologists and psychotherapists in mental health care we have experienced that applying positive psychology interventions can be rewarding for both client and therapist.

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