The Journal of Positive Psychology, 2015
Vol. 10, No. 1, 25–40, http://dx.doi.org/10.1080/17439760.2014.920411

Routledge
Taylor & Francis Group

Positive psychotherapy: A strength-based approach

Tayyab Rashid*

Health & Wellness Centre, University of Toronto Scarborough, Toronto, Ontario, Canada

(*Received 15 March 2014; accepted 8 April 2014*)

Positive psychotherapy (PPT) is a therapeutic approach broadly based on the principles of positive psychology. Rooted in Chris Peterson's groundbreaking work on character strengths, PPT integrates symptoms with strengths, resources with risks, weaknesses with values, and hopes with regrets in order to understand the inherent complexities of human experiences in a way that is more balanced than the traditional deficit-oriented approach to psychotherapy. This paper makes the case of an alternative approach to psychotherapy that pays equal attention and effort to negatives and positives. It discusses PPT's assumptions and describes in detail how PPT exercises work in clinical settings. The paper summarizes results of pilot studies using this approach, discusses caveats in conducting PPT, and suggests potential directions.

Keywords: positive psychotherapy; character strengths in clinical practice; strength-based therapy/counseling; positive emotions; engagement; meaning; PERMA

Positive psychotherapy (PPT) is a therapeutic approach based on a premise, articulated and empirically explored by Chris Peterson, who emphasized that psychology ought to be concerned with strength as with weakness; as interested in building the best things in life as in repairing the worst; and as concerned with making lives of normal people fulfilling as with healing pathology (Peterson, 2006a). Strongly influenced by Peterson's seminal work *Classification of Virtues and Strengths* (CVS; Peterson & Seligman, 2004), PPT which integrates symptoms with strengths, resources with risks, weaknesses with values, and hopes with regrets in order to understand inherent complexities of human experiences in a balanced way. Clients seeking therapy are neither mere conglomerate of symptoms nor embodiments of strengths. PPT systematically amplifies their positive resources; specifically, positive emotions, character strengths, meaning, positive relationships, and intrinsically motivated accomplishments. PPT neither suggests that other psychotherapies are negative nor aims to replace well-established practices. PPT is refocusing rather than revamping therapeutic regimens. It is not meant to be paradigm shift; it is an incremental change to balance therapeutic focus on strengths and weaknesses.

An improvement of psychotherapy via an alternative perspective

Psychotherapy's focus on alleviation of symptoms is understandable. The human mind defaults towards negativity such that it responds more strongly to negatives than to positives (Rozin & Royzman, 2001). Negative impressions and stereotypes are quicker to form and harder to undo (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001). In the clinical context, negatives, because of their apparent greater informational value, typically receive more attention and form more complex cognitive representations (Peeters & Czapinski, 1990).

Psychotherapy, responding to discernible psychological distress of clients, has done well. It significantly outperforms placebo and in many cases, psychotherapy fares better in the long run than medications (Castonguay, 2013; Leykin & DeRubeis, 2009). However, effectiveness of psychotherapy can be improved. First, clinical psychology and psychotherapy have traditionally been about deficits and remediations (Maddux, 2008). Watkins has noted, 'It [psychotherapy] can also be about optimization and transformation' (2010, p. 198). Peterson's seminal work on character strengths offers psychotherapy a tremendous opportunity to expand its scope, making it more inclusive and balanced. Doing so may be necessary because the use of psychotherapy declined from 15.9 to 10.5% from 1998 to 2008, whereas during the same period, the use of psychotropic medications increased from 44.1 to 57.4% (Olfson & Marcus, 2010). Some individuals, especially those who could benefit more from psychotherapy, avoid it due to the stigma of being labeled with a psychiatric diagnosis (Corrigan, 2004). Integration of strengths within the complex and often negatively skewed narrative may resocialize potential clients to perceive that psychotherapy is not only about untwisting their distorted thinking or restoring their troubled relationships; it is also about

*Corresponding author. Email: trashid@utsc.utoronto.ca

learning to use one's strengths, skills, talents, and abilities to face challenges. Even before the current movement of positive psychology, researchers recognized the important of assessing and using clients' strengths of to gain their cooperation and acceptance of therapy (Conoley, Padular, Payton, & Daniels, 1994). Second, the effectiveness of psychotherapy is primarily assessed by symptom remittance, while variables such as quality of life or personal recovery are not commonly considered as part recovery (Rapaport, Clary, Fayyad, & Endicott, 2005). In recent years, the concept of recovery has been expanded to include hope, a meaningful and fulfilling life, a positive sense of identity, and taking responsibility for one's own wellbeing (Slade, 2010). Strengths-Based Case Management (SBCM; Rapp & Goscha, 2006) is an illustration. Studies of SBCM, including a number of randomized controlled trials (RCTs) and quasi-experimental designs, have reported a range of positive outcomes including reduced hospitalization and increased social support (Rapp & Goscha, 2006). Third, psychotherapists have inherent vulnerability to burnout, which is characterized by emotional exhaustion, depersonalization, and lack of personal accomplishment. These harmful consequences adversely impact the quality of their therapeutic work (Rosenberg & Pace, 2006). Burnout could occur due to multiple reasons. One of them is when available resources are too limited to meet the demand of work (Hobfoll, 1989). Understanding client's challenges, deficits, dysfunction, and disorders in tandem with their assets, strengths, skills, and abilities may not only offer clients additional therapeutic possibilities, it also helps psychotherapists to be more effective and have a greater sense of accomplishment, which could buffer against burnout. In a psychotherapy study, Flückiger and Grosse Holtforth (2008) primed therapists' attention on clients' strengths (resource priming) before each of five therapy sessions. Results showed that resource activation, as perceived by independent observers, improved therapy outcome at session 20. Cheavens, Strunk, Sophie Lazarus, and Goldstein (2012) found that personalizing Cognitive Behaviour Therapy (CBT) to client's relative strengths led to better outcome than CBT personalized to client's' relative deficits.

Assumptions & theory

PPT has three assumptions about the nature, cause, course, and treatment of specific behavioral patterns. First**,** *psychopathology results when clients' inherent capacities for growth, fulfillment, and wellbeing are thwarted by psychological and sociocultural factors.* Well-being and psychopathology do not reside entirely inside clients, but derive from a complex interaction between clients and their environment. When this interaction becomes dysfunctional, clients' growth is thwarted and they experience symptoms of psychiatric distress. In other words, psychopathology surfaces when growth and wellbeing are diminished. Psychotherapy offers a unique opportunity to realize or revitalize potential and growth of clients. Reflection about negative aspects of one's life is important, but growth happens through assessing, acknowledging, and building strengths. Evidence shows that strengths can play a key role in growth even in dire life circumstances (Seery, Holman, & Silver, 2010). Second, PPT considers *positive emotions and strengths to be as authentic and as real as symptoms and disorders*, and they are valued in their own right. Strengths are neither defenses nor Pollyannaish illusions. Attributes such as honesty, co-operation, gratitude, and kindness are as real as deception, competition, grudge, greed, and worry. The absence of mental illness does not necessarily mean the presence of well-being (Keyes & Eduardo, 2012). Amelioration of symptoms will not engender well-being per se. However, amplifications of strengths may make lives of clients satisfying and fulfilling and which in turn, may buffer against future recurrence of symptoms.

The third and final assumption is that *effective therapeutic relationships can be formed through the discussion of positive personal characteristics and experiences*. Not all clients need or will benefit from deep and protracted analysis and discussions of their troubles. The media portrayal of psychotherapy has reinforced the belief that therapy exclusively entails talking about troubles, ventilating bottled-up emotions, and recovering self-esteem. It not only maintains an unhelpful stigma about mental health, it also reinforces a belief in clients that they are somehow deeply flawed or fragile. It is not that troubles are not worth discussing, but powerful therapeutic bonds can also be built by deeply discussing positive emotions and experiences (Burton & King, 2004). Scheel, Davis, and Henderson (2012), through a qualitative study examining therapists' use of client strengths, found that a strength-based approach helped therapists in building trusting relationships and motivated clients by instilling hope.

PPT is primarily based on Seligman's conceptualization of happiness and well-being (Seligman, 2002, 2011). Seligman sorts highly subjective notions of happiness and well-being into five scientifically measurable and manageable components: (i) Positive emotion, (ii) Engagement, (iii) Relationships, (iv) Meaning and (v) Accomplishment, with the first letters of each component forming the mnemonic PERMA (Seligman, 2011). This list of elements is neither exhaustive nor exclusive, but it has been shown that fulfillment in these elements and is associated with lower rates of depression and higher life satisfaction (Bertisch, Rath, Long, Ashman, & Rashid, 2014; Headey, Schupp, Tucci, & Wagner, 2010; Lamont, 2011; Sirgy & Wu, 2009). It should also be noted that

Peseschkian in Germany has also worked on *Positive Psychotherapy* for more than 20 years and is distinct from PPT discussed in this article. Peseschkian's approach to therapy is inherently and systematically integrative, incorporating cross-cultural, multidisciplinary, therapeutically, and psychologically intertheoretic (Peseschkian, 2000). PPT on the other hand is rooted in the current movement of positive psychology.

How does PPT work?

The following section describes operationalization of PERMA in concrete PPT exercises and explains the process of conducting these exercises. PPT exercises and their relationship with various character strengths, postulated by Chris Peterson and Seligman (2004), are presented in Table 1. Definitions of these character strengths are given in Table 2. PPT was initially validated with clients experiencing moderate to severe symptoms of depression in individual and group settings (Seligman, Rashid, & Parks, 2006). PPT can be a standalone treatment, its protocol can be adapted to meet specific needs or its exercises can be incorporated in other treatment approaches. Pilot studies listed in Table 3, have applied PPT to treat symptoms of depression, anxiety, psychosis, borderline personality disorder, and to support smoking cessation.

PPT can be divided into three phases. The first phase focuses on exploring a balanced narrative of the client and exploration of her/his signature strengths from multiple perspectives. These signature strengths are operationalized into personally meaningful goals. The middle phase focuses on cultivating positive emotions and adaptively dealing with negative memories. The final phase include exercises on fostering positive relationships and meaning and purpose.

The therapeutic relationship is one of the most curative factors of psychotherapy (Norcross, 2002). From the onset, the therapist empathically listens to clients' concerns to build and maintain a trusting therapeutic relationship. Meanwhile, the therapist searches for opportunities to help clients identify and own their strengths. Throughout PPT, negatives are balanced with positives; for instance, a discussion of some perceived offense or personal injustice is balanced with recall of recent acts of kindness shown to clients. Pain associated with trauma is empathetically attended, but potential for growth from trauma is also explored, whenever appropriate. Exploring and amplifying strengths doesn't come at the cost of dismissing or minimizing problems and weaknesses.

Recall of positive memories plays an important role in mood regulation (Joormann, Dkane, & Gotlib, 2006). Such a recall allows individuals to 'savor' these positive emotions (Bryant & Veroff, 2006). Fitzpatrick and Stalikas (2008) posit that positive emotions, especially in the early phase of therapeutic process, powerfully predict therapeutic change by enabling clients to consider new ideas and perspective and can build long-term cumulative resources. If such a recall is initiated at the onset of the therapy, positive emotions are likely to be generated. To facilitate this process, after empathically attending to clients' presenting concerns, they are encouraged to introduce themselves through a real-life story that called for the best in their lives in order to accomplish something personally meaningful, or through a story of overcoming a significant challenge or adversity (Rashid & Ostermann, 2009). The exercise, known as the *Positive Introduction,* in the group setting is found to be motivating for others and also builds trust among group members. Clients often start this exercise in the session but then complete it as homework using a more structured worksheet. Clients are encouraged to draw parallels from the story to their current life situations. Without providing any list of strengths, they are asked to think about strengths depicted in their stories. The goal is to help clients have a narrative that encapsulates their complexities of deficits and of strengths. Through *Positive Introduction* clients not only are able to tell and retell their stories; with the therapist's guidance, they may also be able to integrate parts of the self that might have slipped from their awareness due to cognitive rigidities, emotional instability, or relational insecurities. Clients are encouraged to make the narrative more personally meaningful and somewhat relevant to their current challenges. This is facilitated through several multimedia illustrations, stories and case illustrations.

After the Positive Introduction, PPT focuses on character strengths. Rather than a simple and straightforward approach of identifying and using more of top five strengths, PPT adapts a comprehensive strength assessment approach. Clients first read brief descriptions of 24 strengths, without their titles/names, and select (*not rank*) five that best describe their personality. Clients also ask to have two significant others (a family member and/or a friend) to confidentially complete a similar measure and return the worksheet to clients in sealed envelopes. Clients then complete the online self-report measure *Values in Action Inventory of Strengths* (VIA; Peterson & Seligman, 2004), which upon completion offers feedback about their top five strengths. Data from all these sources is aggregated to determine client's signature strengths. Therapists encourage clients to share memories, experiences, real-life stories, anecdotes, accomplishments, and skills, which illustrate their signature strengths. At the same time, therapists invite clients to conceptualize their presenting issues as lack or excess of strengths (Table 2). In doing so, clients are encouraged to develop a key strength, *psychological flexibility* which is an ability to adapt to fluctuating situational demands, reconfiguring mental resources including strengths, shifting perspective,

Table 1. PPT: An overview of PPT model.

Session & topic		Description	Character strength
1	Orientation to PPT. Lack of positive resources	Psychological distress is discussed as lack of or diminished positive resources such as Positive emotions, Engagement, Relationships, Meaning, and Accomplishment (PERMA) *Exercise*: Positive Introduction: Clients write one page real-life story which called for the best in them and which ends positively, not tragically	Emotional Intelligence, Authenticity, Courage,
2	Character strengths	Character strengths are introduced. Notion of engagement and flow is discussed *Exercise*: Clients identify their signature strengths in-session and complete an online self-report measure at home Two others (a family member and a friend) also identify (*not rank*) their five most salient signature strengths	Emotional Intelligence, Perspective
3	Signature strengths and positive emotions	Signature strengths are discussed. Clients compile their signature strengths profile incorporating various perspectives *Exercise*: Clients devise specific, measurable and achievable goals targeting specific problems. The benefits of positive emotion are discussed *Exercise*: Blessing Journal: Clients starts a journal to record three good things every night (big or small)	Creativity, Hope and Optimism, Gratitude
4	Good vs. bad memories	The role of negative memories is discussed in terms of how they perpetuate psychological symptoms. The role of good memories is also highlighted *Exercise*: Clients write about feelings of anger and bitterness and their impact in perpetuating distress	Gratitude, Appreciation of Beauty and Excellence
5	Forgiveness	Forgiveness is introduced as a tool to transform anger and bitterness and to cultivate neutral or positive emotions *Exercise*: Clients describe a transgression, its related emotions and pledge to forgive the transgressor. Letter is not necessarily delivered	Forgiveness and Mercy, Kindness, Social intelligence, Self-regulation
6	Gratitude	Gratitude is discussed as an enduring thankfulness. The roles of good and bad memories are discussed again, with an emphasis on Gratitude *Exercise*: Clients write and delivers in person a gratitude letter to someone he/she never properly thanked	Gratitude, Love, Social and Emotional Intelligence, Authenticity
7	Mid-therapy check	The forgiveness and gratitude assignments are followed up. Experiences related to the signature strengths and Blessing Journal activities discussed Clients and therapist discuss therapeutic gains and hurdle and ways to overcome these hurdles *Exercise*: Clients complete the Forgiveness and Gratitude assignments	Perseverance, Perspective, Self-regulation
8	Satisficing vs. maximizing	Concepts of satisficing (good enough) and maximizing are discussed *Exercise*: Clients devise ways to increase satisficing	Self-regulation, Gratitude
9	Hope and optimism	Optimism and hope are discussed in detail. Clients think of times when important things were lost but other opportunities opened up *Exercise*: One Door Close, One Door Opened: Clients think of three doors that closed and then ask, What doors opened?	Hope & Optimism
10	Positive communication	Active-Constructive – a technique of positive communication is discussed *Exercise*: Active-Constructive Responding: Clients to look for active-constructive opportunities	Love, Kindness, Curiosity, Social Intelligence
11	Signature strengths of others	The significance of recognizing and associating through character strengths of family members is discussed *Exercise*: Family Strengths Tree: Clients ask family members to take the complete signature strength measure. A family tree of strengths is drawn up and discussed at a gathering	Love, Social Intelligence
12	Savoring	Savoring is discussed, along with techniques and strategies to safeguard against adaptation *Exercise*: Savoring Activity: Clients plan a savoring activity using specific techniques	Appreciation of Beauty and Excellence, Gratitude

(*Continued*)

Table 1. (*Continued*).

Session & topic	Description	Character strength
13 Positive Legacy & Gift of Time	Clients visualize what would be positive legacy; therapeutic benefits of helping others are discussed. *Exercises*: Positive Legacy: Clients write how they would like to be remembered. Gift of Time: Clients Write How they would like to be remembers and also make plans to give the gift of time doing something that also use their signature strengths	Teamwork, Kindness
14 The Full Life	Full life is discussed as the integration of Pleasure, Engagement, and Meaning Therapeutic gains and experiences are discussed and ways to sustain positive changes are devised	Perspective

and balancing competing desires, needs, and life domains (Kashdan & Rottenberg, 2010). In PPT, the psychotherapist helps clients to carefully re-conceptualize that certain challenges could be due to competing demands of two strengths (such as should one to honest or kind with a close friend who may be involved in unethical behavior); self-regulation in one domain of life (e.g. eating or exercise) may be associated with weak interpersonal relationships; fear of failure or giving up may lead to persisting with goals which may be unrealistic; forgiving loved ones for their transgression without a concrete behavior change may be compromised fairness (see Table 1 for more examples). These characteristic are adapted from Christ Peterson's notion of conceptualizing psychopathology as Access (A), Opposite (O), and Exaggeration (E) (together, AOE) of character strengths (Peterson, 2006b).

One common features of psychological disorders is the inability to effectively regulate emotions and self-evaluations in different contexts (American Psychiatric Association, 2013; Kashdan & Rottenberg, 2010). PPT helps clients to regulate emotions and enhance self-evaluation in various contexts by teaching them nuanced, calibrated and contextualized use of both positives and negatives. For example, clients may be motivated to experience or even reinforce negative emotions because these may more useful than positive ones. Anger, frustration, or disappointment in close relationship may signal wrongdoing by the other person. Confidence about completing an important task, without optimal level of anxiety may turn into procrastination. Avoiding the acknowledgment of loss and grief and resorting to unhealthy coping means (e.g. drugs, sex, and shopping) may prevent clients from comprehending the meaning of loss and contemplating a revised personal narrative that may be necessary for adaptive coping. PPT does not necessarily ask clients to use specific strengths more; rather, it engages clients in deeper reflection of when and how expression of specific strengths could be adaptive or maladaptive (Biswas-Diener, Kashdan, & Minhas, 2011; Kashdan & Rottenberg, 2010).

Following the assessment of signature strengths, clients and therapist collaborate to set personally meaningful goals. Typically these are linked directly to reducing psychiatric distress, increasing well-being, and improving daily functioning. Clients and therapist agree to monitor progress and modify according to situational needs, and they regularly discuss an adaptive, calibrated, contextualized, and flexible use of signature strengths so that clients gradually learn skills to meet the varying needs of a diverse situations. Therapists continue to highlights that symptoms could also be explained either through lack or excess of strengths. Due to limitations of space, instead of brief clinical vignettes, following are some illustrations from author's first hand clinical experience of helping clients to conceptualize symptoms. Feeling hopeless or slow as a result of lack of zest and playfulness; worrying excessively due to a lack of gratitude or inability to let go; indecision from lack of determination; repetitive intrusive thoughts due to lack of mindfulness; narcissism due to lack of modesty; feeling inadequate as lack of self-efficacy; and difficulty making decisions because of an excess of prudence. Furthermore, therapists also point out that sometimes clients get into trouble for overuse of love and forgiveness (being taken for granted), underuse of self-regulation in a specific domain of life (indulgence), or fairness only in few situations or teamwork only with preferred groups (bias and discrimination). Throughout the course of therapy, clients and therapists monitor progress towards goals and make necessary changes as well as continuously explore the nuances and subtleties of strengths, especially about encountering their challenges through strengths. Clients learn to identify their troubling emotions and memories by harnessing their social intelligence; to tone down grudges by accessing positive memories of specific situations, individuals, or experiences; and that instead of avoiding difficult situations, they need to muster courage and self-regulation to face them.

Whereas personalized goals using signature strengths aim to reduce symptomatic distress, a number of PPT exercises explicitly focus on cultivating positive emotions such as gratitude, savoring, and playfulness. Whereas negative emotions narrow cognitive, attentional, and physiological resources to deal with an immediate threat,

Table 2. Character strengths: definitions and usage (lacking/excess).[a]

	Character strengths	Description	Lacking/under use	Excess/over use
1	Appreciation of beauty and excellence	Being moved deeply by beauty in nature, in art (painting, music, theatre, etc.) or in excellence in any field of life	Oblivion	Snobbery
2	Authenticity and honesty	Not pretending to be someone one is not; coming across as a genuine and honest person	Shallowness, phoniness	Righteousness
3	Bravery and valor	Overcoming fears to do what needs to be done; not give up in face of a hardship or challenge	Fears, easily scared	Foolhardiness, risk-taking
4	Creativity and originality	Thinking of new and better ways of doing things; not being content with doing things in conventional ways	Conformity	Eccentricity
5	Curiosity, interest in the world and openness to experience	Being driven to explore things; asking questions, not tolerating ambiguity easily; being open to different experiences and activities	Disinterest, boredom	Nosiness
6	Fairness, equity and justice	Standing up for others when they are treated unfairly, bullied or ridiculed; day-to-day actions show a sense of fairness	Prejudice, partisanship	Detachment
7	Forgiveness and mercy	Forgiving easily those who offend; not holding grudges	Mercilessness	Permissiveness
8	Gratitude	Expressing thankfulness for good things through words and actions; not take things for granted	Entitlement	Ingratiation
9	Hope, optimism and future-mindedness	Hoping and believing that more good things will happen than bad ones; recovering from setbacks and taking steps to overcome them	Present orientation	Panglossism
10	Humor and playfulness	Being playful, funny and uses humor to connect with others	Humourlessness	Buffoonery
11	Kindness and generosity	Doing kind deeds for others, often without asking; helping others regularly; being known as a kind person	Indifference	Intrusiveness
12	Leadership	Organizing activities that include others; being someone others like to follow; being often chosen to lead by peers	Compliance	Despotism
13	Capacity to love and be loved	Having warm and caring relationships with family and friends; showing genuine love and affection through actions regularly	Isolation, detachment	Emotional promiscuity
14	Love of learning	Loving to learn many things, concepts, ideas, facts in school or on one's own	Complacency, smugness	'Know-it-all'-ism
15	Modesty and humility	Not liking to be the center of attention; not acting as being special; admitting shortcomings readily; knowing what one can and cannot do	Footless self-esteem	Self-depreciation
16	Open-mindedness and critical thinking	Thinking through and examining all sides before deciding; consulting with others; being flexible to change one's mind when necessary	Unreflective	Cynicism, skepticism
17	Perseverance, diligence and industry	Finishing most things; being able to refocus when distracted and completing the task without complaining; overcoming challenges to complete the task	Slackness, laziness	Obsessiveness, fixation, pursuit of unattainable goals
18	Perspective (wisdom)	Putting things together to understand underlying meaning; settling disputes among friends; learning from mistakes	Superficiality	Ivory tower, arcane and pedantic thinking
19	Prudence, caution and discretion	Being careful and cautious; avoid taking undue risks; not easily yielding to external pressures	Recklessness	Prudishness, stuffiness
20	Religiousness and spirituality	Believing in God or higher power; liking to participate in religious or spiritual practices e.g. prayer, meditation … etc.	Anomie	Fanaticism
21	Self-regulation and self-control	Managing feelings and behavior well most of the time; following gladly rules and routines	Self-indulgence	Inhibition
22	Social intelligence	Easily understanding others' feelings; managing oneself well in social situations; displaying excellent interpersonal skills	Obtuseness, cluelessness	Psycho-babbling
23	Teamwork, citizenship and loyalty	Relating well with teammates or group members; contributing to the success of the group	Selfishness and rebelliousness	Mindless and automatic obedience
24	Zest, enthusiasm and energy	Being energetic, cheerful and full of life; being liked by others to hang out	Passivity, restraint	Hyperactivity

[a]Adapted from Peterson (2006b).

Table 3. PPT: overview of pilot studies.

	Authors and publication status	Intervention description and sample characteristics	Primary outcome measures	Key findings
	Randomized			
1	Seligman et al. (2006); published	Individual PPT; $n = 11$), 12–14 sessions, with clients diagnosed with Major Depressive Disorder (MDD), compared with Treatment as Usual (TAU; $n = 9$) & Treatment as Usual plus medication (TAUMED; $n = 12$); under & postgraduate students-seeking treatment at a university counseling center	Depression (*ZDRS* & *Hamilton*), Overall psychiatric distress (*OQ-45*), Life Satisfaction (*SWLS*) & Well-being (*PPTI*)	Post, Depression PPT < TAU (ZDRS & *Hamilton*, $d = 1.12$ & 1.14) & PPT < TAUMED (*ZDRS* $d = 1.22$) & Overall psychiatric distress (*OQ-45* $d = 1.13$); Post Well-being PPT > TAU & TAUMED ($d = 1.26$ & 1.03)
2	Seligman et al. (2006), published	Group PPT ($n = 21$) with clients experiencing mild-to-moderate depressive symptoms compared with no-treatment control ($n = 21$) in six sessions; undergraduate students at a university	Depression (*BDI-II*) & Life Satisfaction (*SWLS*)	Post, Depression PPT < Control (*BDI-II*, $d = 0.48$), and at 3, 6 & 12 month follow ups ($d = 0.67$, 0.77 & 0.57, respectively) with a reduction of 0.96 points per week ($p < .003$), a rate of change that was significantly greater than that of the control group ($p < .05$)
3	Parks-Schiener (2009), dissertation	Individual ($n = 52$) completing six PPT exercises online, compared with no treatment control group ($n = 69$), Online sample	Depression (*CES-D*), Life Satisfaction (*SWLS*) & Positive and Negative affect (*PANAS*)	Post, Depression (*CES-D* $d = 0.21$, at the six-month follow-up); Post, PPT > Positive & Negative Affect ($d = 0.16$, 0.33 & 0.55 at three and six month follow-up,respectively)
4	Lü, Wang, and Liu (2013), published	Group PPT ($n = 16$), (2 h for 16 weekly sessions), compared with a no treatment control group ($n = 18$), exploring the impact of positive affect on vagal tone in handling environmental challenges	Positive and negative affect (*PANAS*) & Respiratory Sinus Arrhythmia (*RSA*)	Depression, PPT < Control, at the six-month follow-up ($d = 0.21$); Positive & Negative Affect, PPT > control, at the post-intervention, three and six month follow-ups ($d = 0.16$, 0.33 & 0.55, respectively)
5	Rashid, Anjum et al. (2013), published	Group PPT ($n = 9$), 8 sessions, with grade 6 & 7 students compared with no treatment control ($n = 9$) at a public middle school	Social Skills (*SSRS*), Student Satisfaction (*SLSS*),Well-being (*PPTI-C*) & Depression (*CDI*)	Post, PPT > Social Skills (*SSRS*-Composite-parent version ($d = 1.88$) and also on *PPTI-C* ($d = 0.90$)
6	Reinsch (2012), dissertation	Group PPT clients ($n = 9$), six sessions with clients seeking psychotherapy through Employee Assistance Program, compared with no treatment control group ($n = 8$)	Depression (*CES-D*) & Well-being (*PPTI*)	Post, Depression (*CES-D* $d = 0.84$). Therapeutic gains maintained one month post-intervention while no treatment control with depression decreasing a statistically significant rate of 45%
7	Rashid, Uliaszek et al. (2013),	Group PPT ($n = 6$) compared group Dialectical Behavior Therapy (DBT; $n = 10$) with clients diagnosed with Borderline Personality Disorder at a university health center	Depression (*SCID*), Psychiatric Symptoms (*SCL-90*), Emotion Regulation (*DER*), Distress Tolerance (*DTS*), Mindfulness (*KIMS*), Well-being (*PPTI*) & Life Satisfaction (*SWLS*)	Both PPT & DBT differed significantly from pre- topost-treatment on most measures with an average effect size of $d = 1.15$ & 1.18, respectively; DBT > PPT (*DERS* $d = 1.44$)
8	Asgharipoor, Farid, Arshadi, and Sahebi (2010), published	Group PPT ($n = 9$) for 12-weeks, with clients diagnosed with MDD, compared with Cognitive Behavior Therapy (CBT), also for 12 weeks, in a hospital affiliated psychological centre in Mashhad, in Iran	Depression (*SCID* & *BDI-II*), Happiness (*OTS*), Life Satisfaction (*SWLS*) & Psychological Well-being (*SWS*)	Post, Happiness, PPT > CBT (*OTS*; *(d* =1.86). On most measures both treatments did not differ
	Non-randomized			
9	Cuadra-Peralta et al. (2010), published	Group PPT ($n = 8$) in nine sessions with clients diagnosed with depression, compared with behavioral therapy ($n = 10$) at a community center in Chile	Depression (*BDI-II* & *CES-D*), Happiness (*AHI*)	Post, Happiness (*AHI,* PPT > Behaviour Therapy ($d = 0.72$); PPT group < on Depression, from pre-topost-treatment (*BDI-II*; $d = 0.90$ & *CES-D* $d = 0.93$)

(*Continued*)

Table 3. (*Continued*).

	Authors and publication status	Intervention description and sample characteristics	Primary outcome measures	Key findings
10	Bay and Csillic (2012), dissertation	Group PPT ($n = 10$) compared with Group Cognitive Behavior Therapy ($n = 8$) & medication ($n = 8$) with client experiencing symptoms of depression at the *le Centre de la Dépression and le Centre Stress Anxiété et Dépression, in France*	Depression (*BDI-Shortened*), Depression & Anxiety (*HADS*), Happiness (*SHS*), Emotional Inventory (*EQ-I*), Life Satisfaction (*SWLS*) & Positive and Negative Affect (*PANAS*)	Post, Depression, PPT < CBT (d =0.66), Happiness (*SHS*; $d = 0.81$), Life Satisfaction (*SWLS;* d =0.66), Optimism (*LOT-R*, $d = 1.62$) & Emotional Intelligence (*EQ-I,* $d = 1.04$). On most measures both PPT and CBT faired better than medication group
11	Meyer, Johnson, Parks, Iwanski, and Penn (2012), published	Group PPT in ten sessions, with six exercises was adapted for clients ($n = 16$) experiencing symptoms of schizophrenia at a hospital affiliated clinic, with baseline, post-intervention, three month follow-up assessment	Psychological Well-being (SWS), Savoring (*SBI*), Hope (*DHS*), Recovery (*RAS*), Symptoms (*BSI*) & Social Functioning (*SFS*)	Post, PPT < CBT, Depression (*BDI* $d = 0.66$), Happiness (SHS, $d = 0.81$), Life Satisfaction (*SWLS* $d = 0.66$), Optimism (*LOT-R* $d = 1.62$) & *EQ-I* ($d = 1.04$). In most cases both PPT and CBT faired better than medication group
12	Kahler et al. (2014), published	Individual PPT ($n = 19$), in eight sessions was integrated with smoking cessation counseling and nicotine patch with at a community medical center	Depression (*SCID, CES-D*), Nicotine Dependence (*FTND*), Positive and Negative Affect (*PANAS*) & Client Satisfaction (*CSQ*-8)	Rate of session attendance and satisfaction with treatment were high, with most participants reported using and benefitting from PPT exercises. Almost one-third (31.6%) of the sample sustained smoking abstinence for six months after their quit date
13	Goodwin (2010) dissertation	Group PPT ($n = 11$), in ten sessions explore if treatment increased relationship satisfaction among anxious and stressed individuals with a community sample at a training clinic	Anxiety *(BAI),* Stress *(PSS),* relationship adjustment *(DAS)*	Post, PPT <, Anxiety (*BAI* $d = 1.48$), Stress < (*PSS* $d = 1.22$), no changes on relationship satisfaction (*DAS*)

positive emotions not only undo effects of negative emotions but also expand cognitive researches resources (Fredrickson, 2001, 2009). Emerging evidence supports this assertion (Jislin-Goldberg, Tanay, & Bernstein, 2012). Therefore, throughout the course of PPT, therapists not only help clients to observe, acknowledge and label positive emotions but also discuss with clients new possibilities of generating alternative ways of solving their problems when clients experience positive emotions.

PPT exercises such as Positive Introduction, Gratitude Journal, Gratitude Letter & Visit, One Door Close, and One Door Open facilitate cultivation of positive emotions throughout the course of therapy. In the Gratitude Journal, clients, just before going to bed, write three good things – small or big – that happened during the course of the day. Most clients find this helpful not only in coping with negative experiences but also in cementing relationships through explicitly noticing the kind acts and gestures of friends and family. Kashdan, Julian, Merritt, and Uswatte (2006) in a diary study with the Vietnam War veterans diagnosed with Post-traumatic Stress Disorder (PTSD), found that gratitude related to more daily self-esteem and positive affect, above the effects of symptomatology. In addition to gratitude, through PPT exercises such as *Satisficing* versus *Maximizing* (Schwartz, Ward et al., 2002) and *Savoring* (Bryant & Veroff, 2006) clients learn to deliberately slow down and enjoy experiences they would normally hurry through (e.g. eating a meal). When the experience is over, clients reflect and write down what they did, and how they felt differently compared to when they rushed through it.

Flourishing individuals, according to Fredrickson's positivity ratio (2009), experience three positives for every one negative. Depressed individuals seeking therapy experience lower than one positive for every one negative (Schwartz et al., 2002). Inevitably clients presenting for therapy report a range of negative emotions. After helping clients to actively and authentically cultivating positive emotions, which relieve acute psychiatric distress, in the middle phase of the therapy clients are encouraged to write down grudges, bitter memories, or resentment and then discuss in therapy the effects of holding onto them. Through positive reappraisal, PPT aims to help clients unpack their grudges and resentments through what it calls Positive Appraisal (Rashid & Seligman, 2013). It includes four strategies: (i) psychological space: write a bitter memory from a third person's perspective; (ii) reconsolidation: recall finer and subtle aspects of a bitter memory in a relaxed state; (iii) mindful focus: observe a negative memory rather than reacting; and (iv) diversion: intentionally

engage behaviorally in an unrelated or playful task. Clients are also invited to consider the process of forgiveness. However, PPT spends one session each on positive appraisal and forgiveness, as the goal here is to support clients' strength-based well-being. It is not uncommon for exercises employed in PPT to generate negative and uncomfortable emotions, some of which could be associated with trauma. Much like any psychotherapy, PPT attends to all varieties of emotional experiences. However, while empathetically attending to pain associated with traumatic experiences, PPT gently encourages clients to also explore meaning and psychological growth (Bonanno & Mancini, 2012) through exercises such as *One Door Closes, One Door Opens* Writing a Positive Legacy. Therapists are to avoid too quickly pointing out the positive outcomes from trauma, loss, or adversity. Incorporating strengths with symptoms helps clients to learn how to encounter negative experiences with a more positive mindset, and to reframe those experiences in ways that are adaptable and helpful.

The third and final phase of PPT exercises continues to use client's strengths, but focus is on placed meaning and purpose and ways signature strengths can be used to serve something meaningful and bigger than oneself. One exercise, *positive communication*, teaches clients ways to validate and capitalize on precious moments when their partners share good news with them (Gable, Reis, Impett, & Asher, 2004). Others such as *Gift of Time* help clients to pursue meaning and purpose by using their strengths, such as strengthening close interpersonal and communal relationships or pursuing artistic, intellectual, or scientific innovations or philosophical or religious contemplation (Stillman & Baumeister, 2009; Wrzesniewski, McCauley, Rozin, & Schwartz, 1997). There is solid evidence that having a sense of meaning and purpose helps individuals to recover or rebound quickly from adversity and buffer against feelings of hopelessness and uncontrollability (Graham, Lobel, Glass, & Lokshina, 2008; Lightsey, 2006).

Some caveats are in order. Despite its title and emphasis on cultivation of strengths, PPT is not prescriptive. Rather, it is descriptive in the sense that converging scientific evidence indicates that certain benefits accrue when individuals attend to the positive aspects of their experience. Wood and Tarrier (2010), in a longitudinal study of 5500 individuals, have shown that people who were low on characteristics such as self-acceptance, autonomy, purpose in life, positive relationships with others, environmental mastery, and personal growth were up to seven times more likely to meet the cut-off for clinical depression 10 years later. Much like CBT, which shows that clients' distorted thinking causes and maintains depression and then counsels them to change it, PPT states that experiencing certain emotions is detrimental or beneficial to one's well-being.

Second, PPT is not a panacea and will not be appropriate for all clients in all situations. Clinical judgment is needed to determine the suitability of PPT for individual clients. For example, a client with an inflated self-perception may use strengths to further support his/her narcissism. Likewise, a client with a deeply entrenched sense of being a victim may feel too comfortable in that role, and may benefit from an insight oriented approach to ascertain the emotional pro and cons of this role first and then could perhaps benefit from PPT exercises. For some disorders, elimination of symptoms is much more needed than cultivation of strengths. For example, a client with symptoms of panic disorder needs an immediate relieve from exposure or a client with symptoms of eating disorder may need structured therapeutic interventions that address acuteness of symptoms first. A client experiencing grief and acute trauma would benefit from interventions that help him/her to cope with sadness and stress.

Third, a therapist using PPT also should not expect a linear progression of improvement, because the motivation to change longstanding behavioral and emotional patterns fluctuates during the course of therapy. The progress of one client should not bias therapists about the likely progress (or lack of) of another client. The mechanism of change in PPT has not been explored systematically, but inferring from the change of mechanism uncovered by Lyubomirsky and Layous (2013) about positive interventions, it can be argued that change brought by positive interventions could be moderated by level of symptom severity, individual personality variables (motivation, effort), flexibility in completing and practicing the exercises and skills, and overall client intervention fit. Nonetheless, the therapist must also be aware that change is not due to expectancy effect. Finally, it is important to be aware of cultural sensitivities in assessing strengths. An emotive style of communication, interdependence on extended family members, and avoiding direct eye contact may convey zest, love, and respect (Pedrotti, 2011).

Positive psychology has been criticized for not exploring people's troubles deeply enough and steering people quickly towards well-being and strengths without comprehending the contextual features of the presenting situations (Coyne & Tennen, 2010; Ehrenreich, 2009; McNulty, & Fincham, 2012). As underscored throughout this paper, PPT, does not deny negative emotions, nor does it encourage clients to search for positives all too quickly through rose-colored glasses. It is a scientific endeavor to encourage clients to explore their intact resources and learn contextual, nuanced and calibrated use of these resources to overcome their challenges in increments but never at the cost of denying, dismissing or avoiding negatives.

Empirical evidence, caveats, and future directions

PPT's empirical support has been found in several (albeit pilot) studies.

In a 6-group, random-assignment, placebo controlled Internet study, Seligman, Steen, Park, and Peterson (2005) found that of 5 purported happiness interventions and 1 plausible control exercise, three exercises (using signature strengths in a new way, three good things & gratitude visit) increased happiness and decreased depressive symptoms. These findings have since been independently replicated with somewhat similar results (Giannopoulos & Vella-Brodrick, 2011; Mongrain & Anselmo-Matthews, 2012). Exploring the finer aspects of PPT exercises, Schueller (2010) has found that it is a person's internal characteristics that make a particular positive psychology intervention more or less beneficial. Table 3 lists thirteen pilot and feasibility studies, with small samples. All have explicitly used the PPT manual (Rashid & Seligman, in press; Seligman et al., 2006) as a packaged treatment. Most have offered PPT as a group intervention, with eight randomized controlled pilot studies, nine published in peer reviewed journals, and three dissertations. Seven of these studies treated community samples (outpatients in hospital settings, community mental health clinics) from Canada, China, Chile, France, Iran, and the United States, addressing clinical concerns including depression, anxiety, borderline personality disorder, psychosis, and nicotine dependence. Four studies have compared PPT with two other treatments, Dialectical Behavior Therapy (DBT) and Cognitive Behavior Therapy (CBT). Due to space limitation, only salient studies are summarized. The first randomized controlled pilot (Seligman et al., 2006) included two studies, a six-session controlled group therapy for participants experiencing mild to moderate symptoms of depression and 12–14 session individual therapy for a clinical sample experiencing severe symptoms of depression. The individual therapy compared PPT with Treatment as Usual (TAU) and clients who received TAU, as well as antidepressant medication (TAUMED). These clients sought counseling services at a large urban university for symptoms of severe depression. PPT took place over up to 14 sessions, mostly weekly, to individual clients in 12–14 sessions. It was custom tailored to meet their circumstances and the feasibility of completing the exercises. The TAU received an integrative and eclectic approach administered by licensed psychologists, two licensed social workers, and two graduate-level interns. Overall, results indicated that PPT did better than two active treatments, with large effect size. These initial results were highly preliminary with small sample sizes, and treatment was offered by some intrinsically interested and trained in PPT. More recently, Asgharipoor and colleagues (2012) compared PPT with CBT (Registration ID in IRCT: 201201268829NI). Eighteen outpatients diagnosed met the inclusion criteria, which included having major depressive disorder as identified by SCID (Axis I. DSM-IV), BDI-II (Beck, Steer, & Brown, 1996; a Persian validated version), Subjective Units of Distress Scale (SUDS), Oxford Happiness Scale, and Subjective Wellbeing Scale. The PPT ($n = 9$) and CBT ($n = 9$) were offered in 12 two-hour sessions at a community counseling center in Mashhad, Iran. Results showed that the two treatments did not differ in reducing symptoms of depression, but PPT was found more effective in increasing happiness. These results are somewhat consist with the ongoing study in which PPT is compared with DBT. Participants are identified after completing SCID and multiple measures of psychiatric distress and emotional dysregulation (see Table 3). Results of the first phase show that both PPT ($n = 6$) and DBT ($n = 10$) worked equally well on most measure, but DBT performed better on measured distress tolerance. However, due to small sample size, these results are highly preliminary. Lü, Wang, and Liu (2013) compared PPT with a control group. PPT ($n = 16$) offered in 16 two hour weekly sessions was compared with no treatment control ($n = 18$). The outcome was impact of positive affect on vagal tone in handling environmental challenges. PPT did significantly better than the control group at post-intervention, three-, and six-month follow-up with medium effect sizes. Reinsch (2012) offered PPT ($n = 9$) in six sessions to clients seeking psychotherapy through Employee Assistance Program and compared it with no treatment ($n = 8$). Results indicated that significant decrease in depression at the post-intervention and therapeutic gains were maintained one month post-treatment with a statistically significant 45% decrease in depression. PPT has also been adapted for various disorders and clinical conditions. Kahler et al. (2014) adapted PPT for smoking cessation (PPT-S). Treatment was offered through individual sessions. Results show that rates of session attendance and satisfaction with treatment were high, and most participants reported using and benefiting from the PPT exercises. Almost one-third of the participants (31.6%) sustained smoking abstinence for six months after their quit date. A manualized adaptation of standard 14-session PPT called WELLFOCUS PPT has been developed at Kings College, London. It aims to increase well-being in service users with an experience of psychosis. The adaptation process synthesized systematic review evidence and qualitative research involving people with a psychosis diagnosis who use mental health services (Schrank et al., 2013). The evaluation of WELLFOCUS PPT in an RCT with 11 groups has been completed (ISRCTN 04199273) and the manuscript is in submission. PPT pilot studies, listed in Table 3, overall, report decrease in depression and increase in well-being compared to control or pre-treatment scores, with medium to large effect sizes. All effect sizes Cohen's *d* (Cohen, 1992) are given in Table 3. When

compared to another treatment such as CBT or DBT, PPT performed equally well or exceeded notably on well-being measures (e.g. Asgharipoor, Farid, Arshadi, & Sahebi, 2010; Cuadra-Peralta, Veloso-Besio, Pérez, & Zúñiga, 2010). One important caution in reviewing these studies is their small sample sizes. The study at the Kings College, London with 11 randomized groups will have with the largest sample administering PPT to date.

Positive interventions typically are one or more positive psychology exercises, often, but not always, used with non-clinical and randomized online samples. Typical illustration of positive interventions would be Seligman et al. (2005), Vella-Brodrick, Park, and Peterson (2009), Mongrain and Anselmo-Mathews (2012) and Schueller & Parks (2012). Two meta-analyses of positive interventions have been published. The first meta-analysis of 51 positive interventions including both clinical and non-clinical samples, conducted by Sin and Lyubomirsky (2009), found that positive interventions are effective, with moderate effect sizes in significantly decreasing symptoms of depression (mean $r = 0.31$) and enhancing well-being (mean $r = 0.29$). The second meta-analysis, by Bolier and her colleagues (2013), reviewing 39 randomized heterogeneous published studies, totaling 6139 participants. Of these only seven included clinical samples. Authors found that positive interventions reduced depression (mean $r = 0.23$) with small effect size but enhanced well-being with moderate effect sizes ($r = 0.34$). Compared to more structured, manualized, sequential PPT that is used with clinical samples, positive interventions could benefit non-clinical patrons as well-being enhancing strategies that could prevent or reduce risk of future psychological disorders.

Empirical foundations of PPT are critical, but equally essential is establishing a repertoire of case studies, vignettes and illustrations of PPT exercises conducted as a packaged treatment, stand alone interventions, and incorporated with established treatments. This will help clinicians to understand day-to-day implementation of PPT. Few developments in this regard are worth noting. *Journal of Clinical Psychology's* May, 2009 issue exclusively focused on positive interventions for clinical disorders with rich case illustrations. Burns (2010) has compiled a 27-chapter casebook, written by a leading practitioner of positive psychology. Each chapter provides a detailed case illustration regarding the clinical use of positive psychology, including PPT exercises with clients in distress. Most of the chapters offer step-by-step strategies. In addition to protocolled treatment packages, single positive interventions have also been applied to examine their effectiveness for specific clinical conditions, such as gratitude in undoing symptoms of depression (Wood, Maltby, Gillett, Linley, & Joseph, 2008), best possible self and three good things for depression (Pietrowsky, 2012), hope as a treatment of PTSD (Gilman, Schumm, & Chard, 2012), the therapeutic role of spirituality and meaning in psychotherapy (Steger & Shin, 2010), positive psychology interventions to treat drug abuse (Akthar & Boniwell, 2010), cultivation of positive emotions in treating symptoms of schizophrenia (Johnson et al., 2009), and forgiveness as a way of slowly letting go of anger (Harris et al., 2006). The role of positive interventions to supplement traditional clinical work is also being explored (e.g. Frisch, 2006; Harris, Thoresen, & Lopez, 2007; Karwoski, Garratt, & Ilardi, 2006; Ruini & Fava, 2009). Links between specific clinical conditions and strengths also been explored, including creativity and bipolar disorder (Murray & Johnson, 2010), positive psychology and brain injury (Evans, 2011), positive emotions and social anxiety (Kashdan et al., 2006), social relationships and depression (Oksanen, Kouvonen, Vahtera, Virtanen, & Kivimäki, 2010), various aspects of well-being and psychosis (Schrank et al., 2013), positive psychology and war trauma (Al-Krenawi et al., 2011), school-based positive psychology interventions (Waters, 2011), and character strengths and mindfulness (Niemiec, Rashid, & Spinella, 2012). In addition, a number of online studies have effectively used PPT-based interventions with promising results (e.g. Parks, Della Porta, Pierce, Zilca, & Lyubomirsky, 2012; Mitchell, Stanimirovic, Klein, & Vella-Brodrick, 2009; Schueller & Parks, 2012). This could be a relatively cost effective way of offering mental health services to nonclinical patrons as a preventative strategy. To help psychotherapists incorporate positive interventions in their clinical practice, a few books are available (e.g. Bannink, 2012; Conoley & Conoley, 2009; Flückiger, Wusten, Zinbarg, & Wampold, 2010; Joseph & Linley, 2006; Levak, Siegel, & Nichols, 2011; Linley & Joseph, 2004; Magyar-Moe, 2009; Proctor & Linley, 2013). Journal articles on theoretical foundation of strengths in the clinical practice have also been published (e.g. Dick-Niederhauser, 2009; Lent, 2004; Slade, 2010; Smith, 2006; Wong, 2006). An outcome measure, Positive Psychotherapy Inventory (PPTI), which can be used to assess specific active ingredients of PPT including positive emotions, engagement, meaning, and relationships, has been devised and validated (Bertisch et al., 2014; Guney, 2011; Rashid, 2008).

Establishing efficacy or effectiveness of interventions takes decades of research, including open trial, case reports, then controlled pilots, and finally multisite studies. PPT has made a tentative but promising start. It has shown effectiveness, and requires discovering and identifying the mechanism of change. It is yet to establish its incremental effectiveness – over and beyond – the traditional approach and more clearly delineate outcomes that are theoretically and empirically related to its content. So far, PPT has mostly been used in group settings. There is dearth of studies, which have used it in individual settings. Moving forward, longitudinal and multimethod (e.g. experiential

sampling, physiological, and neurological indices) research designs may uncover effectiveness of PPT for specific disorders. There is a lack of coherent theory that explains the epistemology of well-being, especially in clinical settings. Clinical practice often runs ahead of evidence. Yet evidence is keeps practice alive through, well defined and refined studies. PPT, without competing, complements the rich repertoire of therapeutic approaches to enrich the field.

References

Akhtar, M., & Boniwell, I. (2010). Applying positive psychology to alcohol-misusing adolescents: A group intervention. *Groupwork: An Interdisciplinary Journal for Working with Groups, 20*, 6–31.

Alipur, A., & Agah Haris, M. (2007). Reliability and validity of oxford happiness index in Iranian people. *Iran psychologist, 12*, 287–298.

Al-Krenawi, A., Elbedour, S., Parsons, J. E., Onwuegbuzie, A. J., Bart, W. M., & Ferguson, A. (2011). Trauma and war: Positive psychology/strengths approach. *Arab Journal of Psychiatry, 22*, 103–112.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders, (5th ed.) (DSM-V)*. Arlington, VA: Author.

Asgharipoor, N., Farid, A. A., Arshadi, H., & Sahebi, A. (2010). A comparative study on the effectiveness of positive psychotherapy and group cognitive-behavioral therapy for the patients suffering from major depressive disorder. *Iranian Journal of Psychiatry and Behavioral Sciences, 6*, 33–41.

Baer, R. A., Smith, G. T., & Allen, K. B. (2004). Assessment of mindfulness by self-report: The Kentucky inventory of mindfulness skills. *Assessment, 11*, 191–206.

Bannink, F. (2012). *Practicing Positive CBT*. New York, NY: Wiley-Blackwell.

Baumeister, R. F., Bratslavsky, E., Finkenauer, C., & Vohs, K. D. (2001). Bad is stronger than good. *Review of General Psychology, 5*, 323–370. doi:10.1037/1089-2680.5.4.323

Bay, M. & Csillic, A (2012). *Comparing positive psychotherapy with cognitive behavioral therapy in treating depression*. Unpublished manuscript. Paris West University Nanterre La Défense (Université Paris Ouest Nanterre La Défense).

Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology, 56*, 893–897.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *BDI-II. Beck Depression Inventory: Manual* (2nd ed.). Boston, MA: Harcourt Brace.

Birchwood, M., Smith, J., Cochrane, R., & Wetton, S. (1990). The social functioning scale: The development and validation of a new scale of social adjustment for use in family intervention programmes with schizophrenic patients. *The British Journal of Psychiatry, 157*, 853–859.

Berntson, G. G., Bigger, J. T., Eckberg, D. L., Grossman, P., Kaufmann, P. G., Malik, M., & van der Molen, M. W. (1997). Heart rate variability: Origins, methods, and interpretive caveats. *Psychophysiology, 34*, 623–648. http://dx.doi.org/10.1111/j.1469-8986. 1997.tb02140.x

Bertisch, H., Rath, J., Long, C., Ashman, T., & Rashid, T. (2014). Positive psychology in rehabilitation medicine: A brief report. *NeuroRehabilitation*. doi:10.3233/NRE-141059

Biswas-Diener, R., Kashdan, T. K., & Minhas, G. (2011). A dynamic approach to psychological strength development and intervention. *The Journal of Positive Psychology, 6*, 106–118.

Bjelland, I., Dahl, A. A., Haug, T. T., & Neckelmann, D. (2002). The validity of the hospital anxiety and depression scale. *Journal of psychosomatic research, 52*, 69–77.

Bolier, L., Haverman, M., Westerhof, G. J., Riper, H., Smit, F., & Bohlmeijer, E. (2013). Positive psychology interventions: A meta-analysis of randomized controlled studies. *BMC Public Health, 13*, 119. doi:http://dx.doi.org/10.1186/1471-2458-13-119

Bonanno, G. A., & Mancini, A. D. (2012). Beyond resilience and PTSD: Mapping the heterogeneity of responses to potential trauma. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*, 74–83. doi:10.1037/a0017829

Bryant, F. B. (2003). Savoring Beliefs Inventory (SBI): A scale for measuring beliefs about savouring. *Journal of Mental Health, 12*, 175–196.

Bryant, F. B., & Veroff, J. (2006). *Savoring: A new model of positive experience*. Mahwah, NJ: Erlbaum.

Burns, G. W. (Ed.). (2010). *Happiness, healing and enhancement: Your casebook collection for applying positive psychology in therapy*. Hoboken, NJ: John Wiley & Sons.

Burton, C. M., & King, L. A. (2004). The health benefits of writing about intensely positive experiences. *Journal of Research in Personality, 38*, 150–163.

Castonguay, L. G. (2013). Psychotherapy outcome: An issue worth re-revisiting 50 years later. *Psychotherapy, 50*, 52–67. doi:10.1037/a0030898

Cheavens, J. S., Strunk, D. S., Lazarus, S. A., & Goldstein, L. A. (2012). The compensation and capitalization models: A test of two approaches to individualizing the treatment of depression. *Behaviour Research and Therapy, 50*, 699–706.

Chibnall, J. T., & Tait, R. C. (1994). The Short form of the beck depression inventory. *The Clinical Journal of Pain, 10*, 261–266.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155–159.

Conoley, C. W., & Conoley, J. C. (2009). *Positive psychology and family therapy*. Hoboken, NJ: Wiley.

Conoley, C. W., Padula, M. A., Payton, D. S., & Daniels, J. A. (1994). Predictors of client implementation of counselor recommendations: Match with problem, difficulty level, and building on client strengths. *Journal of Counseling Psychology, 41*, 3–7.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*, 614–625.

Corrigan, P. W., Salzer, M., Ralph, R., Sangster, Y., & Keck, L. (2004). Examining the factor structure of the recovery assessment scale. *Schizophrenia Bulletin, 30*, 1035–1041.

Coyne, J. C., & Tennen, H. (2010). Positive psychology in cancer care: Bad science, exaggerated claims, and unproven medicine. *Annals of Behavioral Medicine: A Publication of the Society of Behavioral Medicine, 39*, 16–26. 10.1007/s12160-009-9154-z

Cuadra-Peralta, A., Veloso-Besio, C., Pérez, M., & Zúñiga, M. (2010). Resultados de la psicoterapia positiva en pacientes con depresión [Positive psychotherapy results in patients with depression]. *Terapia Psicológica, 28*, 127–134. doi:10.4067/S0718-48082010000100012

Dawda, D., & Hart, S. D. (2000). Assessing emotional intelligence: Reliability and validity of the bar-on emotional quotient inventory (EQ-i) in university students. *Personality and Individual Differences, 28*, 797–812.

Derogatis, L. R. (1993). *Brief symptom inventory (BSI): Administration, scoring, and procedures manual* (3rd ed.). Minneapolis, MN: National Computer Systems.

Derogatis, L. R. (1994). *Symptom Checklist-90-Revised (SCL-90-R): Administration, scoring, and procedures manual* (3rd ed.). Minneapolis, MN: National Computer Systems.

Dick-Niederhauser, A. (2009). Therapeutic change and the experience of joy: Toward a theory of curative processes. *Journal of Psychotherapy Integration, 19*, 187–211.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The Satisfaction with life scale. *Journal of Personality Assessment, 49*, 71–75.

Ehrenreich, B. (2009). *Bright-sided: How positive thinking is undermining America*. New York, NY: Metropolitan Books.

Evans, J. (2011). Positive psychology and brain injury rehabilitation. *Brain Impairment, 12*, 117–127. doi:10.1375/brim.12.2.117

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. (2007). *Structured clinical interview for DSM-IV-TR axis I disorders, research version, patient edition (SCID-VP)*. New York, NY: Biometrics Research, New York State Psychiatric Institute.

Fitzpatrick, M. R., & Stalikas, A. (2008). Integrating positive emotions into theory, research, and practice: A new challenge for psychotherapy. *Journal of Psychotherapy Integration, 18*, 248–258.

Flückiger, C., & Grosse Holtforth, M. (2008). Focusing the therapist's attention on the patient's strengths: A preliminary study to foster a mechanism of change in outpatient psychotherapy. *Journal of Clinical Psychology, 64*, 876–890.

Flückiger, C., Wüsten, G., Zinbarg, R. E. & Wampold, B. E. (2010). *Resource activation – Using the client's own strengths in psychotherapy and counseling*. Cambridge, MA: Hogrefe.

Fredrickson, B. L. (2001). The role of positive emotions in positive psychology. *American Psychologist, 56*, 218–226.

Fredrickson, B. L. (2009). *Positivity: Discover the ratio that tips your life toward flourishing*. New York, NY: Crown.

Frisch, M. B. (2006). *Quality of life therapy: Applying a life satisfaction approach to positive psychology and cognitive therapy*. Hoboken, NJ: Wiley.

Gable, S. L., Reis, H. T., Impett, E. A., & Asher, E. R. (2004). What do you do when things go right? The intrapersonal and interpersonal benefits of sharing positive events. *Journal of Personality and Social Psychology, 87*, 228–245.

Giannopoulos, V. L., & Vella-Brodrick, D. (2011). Effects of positive interventions and orientations to happiness on subjective well-being. *The Journal of Positive Psychology, 6*, 95–105. doi:10.1080/17439760.2010.545428

Gilman, R., Schumm, J. A., & Chard, K. M. (2012). Hope as a change mechanism in the treatment of posttraumatic stress disorder. *Psychological Trauma: Theory, Research, Practice, and Policy, 4*, 270–277. doi:10.1037/a0024252

Goodwin, E. M. (2010). *Does group positive psychotherapy help improve relationship satisfaction in a stressed and/or anxious population?* (Order No. 3428275, Palo Alto University). ProQuest Dissertations and Theses, 166. Retrieved from http://search.proquest.com/docview/822195958?accountid=14707. (822195958)

Graham, J. E., Lobel, M., Glass, P., & Lokshina, I. (2008). Effects of written anger expression in chronic pain patients: Making meaning from pain. *Journal of Behavioral Medicine, 31*, 201–212.

Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the Difficulties in Emotion Regulation Scale. *Journal of Psychopathology and Behavioral Assessment, 26*, 41–54.

Gresham, F. M., & Elliott, S. N. (1990). *Social skills rating system manual*. Circle Pines, MN: AGS.

Guney, S. (2011). The positive psychotherapy inventory (PPTI): Reliability and validity study in Turkish population. *Social and Behavioral Sciences, 29*, 81–86.

Hamilton, M. (1960). A rating scale for depression. *Journal of Neurology, Neurosurgery and Psychiatry, 23*, 56–62.

Harris, A. H. S., Luskin, F., Norman, S. B., Standard, S., Bruning, J., Evans, S., & Thoresen, C. E. (2006). Effects of a group forgiveness intervention on forgiveness, perceived stress, and trait-anger. *Journal of Clinical Psychology, 62*, 715–733. doi:10.1002/jclp.20264

Harris, A. S. H., Thoresen, C. E., & Lopez, S. J. (2007). Integrating positive psychology into counseling: Why and (when appropriate) how. *Journal of Counseling & Development, 85*, 3–13.

Headey, B., Schupp, J., Tucci, I., & Wagner, G. G. (2010). Authentic happiness theory supported by impact of religion on life satisfaction: A longitudinal analysis with data for Germany. *The Journal of Positive Psychology, 5*, 73–82.

Heatherton, T. F., Kozlowski, L. T., Frecker, R. C., & Fagerström, K. (1991). The Fagerström test for nicotine dependence: A revision of the Fagerström tolerance questionnaire. *British Journal of Addiction, 86*, 1119–1127. doi:http://dx.doi.org/10.1111/j.1360-0443.1991.tb01879.x

Hobfoll, S. E. (1989). Conservation of resources: A new attempt at conceptualizing stress. *American Psychologist, 44*, 513–524.

Huebner, E. S. (1991). Initial development of the student's life satisfaction scale. *School Psychology International, 12*, 231–240.

Jislin-Goldberg, T., Tanay, G., & Bernstein, A. (2012). Mindfulness and positive affect: Cross-sectional, prospective intervention, and real-time relations. *The Journal of Positive Psychology, 7*, 349–361. doi:10.1080/17439760.2012.700724

Johnson, D. P., Penn, D. L., Fredrickson, B. L., Meyer, P. S., Kring, A. M., & Brantley, M. (2009). Loving-kindness meditation to enhance recovery from negative symptoms of schizophrenia. *Journal of clinical psychology, 65*, 499–509. doi:10.1002/jclp.20591

Joormann, J., Dkane, M., & Gotlib, I. H. (2006). Adaptive and maladaptive components of rumination? Diagnostic specificity and relation to depressive biases. *Behavior Therapy, 37*, 269–280. doi:10.1016/j.beth.2006.01.002

Joseph, S., & Linley, A. P. (2006). *Positive therapy: A meta-theory for positive psychological practice*. New York, NY: Routledge.

Kahler, C. W., Spillane, N. S., Day, A., Clerkin, E. M., Parks, A., Leventhal, A. M., & Brown, R. A. (2014). Positive psychotherapy for smoking cessation: Treatment development, feasibility, and preliminary results. *The Journal of Positive Psychology, 9*, 19–29. doi:10.1080/17439760.2013.826716

Karwoski, L., Garratt, G. M., & Ilardi, S. S. (2006). On the integration of cognitive-behavioral therapy for depression

and positive psychology. *Journal of Cognitive Psychotherapy, 20*, 159–170.
Kashdan, T. B., Julian, T., Merritt, K., & Uswatte, G. (2006). Social anxiety and posttraumatic stress in combat veterans: Relations to well-being and character strengths. *Behaviour Research and Therapy, 44*, 561–583.
Kashdan, T. B., & Rottenberg, J. (2010). Psychological flexibility as a fundamental aspect of health. *Clinical Psychology Review, 30*, 865–878.
Keyes, C. L. M., & J. S., Eduardo. (2012). To flourish or not: Level of positive mental health predicts ten-year all-cause mortality. *American Journal of Public Health, 102*, 2164–2172.
Kovacs, M. (1992). *Children depression inventory: Manual*. New York, NY: Multi Health System.
Lambert, M. J., Burlingame, G. M., Umphress, V. J., Hansen, N. B., Vermeersch, D., Clouse, G., & Yanchar, S. (1996). The reliability and validity of the outcome questionnaire. *Clinical Psychology and Psychotherapy, 3*, 106–116.
Lamont, A. (2011). University students' strong experiences of music: Pleasure, engagement, and meaning. *Music and Emotion, 15*, 229–249.
Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: Development of a general scale. *Evaluation and Program Planning, 2*, 197–207. doi:http://dx.doi.org/10.1016/0149-7189(79)90094-6
Lent, R. W. (2004). Toward a unifying theoretical and practical perspective on well-being and psychosocial adjustment. *Journal of Counseling Psychology, 51*, 482–509. doi:10.1037/0022-0167.51.4.482
Levak, R. W., Siegel, L., & Nichols, S. N. (2011). *Therapeutic feedback with the MMPI-2: A positive psychology approach*. New York, NY: Taylor & Francis.
Leykin, Y., & DeRubeis, R. J. (2009). Allegiance in psychotherapy outcome research: Separating association from bias. *Clinical Psychology: Science and Practice, 16*, 54–65. doi: 10.1111/j. 1468-2850.2009.01143.x
Lightsey, O. (2006). Resilience, Meaning, and Well-Being. *The Counseling Psychologist, 34*, 96–107. doi:10.1177/0011000005282369
Linley, P. A., & Joseph, S. (Eds.). (2004). *Positive psychology in practice*. Hoboken, NJ: Wiley. doi:10.1002/9780470939338
Lü, W., Wang, Z., & Liu, Y. (2013). A pilot study on changes of cardiac vagal tone in individuals with low trait positive affect: The effect of positive psychotherapy. *International Journal of Psychophysiology, 88*, 213–217. doi:10.1016/j.ijpsycho.2013.04.012
Lyubomirsky, S., & Layous, K. (2013). How Do Simple Positive Activities Increase Well-Being? *Current Directions in Psychological Science, 22*, 57–62. doi:10.1177/0963721412469809
Maddux, J. E. (2008). Positive Psychology and the Illness Ideology: Toward a Positive Clinical Psychology. *Applied Psychology, 57*, 54–70. doi:10.1111/j.1464-0597.2008.00354.x
Magyar-Moe, J. L. (2009). *Therapist's guide to positive psychological interventions*. New York, NY: Elsevier Academic Press.
McNulty, J. K., & Fincham, F. D. (2012). Beyond positive psychology? Toward a contextual view of psychological processes and well-being. *American Psychologist, 67*, 101–110.
Meyer, P. S., Johnson, D. P., Parks, A., Iwanski, C., & Penn, D. L. (2012). Positive living: A pilot study of group positive psychotherapy for people with schizophrenia. *The Journal of Positive Psychology, 7*, 239–248. doi:10.1080/17439760.2012.677467
Mitchell, J., Stanimirovic, R., Klein, B., & Vella-Brodrick, D. (2009). A randomised controlled trial of a self-guided internet intervention promoting well-being. *Computers in Human Behavior, 25*, 749–760. doi:10.1016/j.chb.2009.02.003
Mongrain, M., Anselmo-Matthews, T. (2012). Do positive psychology exercises work? A replication of Seligman et al. (2005). *Journal of Clinical Psychology, 68*, 382–389.
Murray, G., & Johnson, S. L. (2010). The clinical significance of creativity in bipolar disorder. *Clinical psychology review, 30*, 721–732. doi:10.1016/j.cpr.2010.05.006
Niemiec, R. M., Rashid, T., & Spinella, M. (2012). Strong mindfulness: Integrating mindfulness and character strengths. *Journal of Mental Health Counseling, 34*, 240–253.
Norcross, J. C. (Ed.) (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patient needs*. New York, NY: Oxford University Press.
Oksanen, T., Kouvonen, A., Vahtera, J., Virtanen, M., & Kivimäki, M. (2010). Prospective study of workplace social capital and depression: Are vertical and horizontal components equally important? *Journal of epidemiology and community health, 64*(684–689), 2008. doi:10.1136/jech.086074
Olfson, M., & Marcus, S. C. (2010). National trends in outpatient psychotherapy. *American Journal of Psychiatry, 167*, 1456–1463.
Park, N., & Peterson, C. (2006). Values in action (VIA) inventory of character strengths for youth. *Adolescent & Family Health, 4*, 35–40.
Parks, A., Della Porta, M., Pierce, R. S., Zilca, R., & Lyubomirsky, S. (2012). Pursuing happiness in everyday life: The characteristics and behaviors of online happiness seekers. *Emotion, 12*, 1222–1234.
Parks-Sheiner, A. C. (2009). Positive psychotherapy: Building a model of empirically supported self-help. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 70*, 3792.
Pedrotti, J. T. (2011). Broadening perspectives: Strategies to infuse multiculturalism into a positive psychology course. *Journal of Positive Psychology, 6*, 506–513. doi:10.1080/17439760.2011.634817
Peeters, G., & Czapinski, J. (1990). Positive-negative asymmetry in evaluations: The distinction between affective and informational negativity effects. *European Review of Social Psychology, 1*, 33–60.
Peseschkian, N. (2000). *Positive psychotherapy.* New Delhi: Sterling Publishers.
Peterson, C. (2006a). *A primer in positive psychology.* New York, NY: Oxford Press.
Peterson, C. (2006b). The values in action VIA classification of strengths. In M. Csikszentmihalyi & I. Csikszentmihalyi (Eds.), *A life worth living: Contributions to positive psychology* (pp. 29–48). Oxford: New York, NY.
Peterson, C., Park, N., & Seligman, M. E. P. (2005). Orientations to happiness and life satisfaction: The full life versus the empty life. *Journal of Happiness Studies, 6*, 25–41.
Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. Washington, DC, New York, NY and Oxford: American Psychological Association and Oxford University Press.
Pietrowsky, R. (2012). Effects of positive psychology interventions in depressive patients? A randomized control study. *Psychology, 03*, 1067–1073. doi:10.4236/psych.2012.312158

Proctor, C., & Linley, A. (Eds.). (2013). *Research, applications, and interventions for children and adolescents: A positive psychology perspective*. New York, NY: Springer.

Radloff, L. (1977). The CES-D scale. *Applied Psychological Measurement, 1*, 385–401. doi:10.1177/014662167700100306

Rapaport, M. H., Clary, C., Fayyad, R., & Endicott, J. (2005). Quality of life impairment in depressive and anxiety disorders. *American Journal of Psychiatry, 162*, 1171–1178.

Rapp, C. A., & Goscha, R. J. (2006). *The strengths model: Case management with people with psychiatric disabilities* (2nd ed.). New York, NY: Oxford.

Rashid, T. (2005). *Positive Psychotherapy Inventory (PPTI)*. Unpublished Manuscript. University of Pennsylvania.

Rashid, T. (2008). Positive psychotherapy Positive psychology: Exploring the best in people. In Lopez Shane, J. (Ed.) *Pursuing human flourishing* (Vol. 4, pp. 188–217). Westport, CT: Praeger

Rashid, T. (2013). Positive psychology in practice: Positive psychotherapy. In Shane J. Lopez (Ed.), *The Oxford handbook of happiness* (pp. 978–993): New York, NY, Oxford University Press.

Rashid, T., & Anjum, A. (2008). *Positive psychotherapy for young adults and children handbook of depression in children and adolescents* (pp. 250–287). New York, NY: Guilford.

Rashid, T., Anjum, A., Quinlin, D., Niemiec, R., Mayerson, D., & Kazemi, F. (2013). Assessment of positive traits in children and adolescents. In A. Linley & C. Proctor (Eds.), *Research, applications and interventions for children and adolescents: A positive psychology perspective* (pp. 81–116). Amsterdam: Springer.

Rashid, T., & Ostermann, R. F. O. (2009). Strength-based assessment in clinical practice. *Journal of Clinical Psychology: In Session, 65*, 488–498.

Rashid, T., & Seligman, M. E. P. (2013). Positive Psychotherapy. In D. Wedding & R. J. Corsini (Eds.), *Current Psychotherapies* (pp. 461–498). Belmont, CA: Cengage.

Rashid, T., & Seligman, M. E. (in press). *Positive Psychotherapy: A manual*. Oxford University Press.

Rashid, T., Uliaszek, A., Stevanovski, S., Gulamani, T., & Kazemi, F. (2013, June). *Comparing effectiveness of positive psychotherapy (PPT) with dialectical behavior therapy (DBT): Results of a randomized clinical trial*. Poster presented at the Third International Positive Psychology Congress. Los Angeles, CA.

Reinsch, C. (2012). *Adding science to the mix of business and pleasure: An exploratory study of positive psychology interventions with teachers accessing employee assistance counselling* (Master's thesis). University of Manitoba, Winnipeg, Manitoba, Canada. Retrieved from http://hdl.handle.net/1993/14436

Rosenberg, T., & Pace, M. (2006). Burnout among mental health professionals: Special considerations for the marriage and family therapist. *Journal of marital and family therapy, 32*, 87–99.

Rozin, P., & Royzman, E. (2001). Negativity bias, negativity dominance, and contagion. *Personality and Social Psychology Review, 5*, 296–320.

Ruini, C., & Fava, G. A. (2009). Well-being therapy for generalized anxiety disorder. *Journal of Clinical Psychology, 65*, 510–519.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well–being. *Journal of Personality and Social Psychology, 57*, 1069–1081.

Scheel, M. J., Davis, C. K., & Henderson, J. D. (2012). Therapist use of client strengths: A qualitative study of positive processes. *The Counseling Psychologist, 41*, 392–427. doi:10.1177/0011000012439427

Scheier, M. F., Carver, C. S., & Bridges, M. W. (1994). Distinguishing optimism from neuroticism (and trait anxiety, self-mastery, and self-esteem): A reevaluation of the life orientation test. *Journal of Personality and Social Psychology, 67*, 1063–1078. doi:10.1037/0022-3514.67.6.1063

Schrank, B., Bird, V., Tylee, A., Coggins, T., Rashid, T., & Slade, M. (2013). Conceptualising and measuring the well-being of people with psychosis: Systematic review and narrative synthesis. *Social Science and Medicine, 92*, 9–21. doi:10.1016/j.socscimed.2013.05.011

Schueller, S. (2010). Preferences for positive psychology exercises. *The Journal of Positive Psychology, 5*, 192–203.

Schueller, S. M., & Parks, A. C. (2012). Disseminating self-help: positive psychology exercises in an online trial. *Journal of Medical Internet Research, 14*, e63. doi:10.2196/jmir.1850

Schwartz, R. M., Reynolds, C. F., III, Thase, M. E., Frank, E., Fasiczka, A. L., & Haaga, D. A. F. (2002). Optimal and normal affect balance in psychotherapy of major depression: Evaluation of the balanced states of mind model. *Behavioral and Cognitive Psychotherapy, 30*, 439–450.

Schwartz, B., Ward, A., Monterosso, J., Lyubomirsky, S., White, K., & Lehman, D. R. (2002). Maximizing versus satisficing: Happiness is a matter of choice. *Journal of Personality and Social Psychology, 83*, 1178–1197. doi:10.1037/0022-3514.83.5.1178

Seery, M. D., Holman, E. A., & Silver, R. C. (2010). Whatever does not kill us: Cumulative lifetime adversity, vulnerability, and resilience. *Journal of personality and social psychology, 99*, 1025–1041. doi:10.1037/a0021344

Seligman, M. E. P. (2002). *Authentic happiness: Using the new Positive Psychology to realize your potential for lasting fulfillment*. New York, NY: Free Press.

Seligman, M. E. P. (2011). *Flourish: A visionary new understanding of happiness and well-being*. New York, NY: Simon & Schuster.

Seligman, M. E., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist. 61*, 774–788. doi:10.1037/0003-066X.61.8.774

Seligman, M. E., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist, 60*, 410–421. doi:10.1037/0003-066X.60.5.410

Simons, J. S., & Gaher, R. M. (2005). The distress tolerance scale: Development and validation of a self-report measure. *Motivation and Emotion, 29*, 83–102. doi:http://dx.doi.org/10.1007/s11031-005-7955-3

Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of Clinical Psychology, 65*, 467–487. doi:10.1002/jclp.20593

Sirgy, M. J., & Wu, J. (2009). The pleasant life, the engaged life, and the meaningful life: What about the balanced life? *Journal of Happiness Studies, 10*, 183–196.

Slade, M. (2010). Mental illness and well-being: The central importance of positive psychology and recovery approaches. *BMC Health Services Research, 10*, 26. doi:10.1186/1472-6963-10-26.

Smith, E. J. (2006). The strength-based counseling model. *The Counseling Psychologist, 34*, 13–79.

Spanier, G. B. (1976). Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads. *Journal of Marriage and the Family, 38*, 15–28.
Steger, M. F., & Shin, J. Y. (2010). The relevance of the meaning in life questionnaire to therapeutic practice: A look at the initial evidence. *International Forum for Logotherapy, 33*, 95–104.
Stillman, T. F., & Baumeister, R. F. (2009). Uncertainty, belongingness, and four needs for meaning. *Psychological Inquiry, 20*, 249–251.
Vella-Brodrick, D. A., Park, N., & Peterson, C. (2009). Three ways to be happy: Pleasure, engagement, and meaning: Findings from Australian and US samples. *Social Indicators Research, 90*, 165–179.
Waters, L. (2011). A review of school-based positive psychology interventions. *The Australian Educational and Developmental Psychologist, 28*, 75–90. doi:http://dx.doi.org/10.1375/aedp.28.2.75
Watkins, C. E. (2010). The hope, promise, and possibility of psychotherapy. *Journal of Contemporary Psychotherapy, 40*, 195–201. doi:10.1007/s10879-010-9149-x
Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*, 1063–1070.
Wong, W. J. (2006). Strength-centered therapy: A social constructionist, virtue-based psychotherapy. *Psychotherapy, 43*, 133–146.
Wood, A. M., Maltby, J., Gillett, R., Linley, P. A., & Joseph, S. (2008). The role of gratitude in the development of social support, stress, and depression: Two longitudinal studies. *Journal of Research in Personality, 42*, 854–871.
Wood, A. M., & Tarrier, N. (2010). Positive clinical psychology: A new vision and strategy for integrated research and practice. *Clinical Psychology Review, 30*, 819–829. doi:10.1016/j.cpr.2010.06.003
Wrzesniewski, A., McCauley, C., Rozin, P., & Schwartz, B. (1997). Jobs, careers, and callings: People's relations to their work. *Journal of Research in Personality, 31*, 21–33.
Zung, W. W. K. (1965). A self-rating depression scale. *Archives of General Psychiatry, 12*, 63–70.

Outcome Measures (in alphabetical order)

Beck Depression Inventory-II (BDI-II; *Beck, Steer, & Brown,* 1996); *Beck Depression Inventory-II -Short Form* (*BDI-SF:* Chibnall & Tait, 1994); *Beck Anxiety Inventory,* (*BAI, Beck, Epstein, Brown, & Steer,* 1988); *Brief Symptom Inventory* (*BSI:* Derogatis, 1993); *Centre for Epidemiological Studies for Depression* (*CES-D*; Radloff, 1977); *Children Depression Inventory* (*CDI;* Kovacs, 1992); *Client Satisfaction Questionnaire* (*CSQ-8*; Larsen, Attkisson, Hargreaves, & Nguyen, 1979); *Difficulties in Emotion Regulation* (*DERS*: Gratz & Roemer, 2004); *Distress Tolerance Scale* (DTS; Simons & Gaher, 2005); Dyadic Adjustment Scale (DAS; Spanier, 1976); *Emotional Quotient inventory* (EQ-I; Dawda & Hart, 2000); *Fagerstrom Test for Nicotine Dependence* (*FTND*; Heatherton, Kozlowski, Frecker, & Fagerström, 1991); *Hamilton Rating Scale for Depression* (*HRSD*; Hamilton, 1960); *Hospital Anxiety and Depression Scale*. (*HADS*; Bjelland, Dahl, Haug, & Neckelmann, 2002); *Kentucky Inventory of Mindfulness Skills*; (KIMS; Baer, Smith, & Allen, 2004); *Orientations to happiness* (Peterson, Park, & Seligman 2005); *Life Orientation Test-Revised* (*LOT-R*; Scheier, Carver, & Bridges, 1994). *Outcome Questionnaire-45* (OQ-45; Lambert et al., 1996); *Positive and negative Affect Schedule* (PANAS; Watson, Clark, & Tellegen, 1988), *Positive Psychotherapy Inventory* (PPTI; Rashid, 2005); *Positive Psychotherapy Inventory-Children Version* (*PPTI-C*; Rashid & Anjum, 2008); *Recovery Assessment Scale* (*RAS;* Corrigan, Salzer, Ralph, Sangster, & Keck, 2004); *Respiratory sinus arrhythmia (RSA;* Berntson et al., 1997; measures the degree of respiration-linked variability in the heart rate); *Satisfaction with Life Scale* (*SWLS*; Diener, Emmons, Larsen, & Griffin, 1985); *Savoring Beliefs Inventory* (*SBI*; Bryant, 2003); *Scales of Well-being* (*SWB*; Ryff, 1989); *Social Skills Rating System* (*SSRS*; Gresham & Elliot, 1990); *Structured Clinical Interview for DSM-IV-Axis I* (*SCID*; First, Spitzer, Gibbon, & Williams, 2007); *Students' Life Satisfaction Scale* (*SLSS*; Huebner, 1991); Symptom Checklist090-Revised (SCL-90-R; Derogatis, 1994); *The social functioning scale* (*SFS*; Birchwood, Smith, Cochrane, & Wetton, 1990); Values in Action (*VIA-Youth*; Park & Peterson, 2006); Zung Self-Rating Depression Scale (ZSRS; Zung, 1965).