POSITIVE PSYCHOLOGY IN CLINICAL PRACTICE

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■ **Abstract** Positive psychology is the scientific study of positive experiences and positive individual traits, and the institutions that facilitate their development. A field concerned with well-being and optimal functioning, positive psychology aims to broaden the focus of clinical psychology beyond suffering and its direct alleviation. Our proposed conceptual framework parses happiness into three domains: pleasure, engagement, and meaning. For each of these constructs, there are now valid and practical assessment tools appropriate for the clinical setting. Additionally, mounting evidence demonstrates the efficacy and effectiveness of positive interventions aimed at cultivating pleasure, engagement, and meaning. We contend that positive interventions are justifiable in their own right. Positive interventions may also usefully supplement direct attempts to prevent and treat psychopathology and, indeed, may covertly be a central component of good psychotherapy as it is done now.

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INTRODUCTION

In this chapter, we summarize advances in the field of positive psychology and propose a complementary relationship between positive psychology and clinical psychology "as usual." We begin with a brief history of positive psychology and its influences. We then propose a conceptual framework and review recently developed measures of well-being, strengths, engagement, and meaning. We consider explicit positive interventions aimed at preventing and treating psychopathology, and we explore the possibility that positive psychology is covertly one central component of good psychotherapy even as it is done now. Finally, we offer a vision of the future and the criteria by which, a decade from now, the usefulness of positive psychology in clinical practice might be judged.

We attempt some generalizations about the definitions, assumptions, and future of positive psychology, and we use the locution "positive psychologist" frequently. However, we emphasize that this, like all growing scientific disciplines, is a wooly field with diverse and conflicting views, and our opinions are simply our own.

POSITIVE PSYCHOLOGY DEFINED

Positive psychology is the scientific study of positive experiences and positive individual traits, and the institutions that facilitate their development. A field concerned with well-being and optimal functioning, positive psychology may at first glance seem peripheral to mainstream clinical psychology. We believe otherwise. That is, we believe that persons who carry even the weightiest psychological burdens care about much more in their lives than just the relief of their suffering. Troubled persons want more satisfaction, contentment, and joy, not just less sadness and worry. They want to build their strengths, not just correct their weaknesses. And, they want lives imbued with meaning and purpose. These states do not come about automatically simply when suffering is removed. Furthermore, the fostering of positive emotion and the building of character may help—both directly and indirectly—to alleviate suffering and to undo its root causes.

Psychology Since World War II

American psychology after World War II took as its main mission the assessment, understanding, and treatment of mental illness. We have made admirable progress with this mission. We now measure previously fuzzy concepts such as depression, schizophrenia, and anger with considerable precision. Empirically validated treatments exist for at least a dozen mental disorders and near cures for two others (i.e., panic disorder and blood-injection-injury phobia) (Barrett & Ollendick 2004, Hibbs & Jensen 1996, Kazdin & Weisz 2003, Nathan & Gorman 2002, Seligman 1994). Rigorous random assignment studies have shown certain psychotherapies

to be as effective as, and perhaps longer-lasting than, most medications. More recently, clinical psychologists have tried to prevent mental illness, and here, too, several interventions have been validated empirically (e.g., Evans & Seligman 2004; Weissberg et al. 2003).

Over the past half century, there has been an explosion in research on the root causes of psychopathology. In particular, we have learned a great deal about the genetics of mental disorder, for example linking specific genes to the regulation of dopamine and serotonin activity (DiMaio et al. 2003, Malhotra et al. 2004, Sen et al. 2004, Turakulov et al. 2004). We have identified acute environmental stressors such as parental divorce, job loss, and the death of a spouse, as well as chronic stressors such as poverty and prejudice. More broadly, the nature-nurture debate has evolved into a far more complex and productive endeavor, involving the investigation of dozens of genes, hundreds of possible gene-gene interactions, and innumerable gene-environment covariations and interactions that together create mental disorder.

By focusing on bad events and innate vulnerabilities, researchers and practitioners have taken a fruitful head-on approach to understanding the etiology of mental disorder. It is possible, however, that a "build-what's-strong" approach to therapy may usefully supplement the traditional "fix-what's-wrong" approach. Although good therapists likely both remediate deficits and build competencies in their clients, historically there has been more empirical attention and explicit training given to the former than to the latter. Consider, for example, cognitive behavioral therapy (CBT), which teaches clients to identify and fight negative automatic thoughts. This particular fix-what's-wrong approach has been proven scientifically to be effective: Hundreds of clinical trials and more than a dozen meta-analyses have compared CBT favorably with alternative psychotherapies, some medications, and no-treatment, wait-list, and placebo control conditions (see Butler & Beck 2000 for a review).

In contrast, very little empirical research has explored the role of positive emotions and of strengths in prevention and treatment. For instance, no published study has tested whether savoring high moments undoes ruminating over low ones. No randomly assigned experiment has quantified the therapeutic effect of identifying one's highest talents and strengths of character. There are no hard data on whether humor would be an effective adjunct treatment to CBT or whether increased gratitude exercises decrease depressive disorder.

Positive psychology aims to broaden the focus of clinical psychology beyond suffering and its direct alleviation. Introduced as an initiative of Martin Seligman in 1998, then president of the American Psychological Association, positive psychology is the scientific study of strengths, well-being, and optimal functioning. Viewing even the most distressed persons as more than the sum of damaged habits, drives, childhood conflicts, and malfunctioning brains, positive psychology asks for more serious consideration of those persons' intact faculties, ambitions, positive life experiences, and strengths of character, and how those buffer against disorder.

Distinguished Ancestors and Contemporary Cousins

Positive psychology has many distinguished ancestors and modern cousins. Since at least the time of Socrates, Plato, and Aristotle, the "good life" has been the subject of philosophical and religious inquiry. And, as the field of psychology took shape over the eighteenth and nineteenth centuries, all of the great psychological traditions—psychoanalysis, behaviorism, cognitive therapy, humanistic psychology, and existential psychology—contributed to our current understanding of the positive aspects of human experience. Consider, for example, the influence of Freud's (1933/1977) notion of the pleasure principle, Jung's (1955) ideas about personal and spiritual wholeness, Adler's (1979) conceptualization of "healthy" individual strivings as motivated by social interest, and Frankl's (1984) work on finding meaning under the most dire human circumstances.

Humanistic psychology is the field most identified with the study and promotion of positive human experience. In a special positive psychology edition of the *Journal of Humanistic Psychology*, contributors traced the roots of positive psychology to the academic humanist psychology movement (cf. Resnick et al. 2001). The grandparents of humanistic psychology—Carl Rogers, Abraham Maslow, Henry Murray, Gordon Allport, and Rollo May—all grappled with many of the same questions pursued by positive psychologists (Sheldon & Kasser 2001). What is the good life? When are individuals at their best? How can we encourage growth in ourselves and in others? What does it mean to be authentic? How can therapists build personal responsibility? Carl Rogers's client-centered therapy developed from his belief that individuals have the power to move themselves toward better functioning by discovering and expressing their authentic selves (Rogers 1961). Of central interest to Maslow (1962) was the process by which individuals could become self-actualized, a state in which they had access to the full range of their talents and strengths. These talents and strengths, which Maslow cited as characteristic of a self-actualized person, are very much the subject of current positive psychology research (Peterson & Seligman 2004). Indeed, Maslow included a chapter entitled "Toward a Positive Psychology" in his landmark *Motivation and Personality* (1954; cited in Resnik et al. 2001).

We are optimistic that contemporary humanistic psychologists will usefully adopt the methods of mainstream psychological science to test their assumptions. Challenging the assumption that humanistic theories are not compatible with rigorous science, Sheldon & Kasser (2001) showed how rigorous research on motivation (Deci & Ryan 2000, 2002; Sheldon & Elliott 1998, 1999) supports the premises of humanistic psychology. Using causal path modeling, motivation researchers (e.g., Sheldon & Elliott 1999, Sheldon & Houser-Marko 2001) demonstrated that growth occurs when individuals pursue goals that are consistent with their core values and beliefs. In these studies, growth was operationalized as increased well-being, increased adjustment, and improved ability to set and attain self-concordant goals in the future (Sheldon & Elliott 1998, 1999; Sheldon & Houser-Marko 2001).

Marie Jahoda (1958), a contemporary of Carl Rogers and Abraham Maslow, wrote a provocative book—*Current Concepts of Positive Mental Health*—that made the case for understanding psychological well-being in its own right, not simply as the absence of disorder or distress. Peterson & Seligman (2004, pp. 65–66) noted that Jahoda's argument is the very premise of today's positive psychology movement. Not only did Jahoda (1958) make a compelling case for positive psychology as we now know it, she provided a framework for understanding the components of mental health (rather than mental illness). From the mental health literature of her time, Jahoda extracted six processes that contribute to mental health: acceptance of oneself, growth/development/becoming, integration of personality, autonomy, accurate perception of reality, and environmental mastery.

Decades later, Carol Ryff and colleagues (Ryff 1989, 1995; Ryff & Keyes 1995; Ryff & Singer 1996, 1998) conducted a similar survey of what different theorists have identified as the psychological components of well-being. They identified what they termed six points of convergence, most of which overlap considerably with those enumerated by Jahoda (1958). Importantly, the researchers subsequently developed a self-report measure of their six points of convergence, making it possible for researchers to explore with scientific rigor the causes, correlates, and consequences of well-being (Ryff 1989, Ryff & Keyes 1995).

The list of contemporary researchers (such as Ryff and her colleagues) who have explored positive human experience and character is extensive. Seminal work on self-efficacy by Bandura (1989); studies of giftedness, genius, and talent (e.g., Winner 2000); broader conceptions of intelligence (e.g., Gardner 1983, Salovey et al. 2002, Sternberg 1985); and expanded studies of the quality of life among psychiatric patients (e.g., Levitt et al. 1990) all provide contemporary examples of work we consider positive psychology. Applications of the accumulating body of literature on the positive human experience range from the schoolroom to the consulting room. For example, Albee (1982) and Cowen (1994) pioneered primary prevention programs based on notions of wellness, and Hayes and colleagues (Blackledge & Hayes 2001, Hayes et al. 1999) pioneered a therapy designed to help clients clarify and enact their values. In very recent years, researchers have explored the biological basis of well-being and positive human experience. Taylor and colleagues (Taylor et al. 2000, 2002) posited that women react to stress by seeking out social relationships ("tend and befriend"), a tendency that is influenced in part by oxytocin and endogenous opioid peptides; and Davidson and colleagues (Davidson 2000, Davidson et al. 2000) have identified cortical and subcortical substrates of positive emotion.

Assumptions of Positive Psychology

Positive psychologists did not invent positive emotion or well-being or good character, nor were positive psychologists even among the first to usher in their scientific study. Rather, the contribution of positive psychology has been to champion these topics as worthy of mainstream scientific investigation, to bring them to the

attention of various foundations and funding agencies, to help raise money for their study, and perhaps to provide an overarching conceptual structure.

If the positive were just the absence of the negative, we would not need a positive psychology, just a psychology of relieving negative states. Similarly, if the positive were just the obverse of the negative, we could deduce everything we needed to know about the positive merely by attaching a negation sign to what we discover about the negative. An underlying assumption of positive psychology is that positive experiences and traits are not necessarily slave processes to some negative state or trait. Sometimes, of course, positive emotions and traits are simply the other end of some bipolar dimension (e.g., agony and relief), but often the positive is not yoked to the negative (cf. Chang et al. 1994, Watson et al. 1988). As early as 1959, Herzberg et al. (1959) showed that although low pay and poor work conditions led to job dissatisfaction, the absence of these factors did not lead to job satisfaction. Similarly, Bradburn (1969) showed in a series of longitudinal studies using cluster analysis that positive and negative affect represent stable, independent factors. We review more recent, compelling evidence that positive emotion represents an entirely separate psychological process, mediated by a separate neural substrate and serving an evolutionary function distinct from negative emotion (Frederickson 1998, 2001, 2003; Davidson et al. 2000).

Perhaps an example will help: Incivility leads to anger and vengeance. The opposite of incivility is the absence of incivility, which leads to no anger or vengeance. Civility, on the other hand, has positive consequences over and above the absence of incivility; it leads to cooperation, friendly alliances, and loyalty. We believe that many of the positive states and traits add factors that cannot be deduced from the mere absence of their negative counterparts. Most centrally, we suggest that the mere relief of suffering does not lead to well-being; it only removes one of the barriers to well-being. Well-being is a process over and above the absence of depression, anxiety, and anger.

The methodological approach of positive psychology is simple: normal descriptive science of just the sort that made clinical research scientifically respectable. Positive psychologists strive for parallel classification systems, reliable, stable, and valid methods of assessment, prospective longitudinal studies, experimental methods, and efficacy and effectiveness studies of interventions. There is one important difference: Empirically, positive psychology is about where clinical research was in the early 1970s. For many constructs of interest to positive psychologists, assessment tools are still in development, longitudinal studies have just begun, and interventions are in pilot form.

Recognizing the relative youth of the field, leaders of the Positive Psychology Network (M.E.P. Seligman, chair) have sought to create a critical mass of academic interest and funding. The purpose of these efforts is twofold: first, to accelerate progress, and second, to promote cross-fertilization of ideas. Several annual conferences are now held, including an International Positive Psychology Summit cosponsored with the Gallup Organization (now in its sixth year), a Positive Psychology Summer Institute for assistant professors and advanced

graduate and postdoctoral students (now in its fifth year), and the European Positive Psychology Summit (with its third meeting to be held in Portugal in 2006). Several listservs (e.g., Friends of Positive Psychology, friends-of-pp@lists.apa.org) and Web sites (e.g., www.positivepsychology.org; www.authentichappiness.org) facilitate communication, and several books and special editions of journals summarize in more detail many of the important findings to date (e.g., *Special Edition of American Psychologist, Special Edition of Psychological Inquiry, Handbook of Positive Psychology, Flourishing: Positive Psychology and the Life Well-Lived*, and *A Psychology of Human Strengths*). Finally, public and scientific interest in positive psychology research is stimulated through prizes (e.g., Templeton Positive Psychology Prize, Seligman Award for Outstanding Dissertation Research), grants (e.g., Templeton Young Scholars Grants, VIA research awards), and fellowships (e.g., Templeton Medici II graduate, junior, and senior fellowships).

CONCEPTUAL ORGANIZATION: THE PLEASANT LIFE, THE ENGAGED LIFE, AND THE MEANINGFUL LIFE

We believe the word "happy" is scientifically unwieldy. We parse the subject matter of positive psychology into three domains; three kinds of lives exemplify each domain (Seligman 2002). We do not believe that these three kinds of happiness are either exclusive or exhaustive, but we consider them a beginning and scientifically useful. The first domain, the pleasant life, concerns positive emotion about the past, present, and future. Positive emotion about the past includes contentment, satisfaction, and serenity. Positive emotion about the present includes the somatic pleasures (i.e., immediate but momentary sensory delights) and the complex pleasures (i.e., pleasures that require learning and education). Positive emotion about the future includes optimism, hope, and faith. The pleasant life is a life that maximizes positive emotions and minimizes pain and negative emotion. This captures what is usually intended by the class of hedonic theories of happiness.

The second domain is the engaged life, which consists of using positive individual traits, including strengths of character and talents. By strengths of character, we mean qualities considered virtuous across cultures and historical eras (e.g., valor, leadership, kindness, integrity, originality, wisdom, and the capacity to love and be loved). Strengths are distinguished from talents insofar as they appear more malleable and subject to volition, and insofar as they are worthy ends in themselves and not just means to a greater end. A life led around these traits comes close to what Aristotle called "eudaimonia" or the "good life," but because of the confusion of this concept with that of champagne and Porsches, and because the wise deployment of strengths and talents leads to more engagement, absorption, and flow, we call this life the "engaged life."

The third domain of positive psychology is the meaningful life, which entails belonging to and serving positive institutions. Historically, sociologists, anthropologists, and political scientists have studied these, but have taken greater interest

in the disabling institutions and conditions such as the "isms"—racism, sexism, and ageism. Positive psychology asks, "What are the institutions that enable the best in human nature?" An incomplete list of institutions that can cultivate positive emotion and positive traits includes mentoring, strong families and communities, democracy, and a free press. We believe that positive traits and positive emotions flourish best in the context of positive institutions. Because meaning derives from belonging to and serving something larger than oneself, a life led in the service of positive institutions is the meaningful life.

Again, the term "happiness" has no theoretical place inside this conceptual structure, except as the name of the field (just as "cognition" names a field, but plays no theoretical role). We see each of these three lives, the Pleasant Life, the Engaged Life, and the Meaningful Life, as three different roads to happiness, each with its own respectable provenance. We turn next to assessment in the clinical setting of pleasure, engagement, and meaning, and then to relevant interventions.

ASSESSMENT

The conclusions of positive psychology research are only as valid as their measures. Recognizing this fact, positive psychology has devoted considerable energy toward the development of reliable, stable, and valid assessment. In some cases, such instruments predated the positive psychology endeavor, but, for the most part, the validation and dissemination of these measures has been accelerated by a community of positive psychologists eager to make use of them in their own areas of interest. We review below assessment strategies for positive psychology constructs of particular relevance to clinical psychology; for a more exhaustive review, see Lopez & Snyder (2004).

Measuring Subjective Well-Being

Subjective well-being, defined as "a person's cognitive and affective evaluations of his or her life" (Diener et al. 2002, p. 63) is, strangely, seldom measured in studies of psychopathology. Considering the components of well-being—the presence of positive emotion, the absence of negative emotion, and a cognitive judgment of satisfaction and fulfillment—and its subjective importance to even the most troubled individuals, this omission is regrettable. Lubin & Van Whitlock (2004, p. 12), who recently developed a brief measure of life satisfaction specifically for the clinical setting, have observed that more commonly used symptom checklists are not always as productive as hoped: "Sometimes, patients later say that they thought of checking some items, but did not do so because they sounded too negative or self-condemnatory. On the other hand, areas rated high in satisfaction may indicate sources of potential resources, strengths, or supports that may be useful in building successful interventions."

Thus, one motivation for including well-being measures is that they bring to the attention of clients and therapists areas of high functioning easily overlooked or

taken for granted. Another benefit, from a research perspective, is a more complete understanding of the psychological processes underlying disorders. For instance, in a clinical psychiatric sample, Heisel & Flett (2004) discovered that satisfaction with life accounts for significant additional variability in suicide ideation beyond what is accounted for by negative psychological factors. In a longitudinal study involving adolescents, Suldo & Huebner (2004) showed that youths who express positive life satisfaction are less likely to act out in the face of stressful life events.

Among the most widely used well-being measures are the five-item Satisfaction with Life Scale by Diener et al. (1985), the four-item Subjective Happiness Scale (Lyubomirsky & Lepper 1999), and the two-item Fordyce Happiness Measures (Fordyce 1988). These self-report measures correlate highly with one another (*r*'s about 0.8), expert ratings, experience sampling measures, memory for positive versus negative life events, reports of family and friends, and amount of smiling (Sandvik et al. 1993). Because depression and well-being correlate inversely, but not perfectly inversely, we generally recommend at least two quick emotion measures for most therapy sessions: the Center for Epidemiologic Studies Depression Scale (Radloff 1977) and the Satisfaction with Life Scale (Diener et al. 1985). Both measures are free and may be used without permission from the authors.

Self-report scales are particularly appropriate given the privileged position of the individual in evaluating his or her own experience of well-being. However, given the possibility of response bias, memory bias, and other artifacts, we recommend a multimethod approach when practical. Clinical researchers in particular should consider including informant reports, diaries, structured interviews, or other supplements to self-report questionnaires. Although global, retrospective reports of subjective well-being reveal how a person evaluates his or her life as a whole, they do not reveal the processes by which people construct such global judgments. Moreover, several studies (e.g., Schwarz & Strack 1999, Diener & Oishi 2005, Thomas & Diener 1990) have demonstrated that self-reported judgments of well-being, although moderately stable over time (Magnus et al. 1993), are also influenced by mood, the valence of salient information, and beliefs about happiness that are at least in part culturally determined.

Measuring Strengths of Character

The second happy life, the engaged life, consists of using one's strengths and talents to achieve flow, and demands measuring positive character traits: talents, interests, and strengths. The measurement of talent and interest has been discussed at length elsewhere, so we focus on the measurement of strengths and virtues here. In 2004, Peterson & Seligman published the *Classification of Strengths*, a first attempt at a positive psychology classification to complement the *Diagnostic and Statistical Manual* (*DSM*) of the American Psychiatric Association (1994). Following the example of the DSM, but attempting to correct for its shortcomings (e.g., overly heterogeneous diagnostic entities, categories rather than continua, inattention to the individual's setting and culture, and a subordination of validity issues to those

of reliability), the *Classification of Strengths* proposes 10 criteria for the 24 human characteristics, of the hundreds initially considered, that were determined to be strengths of character. These criteria are neither necessary nor sufficient conditions for character strengths, but rather are pertinent features that, taken together, capture a "family resemblance" (cf. Wittgenstein 1953). A character strength is valued in its own right, even in the absence of obvious beneficial outcomes; the display of a strength by one person does not diminish other people in the vicinity; and a character strength is embodied in consensual paragons, either real, apocryphal, or mythic, who exemplify the strength.

The strengths are organized into six virtues, broad categories of moral excellence that emerged consistently from historical surveys: wisdom and knowledge, courage, love, justice, temperance, and transcendence. The *Classification of Strengths* can be distinguished from previous attempts to classify good character by its simultaneous concern with assessment. Two self-report inventories, the Values in Action Inventory of Strengths and the Values in Action for Young People, have been refined and validated using very large samples (n = 200,000) of English-speaking respondents who accessed the surveys on the Internet (www.authentic happiness.org): All subscales for both measures have satisfactory alphas (>.70), test-retest correlations for all scales over a four-month period are substantial (>.70), and scores are skewed to the right but still show variation. More detailed progress reports on reliability and validity can be found in Park & Peterson (2005), Peterson et al. (2005), and Peterson & Seligman (2004). Translated versions of the Values in Action Inventory in Chinese, Japanese, German, Urdu, Norwegian, and Spanish are now under development, as are structured interviews and measures that rely on informant reports.

Although the Values in Action Inventory of Strengths and Values in Action for Young People have not yet been used extensively in clinical populations, their potential as a diagnostic tool is easy to imagine. As a complement to self-report batteries quantifying weaknesses such as selfishness, narcissism, and delinquency, these inventories may reveal to both client and therapist strengths upon which to build the foundations of a treatment strategy (Saleebey 1992, Seligman & Peterson 2003). In fact, Peterson & Seligman (2004) have suggested that the "real" psychopathologies, the ones that cut nature at the joints, are the absence of these strengths, and not congeries of symptoms like depression and substance abuse. But that deep question is for another day.

Measuring Engagement and Flow

The engaged life consists of using one's strengths and talents to meet challenges. Engagement and flow are the usual reward of deploying strengths and talents. Engagement does not generate pleasure in the hedonic sense, but is a qualitatively different sort of gratification. Flow is the experience associated with engaging one's highest strengths and talents to meet just-doable challenges (Csikszentmihalyi 1990). Loss of consciousness characterizes such complete immersion: Time stops

for us, we concentrate, we feel completely at home. Although we often say "Wow!" or "That was fun" afterward, we are not usually referring to a past hedonic event, but rather to the fact that we were totally engaged, completely focused on the endeavor, "one with the music," and that all thoughts and feelings were blocked. Flow is devoid of thought and feeling. This void may be the result of the withdrawal of all psychological resources that subserve thought and feeling and their redeployment to concentration on the task. Importantly, flow is distinct from pleasure insofar as it is not introspectable in the moment. Although therapists are familiar with instruments to measure the contrasting states of boredom, anxiety, and apathy, flow is a construct whose potential application to the therapeutic setting is almost entirely unexplored.

Several self-report assessment strategies exist for measuring flow, including semistructured interviews, questionnaires, and the experience sampling method (ESM). The semistructured interview is the "approach of choice in studies directed toward rich, integrated description" (Nakamura & Csikszentmihalyi 2002, p. 93). Paper-and-pencil measures [e.g., the Flow Questionnaire (Csikszentmihalyi & Csikszentmihalyi 1988) and the Flow Scale (Mayers 1978)] are more expedient, of course, and appropriate "when the goal is not to identify but instead to measure dimension of the flow experience and/or differences in its occurrence across contexts or individuals" (Nakamura & Csikszentmihalyi 2002, p. 93).

ESM is the most widely used approach for measuring flow, and it is not limited by reliance on retrospective evaluation (Csikszentmihalyi & Larson 1987). In ESM, subjects are paged periodically and asked to fill out questionnaires describing the moment at which they are paged. The ESM technique in general, and flow theory in particular, suggests a novel approach to therapy that capitalizes on existing patterns in everyday behavior and experience. ESM may reveal to both patients and therapists activities that are intrinsically rewarding. An illustrative case study reported by Delle Fave & Massimini (1992) involved a young Italian woman who was struggling with agoraphobia. Informed by nine weeklong ESM samples and the results of a flow questionnaire, this woman was helped to reallocate her time and attention away from homebound, passive activities such as TV viewing, and toward activities in high-challenge, high-skill situations such as volunteer work and socializing. Over the course of one year, the symptoms of agoraphobia were eliminated and drug treatment was discontinued.

Measuring Meaning

The third happy life, the meaningful life, consists of attachment to, and the service of, something larger than oneself. Baumeister & Vohs (2002) pointed out that the "something" to which individuals choose to connect varies widely. Some find meaning in their connection to family and friends or to church, synagogue, or mosque; others find greatest meaning in their work, or perhaps in a serious avocation. Individuals almost invariably seek meaning not from a single source, but rather from multiple, overlapping attachments. Although a common symptom

of depression and substance abuse is emptiness, or the lack of perceived meaning in life, therapists outside of the humanistic-existential tradition are not trained to focus on meaning as a route to relieving disorder, and almost no therapists are trained to measure meaning.

Because the choice of context wherein individuals seek meaning is individual and often idiosyncratic, methods for measuring meaning are often open-ended. Primarily, researchers study meaning-making through interviews that allow for the exploration of a variety of topics (e.g., Davis et al. 1998, Gardner et al. 2001). McAdams and colleagues (McAdams et al. 2001) have developed a two-hour interviewing technique in which participants are asked to consider their life as if it were a book. Participants are asked to describe specific scenes, including a high point, a low point, a turning point, and an earliest memory, as well as important scenes from childhood, adolescence, and adulthood. Afterward, the participant is asked about important characters in the story, future chapters, and life-story motifs and messages.

A second category of measures is based on written narratives, often about a significant life event, a life transition, or a period of struggle (e.g., Bauer & McAdams 2004, Pennebaker 1988). Although considerable evidence exists about the physical and psychological benefits of writing about traumas and periods of struggle (e.g., Esterling et al. 1999, Smyth 1998, Smyth et al. 1999), evidence is only beginning to accumulate about what happens when people write or talk about their highest moments (e.g., Burton & King 2004). Moreover, research employing life narrative measures tends to consider candid and disclosing writing as an intervention rather than as a diagnostic tool (Niederhoffer & Pennebaker 2002).

We recommend two self-report measures that focus on the meaning-making process rather than on its target. The widely used, 20-item Purpose in Life test (Crumbaugh & Maholick 1969) is a unidimensional measure of how meaningful a respondent judges his or her life to be. The Orientations to Happiness questionnaire by Peterson et al. (2005) asks respondents to endorse three different ways to be happy: through pleasure, through engagement and flow, and through meaning.

TREATMENT AND PREVENTION

The first sentence we hear from our clients is often, "Doctor, I want to be happy." Until recently, there was little to justify our thinking that we could make our clients happier, but there was ample evidence to justify our thinking that we could reduce their disorders and negative emotions. This state of affairs is beginning to change, and we now believe that we can actually bring more pleasure, engagement, and meaning into clients' lives, and not just reduce depression, anxiety, and anger. Relieving the negatives, even in the rare event that we are completely successful, does not bring about "happiness"; the skills of pleasure, engagement, and meaning are supplementary to the skills of fighting depression, anxiety, and anger. Further, we believe that the job of the therapist of the future will not be simply to

relieve the negative, but to help clients build the pleasant life, the engaged life, and the meaningful life. We call the techniques that build these three lives "positive interventions."

Why We Think Positive Psychology Interventions Will Work

We believe that positive psychology interventions are worthwhile in therapy for two reasons. First, positive interventions, by definition, build pleasure, engagement, and meaning, and we believe they are therefore fully justifiable in their own right. Second, we believe that building positive emotion, engagement, and meaning may actually counter disorder itself.

Evidence is mounting for the "undoing effect" of positive emotions. Fredrickson (1998) demonstrated that positive emotion induced in the lab caused negative emotion to dissipate more rapidly. In a subsequent study, Tugade & Fredrickson (2004) found that positive emotions also serve to undo the cardiovascular aftereffects of negative emotions (e.g., increased heart rate, increased blood pressure, increased vasoconstriction). A final benefit of positive emotions, demonstrated by Tugade & Fredrickson (2004), is that they appear to help individuals find positive meaning in stressful situations. Frederickson & Joiner (2002) have speculated that there exists an "upward spiraling" effect of positive emotion and broadened thinking: Individuals who experience positive emotions are more likely to find meaning in negative events, and this meaning-making in turn leads to greater positive emotion.

More broadly, resilient individuals experience more positive emotions (Block & Kremen 1996, Klohnen 1996, Tugade & Fredrickson 2004). Resilient college students tested before and after the September 11, 2001, terrorist attacks provided a striking example of this association. In the wake of the attacks, they experienced gratitude, interest, love, and other positive emotions. Mediational analyses showed that these positive emotions buffered trait-resilient individuals against depression (Fredrickson et al. 2003) and that positive emotion completely mediated resilience. A review of the literature on resilience and positive emotions adds further support to the notion that positive emotions buffer individuals from stress (Folkman & Moskowitz 2000).

A review of psychotherapy effectiveness research suggests that positive psychology may already be a critical and implicit (though unnamed and untrained) component of effective therapy as it is done now (Seligman & Peterson 2004). Large-scale outcome studies have shown that most individuals experience substantial benefits from therapy (Seligman 1995, 1996; Smith & Glass 1977). And, importantly, when one active treatment is compared with another active treatment, specificity tends to disappear or is reduced to a small effect (Elkin et al. 1989, Luborsky et al. 1975, Smith & Glass 1977). Furthermore, there is a large placebo effect in almost all studies of psychotherapies and drugs (Kirsch & Saperstein 1998). What is going on?

Many of the relevant explanations are called "nonspecific factors"; however, careful consideration of these nonspecific factors reveals that many are strategies

suggested by positive psychology research and theory. One such strategy is instilling hope (Seligman 1991, Snyder et al. 2000). Another is the building of buffering strengths such as courage, interpersonal skill, insight, optimism, authenticity, perseverance, realism, pleasure capacity, future-mindedness, personal responsibility, and purpose (Seligman 2002). A final illustrative strategy is narration. Telling the stories of one's life and retelling them from a new perspective can be a transformative experience (Csikszentmihalyi 1993, Pennebaker 1997). With more systematic evaluation, new therapists can be taught what skilled therapists have learned through intuition or experience, and the positive psychology perspective provides a rich framework through which we can interpret these strategies. Could it be that these positive strategies are active, specific ingredients, and when they are tested empirically and in isolation, they will be found to relieve disorders? We think so, and thus we turn to a review of explicit, evidence-based positive interventions.

Evidence-Based Positive Interventions

At least one hundred positive interventions have been suggested, from the Buddha to Tony Robbins. Which ones actually work? Which make people lastingly happier and which actually relieve negative states? Several have been tested in controlled designs as well as in random-assignment placebo controlled designs, and have been found efficacious.

Fordyce (1977, 1983) was among the first empirical researchers to develop and test a happiness intervention. Basing his intervention on the premise that "happy is as happy does," Fordyce surveyed research on characteristics of happy people, focusing in particular on habits within the short-term control of most individuals. In one study, Fordyce randomly assigned intact community college classes to an intervention condition involving detailed instruction on strategies for increasing happiness (e.g., keep busy and be more active, spend more time socializing), and control groups who received no information at all or who received instruction about happiness-increasing strategies in summary form only. Students in the intervention condition were happier, less anxious, and less depressed at the end of the term than were participants in either control group. Among participants in the intervention group who returned the survey 9 to 18 months later, most reported continued happiness increases. Fordyce's contribution to the field is substantial because he demonstrated the possibility of making people happier. And, although his follow-up sample may have been biased toward happier individuals, the results suggest that a lasting change in happiness is at least possible.

Burton & King (2004) employed a random-assignment, placebo-controlled design to test the effect of a writing intervention on mood and physical health. For 20-minute intervals on three consecutive days, participants in the intervention condition wrote about intensely positive experiences, and participants in the control group wrote about relatively neutral subjects (e.g., their schedule, their bedroom, and their shoes). Writing about positive experiences caused a short-term boost in mood; unfortunately, the researchers did not assess mood beyond the third day of

writing. However, they did find that participants in the intervention group made fewer visits to the health center over the next three months.

Emmons & McCullough (2003) found that participants randomly assigned to a gratitude intervention showed increased positive affect relative to control participants. Specifically, they asked participants in the gratitude condition to write about five things for which they were thankful, every week for 10 weeks. In two control conditions, participants wrote about either daily hassles or neutral life events. All participants were asked to complete weekly ratings of how they felt about life as a whole [from −3 (terrible) to +3 (delighted)]; weekly ratings about their expectations for the week to come [from −3 (pessimistic) to +3 (optimistic)]; and weekly ratings of how connected they felt to others [from −3 (isolated) to +3 (well-connected)]. Relative to the control groups, participants in the gratitude condition reported feeling better about their lives in general, more optimistic about the coming week, and more connected with others. They also demonstrated more positive affect and less negative affect (as measured by a 30-item survey).

In a follow-up study, gratitude journals were kept daily for two weeks; control participants wrote about ways they were better off than were others, or about neutral events. In addition, the researchers collected observer reports of participants' positive affect, negative affect, and global life satisfaction. The positive effects found in the first study were replicated; in addition, the observer reports indicated that participants were higher in life satisfaction and positive affect (but not lower in negative affect).

Lyubomirsky et al. (2005) explored a "count your blessings" intervention. Participants in a no-treatment control condition were compared with participants who either counted their blessings once per week or three times per week. At the end of the six-week study, only those participants who counted their blessings once per week were happier. The authors suggested that a "less is more" philosophy may prevent habituation in some happiness interventions.

In a six-week kindness study (Lyubomirsky et al. 2005), participants in a no-treatment control condition were compared with participants asked to perform five acts of kindness all in one day and another group of participants asked to perform five acts of kindness spread out over one week. Interestingly, only the students who performed acts of kindness all in one day were happier than were the others, as measured by Lyubomirsky's four-item Subjective Happiness Scale (Lyubomirsky & Lepper 1999). The authors speculated that the passage of time between acts of kindness kept the exercise fresh, thereby preventing habituation. Alternatively, the day in which five acts of kindnesses are performed may be considered a larger and more concentrated "dose" of intervention.

In a rigorous random-assignment placebo controlled Internet study with 471 participants, Seligman and colleagues (M.E.P. Seligman, T.A. Steen, C. Peterson, manuscript in preparation) compared five positive psychology interventions with a placebo control exercise. Participants completed happiness and depression surveys (the Steen Happiness Index and the Center for Epidemiologic Studies Depression

Survey, respectively) at pretest and then at one week, two weeks, one month, three months, and six months following completion of their randomly assigned exercise. One of the exercises, termed the "Three Good Things" exercise, was similar to the exercises described above by Lyubomirsky et al. (2005) and Emmons & McCullough (2003). Participants in this condition were asked to write every day for one week about three good things that happened to them and why they happened. Another exercise focused on the expression of gratitude: the "gratitude visit." Participants assigned this condition were asked to write a letter of gratitude, make an appointment with the individual to be thanked, and then read it aloud in person.

Two other exercises focused on recognizing character strengths—such as curiosity, loyalty, generosity, kindness, and spirituality—that were identified through the Values in Action Inventory (described above in Measuring Strengths of Character section). In one exercise, participants took the test and received feedback about their highest strengths. In the other, titled "Using Your Strengths," participants were given feedback about their highest strengths and were told to use a different strength in a new way every day for one week. Finally, individuals who were randomly assigned to the control exercise were asked to write about their earliest memories every night for one week.

Regardless of their assigned exercise, all participants—even those in the control group—were happier and less depressed at immediate post-test. This highlights the importance of a random-assignment placebo-controlled design in future research of this nature. It may be that the act of *doing something* assigned by a professional figure in the expectation of gain (a boost in happiness) is sufficient to lift one's spirits in the short-term.

One week later, participants in the placebo early-memory intervention had returned to their baseline levels of happiness and depression symptoms, and remained there through the six-month follow-up. Those participants who were asked to write a story about themselves at their best—titled the "You at Your Best" intervention—showed the same pattern as that of participants in the placebo intervention: an immediate boost in happiness and a reduction in depressive symptoms that did not last post-test.

The gratitude visit group had somewhat longer-lasting effects than did the early-memory placebo group and the "You At Your Best group": Participants in the gratitude visit group were markedly happier through the one-month follow-up period (the biggest quantitative effect in the study), but they had no fewer depressive symptoms than did the controls at the one-month follow-up. Thereafter they did not differ from controls.

Participants in both the "Using Your Strengths" and the "Three Good Things" interventions were no happier and no less depressed than were participants in the early-memory control group at post-test, yet they were significantly happier and less depressed than were participants in the control group at the one-, three-, and six-month follow-ups. In contrast to the gratitude visit exercise, which essentially ended after the presentation of the letter, the "Using Your Strengths" and "Three Good Things" interventions required daily effort and the exercise of skills that

continued to be used over the six months. Mediation analysis showed that participants who voluntarily continued their assigned exercise beyond the required week were more likely to experience continued benefits.

We know of only one positive psychology intervention study to date that targeted individuals with a clinical diagnosis (Grant et al. 1995). In a small and uncontrolled bibliotherapy study, 16 depressed individuals who scored 20 or higher on the Beck Depression Index and 14 or higher on the Hamilton Rating Scale of Depression read about strategies for increasing their satisfaction in various domains of life (e.g., health, self-esteem, goals, values, money, work, play, learning, creativity, love, helping, friends, children, relatives, home, neighborhood, and community). Participants met weekly for 15 weeks to discuss the assigned readings (found in Frisch 1994). After 15 weeks, none of the 13 participants who completed the intervention met the criteria for clinical depression as assessed by the Hamilton Rating Scale of Depression or the Beck Depression Inventory. At a follow-up one week later, all but one of the 13 participants had maintained their gains.

Recommendations for Future Research

The intervention studies reviewed above evaluated the efficacy of positive psychology interventions almost entirely with nonclinical participants. Some of the interventions, however, showed beneficial effects on relieving depressive symptoms as well as increasing happiness. This is not surprising, since depressive symptoms and measures of happiness correlate between $r = -.2$ and $r = -.5$ (T. Rashid & M.E.P. Seligman, manuscript in preparation). However, it strongly suggests that one way to relieve depression may be through directly building positive emotion, engagement, and meaning. So a central question for future researchers is whether interventions designed to build positive emotion, engagement, and/or meaning also benefit clinically or subclinically depressed individuals. In a random assignment study, Parks & Seligman (2004) evaluated the efficacy of a six-week positive intervention consisting of six exercises designed to increase pleasure, engagement, and meaning as a means of treating depressive symptoms in mildly to moderately depressed young adults. Results were promising: Participants who received the positive interventions scored an average of six points lower on Beck Depression Inventory measures of depressive symptoms than did a no-intervention control group at the end of the intervention. Positive intervention participants also experienced notable, but not statistically significant, increases in happiness measures and decreases in anxiety symptoms. The researchers are currently evaluating the efficacy of these interventions for preventing future depression.

When Parks & Seligman (2004) developed their six-week intervention for depressed students, they chose from among those exercises that Seligman and colleagues (M.E.P. Seligman, T.A. Steen, C. Peterson, manuscript in preparation) determined were most effective in isolation. Therapy never is administered with one intervention in isolation, so future research should study optimal combinations and sequencing of positive psychology exercises. For example, does it make sense to begin an intervention program with a "big bang" exercise such as the gratitude

visit exercise used by Seligman et al. (M.E.P. Seligman, T.A. Steen, C. Peterson, manuscript in preparation)? The gratitude visit produced an immediate and large impact on participants, and it may inspire commitment to exercises that require skill-building (e.g., the "Using Your Strengths" exercise that required participants to use their strengths in new and different ways every day or the "Three Good Things" exercise that required participants to note their daily blessings and write about why these blessings had happened). Or should one begin with the "Positive Introduction," which in isolation produced no impact, but as part of a package of interventions leads logically to the Values in Actions Inventory of strengths exercises, which do work? Moreover, how should antidepression techniques, such as decatastrophizing, be interlarded with sessions designed to promote positive emotion, engagement, and meaning? In addition, is the combination of CBT for depression and positive psychology interventions additive? How about antidepressant medications plus positive psychology interventions?

Our final recommendation concerns the collection and testing of new positive psychology interventions. In a review and critique of the field of positive psychology, Cowen & Kilmer (2002) reminded readers that positive psychology researchers are far from the first to contemplate the nature of happiness and how to build it. An important task for positive psychologists is to collect and consolidate ideas about how to build positive emotion, engagement, and meaning—ideas that may have their roots in philosophy, religion, or education—and then put them to rigorous empirical test.

The frontiers of research do not begin on the edge of nothing; they push ahead from a vast, fruitful landscape of older frontiers. If positive psychology is on the cusp of something new, it derives from something as old as humanity itself, the search for happiness. As researchers, our goal is to facilitate that search, shining the light of empirical inquiry on the wisdom of the past using the technology of the present.

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