Chapter 15
Positive Psychotherapy and Social Change

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Defining the Unknown: Mental Health in Clinical Psychology

The debate around health and well-being is increasingly expanding in our societies, among professionals, researchers, policy-makers, non-profit organizations, and political movements. This phenomenon reflects the relevance of this issue, at the same time shedding light on the ambiguities it endorses and the contradictory attitudes of society towards the conceptualization of mental health. We can identify at least three aspects of this debate that highlight these ambiguities and contradictions.

The first contradiction concerns the dichotomy between definition of mental health and clinical intervention. WHO (2004) defined mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community". This definition includes terms such as well-being, abilities, coping, work performance, and social contribution that are widely used in positive psychology research. However, in the same year the last version of DSM was published, in which clinical intervention was strictly confined within the pathology-focused model of disorders, symptoms, and their diagnostic classification. No reference can be found in it to resource development, personal growth, self-actualization, meaning-making, strengths and assets of the individuals.

The second ambiguity concerns the term "well-being". The WHO definition is substantially focused on individuals' performance, within a narrow Western pragmatist perspective. Well-being means doing, working, making. What about being? In this definition there is no trace of the mental health dimensions that research in the last 20 years had already identified among the basic fuel that feeds human action. The need for relatedness, positive emotions such as love and gratitude, identity building through the search for meaning, strengths such as spirituality, wisdom and equanimity find no place in WHO's definition.

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Moreover, many terms in the WHO definition are discriminatory towards some categories of citizens. Can we really consider a person who is unable to work because of quadriplegia or multiple sclerosis as lacking mental health? Can we assume that a 90-year-old woman, living in a residential community and spending her time talking with the other guests, waiting for the visits of her beloved ones and writing her memoirs is affected by some kind of mental disorder? Do we consider a hermit who spends most of his time practicing meditation, rituals, and prayer as a mentally disturbed person? And – on the contrary – what about people with Down Syndrome, labelled as mentally retarded, who are fond of gardening, work productively and fruitfully, go to the movies with their friends, and devote their free time to a non-profit organization?

Seligman (2002) proposed a definition and operationalization of *positive mental health*, by taking into account the variables and dimensions addressed by positive psychology. Similarly, the crucial conceptualization of flourishing versus languishing developed by Keyes (2003, 2007) brought the difference between presence of mental health and absence of mental illness into focus. Maddux (2008) claimed the necessity to overcome the illness ideology, deeply rooted in the biomedical model, which is still dominant in clinical psychology. This process requires a systematic overhaul of the basic assumptions underlying classification of disorders and treatment models. The findings accumulated in the last decade by researchers and professionals in positive psychology suggest that this process is not only necessary, but that the instruments to start it are already available to the clinical community.

On the basis of the empirical evidence gathered through studies in positive psychology, in the following sections we will focus on some key issues to be included in a positive mental health model, moving from the premise that health and well-being can only be evaluated by assessing the dynamic interplay between individual and environment.

Building Positive Mental Health: The Bricks

A growing number of theoretical and empirical studies in positive psychology are shedding light on the dimensions that should be considered and evaluated in clinical intervention in order to promote positive mental health. We will briefly outline the major ones.

Opportunities and Constraints

The amazing increase in facilities, material goods, pharmacological treatments, and behavioural possibilities offered by the explosion of technology has instilled in citizens of the Western world the feeling that everything can be achieved. However, this is not true, and we have to accept that various aspects of our life, environment, health, and society cannot be modified. Therefore, in line with what Epictetus said 2,000 years ago, the pathway towards happiness includes ceasing to worry about the things we cannot change. This is a crucial point to be discussed with patients in the psychotherapy process, particularly when using a positive approach. Situational

constraints can be related to any aspect of daily life. We will briefly exemplify some of them: the work and leisure settings; the health conditions; the experience of traumatic events.

In post-industrial countries the evolution of technology, the growing flexibility in work organization, and the demand for highly specialized job skills pose new challenges to the individuals as concerns job choices and work-related stress (Maslach, 1982; Maslach, Schaufeli, & Leiter, 2001; Rifkin, 1995). During the last two decades, however, theoretical and empirical studies have also explored the role of work in promoting well-being and life satisfaction (Danna & Griffin, 1999; Donaldson, Berger & Pezdek, 2006; Karasek & Theorell, 1990; Linley & Joseph, 2004; Schaufeli & Bakker, 2004; Sivanathan, Arnold, Turner, & Barling, 2004; Warr, 1999). In addition, changes in the workplace in Western countries have brought about an increasing amount of free time, and the enormous proliferation of leisure opportunities. The relationship between work and leisure is not homogeneous within a given society, but it depends on people's occupation (Parker, 1997). In particular, people involved in creative and autonomy-supporting jobs, such as artists, scientists, and specialized professionals, tend to extend their skill cultivation and level of satisfaction from work to the other areas of life. People enrolled in risky and damaging jobs compensate with leisure the frustrations and constraints of work. Finally, the great majority of today's workers, employed in neither particularly creative nor dangerous jobs, perceive work and leisure as two independent life domains, with no mutual influences (Parker, 1997).

Several studies show that active engagement in daily tasks can be used as an index of complexity and predictor of future goals and activity cultivation (Greene & Miller, 1996; Higgins & Trope, 1990). In particular, when daily activities are perceived as sources of rewarding and complex experiences, their selective cultivation provides the individual with increasingly higher challenges and skill refinement, fostering personal growth and development (Delle Fave, 2007). However, not all workers can enjoy creativity, autonomy, and engagement in their daily tasks, and work organization posits various constraints which are not always modifiable. For this reason, a more practicable way to foster complexity, self-expression, and well-being is the promotion of engagement in "serious leisure" activities (Stebbins, 1997), providing opportunities for personal growth and social awareness, and preserving an ethical dimension that has been obscured by consumer culture (1995). This strategy is also consistent with the previously described importance of finding a balance between the perceived quality of life in different domains.

Situational constraints are also experienced by people with chronic diseases and physical or mental disabilities. The disadvantages they face in daily life are not related to their biological impairments only, but also to the social attitude towards such limitations, as well as to material and organizational constraints (Delle Fave & Massimini, 2005a; Ingstad, 1999). Many people with disabilities perceive themselves as ordinary persons coping with extraordinary circumstances (Saravanan, Manigandam, Macaden, Tharion, & Bhattacharji, 2001). Supporting them in the process of adjustment to disease and to its consequences is a demanding task, and it has to be designed according to the bio-psycho-social aspects of the specific

situation: psychological features, family and social support, material and economic resources, educational background, cultural representations, and social policies (Ustün et al., 2001). It thus behooves psychotherapists and, indeed, all health workers to be aware of *all* of these factors and to take them into account in their intervention, helping the patient distinguish between aspects that can be modified (within the person, but also in the environment) and aspects that have to be accepted as they are.

A similar approach has to be adopted in the case of traumatic events. It is impossible to deny or to modify their negative nature, as well as their dramatic consequences on the person's life. As suggested by Tedeschi and Calhoun (2004), the post-traumatic growth process after trauma should be viewed as originating from the elaboration and contextualization of the event in the individual's life and representation of reality.

Balance and Harmony Across Life Domains

In a recent theoretical paper, Sirgy and Wu (2009) have proposed to expand the threefold orientation to happiness model proposed by Seligman (2002), by adding to it the contribution of balance to well-being. They define balance as a state "reflecting satisfaction or fulfilment in several important domains with little or no negative affect in other domains" (p. 185). According to Sirgy and Wu, in order to satisfy the full spectrum of human survival and growth needs, people have to be involved and actively invest their attention and resources in multiple life domains. Balance contributes to subjective well-being because of the satisfaction limit that people can derive from a single domain. Different life domains tend to focus on different human developmental needs. Moreover, an excessive investment on one or few life domains can be detrimental to well-being in other domains. The person could feel unable to devote the desired amount of time and resources to them, thus experiencing negative feelings and dissatisfaction in these neglected domains. A typical example is the widespread problem of the over-investment of psychological and material resources in work, to the detriment of family or leisure activities (Haworth, 1997).

Data collected in seven Western countries by an international team (Delle Fave, Brdar, Freire, Vella-Brodrick, & Wissing, 2010) confirmed the importance of harmony/balance as a component of well-being. When asked to provide their own definition of happiness, participants often referred to the achievement of a balance between different needs, commitments, and aspirations, using the term "harmony" to describe this condition. However, this conceptualization of harmony does not primarily convey the interpersonal nuance often associated with it (Early, 1997; Ferriss, 2002; Ho & Chan, 2009; Morling & Fiske, 1999; Muñoz Sastre, 1998). It reflects more specifically the perception of inner peace, self-acceptance, and serenity; a condition of balance and evenness that was best formalized by philosophical traditions in Asian cultures. In the Chinese language, the term used for harmony includes such meanings as "gentle", "mild", "peace", "quiet in mind and peaceful in disposition". Yan Ying (fourth century BC, quoted by Chenyang, 2008) additionally defined

harmony as mixing different things and balancing opposite elements into a whole, like in cooking and making music. From a different cultural and philosophical perspective, the Greek tradition provided similar definitions of harmony, as in the Stoics' ideal of evenness of judgment and detachment, in Plato's description of the just man – which relies on the balance between reason, spirit, and appetites – and in Epicure's concept of *ataraxia* – freedom from worries or anxiety through the ability of maintaining balance and serenity in both enjoyable and challenging times (Chenyang, 2008).

The importance of cross-domain balance clearly emerged in the WHO's definition of quality of life as a multi-componential construct (WHOQOL Group, 1994). The focus on individual's perception of different life domains allows for identifying areas of potential change or development, as well as domain-specific difficulties, resources, and strengths (WHOQOL Group, 2004).

Another study (Wu, 2009) investigated the relationship between life satisfaction and the tendency to shift the importance of life domains according to the perceived have – want discrepancy, more specifically by upgrading the domains with small have – want discrepancy. Shifting tendency resulted to be positively and significantly correlated with both global life satisfaction and average domain satisfaction.

These findings are consistent with other studies, highlighting the complex interplay between different life domains in contributing to the general QOL ratings. In particular, impairments or limitations in one domain do not significantly modify the general QOL level, which is relatively stable (Cummins, 2000). For example, no significant differences were detected in the QOL ratings between people with chronic diseases and healthy participants (Arnold et al., 2004). Adaptation, as well as the shifting tendency can contribute to this process.

The relationship between overall quality of life and well-being across life domains was also detected in a study conducted among four groups of immigrants in Italy, characterized by different country of origin, years of stay in the host country, legal immigrant status, SES, and acculturation pattern (Delle Fave, & Bassi, 2009). Participants were invited to report their daily opportunities for optimal experience – the engaging and rewarding state of deep concentration and absorption in the ongoing activity first described by Csikszentmihalyi (1975). Findings detected group differences according to the level of socio-cultural adjustment, identified with higher SES, lower cultural distance between the homeland and the hosting country, more qualified job, and availability of social and family network providing support (Ataca & Berry, 2002; Zlobina, Basabe, Paez, & Furnham, 2006). In particular, groups with better socio-cultural adjustment reported both an easier access to optimal experiences in daily life and a greater variety of associated activity domains.

Cultural Diversity

There is overwhelming evidence of major cross-cultural differences in the definition and evaluation of both well-being and psychopathology (Diener, Oishi, & Lucas, 2003; Massimini & Delle Fave, 2000; Marsella & Yamada, 2007; Park, Peterson, &

Seligman, 2006). This is not surprising: cultures shape individuals' behaviour and conception of what a good life is, both providing a meaning-making system for daily events and interactions and fostering or limiting opportunities for goal setting, personal growth, and self-expression (Ryan & Deci, 2001; Uchida, Norasakkunkit, & Kitayama, 2004).

Before or besides being individual constructs, meanings and goals derive from the cultural context and its value system (Smith, Christopher, Delle Fave, & Bhawuk, 2002). Cultural differences substantially concern the weight and the meaning attributed to collective norms, daily activities, and social roles (Massimini & Delle Fave, 2000; Triandis, 1994). For example, most human communities attribute importance to formal education. However, both the degree of relevance and the meaning of education can vary across cultures. Specific activities or behaviours do not necessarily have the same meaning or function in different cultures: therefore, we should not expect them to have an invariant relation to well-being or individual development (Deci & Ryan, 2000).

Until now, well-being research has been grounded in the Western tradition, with its individualistic features shared by a minority of nations (Triandis, 1995). However, all human cultures are concerned with well-being (Kiran Kumar, 2004; Oishi, 2000). A broader, less culture-bound interpretation frame could promote a better understanding of the cross-cultural variations in definition, operationalization, and evaluation of the related constructs. For instance, research showed that the higher levels of SWB reported by European Americans compared with Eastern Asians are clearly grounded in cultural expectations and conceptualizations (Kitayama, Markus, & Kyurokawa, 2000; Kitayama, Snibbe, Markus, & Suzuki, 2004; Rao, Paranjpe, & Dalal, 2008; Suh, 2000).

Following the seminal work about self-construal by Markus and Kitayama (1991), and on the basis of previous research (Miller, 1984; Shweder & Bourne, 1984), several studies showed that members of cultures promoting independence build mental representations of their surroundings through the identification of their specific components, focus on individual dispositions in evaluating events or behaviours, and attribute power and authority to the individual. In contrast, people belonging to cultures promoting interdependence tend to represent their environment holistically, evaluate behaviour according to situational factors and attribute power to the group. Members of independent cultures are more motivated by contexts allowing personal agency and autonomy, while members of interdependent cultures are more motivated by contexts allowing for collective agency (Hernandez & Iyengar, 2001; Menon, Morris, Chiu, & Hong, 1999; Peng & Nisbett, 1999; Shweder, 2003).

All these elements should be taken into account in the psychotherapy process. From the perspective of positive psychology, the promotion of well-being should comprise the cultural competence of the patients, which is their optimal functioning contextualized in their daily cultural environment (Leong & Wong, 2003). In non-Western cultures people with behavioural limitations derived from various disabilities and chronic pathological conditions are often more integrated in society. Together with social cohesion and low levels of individualism, lack of facilities

and specialized institutions paradoxically facilitate their active participation in the community life (Agarwal, 1995; Brown et al., 1998; Tanaka-Matsumi, & Draguns, 1997). In multi-cultural societies, minority citizens often interact with at least two social environments in their daily life: the host culture and the local community and family network from their own culture. The fitness of a given strength or coping strategy to both contexts should not be taken for granted. The process of acculturation, which comprises socio-cultural adjustment (Ward, 2001; Ward & Kennedy, 1994) and psychological adaptation, can unfold through different patterns: assimilation, separation, integration, and marginalization (Berry, 1997). These four patterns represent different degrees of co-presence of elements of the two cultures in the behaviour, experience, value system, and world outlook of the person. It is important to explore which acculturation pattern is prominent in the person's life, in order to implement those resources which are actually needed in their social context. For example, MacLachan and Carr (1994) have highlighted that in some cultures attributing the cause of mental disorders to social or supernatural causes, rather than to biological ones, can facilitate the patient's acceptance within the native community. At the same time, it is important to avoid prejudices, a priori attributing to the person from a different country culture-related stereotypical behaviours and representations of reality and of the therapeutic process. Besides empathy, which is a crucial component of the psychotherapeutic relation, openness and curiosity towards the client's expectations and acculturation pattern are essential dimensions of the therapists' attitude. They also represent basic prerequisites to build an effective intervention and to broaden their human and professional knowledge of other ways to interpret reality and to pursue well-being.

Goals and Meanings

Considering the complex pathways through which individual development unfolds, we have to acknowledge that good life is not necessarily related to good feelings. As reported by scholars from different disciplines (Bruni & Porta, 2006; Peterson, Park, & Sweeney, 2008; Ryff & Keyes, 1995; Sen, 1992), people can commit themselves to the pursuit of goals that they perceive as valuable, but that can undermine their quality of life in the short term. As suggested by several studies, the kind of goals individuals set and pursue sheds light on their level of perceived self-concordance and self-determination in goal orientation (Gong & Chang, 2007; Sheldon et al., 2004). In a set of cross-cultural studies investigating optimal experiences and their relationship with future goals, participants mostly stressed the intrinsic value over the immediate reward derived from their goals. Pursuing fulfilment in energy consuming and challenging jobs (Delle Fave & Massimini, 2003a); investing resources in parental care to promote children's well-being (Delle Fave & Massimini, 2004); cultivating psychological complexity through high-concentration and engaging activities like volunteering, prayer, and meditation (Coppa & Delle Fave, 2007) joined participants within the shared perspective of self-selected goals.

This perspective, however, can be referred to the overarching dimension of meaning-making (Emmons, 2005). Through meaning-making humans organize

their experience moment by moment (Kegan, 1994), integrating events and information into their own life history and developmental trajectory (Singer, 2004). Moreover, meaning-making is a dynamic process: throughout their lives, individuals ceaselessly revise their experiences, attribute new meanings to them, expand or narrow their own meaning system. In periods of uncertainty or change and in the adjustment to stressful events, high levels of meaning-making can counterbalance low levels of subjective well-being (Park, 2005; Park & Folkman, 1997; Shmotkin, 2005; Shmotkin, Berkovich, & Cohen, 2006). A meaning-centred coping strategy promotes adjustment and well-being in stressful situations, such as chronic disease (Emmons, Colby, & Kaiser, 1998; Folkman & Greer, 2000). In Antonovsky's construct of Sense of Coherence (SOC; Antonovsky, 1987), the attribution of meaning to life is related to the capacity to establish a coherence among different sensorial stimuli, referring them to a unitary and shared shape, or Gestalt (Amrikhan & Greaves, 2003). Several studies have highlighted that meaningfulness supports SOC even in situations characterized by low controllability or manageability. For example, the high levels of SOC reported by people with degenerative diseases are related to meaningfulness, rather than to the objectively low potential for controllability of the situation (Flannery & Flannery, 1990).

Meanings primarily stem from culture, allowing individuals to transcend their own limited self towards a wider vision of reality. Faith and religion have been specifically investigated from this perspective (Koenig, McCullough, & Larson, 2001; Sperry & Shafranske, 2005). In their turn, individuals are connected to the cultural meaningful world through processes of internalization and externalization (Vaalsiner, 2007). Individual experience of the world "transforms collective-cultural meanings into a personal-cultural system of sense" (Vaalsiner, 2007, p. 62), which undergoes a personal reconstruction and can be externalized through behaviours, goals, and strivings.

To this purpose, a distinction should be made between the long-term meaning-making process and meaning of daily activities within this lifelong perspective. Studies conducted in Western countries showed that a great majority of people spend a relevant portion of their daily time in low-challenge, low-meaning activities. Besides maintenance tasks, that are anyway related to basic needs, this is the case of unstructured leisure activities, such as buying and consuming goods, watching TV, surfing in Internet, and idling (Iso-Ahola, 1997; Larson & Verma, 1999). The quality of experience people associate to these activities is prominently negative. Boredom and apathy prevail, as well as low levels of physical and mental health (Delle Fave & Massimini, 2005b; Iso-Ahola, 1997). Intervention should take into account this problem, which is one of the prerequisites to engage in deviant behaviours or in substance abuse (Delle Fave & Massimini, 2003b; Larson, 2000) and can be related to the more general condition of languishing (Keyes, 2007).

Finally, individuals can intentionally attribute meaning to activities that are not valued or approved by the cultural context. By the way, this phenomenon is not limited to criminals, people suffering of marginalization, or substance addicts. In this case, a conflict can arise between the individual's meaning-making process and social rules and norms. The consistency or discrepancy between meanings that the

individual and the cultural environment attribute to a given activity or domain is a critical issue in psychotherapy, because it involves not only the developmental pathway of the patient, but also the ethical principles and responsibility of the therapist.

Agency and Responsibility

Agency represents a central construct within the framework of positive psychology. It has been conceptualized in various ways, but some of them are specifically relevant to positive intervention (Bassi, Sartori, & Delle Fave, 2010). According to Bandura's socio-cognitive theory, there is a deep connection between human agency and social structure (Bandura, 2001). Social systems are the products of human activity which organize, guide, and regulate human behaviour. The most distinctly human core property of agency is the metacognitive ability to reflect upon oneself and the adequacy of one's thoughts and actions. The sense of agency emerges from intentional behaviour and high self-efficacy beliefs (Bandura, 1997). Social cognitive theory distinguishes between three modes of agency: individual, proxy, and collective agency, which are strictly related in everyday functioning. Personal agency is exercised individually. However, in many spheres of functioning, people do not have direct control over conditions that affect their lives. They exercise socially mediated agency, or proxy agency, through their influence on others who have resources, knowledge, and act on their behalf. Finally, many of the things people look for are achievable only by working together through interdependent effort. In the exercise of collective agency, they pool their knowledge, skills, and resources, and act in concert to shape their future (Bandura, 2006).

From a motivational and developmental perspective, self-determination theory (Deci & Ryan, 2000) describes human agency as a process that refers to those motivated behaviours emanating from one's integrated self. To be agentic is to be self-determined, and thus to be autonomous. The prototype of autonomous activity, from which agency emerges as an integrated process, is the intrinsically motivated behaviour, which is performed out of interest and requires no separable consequence, no external or intrapsychic promises or threats. Intrinsic motivation entails curiosity, exploration, spontaneity, and interest. Intrinsically motivated behaviours are performed when individuals are free from demands and constraints, and when the context fosters volition and self-determination

The economist Amartya Sen (1992) highlighted the connection between agency, intentionality, and responsibility. The sense of agency represents the property according to which relevant and meaningful actions take into account the relation between the person, the social context, and other people's needs. This approach emphasizes the mobilization of resources, the development and implementation of abilities and skills, self-determined behaviour, the building of social competencies and interpersonal relations, the pursuit of aims and activities which are meaningful for the individual and the society. This also implies that people can actively and voluntarily commit themselves to activities, goals, or relations that are considered as important, but that do not necessarily lead to individual benefits and pleasure. Individuals can invest psychic and material resources into activities which

are relevant for the community, sometimes sacrificing – totally or partially – their own personal functioning (free time, relaxation, material goods, comforts).

As concerns application to psychotherapy, the construct of agency has two implications. First, it is of paramount importance to promote patients' awareness and active participation in the process of change, in all its components: from adherence to treatments to the adoption of a healthier lifestyle (Gregor, Zvolensky, Leen-Feldner, Yartz, & Feldner, 2006; Kipling, Forgas, & Von Hippel, 2005), from the cultivation of skills and competences to the active understanding and reinterpretation of stressful events and of their psychological consequences. Second, if we exclude the most extreme conditions, the person always has a more or less wide range of alternative activities to be engaged in during her life. A process of active selection takes place at the psychological level, leading individuals to preferentially select and pursue in their daily life activities, interests, meanings and goals (Csikszentmihalyi & Massimini, 1985; Massimini & Delle Fave, 2000). However, the evolution trend supported by psychological selection does not necessarily lead to an improvement of behaviour and quality of life. The ultimate result depends upon the type of activities and goals individuals pursue in their life. Development means growing complexity: to bring positive effects, change has to promote internal order and integration of the individual, and at the same time constructive information exchange with the environment. The outcome of an authentic development at the psychological level includes high levels of both personal and social well-being (Keyes, 1998), the latter comprising social integration as well as commitment to the improvement of the culture and of the quality of life of the others. An example of agency and responsibility promotion is the activity of CBR centres (Community Based Rehabilitation centres), whose inspiring principle is that the sustainable development of a social system has to start from the efforts of the community members, from the local awareness of priorities and from intervention strategies coherent and well suited to the local cultural background (Atkinson, Rolim Medeiros, Lima Oliveira, & Dias de Almeida, 2000). CBR centres run intervention programs in the domains of employment, welfare distribution, health care and prevention, disability, and education. Their main resources are the competence and know-how of community members, their agency and responsibility, in terms of both personal involvement and financial support of the programs.

Individual and collective agency and responsibility can be mobilized in stressful situations. Quarantelli (1985) reported that community wide behavioural data, such as the number of psychiatric hospitalizations, drug use, and police reports decreased following a devastating tornado. One of the features of growth is its interpersonal dimension. "Growthful" interactions should be facilitated to promote well-being of individual and of their communities (Joseph & Linley, 2006). Further research should be conducted on this topic in the psychotherapy perspective.

Being Versus Doing

Lanza del Vasto, a writer, philosopher, and follower of Gandhi's movement for non-violence, made a distinction between living and functioning, underlying the

superiority of the former (1944). Psychotherapists should carefully consider this issue, especially within the approach of positive psychology. The term *optimal functioning* is often used in this context. However, it is quite easy to use it interchangeably with "optimal doing". Western societies are obsessed with performance, productivity and efficiency. People are often overwhelmed by the kind of social pressures and expectations coming from work, family, and relationships. Rogers (1963), who first attempted to provide a systematic description of the fully functioning person, referred to qualities such as self-acceptance, awareness of one's strengths and weaknesses, experience of life as a process, perception of purpose and meaning in life, authenticity, openness to change, and trust in relationships and cooperation. Similarly, Maslow (1970) defined self-actualization as being what a person is able to be. In their pioneer cross-cultural classification of value orientations, Kluckhohn and Stroedbeck (1961) used the term "being in becoming", referring to the development and integration of personality. This emphasis on identity building is sometimes forgotten in psychotherapy. Patients are often focused on practical, domain-related problems, and they look for quick and effective solutions to modify the situation and remove the problem. However, as widely discussed in stress and coping research, the problem-centred coping is not always viable and valuable as a pathway towards well-being. Not all situations can be changed or controlled. Many events happen despite and beyond human intentionality and expectations. As concerns therapists, they are often focused on prescriptions, be they tablets or lists of exercises that the patients have to perform between sessions. This attitude entails a twofold problem: it adds burden to the patients' already overloaded lives, and it prevents from achieving the ultimate goal of the intervention. Echoing the Greek philosopher Epictetus, one should first decide what he/she wants to be, and then act consequently.

Eudaimonia and Hedonia

Issues such as the building of human strength in different psychotherapeutic strategies and the characteristics of subjective well-being have become increasingly important in psychological research (Diener, Suh, Lucas, & Smith, 1999; Gillham & Seligman, 1999). According to the eudaimonic perspective, well-being consists of fulfilling one's potential in a process of self-realization. Under this umbrella some clinical researchers described concepts such as fully functioning person, meaningfulness, self-actualization, and vitality. From a different perspective, the hedonic approach to well-being focuses on subjective happiness, experiencing positive emotions versus negative emotions, and satisfaction in various domains of life (Diener et al., 1999; Gillham & Seligman, 1999). These two approaches are quite different but they complement each other in the construction of optimal well-being (Ryan & Deci, 2001). However, in psychotherapy research the eudaimonic view has found much more feasibility because it concerns human potential and personal strength (Ryff & Singer, 1996). In particular, Ryff's model of psychological well-being, encompassing autonomy, personal growth, environmental mastery, purpose in life, positive relations and self-acceptance has been found to fit specific impairments of

patients with affective disorders (Fava et al., 2001; Rafanelli et al., 2002; Rafanelli et al., 2000; Ruini et al., 2002). It was thus chosen as a theoretical underpinning for a novel psychotherapeutic strategy aimed at increasing eudaimonic well-being: Well-Bing Therapy (WBT) (Fava, 1999), that will be described in detail in the next section.

Building Positive Mental Health: The Cement

After this synthetic overview of the issues that are worth analysing in positive psychotherapy interventions, we now provide some hints on evaluation instruments and clinical protocols that can be fruitfully utilized besides the traditional ones. In the clinical work, well-established and validated quantitative instruments are available to therapists, especially for the purpose of diagnosis. Most of these tools are designed to evaluate pathological symptoms, and they can be used longitudinally for monitoring changes and evidencing benefits of the therapy. The positive approach to clinical intervention has brought to the attention of professionals a wide range of new instruments that provide information on well-being and development. Since for many positive psychology constructs we are still in the identification and definition phase of research, only few of these instruments have been presently standardized and are available for professionals' clinical use.

The most popular scales assessing well-being dimensions have been extensively used with non-clinical populations, and their potential as clinical resources has still to be verified. This is true of the Satisfaction with Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985), scales assessing post-traumatic growth (Joseph & Linley, 2006), the Values in Action Inventory of Strengths (VIA-IS; Peterson & Seligman, 2004), scales assessing gratitude (Emmons & McCullough, 2003), meaning (Schlegel, Hicks, Arndt, & King, 2009; Steger, Frazier, Oishi, & Kaler, 2006), values and goals (Sheldon & Kasser, 2001). Nevertheless, their potential as diagnostic tools primarily consists in their effectiveness in revealing to both client and therapist resources upon which to build the foundations of a treatment strategy (Seligman & Peterson, 2003).

Other instruments can be useful in the clinical practice. Among scales, WHOQOL-100 – briefly referred to in the section about balance across life domains – provides details on the quality of life perceived in the daily activities and contexts. A short form is also available, the WHOQOL-Bref (Skevington, Lofty, & O'connell, 2004). Findings obtained from large cross-cultural samples showed that perceived quality of life is a good predictor of future health outcomes, such as relapses and survival rates, without the need to adopt objective measures (Idler & Benyamini, 1997; Ried, Tueth, Handberg, & Nyanteh, 2006).

The Symptom Questionnaire (SQ) (Kellner, 1987) is as self-rating scale for assessing distress (anxiety, depression, somatic symptoms, and hostility) and well-being (relaxation, contentment, physical well-being, and friendliness). It has extensively been used in clinical studies, including psychotherapy research and drug trials. Well-being scales have frequently been found to be more sensitive in detecting differences between experimental and control conditions (Kellner, 1987).

Positive psychotherapy can also derive useful information from several qualitative instruments designed for research and intervention. For example, written narratives of external and inner events and emotions have proved to be beneficial for mental and physical health (Morrow & Nolen-Hoeksema, 1990; Niederhoffer & Pennebaker, 2002; Pennebaker, 1997; Stanton et al., 2000).

Finally, experience sampling procedures can be an effective tool for evaluating the course of treatment. For example, the experience sampling method (ESM; Csikszentmihalyi & Larson, 1987; Hektner, Schmidt, & Csikszentmihalyi, 2007) provides glimpses into the real life and habits of individuals thanks to the on-line repeated self-reports that people fill out during 1-week session, describing their behaviour and experience in the daily context. This information is otherwise difficult to detect through single administration instruments and during therapy sessions. In the ESM participants directly describe themselves while interacting with their environment, be it social, material, or natural. They report their experience during activities ranging from biologically driven behaviours, such as eating and resting, to more complex and culture-related tasks, such as solving a mathematical problem, reading a book, driving a car, and watching TV.

ESM can document the daily patterns of clinical change and the behavioural and experiential features of these changes (Hektner et al., 2007). In particular, studies were conducted on the transition process of long-time heroin addicts who were adjusting to life in a residential community treatment centre (Ravenna, Hölzl, Kirchler, Palmonari, & Costarelli, 2002), and on craving during methadone therapy (deVos, Van Wilgenburg, Van den Brink, Kaplan, & DeVries, 1996). Depressed individuals were followed to assess the effects of pharmacotherapy on daily mood fluctuation and behaviour (Barge-Schaapveld & Nicolson, 2002). ESM was also used in a comparative study to evaluate the treatment of panic disorders through CBT therapy based on traditional clinical sessions conducted by a therapist, and through a computer-assisted therapy partially replacing the sessions (Newman, Kenardy, Herman, & Taylor, 1997). Norton and colleagues (2003) explored with ESM the daily life of their bulimic patients. In a case study of a woman with panic disorder and agoraphobia, Delle Fave and Massimini (1992) integrated the use of ESM into ongoing psychotherapy.

However, the only instrument which presently has a clear and thoroughly tested clinical use is Ryff's Psychological Well-Being Scales. They are used within a specific psychotherapy for enhancing well-being (Well-Being Therapy, WBT) developed by Fava (1999) and tested in controlled trials, both alone (e.g. Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998a) and in addition to CBT (e.g. Fava et al., 2004, 2005). Well-Being Therapy is based on Ryff's (1989) six dimensions of psychological well-being (PWB). The final goal of the therapist is to lead the patient from an impaired level to an optimal level in the six dimensions of psychological well-being (Fava, 1999; Fava & Ruini, 2003).

Well-Being Therapy and Its Applications

WBT is a short-term treatment designed to extend over 8–12 sessions, which may take place every week or every other week. The duration of each session may range

from 30 to 50 min. WBT emphasizes self-observation (Emmelkamp, 1974), with the use of a structured diary. It is directive, oriented on current problems which hinder sustained psychological well-being, and is based on an educational model (Fava, 1999; Fava & Ruini, 2003). It is structured so that early treatment emphasizes developing skills and capacity to sustain attention to aspects of daily experience/emotions that are positive, and subsequent sessions emphasize the promotion of psychological well-being.

WBT has been employed in several clinical studies. Other studies are currently in progress. In some cases WBT has been used alone. In other cases, it has been added to cognitive therapy using a sequential combination (first psychotherapy addressed the abatement psychological distress and subsequently the promotion of well-being). In some other cases it has been added to pharmacotherapy or behavioural treatment based on exposure. The effectiveness of well-being therapy has been tested through controlled investigation in a wide range of disorders. First of all, WBT proved to be effective in reducing the residual symptoms of affective disorders in the long term, similarly to CBT (Fava et al., 1998a). However, the comparison of two groups of patients randomly assigned to either a well-being therapy or cognitive behavioural treatment of residual symptoms showed a significant advantage of well-being therapy over cognitive behavioural strategies immediately after treatment. Well-being therapy was associated also with a significant increase in PWB, particularly in the Personal Growth scale. The small number of subjects suggested caution in interpreting this difference and the need for further studies with larger samples of patients with specific affective disorders. However, these preliminary results pointed to the feasibility of well-being therapy in the residual stage of affective disorders.

WBT was also used for the treatment of generalized anxiety disorder (GAD) (Fava et al., 2005). Significant advantages of the WBT-CBT sequential combination over CBT were observed, both in terms of symptom reduction and psychological well-being improvement. These results suggested the feasibility and clinical advantages of adding WBT to the treatment of GAD. A possible explanation for these findings is that self-monitoring of episodes of well-being may lead to a more comprehensive identification of automatic thoughts than that entailed by the customary monitoring of episodes of distress in cognitive therapy (Beck & Emery, 1985), and may thus result in a more effective cognitive restructuring. These results lend support to a sequential use of treatment components for achieving a more sustained recovery. The clinical description of a young patient with GAD, who successfully underwent this sequential treatment (CBT/WBT), has been recently published (Ruini & Fava, 2009).

A cognitive behavioural package including WBT, cognitive behavioural treatment of residual symptoms, and lifestyle modification was applied to recurrent depression and its effects were compared to classical CBT treatment (Fava, Rafanelli, Grandi, Conti, & Belluardo, 1998b). The combination of CBT and WBT produced a significantly lower level of residual symptoms after drug discontinuation, a significantly lower relapse rate at a 2-year and 6-year follow-up (Fava et al., 2004).

WBT's effectiveness was also tested in the attempt to identify strategies to improve medication effects during maintenance antidepressant treatment. The return of depressive symptoms during these treatments is a common and vexing clinical phenomenon (Baldessarini, Ghaemi, & Viguera, 2002; Bockting et al., 2008; Papakostas, Perlis, Seifert & Fava, 2007), and the efficacy of pharmacological strategies has proven limited (Schmidt, Fava, Zhang, Gonzales, Raute, & Judge, 2002, Chouinard & Chouinard, 2008). To examine whether an intervention that included well-being therapy might improve maintenance of medication effects, a strategy based on dose increase was compared with a sequential combination of cognitive-behaviour and well-being therapy with continuation of antidepressant drugs at the same dosage (Fava, Ruini, Rafanelli, & Grandi, 2002). All the patients treated only with antidepressants relapsed by 1-year follow-up while only one of the patients treated with psychotherapy did. The specific contribution of WBT, however, cannot be discerned from this type of study. Tolerance to antidepressant treatment has been associated with activation of the hypothalamic-pituitary-adrenal (HPA) axis (Fava, 2003). In a single case report, well-being therapy induced a normalization of the HPA axis (Sonino & Fava, 2003). It is thus conceivable that well-being therapy may, through this mechanism, restore and maintain remission with antidepressant drugs when response fails or is about to fail.

WBT could also be used in the treatment of post-traumatic stress disorder (Cottraux et al., 2008; Schnyder, 2005; Van Emmerik, Kamphuis, & Emmelkamp, 2008). Two cases were reported (Belaise, Fava, & Marks, 2005) in which patients improved, even though their central trauma was discussed only in the initial history-taking session. The findings from these two cases should of course be interpreted with caution (the patients may have remitted spontaneously), but are of interest because they indicate an alternative route to overcoming trauma and developing resilience. A randomized controlled trial is now in order.

Finally, WBT has been recently modified to be applied with children and adolescents, both in clinical and educative settings. These are pilot experiences which require confirmation with further research; however, their results are very promising. WBT school interventions were performed both in middle (Ruini, Belaise, Brombin, Caffo, & Fava, 2006; Tomba et al., 2010) and high schools (Ruini et al., 2009) demonstrating a significant effectiveness in promoting psychological well-being – particularly personal growth – compared to an attention placebo condition. WBT school interventions were found to be effective also in decreasing distress – particularly anxiety and somatization – and this effect persisted at 1-year follow-up. Other studies investigated WBT effects in reducing symptoms and in improving skills and competencies in children with mood, anxiety, and conduct disorders (Albieri, Visani, Offidani, Ottolini, & Ruini, 2009). Child WBT was associated in all patients with a decrease in symptomatology (particularly anxiety and somatization) and an improvement in psychological well-being (particularly autonomy and interpersonal functioning). In two of our four patients, WBT was associated also with improvements in school performance (Caffo, Belaise, & Forresi, 2008). These results are promising but further research with controlled design is needed.

To summarize, WBT has been originally developed as a strategy for promoting psychological well-being which was still impaired after standard pharmacological or psychotherapeutic treatments. It was based on the assumption that these impairments may vary from one illness to another, from patient to patient, and even from episode to another of the same illness in the same patient. This individualized approach characterizes the treatment protocol which requires careful self-monitoring before any cognitive restructuring takes place. As a result WBT may be used to address specific areas of concern in the course of treatment, in sequential combination with other approaches of pharmacological and psychological nature. The model is realistic, instead of idealistic, but more in line with the emerging evidence on the unsatisfactory degree of remission that one course of treatment entails and need of addressing several areas of concern in the treatment of patients with mood and anxiety disorders (Fava, Tomba, & Grandi, 2007). It is quite difficult to apply WBT in an acutely ill patient (e.g. in a major depressive episode), since the amount of negative thoughts may be at that stage overwhelming. WBT appears to be more suitable for addressing psychological issues that other therapies have left unexplored. However, these conclusions are, at present, tentative and may be modified by further studies and clinical experience. In the same vein, most studies have involved clinical individual WBT. Group format WBT has been applied only in educational settings. However, it is conceivable that the group format may be a future line of development of this strategy.

Building Positive Mental Health: Carpenters and End Users

Any process of change and growth, in the physical and in the psychological domains, requires the alliance between the two main characters: the therapist and the client. Rogers (1967) considered crucial for alliance promotion three components of the therapist's attitude: empathy, coherence, and unconditioned openness towards the client. More recently, research focused on additional cognitive dimensions, such as the shared definition of treatment goals, and client's perception of the relevance and adequacy of the proposed therapeutic pathway (Roth & Fonagy, 1996). The achievement of a strong alliance is even more important for a positive health psychology treatment, because of its innovative aspects. In particular, the expectations of the patients can be apparently frustrated by the therapist's attention to strengths rather than problems, to patient's blessings and responsibility rather than to stressors and victimization. A major challenge for the positive therapist is to balance the emphasis on resources with the acknowledgement of negative aspects. This balance can differ according to client's attitude, request, objective condition, and social support. A thorough exploration of the alliance building in positive psychotherapy is a priority for future research.

In spite of the cautions and open issues described in the previous pages, the spreading of positive therapy can have a tremendous impact on society. Instead of providing people with relief from symptoms, therapists will be able to offer

support to growth and thriving through the exercise of personal agency, competences, and commitment (Duckworth, Steen, & Seligman, 2005). Such a change of perspective can mobilize resources at various levels: not only the clients would benefit from it, but also their families and their community. Supporting individuals in becoming aware of their strengths, in developing a more optimistic attributional style, in pursuing meaningful goals, personal growth, and self-expression can contribute to enhance their active participation in society. As shown in several studies, flourishing people are usually friendlier, more optimistic, more effective in work, more concerned with others' well-being, more sensitive to social issues (Keyes, 2007). Making people flourishing through positive psychology-based intervention is a valuable instrument to increase the well-being of communities.

Like in any psychotherapeutic process, clients in positive theraphy settings can learn about the mind, cognitive processes, and emotional regulation. They can become aware of their own cognitions, and they may begin to appreciate the interplay between perceptions, interpretations, evaluations, attributions, expectations, and emotions (Overholser, 2004). They can move from thinking about strategies for developing positive emotions or overcoming negative thoughts to experiencing them through mindfulness and awareness (Teasdale, 1999). When these intrinsic assets of the therapy process additionally involve the ability to experience growth, agency, self-efficacy, resilience, and meaning, individual development becomes the unfolding of the true human nature, as Aristotle meant when he defined eudaimonia.

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