Cross-Cultural Advancements in Positive Psychology 8
Series Editor: Antonella Delle Fave

Giovanni Andrea Fava
Chiara Ruini *Editors*

Increasing Psychological Well-being in Clinical and Educational Settings

Interventions and Cultural Contexts

Springer

Increasing Psychological Well-being in Clinical and Educational Settings

Cross-Cultural Advancements in Positive Psychology

Volume 8

Series Editor:

ANTONELLA DELLE FAVE
Università degli studi di Milano, Italy

Editorial Board:

MARTIN E.P. SELIGMAN
Positive Psychology Center, University of Pennsylvania, USA
MIHALY CSIKSZENTMIHALYI
Quality of Life Research Center, Claremont Graduate University, USA
BARBARA L. FREDRICKSON
University of North Carolina at Chapel Hill, USA
ALAN WATERMAN
The College of New Jersey, USA
ROBERT A. EMMONS
University of California, Davis, USA

The aim of the *Cross Cultural Advancements in Positive Psychology* book series is to spread a universal and culture-fair perspective on good life promotion. The series will advance a deeper understanding of the cross-cultural differences in well-being conceptualization. A deeper understanding can affect psychological theories, interventions and social policies in various domains, from health to education, from work to leisure. Books in the series will investigate such issues as enhanced mobility of people across nations, ethnic conflicts and the challenges faced by traditional communities due to the pervasive spreading of modernization trends. New instruments and models will be proposed to identify the crucial components of well-being in the process of acculturation. This series will also explore dimensions and components of happiness that are currently overlooked because happiness research is grounded in the Western tradition, and these dimensions do not belong to the Western cultural frame of mind and values.

For further volumes:
http://www.springer.com/series/8420

Giovanni Andrea Fava • Chiara Ruini
Editors

Increasing Psychological Well-being in Clinical and Educational Settings

Interventions and Cultural Contexts

Springer

Editors
Giovanni Andrea Fava
Department of Psychology
University of Bologna
Bologna, Italy

Chiara Ruini
Department of Psychology
University of Bologna
Bologna, Italy

ISSN 2210-5417 ISSN 2210-5425 (electronic)
ISBN 978-94-017-8668-3 ISBN 978-94-017-8669-0 (eBook)
DOI 10.1007/978-94-017-8669-0
Springer Dordrecht Heidelberg New York London

Library of Congress Control Number: 2014933803

© Springer Science+Business Media Dordrecht 2014
This work is subject to copyright. All rights are reserved by the Publisher, whether the whole or part of the material is concerned, specifically the rights of translation, reprinting, reuse of illustrations, recitation, broadcasting, reproduction on microfilms or in any other physical way, and transmission or information storage and retrieval, electronic adaptation, computer software, or by similar or dissimilar methodology now known or hereafter developed. Exempted from this legal reservation are brief excerpts in connection with reviews or scholarly analysis or material supplied specifically for the purpose of being entered and executed on a computer system, for exclusive use by the purchaser of the work. Duplication of this publication or parts thereof is permitted only under the provisions of the Copyright Law of the Publisher's location, in its current version, and permission for use must always be obtained from Springer. Permissions for use may be obtained through RightsLink at the Copyright Clearance Center. Violations are liable to prosecution under the respective Copyright Law.
The use of general descriptive names, registered names, trademarks, service marks, etc. in this publication does not imply, even in the absence of a specific statement, that such names are exempt from the relevant protective laws and regulations and therefore free for general use.
While the advice and information in this book are believed to be true and accurate at the date of publication, neither the authors nor the editors nor the publisher can accept any legal responsibility for any errors or omissions that may be made. The publisher makes no warranty, express or implied, with respect to the material contained herein.

Printed on acid-free paper

Springer is part of Springer Science+Business Media (www.springer.com)

Foreword

In the past decades, psychological well-being has achieved a prominent role in the biopsychosocial consideration of the dynamic balance between health and disease. Early pioneers were physicians and scientists embracing the psychosomatic approach. George Engel defined etiologic factors as "factors which either place a burden on, or limit the capacity of systems concerned with growth, development or adaptation" (Engel 1960, p. 473). In 1987, Aaron Antonovsky introduced the salutogenic approach, which called for a focus on resources for health and health-promoting processes. He described a state of health and well-being, characterized by the presence of competence, internal and external resources and active use of coping strategies. The Ottawa Charter (1986) declared that health promotion is the process of enabling the individuals to increase control over and to improve their health, in order to reach a state of complete physical, mental and social well-being. This means that individuals all over the world should be able to identify and realize aspirations, as well as to satisfy needs and cope with their environment. Ryff and Singer (1998) proposed the concept of 'positive human health', which refers to a comprehensive – holistic – consideration of health, where stressors but also positive resources are taken into account. Accordingly, health is maintained by good health habits (i.e. good nutrition, regular physical activity, no smoking, nor use of drugs and other risky habits) and by the presence of emotional and psychological well-being.

Psychological well-being, by a biological viewpoint, was found to display a protective role as to the vulnerability to illness. By a psychological viewpoint, the growing awareness of the limited degree of remission that current symptom-oriented therapeutic strategies of mental disorders entail, has underscored the need of shifting the emphasis on increasing the positive. By a social viewpoint, the role of psychological well-being in determining the true wealth of a nation and in addressing disparities in health risks has emerged.

All these issues converged inside the Positive Psychology movement, founded by Martin Seligman in 2000. As President of the American Psychological Association, he declared that the future mission for psychology research was the scientific study of all factors in human existence that contribute to, and are

associated with, happiness, fulfillment and well-being. Since then, Positive Psychology paved the way for subsequent scientific enquiries across various fields of psychological research, all concerned with positive emotions, resilience, character strengths, life satisfaction and eudaimonic well-being. The promotion of these elements has received increasing attention in clinical and non-clinical populations, including public institutions and educational settings (Seligman et al. 2005; Duckworth et al. 2005).

An attempt to assess and increase well-being, however, cannot be exempt from consideration of the cultural factors underlying its definition. Not only there may be differences among nations (e.g., Western vs. Eastern countries) or among various ethnic groups in the same societal context, but also within the same cultural background there might be differences in the pathway to a positive evaluation of one's self, to a sense of continued growth and development, to the belief that life is purposeful and meaningful, to the possession of quality relations to others, to the capacity to manage effectively one's life, and to a sense of self-determination.

Cross-cultural psychology may thus provide the flexibility that is required for increasing psychological well-being in clinical and preventive interventions.

This book consists of two parts. In the first one, attention is given to clinical interventions for increasing well-being and positive functioning with adult populations.

In the initial chapter, Ryff, and associates examine cultural differences in the experience of psychological well-being, as gleaned from a series of studies comparing aging adults from Japan and the USA. In these investigations, notably distinct cultural formulations in what constitutes ill-being and well-being emerged, accompanied by differences in the factors thought to promote it.

Ruini and Fava analyze the clinical concept of psychological well-being. A specific psychotherapeutic strategy (well-being therapy; WBT) aimed to the promotion of psychological well-being in clinical populations with affective disorders is presented. A particular emphasis is given to the polarities in well-being dimensions, that can be addressed with WBT in order to facilitate optimal human functioning.

MacLeod and Luzon address the extent to which well-being has a place within the aims, content and underlying philosophy of cognitive behavioral therapy (CBT). The authors suggest that well-being is represented to varying degrees and in varying ways within some of the more recent developments of CBT, but there remains further scope for integrating well-being within CBT approaches.

Vazquez, Perez-Sales and Ochoa provide a detailed review of a concept which has attracted increasing clinical attention, post-traumatic growth (PTG). They examine it with a cross-cultural approach, providing differences among cultures and various clinical strategies to promote it.

Linden describes the concept of wisdom which is considered to be as an important resilience factor. Wisdom is associated with well-being, and can be described as a multidimensional psychological capacity that can be learned. A new psychotherapeutic strategy (wisdom psychotherapy) is presented, as a structured approach to help patients with severe and prolonged adjustment disorders.

Guse provides a review on a psychotherapeutic strategy that is currently neglected in well-being research, hypnosis. This approach is still in a very preliminary stage of scientific validation and requires adequate research. However, it may yield interesting implications and should be seen as a stimulus in such direction.

Lastly, Heldt, Blaya and Gus Manfro describe the importance of motivation in clinical settings. Motivation could be considered a way of directing attention to elicit the patients' desire for their behavior changes in the best interest of their health and well-being. Strategies like motivational interviewing (MI), thought mapping (TM) and psychoeducation are presented.

The second part of the book is concerned with the area of psychological interventions in childhood and adolescence and has a strong emphasis on educational settings. The main reason for this choice is the fact that there is emerging awareness that addressing the origins of disparities in physical and mental health care early in life may produce greater effects than attempting to modify health-related behaviors in adulthood (Shonkoff et al. 2009). As a result, school might be the place for the most successful interventions. This is in line with the observation that lifestyle modification, prevention of distress and psychopathology, and promotion of health and well-being could be more successfully and lastingly achieved during childhood and young age (Shonkoff et al. 2009).

The second parts opens with a chapter by Albieri and Visani. It gives a brief overview of the main evidence-based psychotherapies for affective disorders in youth, considering both the ingredients of traditional protocols and new therapeutic approaches, which aim to cultivate positive emotions, cognitions, and behaviors. Authors underline a more comprehensive conceptualization of remission and recovery in childhood, which should not be limited to symptoms reduction, but also encompasses the improvement of well-being and resilience.

Noble and Mcgrath underline the importance of positive education considered as specific educational policy and school practices that can help children and young people to develop resilience and a sense of well-being. This chapter provides operational definitions for well-being and resilience that can guide educators working in school settings. Six evidence-based foundations of positive education that link school-based pedagogy and practices are outlined, with implications for cross-cultural implementation.

Rashid, Anium, Stevanoski, Chu, Zaniani and Lennox present an overview of resilience research and introduce a holistic model of resilience called Strength-Based Resilience (SBR), which focuses on integrated risks and resources, namely, character strengths, to buffer against vulnerabilities. The chapter suggests practical implications on how to incorporate character strengths in fostering resilience.

Visani, Albieri and Ruini provide an overview of the main effective, evidence-based school interventions. One of them is specifically focused on well-being according to the eudaimonic perspective: Well-being Therapy (WBT)-school intervention. Its applicability and effectiveness are described, documenting that enhancing specific well-being dimensions among students may result in reducing distress and anxiety, and in improving developmental processes.

Marques and Lopez describe one of the most potent predictors of success of our youth: hope, considered as ideas and energy for the future. It has resulted to be consistently related to better outcomes across ages and cultures. Authors also describe how to measure and promote hope in school-aged children, with its implications for use by psychologists and educators.

The book ends with a chapter by Proctor and Linley on the role that life satisfaction plays in successful functioning in youth. This chapter reviews the factors that are associated with, and predictive of, life satisfaction in youth, including supportive interpersonal environment, participation in meaningful instrumental activities, having a healthy lifestyle, cultural integration and positive behavior and peer interactions. Further, the chapter also reviews specific positive psychology interventions that have been shown to increase life satisfaction, including gratitude diaries, the teaching of well-being in schools, and character strengths interventions.

This book thus indicates that increasing psychological well-being may entail important clinical and practical implications (Ryff 2014), that the application of interventions can be performed in a variety of settings, and cannot be exempt from consideration of cultural diversities.

Department of Psychology
University of Bologna

Giovanni A. Fava
Chiara Ruini

References

Antonovsky, A. (1987). *Unraveling the mystery of health: How people manage stress and stay well*. San Francisco: Jossey-Bass.

Duckworth, A. L., Steen, T. A., & Seligman, M. E. P. (2005). Positive psychology in clinical practice. *Annual Review of Clinical Psychology, 1*, 629–651.

Engel, G. L. (1960). A unified concept of health and disease. *Perspectives in Biology and Medicine, 3*, 459–485.

Ryff, C. D. (2014). Psychological well-being revisited: Advances in the science and practice of Eudaimonia. *Psychotherapy and Psychosomatics, 83*, 10–28.

Ryff, C. D., & Singer, B. (1998). The contours of positive human health. *Psychological Inquiry, 9*, 1–28.

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction (special issue). *American Psychologist, 55*, 5–15.

Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist*, *60*(5), 410–421.

Shonkoff, J. P., Boyce, W. T., & McEwen, B. S. (2009). Neuroscience, molecular biology and the childhood roots of health disparities. *JAMA, 301*, 2252–2259.

World Health Organization. (1986, November 17–21). Ottawa charter for health promotion: An international conference on health promotion, the move towards a new public health. Geneva: World Health Organization.

Contents

Chapter 1
Culture and the Promotion of Well-being in East and West: Understanding Varieties of Attunement to the Surrounding Context

Carol D. Ryff, Gayle D. Love, Yuri Miyamoto, Hazel Rose Markus, Katherine B. Curhan, Shinobu Kitayama, Jiyoung Park, Norito Kawakami, Chiemi Kan, and Mayumi Karasawa

1.1 Introduction

The purpose of this chapter is to examine scientific findings on cultural differences in the experience of psychological well-being, as gleaned from a series of studies comparing adults from Japan and the U.S. These investigations, drawn primarily from our own prior work, point to notably distinct cultural formulations in what constitutes well-being, accompanied by differences in the factors thought to promote it. We then provide a brief summary of differences between Japan and the U.S. in

C.D. Ryff (✉)
Institute on Aging/Department of Psychology,
University of Wisconsin-Madison, Madison, WI, USA
e-mail: cryff@wisc.edu

G.D. Love
Institute on Aging, University of Wisconsin-Madison,
Madison, WI, USA

Y. Miyamoto
Institute on Aging, University of Wisconsin-Madison, Madison, WI, USA

H.R. Markus • K.B. Curhan
Department of Psychology, Stanford University, Stanford, CA, USA

S. Kitayama • J. Park
Department of Psychology, University of Michigan, Ann Arbor, MI, USA

N. Kawakami • C. Kan
Graduate School of Medicine, University of Tokyo, Hongo, Bunkyo, Tokyo, Japan

M. Karasawa
Department of Communications, Tokyo Women's Christian University,
Zenpukuji, Suginami, Tokyo, Japan

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_1, © Springer Science+Business Media Dordrecht 2014

what comprises psychological ill-being; that is, the nature of mental illness occurring in both contexts. Emphasis is given to cultural differences in prevalence of major psychological disorders. These contrasting formulations of well-being and ill-being provide the background for considering clinical practices intended to treat emotional distress in the two cultural contexts. We examine a limited number of intervention strategies to illustrate differences between Eastern and Western approaches to helping people regain emotional well-being. A conclusion emerging from this work is that positive and negative emotions are construed in notably distinct ways in Japan and the U.S. Not surprisingly, such differences shape the goals and practices of clinicians seeking to promote optimal functioning. The larger message emerging from our research as a whole is that cultural contexts shape ideal formulations of human well-being as well as the practices designed to promote them. We offer several closing observations, including the need to foster greater communication and interplay between these domains and disciplines, which do not often intersect enough with each other, and the hope that cultures might learn more from each other based on in-depth understanding of their respective strengths and weaknesses.

1.2 Culture and Well-being in East and West

1.2.1 Guiding Conceptions

Over the last decade extensive scientific attention has been devoted to the question of whether and how the experience of well-being differs across cultures (Diener and Suh 2000; Kitayama and Markus 2000). Going back several decades, a U.S. review of the correlates of happiness emphasized a variety of qualities including being young, educated, healthy, wealthy, optimistic, intelligent and having self-esteem (Wilson 1967). Kitayama and Markus (2000) questioned the relevance of these findings for other cultural contexts. Drawing on distinctions between two different models of self and social relationships, they underscored that well-being is likely to be enhanced by *attunement to one's surrounding cultural context.* In the West, where the individual is viewed as an active, independent agent influencing other people, well-being is viewed as personal and individual in scope and thus is associated with self-esteem and the pursuit of one's own happiness. This formulation was contrasted with an Eastern conception of well-being that is more relational, intersubjective and collective in scope. The person in the latter context is as an interdependent agent who must adjust to other people in both a proactive and contingent manner. Well-being is thus related to self-criticism and personal discipline, both of which give rise to feelings of sympathy to and from others.

In the West, the individual is commonly viewed as an active, independent agent who is relatively separate from both the physical and social environment. This independence is realized by expressing and promoting one's interests and goals, often through influencing others. Well-being from this perspective is understood as

a personal project and is manifest in subjective, positive feelings about the self. In the East, the individual is more commonly understood as a relational and socially responsive agent who is connected with both the physical and social environment. This interdependence is realized by fitting in and by adjusting to the expectations of others and role requirements in specific situations, both of which require a capacity for self-criticism. Well-being from this perspective is thus less a subjective or personal project and depends more on meeting objective or consensually held standards and is thus manifest in maintaining the sympathy and respect of others with whom one is interconnected.

Distinctions between self-enhancement in the U.S. and self-criticism in Japan (Heine et al. 1999), in turn, influence how people describe themselves. In the U.S., self-descriptions are primarily positive, whereas in Japan they tend to be more negative. Similarly, maximizing personal happiness is an avowed goal in the U.S., whereas finding balance and moderation are the ideal objectives in Japan. These contrasting stances underlie the documented differences in the degrees of positivity that are empirically evident among U.S. and Japanese respondents. In contrast to the more honorific self-evaluations in the U.S., self-critical attitudes are prerequisites for well-being in Japan, where sympathy, compassion, adjustment and orientation to others are valued modes of being.

These ideas were elaborated by Uchida et al. (2004). Because happiness in the West is construed as a personal achievement, it requires autonomy and independence, which fuel personal achievements and self-esteem. Individuals reared and living in this cultural and societal context are motivated to maximize their feelings of positive affect. In the East Asian context, happiness is construed in terms of interpersonal connectedness with more embedding of the self in social relationships. It is thus commitment to social roles, social obligations, and readiness to respond to social expectations that are primary. Emotional experience and emotional ideals are, in sum, saturated with cultural meaning.

1.2.2 Minimalist Well-being in Japan

Considering culturally unique meanings of well-being, Kan et al. (2009) put forth a Japanese conception known as "minimalist well-being." The work was motivated by the observation that despite dramatic economic growth in the last half century in East Asian societies – Japan is sometimes referred to as the economic miracle – the country nonetheless seemed to lag far behind other advanced technological societies in psychological health and well-being. Inglehart and Welzel (2005) reported that Japan was the 3rd largest economy in the world at that time, but its mean life satisfaction score was 42nd among 50 countries tested.

One possible explanation for the apparent unhappiness of the Japanese was the possibility of cultural bias in existing instruments for measuring happiness and well-being, most having been developed in the West. For example, Kan et al. (2009) suggested a different conceptualization of well-being derived from

minimalist virtues embedded in a distinct perspective on reality – namely, that it is fundamentally fluid, transitory, and possibly incomprehensible nature. As conveyed by a Japanese respondent, "happiness is something that never lasts long." This formulation of reality gives rise to a different kind of well-being in which one is deeply grateful for the mere fact of existence. Happiness in this construal does not reside in the self, or personal achievements, but in immersion of the self in nothingness, which can lead to feelings of gratitude, calmness and peacefulness (Tsai 2007). These types of low arousal positive emotions are commonly considered ideal affective states in East Asian contexts (in contrast to high arousal positive states like cheerfulness and excitement that are commonly considered ideal affect status in the U.S.) (Tsai 2007).

A further component of Japanese well-being, linked to its historical merger of distinctly Asian philosophical and religious traditions (Confucianism, Taoism, Bushido, Buddhism, Shintoism) is that happiness cannot be accumulated. Additionally, embedded within this perspective are inherent negatives, such as the jealousy of others, or the failure to pay attention to others when one is consumed with happiness. Their minimalist formulation serves as the basis for generating two alternative indicators of well-being. One dimension, labeled gratitude, was measured with items designed to assess appreciation of the mere fact of living, and another, labeled peaceful disengagement, was measured with a focus on finding pleasure and satisfaction in disengaging from a constantly changing, constraining, and confusing world.

In a related effort, Uchida and Kitayama (2009) examined "folk models of emotion" via spontaneously generated descriptions of happiness and unhappiness among Japanese and U.S. respondents. The goal was to probe cultural differences in what people do to attain happiness and avoid unhappiness. Most cultures, they note, prescribe ways of coping with unhappiness, including how people deal with failure and personal problems. This analysis of folk models supported the previously described distinctions between happiness in the U.S., which is regarded primarily as a personal achievement, and happiness in Japan, which is formulated as the realization of social harmony. Consistent with Confucian beliefs in yin and yang, in which positives (happiness) contain negatives (envy, jealousy) within themselves, and also that negatives (unhappiness) contain positives (sympathy, motivation for self-improvement) within themselves, they also found that the Japanese respondents were more likely than Americans to mention social disruption and transcendental reappraisal (avoiding reality, elusive) as features of happiness. When confronted with unhappiness, Americans focused on externalizing behavior (anger, aggression), whereas Japanese were more likely to highlight transcendental reappraisal and self-improvement.

1.2.3 Dialectical Emotions

Cultural influences are also prominent in how emotions are experienced and expressed. In the West, Bradburn's (1969) seminal work on positive and negative

affect launched decades of U.S. studies that probed relationships between the two types of affect as well as examining their correlates, antecedents, and consequents. Whether positive and negative emotional experiences are construed similarly across cultures was not part of these early queries, but is a relevant question. If happiness is perceived to be a transitory state and is seen to encompass not only positive but also negative feelings in Japan, people in that context may seek *balance* between the two types of affect rather than try to maximize only one. Stated otherwise, whereas positive and negative emotions are seen as contradictory in U.S. and European cultures, and indeed, are known to be inversely correlated (Schimmack et al. 2002), in East Asian cultures, they are seen as complementary (Kitayama et al. 2000; Peng and Nisbett 1999). The balance between positive and negative emotions seems to have a peculiar role also in clinical settings, as described in details in Chap. 2 of this book.

Building on these ideas, Miyamoto and Ryff (2011) investigated the idea of "dialectical" (i.e., feeling positive *and* negative emotions with similar frequency) and "non-dialectical" (i.e., feeling predominantly positive *or* negative emotion) emotion styles in Japan and the U.S. In dialectical formulations, reality is constantly changing and contradiction is tolerated. This leads to an inclination to find the middle way; that is, to experience balance in positive and negative emotions. They summarized prior literature showing that Westerners show a stronger polarity (inverse correlation) between positive and negative emotions. East Asians, in contrast, are more likely to show the dialectical emotional style (reporting both positive and negative emotions). Their findings clarified that the most common emotional styles in the U.S. was the mostly positive non-dialectical type, followed by the mostly negative non-dialectical type, whereas in Japan, the two most common emotional types were the moderate dialectical type and the mostly positive non-dialectical type. Importantly, these reported profiles were linked to health: the moderate dialectical type was associated with fewer health symptoms in Japan compared to the U.S.

Miyamoto and Ma (2011) extended ideas of dialectical versus non-dialectical cultural scripts via examination of East/West differences in how individuals regulate positive emotion. Such regulation can occur via efforts to increase (up-regulate), maintain, or decrease (down-regulate) positive hedonic emotional experiences. The guiding prediction was that Westerners are more inclined to *savor and augment* (i.e., up-regulate, maintain) positive emotions whereas Easterners are more likely to *dampen* (i.e., down regulate) positive emotions. The findings showed that although most people want to savor rather than dampen their positive emotions, this pattern was less pronounced for East Asian compared to European American respondents. For example, when recalling a positive event, Asians engaged in less savoring than European Americans. In addition, respondents' dialectical beliefs about emotions were found to mediate cultural differences in the regulation of positive emotions. Finally, via examination of on-line reports of emotion regulation strategies, Asians reported feeling less positive compared to negative emotion on the day after a positive event compared to Americans, with these differences also linked to dialectical beliefs about emotional experience. The significance of such findings for broader efforts to promote well-being across cultures is the recognition that the up-regulation or maintenance of positive emotion is not universally endorsed – in some contexts where

cultural beliefs construe happiness and misery as wrapped inextricably to each other, there is less interest in promoting and sustaining exclusively positive feelings.

1.3 Within the West: Hedonic and Eudaimonic Conceptions

The above studies illustrate East-west cultural differences, via comparative data from Japan and the U.S. with regard to what well-being is and how one achieves it. Such broad contrasts, anchored in notably distinct cultural contexts, are accompanied by varying conceptions of well-being *within the Western context.* In the U.S., there is increasing recognition of the distinction between hedonic aspects of well-being (Kahneman et al. 1999), which emphasize feeling good (positive affect, life satisfaction), and eudaimonic conceptions of well-being (Ryan and Deci 2001), which address existential tasks, such as being purposefully engaged in life and experiencing personal growth (Ryff 1989). These broad distinctions are traceable to the ancient Greeks, as evident in differing formulations of positive functioning articulated by Epicurus and Aristotle (see Ryff and Singer 2008).

Current evidence supports the empirical distinction between these two types of well-being (Keyes et al. 2002), each of which has been linked to diverse indices of health (Boehm and Kubzansky 2012; Morozink et al. 2010; Pressman and Cohen 2005; Steptoe et al. 2006). Age differences in both types of well-being have also been documented in Japan and the U.S. (Karasawa et al. 2011). Cross-sectional data revealed age increments, from midlife to old age, in personal growth in Japan, whereas age decrements were evident in the U.S. Adults in both cultures showed an age-related decline in purpose in life, accompanied by age increments in positive affect. As predicted, interpersonal well-being was rated significantly higher, relative to overall well-being, in Japan compared to the U.S.

Overall, the above literatures draw attention to cultural differences in core elements of psychological well-being. Numerous findings, based on comparative samples from Japan and the U.S., underscore the distinction between happiness as an experience of personal achievement and self-esteem in the West, contrasted with happiness as social harmony tied to self-criticism, discipline, and adjusting to others in the East. Minimalist conceptions of well-being in Japan underscore the transitory nature of happiness as well as the gratitude, calm, and peacefulness that can come from immersing oneself in nothingness. A further Eastern theme is the intertwining of positive and negative emotions – that each is embedded within the other. Dialectical emotions, which involve a balanced experience of positive and negative emotions, was emphasized in Eastern contexts, in contrast to the more common bipolar pattern in the West wherein positive and negative affect are inversely related. Finally, in the West, there is growing distinction between hedonic (feeling good) well-being and eudaimonic (striving, pursing goals, making the most of personal talents) aspects of well-being, with both showing linkages to health. In the section below, we address cultural differences in the counterpoint question: namely, what constitutes psychological ill-being. These literatures on well-being and ill-being differ primarily in the valence of the psychological phenomena of interest. Rarely do these two realms intersect.

1.4 Mental Distress: Comparisons Between East and West

Our guiding assumption is that the upside and downside of psychological functioning – that is, distinctions between mental health and mental illness – are inextricably connected. Indeed, when we examine intervention strategies in a subsequent section, we emphasize that efforts to treat psychological disorders are guided, implicitly or explicitly, by what is construed as well-being or good mental health. Before considering such issues, here we examine cultural differences in the nature of psychological disorders, giving primary emphasis to psychiatric epidemiology, as examined across cultural contexts. We maintain our emphasis on Japanese-U.S. comparisons in this review, focusing on the types and prevalence of major mental disorders in the two countries.

1.4.1 Psychiatric Epidemiology: East/West Perspectives

Due to advances in international collaboration, the last decade witnessed novel efforts to assess mental illness around the globe. This inquiry emerged from a universally adopted formulation of mental disorders as described below. Thus, in contrast to the preceding inquiries on culture and well-being, which explicitly addressed how formulations of positive functioning differ by cultural context, scientific research on the prevalence distribution of mental illness across countries has been less attuned to whether the guiding conceptions of emotional distress are themselves culturally-infused, and therefore, potentially distinct, depending on the culture considered. We note, however, some prior consideration given to how cultural context might influence the expression of affective disorders (Kleinman and Good 1985). For example, in collectivist societies, adults may be more likely to express emotional distress through bodily symptoms (somatization) because so doing is less disruptive of social harmony (Kleinman and Kleinman 1985). This earlier anthropologically oriented work is largely absent in more recent efforts to examine psychiatric epidemiology across nations.

Using standardized criteria (developed in the West) to assess mental disorders, we examine below rates of mental disorders in Japan and the U.S. Such findings show higher prevalence of mental disorders in the U.S. compared to Japan. Second, we address other types of mental disorders that may be unique to Japan.

1.4.2 Prevalence of Emotional Disorders in Japan and the U.S.

Kawakami et al. (2005) reported on the 12-month prevalence, severity, and treatment of common mental disorders in Japan, based on face-to-face household surveys conducted in four community populations. Using the World Health Organization

(WHO) Composite International Diagnostic Interview (WMH-CIDI), they found that the prevalence of any disorder in the prior year was 8.8 %, of which 17 % of cases were severe and 47 % were moderate. The most prevalent disorders were anxiety disorders (4.8 %), mood disorders (which includes major depression) (3.1 %), and substance use disorders (1.7 %). Only 19 % of serious or moderate cases received medical treatment in the 12 months before the interview. Overall, greater risk was evident among older and unmarried individuals. Those with higher educational levels were more likely to seek treatment. The findings confirmed the prevalence of mental disorders as equal to that observed in other Asian countries (Beijing, Shanghai), but were lower than seen in Western countries (WHO 2000).

Kessler et al. (2005) generated comparable data from the National Comorbidity Survey in the U.S. They reported the prevalence of any disorder to be 26.2 %, of which 22.3 % were classified as serious and 37.3 % as moderate. The most prevalent disorders were anxiety disorders (18.1 %), mood disorders (which included major depression) (9.5 %), impulse control (8.9 %) and substance use disorders (3.8 %). Thus, at the level of DSM-IV disorders (Diagnostic and Statistical Manual of Mental Disorders, 4th Ed.), the U.S. population has nearly three times as many mental disorders as were reported in Japan, with comparable or greater differences in specific disorders across the two nations.

Interpreting these differences requires taking into account the stigma of mental illness in Japan (Desapriya and Nobutada 2002). Loss of mental control in that cultural context is seen as something over which a person should be able to exercise will power. Thus, Japanese adults may be more likely to feel shame if they lack this power, which may explain why approximately two-thirds of Japanese sufferers are not thought to seek help from professionals. In an attempt to address the problem, the Japanese Society of Psychiatry and Neurology recently changed the name of schizophrenia to help dispel prejudice against people who have the illness, from *seishi bunretsu byo* (split-mind disorder) to *togo shiccho sho* (loss of coordination disorder), according to the 2002 World Congress of Psychology. Framing mental illness in a broader health context, Desapriya and Nobutada (2002) emphasized that mental health disorders are among the leading causes of disease and death in the current world. Specifically, depressive disorders were ranked as the fourth leading cause of global disease burden (Murray and Lopez 1997), with the expectation that they will be ranked second by 2020, only behind ischaemic heart disease.

1.4.3 Other Disorders in Japan

Hikikomori (severe social withdrawal) constitutes another mental health concern in Japan (Kato et al. (2011)), particularly in young people. It has been referred to as "modern-type depression" and is characterized by a shift in values from collectivism to individualism, distress and reluctance to accept prevailing social norms, a vague sense of omnipotence, and avoidance of effort and strenuous work. It seems

to have affected those born after 1970, the generation growing up with high economic growth and many technological and computer resources, including video games. Young people with this type of disorder have trouble adapting to work or school, or participating in the labor market. However, recent epidemiological research shows a low lifetime prevalence of hikikomori (1 %) among Japanese adults (Koyama et al. 2010). Similar cases have been noted in Oman, Korea, and Spain, raising questions as to whether it is a culture-bound syndrome specific to Japan or a new form of maladjustment linked to modernization. Some suggest it may be a form of personal addiction to the attractive features of internet resources and services, which may be an easier alternative to engaging in the rigors of daily life and traditional societal demands.

Suicide is also a relevant topic for consideration of mental health in Japan. In 2008, more than 30,000 people killed themselves in Japan (McCurry 2008), which translates to one person every 15 min. This number has increased each year for 10 years in a row. Seven of ten suicides in 2006 were male and about a third were aged 60 or older. Japanese men are seen as particularly at risk because they are expected to keep their feelings to themselves and not show signs of personal weakness. The biggest catalysts for suicide are thought to be poor health and financial worries. The government has approved measures for better counseling and the installation of barriers at rail and subway stations (common locations for suicide). National health insurance, however, does not cover counseling, and sessions are thought to be too expensive for many.

The cultural context is again relevant – Buddhist teachings, for example, offer no clear message on the moral rightness or wrongness of taking one's life, unlike the prohibition against suicide in most Western religions. Suicide also has a central place in the samurai code of honor. For many Japanese individuals confronted with the stigma of mental illness, or failure in personal or professional life, death may seem the only acceptable means of escape. Yuzo Kato, Director of the Tokyo Suicide Prevention Center, stated that "the most common factor behind suicide in Japan is depression caused by a failure to cope with the pressure to play a part in society, either because of poverty or the demands of work." He noted that number of people who committed suicide or attempted to due to work-related stress has doubled in the past 5 years.

To summarize, epidemiological studies show that mental disorders, assessed with formulations conceived in the West, are far more common in the U.S. than Japan, with many more receiving treatment as well. Part of the differences may be due to the stigma of mental illness in Japan, which probably also results in some under-reporting. Other syndromes, such as hikikomori, may be more culture specific. Whether the prevalence will increase with the aging of the current generation of young people for whom such problems seem to be more common is an important future question. Despite the lower prevalence of most mental disorders in Japan, there is a notably high rate of suicide. Interpretations of these patterns are challenging. If expressing emotional distress is construed as a personal failing, higher suicide rates could indicate many who need treatment are not receiving it. Alternatively, higher suicide rates may also be tied to the view that taking one's life is less explicitly prohibited by philosophical and religious beliefs in Japan.

Having summarized cultural differences in the rates and types of emotional disorders, we now examine cultural differences in approaches to the treatment of psychological disorders. Such contrasts underscore notable distinctions in what constitutes the target of treatment (i.e., promoting good mental health), thus invoking our earlier discussion of culture influences on well-being.

1.5 Interventions for Treating of Mental Disorders: Cultural Comparisons

Psychotherapy and clinical interventions come in many varieties. Our objective herein is not to provide a comprehensive overview of what exists in the realm of practice, either in Japan or the U.S. Instead, we highlight select therapeutic interventions, one in the West and two in the East, to illustrate how strategies to improve mental health are themselves culturally constituted. As such, they differ in how mental health problems are construed as well as in what needs to be done to alleviate them. Our contrast focuses on *well-being therapy*, as developed and practiced in the West and further described in Chap. 2 of this book, and *Morita and Naikan therapies*, as developed and practiced in Japan.

1.5.1 Well-being Therapy

Created by practicing clinicians from the University of Bologna in Italy, well-being therapy (Fava et al. 1998) was initially designed for the residual phase of treatment among individuals suffering from recurrent major depression. During this phase, most debilitating symptoms have subsided, but the client remains at risk for relapse. The guiding idea is that during this period it is critically important to have positive psychological experiences, both for their impact on subjective experience, but also in terms of underlying neural processes. The core assumption is that the *absence of well-being* creates vulnerabilities to risk of relapse.

As described in details in Chap. 2, Well-being therapy itself reflects a cognitive behavioral approach and consists of a short-term strategy (8 weeks) during which the client is required to keep a daily diary of positive experiences. Events and feelings recorded in the diary become the focus of weekly sessions with the therapist (Fava and Ruini 2003). In the initial sessions, the focus is on helping clients identify positive experiences from daily life. The therapy builds around these experiences and focuses on identifying thoughts and beliefs that lead to the premature interruption of well-being. For example, the client may feel unworthy or uncomfortable having positive emotions, given the rarity of such experiences. Or, the client may worry that that such good feelings are not going to last. Additional sessions link self-generated positive experiences to existing dimensions of well-being, as derived from the multidimensional model of well-being developed by

Ryff (1989). The intent is to enrich clients' thinking about what constitutes types of well-being, such as experiencing positive self-regard, having good relationships with others, feeling a sense of mastery and purpose in daily life, and seeing growth and development in one's capabilities.

The first empirical assessment of well-being therapy (Fava et al. 1998) showed strong differences in remission profiles for those receiving the treatment compared to standard clinical management (antidepressant medication, minimal psychotherapy). A subsequent follow-up showed that these benefits persisted over a 6-year period (Fava et al. 2004). Additional work extended the approach to treatment for generalized anxiety disorders (Ruini and Fava 2009). Recent endeavors have taken the approach beyond the clinic to interventions in the community. Ruini et al. (2009) implemented a high school program to promote psychological well-being. Compared to an attention placebo group, the intervention group showed improvements in adolescents' psychological well-being, along with reductions in distress, particularly anxiety and somatization. Additional efforts in school settings have examined the differential effects of well-being therapy (WBT) with anxiety management strategies (AM) (Tomba et al. 2010) and found that WBT, by facilitating a progression toward positive and optimal functioning, integrates symptom-centered strategies. Further details on these WB enhancing school interventions in the Western cultures are addressed in Chap. 11 of this book.

From a cultural perspective, it is useful to reflect on the thinking that underlies well-being therapy. Central to the enterprise is a basic question in the treatment of psychological disorders – namely, what constitutes recovery? Fava et al. (2007) clarify that traditional conceptions in the treatment of major depression (e.g., Frank et al. 1991) define recovery as reduced and less severe symptoms that persist over a specified period of time. In contrast, they offer a more expansive formulation of recovery, which includes: (a) remaining free of symptoms despite discontinuation of treatment, (b) if subclinical symptoms are present, they do not interfere with everyday life and social adjustment, (c) the patient reports well-being in at least one of six areas (Ryff 1989), and (d) there is normalization of altered biomarkers, which may have been abnormal in the acute phase of illness. Of particular significance herein is the emphasis on experiencing well-being as a component of recovery. Such a requirement necessitates having a clear conception of what well-being is in order for the goal to be attained. As emphasized in our opening section above, there is good reason to believe such conceptions vary across cultural contexts. As evident from the examples below, therapies indigenous to Japan begin with notably different assumptions about what constitutes well-being.

1.5.2 Morita Therapy

Developed in the early 1900s by Dr. Shoma Morita, a psychiatrist at the Jikei University School of Medicine in Tokyo, Morita therapy blends ideas from Buddhist thought with ideas from Western psychotherapies (Reynolds 1982). Its aim is to

build character so that the person can take action in life, regardless of symptoms, fears, or wishes. Character is believed to be cultivated by mindfulness, one part of which involves knowing what is controllable and what is not. A further emphasis is on doing, in contrast to what one is feeling. The cure is thus not defined by the alleviation of emotional discomfort, or the attainment of some ideal feeling state, but by being able to take constructive action in one's life – i.e., being able to live a full and meaningful existence, rather than be ruled by passing emotions.

Professor Morita, in fact, felt that trying to control emotions was like trying to return the water of a river back upstream. Moods and feelings are recognized as part of the human experience, but they are viewed as largely outside what one can control and therefore beyond the scope of personal responsibility. What can be controlled, however, is what one does. At all times and under all conditions, emphasis thus needs to be on what one is doing. Successful therapy means learning to accept internal fluctuations in thought and feelings, while maintaining a strong focus on personal action and behavior.

Morita therapy is divided into four areas of treatment. The first, known as the "rest phase," typically means 1 week of isolated bed rest. During this period, the individual is separated from the usual intrusions of daily life. It is a time of solitude intended to have the client encounter him or herself with minimal distractions. Clients are told to accept whatever thoughts and feelings bubble up into awareness. These experiential observations are meant to illustrate that emotions come and go without conscious control. A further function of the rest phase is to teach that withdrawal from social interaction is unnatural and eventually uncomfortable. Boredom typically ensues during the last days of this period.

The second phase may last from 3 days to a week and involves doing light manual tasks – i.e., monotonous work that is conducted in silence. The client remains largely isolated from others, but is allowed to read or write in a journal. Attention is directed toward completing small tasks (cooking, heating a bath, walking outside). In the third phase, lasting from 3 days to 1 week, the patient remains restricted from associating freely with others or participating in entertainment, but there is a shift toward hard physical work (chopping wood, gardening, farming, carpentry). Reading is allowed, but the emphasis is on completing work irrespective of how one feels. Joy may be experienced in finishing tasks.

The fourth phase, called the "life-training period," is when the patient is sent outside the hospital or clinical setting. This is when s/he learns to integrate what has been learned into a new lifestyle of meditation, physical activity, clear thinking, ordered living, and renewed ties with the natural world. Re-integration means bringing one's new practices into daily life.

In contrast to Western psychotherapies, anxiety, which may be the cause for seeking treatment, is not, in itself, a focus of the treatment. There is no goal of trying to erase anxiety and bring the patient back to a "normal" state. Rather, the aim is to cultivate a different approach to living wherein doing is elevated over feeling, and emotions (good or bad) are accepted as transitory and not conducive to conscious control.

Diaries may be included in the therapy. Reynold's (1982) examples of diary entries, along with annotated responses from the therapist, illustrate the emphasis on directing energy toward controllable behaviors rather than on how one feels. To illustrate, one diary entry was about sitting in a seminar and trying to be interested. The therapist's response was that interest, or lack of interest should not be the focus; rather, the focus should be on paying attention, taking notes, and sitting erectly. Such behaviors may, or may not, lead to interest. Another entry was about neglecting to write in the diary because of feeling unhappy. The therapist's response was first to question whether it is better to feel happy than unhappy. A further message was to learn how to handle happiness and unhappiness with equanimity, by evaluating life in terms of what one is accomplishing in each moment.

Reynolds (1976) summarized a number of studies using Morita therapy, which reported rates of cured and improved patients in the 90 % range. Suzuki and Suzuki (1977) surveyed over 1,200 patients treated at a Morita Clinic, finding that among those who returned their questionnaires (71 %), responses indicated notable improvement in daily life, including reductions, or elimination of neurotic tendencies and worries, evident years after treatment began. Fully incorporating the principles of the therapy into one's daily life may take years, however. Morita therapy is seen as particularly effective in treating *shinkeishitsu* neuroses, which are considered largely anxiety disorders characterized by over-sensitivity to others, shyness, and feelings of inferiority. Many of the treated patients are young adults.

1.5.3 Naikan Therapy

Also known as "introspection" therapy, Naikan therapy is a structured method of self-reflection developed by Yoshimoto Ishin in the 1950s (Reynolds 1982). Mr. Ishin was a business man and devout Jodo Shinshu Buddhist who had engaged in ascetic contrition (dwelling in a dark cave without food, water or sleep) as a young man. He developed Naikan therapy to make introspection available to others. The practice of self-reflection is part of multiple spiritual traditions, including adherents among Christian hermits and Japanese samurai.

The practice is based on three questions posed to the client: (1) what have you received from person X (typically, it begins with a focus on one's mother)? (2) What have you given to person X? (3) What troubles, inconveniences, deceit and pettiness have you caused person X? The question of what troubles and difficulties person X may have contributed to the client's life is purposefully ignored. The assumption is that much misery in daily life is rooted in focusing on how one has been treated badly by others.

The typical practice involves 1-week at a Naikan retreat. Reinterpretation of the past is a key feature of the practice. The work begins by focusing on the above three questions, beginning with the client's relationship with his/her mother. Questions are then expanded outward to other relationships (fathers, siblings, teacher, spouse, employer). Most clients soon evolve progressively into reporting having received a

great deal, returned little, and caused a great deal of trouble to the person on whom they are reflecting. Self-aggrandizement and complaints about treatment one has received from others are viewed as self-centered and improper.

Deep emotions may be stirred by the process; tears are common. Clients are known to pass through a number of stages as the week progress (Takeuchi 1965; Kitsuse 1964). Initial difficulties in concentrating and feeling bitterness toward others tend to gradually be replaced by feelings of regret, guilt, and sorry over how one has treated significant others. This awareness prompts repentance and the desire to serve and repay them. The underlying objective is to prompt gratitude from within, while getting beyond the view that others are there to satisfy personal needs. Self-centeredness is seen as a problem to be recognized. So doing should prompt self-reproach, guilt, and lowered self-esteem. Failure to make progress is interpreted as failure of the client, not the method, therapist, or society.

Like Morita therapy, the emphasis of Naikan therapy is not on providing symptom relief, but on promoting character development. It was initially conceived by Mr. Yoshimoto as a means to treat prison inmates. Since the 1950s, numerous (nearly 60 %) adult prison facilities tried the therapy at one time or another (Reynolds 1982) and reported improved rates among *naikansha* (client) prisoners compared to prisoners who did not undergo the therapy. In addition, thousands of clients have been treated at more than 40 Nara centers in Japan over the past four decades. It has been used for mental health counseling and treatment for addictions. Clients tend to be more male than female. With regard to effectiveness, Yamamoto (1972) reported decreased self-evaluation and increased evaluation of others in postnaikan subjects. Ishida (1969) reported over 90 % effectiveness in treating neurotic and psychosomatic patients with Naikan alone or in conjunction with other therapies.

Both treatments considered above represent prior eras of psychotherapy in Japan, but they nonetheless offer notable contrasts to Western approaches, such as well-being therapy. A more modern and distinctly Japanese mode of therapy is called *shinrin-yoku* or ‘forest-bathing therapy’, which focuses on reconnecting the person with nature and inner harmony by promoting personal mindfulness through walks in the woods and mountains (Tsunetsugu et al. 2010). Viewed from these Eastern perspective, Western approaches have generally tended to ignore, not only the surrounding natural environment, but also that individual well-being is fundamentally tied to commitment and service to others. In addition, Western therapies overemphasizing feeling states, which are seen as fleeting and beyond one’s control. Viewed from the Western perspective, Eastern treatment approaches, in turn, give inadequate attention to experience of emotional distress and how it both influences and is influenced by patterns of thought and behavior.

1.6 Integration and Summary Reflections

Our objective in this chapter was to utilize ongoing programs of research in Japan and the U.S. to examine cultural differences in what constitutes psychological well-being and the treatment and response to ill-being. Drawing on multiple sources of

evidence, we emphasized that Japanese conceptions of well-being give greater emphasis to social harmony and related capacities of self-criticism, discipline, and adjustment to others, whereas U.S. conceptions place greater emphasis on self-esteem, happiness, and realization of personal talents and capacities. The interplay between positive and negative emotions also reveals cultural differences. In the West, they are construed as opposites and in empirical studies tend to be inversely related, whereas in the East are seen an inherently tied to, if not embedded with each other. As such, Japanese adults show moderate levels of both. Qualitative studies in Japan point to minimalist well-being, which involves feeling calm, at peace, and grateful for one's existence.

Our brief examination of mental distress emerged from standardized assessments (developed in the U.S.) that have been used to assess prevalence rates of psychiatric problems across countries. Population-based comparisons show notably higher rates of depression and anxiety in the U.S. relative to Japan. Given the stigma that is attached to mental illness in Japan, some degree of under reporting may be involved. Another Japanese-specific disorder pertains to severe social withdrawal (*hikikomori*), which occurs primarily among contemporary young adults. Some see the problem as possibly linked to shifting values from collectivism to individualism. The high rate of suicide in Japan relative to other countries was noted. Interpreting this difference requires attending to cultural differences in views on taking one's own life.

How mental disorders are treated reflects cultural differences in what constitutes the problem to be resolved as well as what defines successful treatment or recovery. We contrasted well-being therapy in the West with Morita and Naikan therapies in Japan for the explicit purpose of showcasing such differences. Well-being therapy, designed initially for treatment of major depression, but subsequently extended to anxiety, seeks to free clients from the debilitating effects of these emotions. A key part of recovery involves experiencing well-being, which involves enriching clients' awareness of positives, such as good quality ties to others, purposeful engagement, self-acceptance, and personal growth. Morita therapy, in contrast, emphasizes the importance of doing over feeling, and further underscores that emotions cannot be controlled. Progress thus occurs through retraining oneself to focus on controllable behaviors, while simultaneously recognizing that positive or negative feelings are inherently fleeting. Naikan therapy emphasizes the importance of introspection, particularly as it relates to the good that one has received from significant others, along with awareness of the difficulties one has caused these others. This form of treatment is thus explicitly aligned with interdependent emphasis on Japanese well-being as detailed in our first section. That is, greater social harmony, a core component of what it means to be well in Japan, is clearly a central objective of the treatment. Again, emotional experience is secondary to the task of improving one's ties with others.

Taken as a whole, our chapter underscores the following key point: promoting well-being, whether among the general population or maladjusted individuals, is inextricably tied to cultural context. Although we have focused primarily on the contrast between Japan and the U.S., similar distinctions could have been illustrated with numerous other cultures as well. Hence, our overarching theme of attunement – the

need for a reasonable degree of fit between what one feels with surrounding norms and values. There is thus no single type of well-being to be promoted across cultures – one size does not fit all. Recognizing that cultures differ in their construal of psychological well-being is not, however, equivalent to blind relativism when it comes improving the human condition. Instead, we close with two opportunities for progress that will emerge from a more refined knowledge of well-being across cultures.

First, whatever the context, research can help clarify the impact (for individuals and for societies) of possessing different types of well-being. One way to pursue this question is to investigate the health consequences of such experiences as happiness, purposeful engagement, and social harmony. Such inquiries are increasingly underway, with evidence showing that higher levels of well-being are linked with better health profiles, measured in terms of morbidity and mortality as well as biological risk factors (e.g., Boehm and Kubzansky 2012; Boyle et al. 2009; Pressman and Cohen 2005; Ryff et al. 2006; Steptoe et al. 2005). Missing from such research to date, however, is consideration of whether such associations vary across cultural contexts (as seen in Miyamoto and Ryff 2011) and depending on the component of well-being assessed. It is an open question whether social harmony better predicts health outcomes in the East versus the West, or whether self-esteem is more strongly predictive of good health in the West compared to the East.

Second, as we achieve greater insights into our respective cultures, we may acquire a deeper understanding of what constitutes their respective strengths and weaknesses. For example, the West is often caricatured as a realm of unbridled individualism that can leave social ties neglected and may instill unrealistic expectations about achieving personal happiness and promote resistance to accepting negativity. Alternatively, Eastern social harmony and concern for meeting obligations to others can hamper opportunities for personal development and self-realization. Importantly, these questions are themselves open to scientific inquiry, to the extent that cross-cultural studies include diverse assessments of well-being (derived from both independent and interdependent formulations) and use them to predict meaningful outcomes, such as health. Thus, rather than engage in arm-chair philosophizing to resolve which kinds of well-being are most conducive to good health, questions can be adjudicated by looking at the evidence across different cultural contexts.

Such empirical evidence will serve another purpose as well – namely, to inform the world about what constitute more effective clinical treatments and interventions, which, in turn, will help in building health education programs and supportive public policies.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.

Boehm, J. K., & Kubzansky, L. D. (2012). The heart's content: The association between positive psychological well-being and cardiovascular health. *Psychological Bulletin*. Advance online publication. doi:10.1037/a0027448.

Boyle, P. A., Barnes, L. L., Buchman, A. S., & Bennett, D. A. (2009). Purpose in life is associated with mortality among community-dwelling older persons. *Psychosomatic Medicine, 71*(5), 574–579. doi:10.1097/PSY.0b013e3181a5a7c0.

Bradburn, N. M. (1969). *The structure of psychological well-being*. Chicago: Aldine.

Desapriya, E. B. R., & Nobutada, I. (2002). Stigma of mental illness in Japan. *The Lancet, 359*(9320), 1866. doi:10.1016/s0140-6736(02)08698-1.

Diener, E., & Suh, E. M. (2000). *Culture and subjective well-being*. Cambridge, MA: The MIT Press.

Fava, G. A., & Ruini, C. (2003). Development and characteristics of a well-being enhancing psychotherapeutic strategy: Well-being therapy. *Journal of Behavior Therapy and Experimental Psychiatry, 34*(1), 45–63. doi:10.1016/S0005-7916(03)00019-3.

Fava, G. A., Rafanelli, C., Grandi, S., Conti, S., & Belluardo, P. (1998). Prevention of recurrent depression with cognitive behavioral therapy. *Archives of General Psychiatry, 55*, 816–821. doi:10.1001/archpsyc.55.9.816.

Fava, G. A., Ruini, C., Rafanelli, C., Finos, L., Conti, S., & Grandi, S. (2004). Six-year outcome of cognitive behavior therapy for prevention of recurrent depression. *American Journal of Psychiatry, 161*(10), 1872–1876.

Fava, G. A., Ruini, C., & Belaise, C. (2007). The concept of recovery in major depression. *Psychological Medicine, 37*(3), 307–317. doi:10.1017/s0033291706008981.

Frank, E., Prien, R. F., Jarrett, R. B., Keller, M. B., Kupfer, D. J., Lavori, P. W., Rush, A. J., & Weissman, M. M. (1991). Conceptualization and rationale for consensus definitions of terms in major depressive disorder: Remission, recovery, relapse, and recurrence. *Archives of General Psychiatry, 48*(9), 851–855. doi:10.1001/archpsyc.1991.01810330075011.

Heine, S. J., Lehman, D. R., Markus, H. R., & Kitayama, S. (1999). Is there a universal need for positive self-regard? *Psychological Review, 106*, 766–794.

Inglehart, R., & Welzel, C. (2005). *Modernization, cultural change, and democracy: The human development sequence* (pp. 13–39). New York: Cambridge University Press.

Ishida, R. (1969). Naikan analysis. *Psychologia, 12*, 81–92.

Kahneman, D., Diener, E., & Schwarz, N. (Eds.). (1999). *Well-being: The foundations of hedonic psychology*. New York: Russell Sage Foundation.

Kan, C., Karasawa, M., & Kitayama, S. (2009). Minimalist in style: Self, identity, and well-being in Japan. *Self and Identity, 8*(2/3), 300–317. doi:10.1080/15298860802505244.

Karasawa, M., Curhan, K., Markus, H., Kitayama, S., Love, G., Radler, B., & Ryff, C. (2011). Cultural perspectives on aging and well-being: A comparison of Japan and the United States. *International Journal of Aging & Human Development, 73*(1), 73–98. doi:10.2190/AG.73.1.d.

Kato, T. A., Shinfuku, N., Sartorius, N., & Kanba, S. (2011). Are Japan's hikikomori and depression in young people spreading abroad? *The Lancet, 378*(9796), 1070. doi:10.1016/s0140-6736(11)61475-x.

Kawakami, N., Takeshima, T., Ono, Y., Uda, H., Hata, Y., Nakane, Y., Nakane, H., Iwata, N., Furukawa, T. A., & Kikkawa, T. (2005). Twelve-month prevalence, severity, and treatment of common mental disorders in communities in Japan: Preliminary finding from the World Mental Health Japan Survey 2002–2003. *Psychiatry and Clinical Neurosciences, 59*(4), 441–452. doi:10.1111/j.1440-1819.2005.01397.x.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627. doi:10.1001/archpsyc.62.6.617.

Keyes, C. L. M., Shmotkin, D., & Ryff, C. D. (2002). Optimizing well-being: The empirical encounter of two traditions. *Journal of Personality and Social Psychology, 82*(6), 1007–1022. doi:10.1037/0022-3514.82.6.1007.

Kitayama, S., & Markus, H. R. (2000). The pursuit of happiness and the realization of sympathy: Cultural patterns of self, social relations, and well-being. In E. Diener & E. M. Suh (Eds.), *Culture and subjective well-being* (pp. 113–161). Cambridge, MA: The MIT Press.

Kitayama, S., Markus, H. R., & Kurokawa, M. (2000). Culture, emotion, and well-being: Good feelings in Japan and the United States. *Cognition and Emotion, 14*(1), 93–124.

Kitsuse, J. I. (1964). *Moral treatment and reformation of inmates in Japanese prisons.* Paper presented at the First International Congress for Social Psychiatry. (Reprinted in *Psychologia* (1965), 8, 9–23).

Kleinman, A., & Good, B. (Eds.). (1985). *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder*. Berkeley: University of California Press.

Kleinman, A., & Kleinman, J. (1985). Somatization: The interconnections in Chinese society among culture, depressive experiences, and the meaning of pain. In A. Kleinman & B. Good (Eds.), *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder* (pp. 429–489). Berkeley: University of California Press.

Koyama, A., Miyake, Y., Kawakami, N., Tsuchiya, M., Tachimori, H., & Takeshima, T. (2010). Lifetime prevalence, psychiatric comorbidity and demographic correlates of hikikomori in a community population in Japan. *Psychiatry Research, 176*(1), 69–74. doi:10.1016/j.psychres.2008.10.019.

McCurry, J. (2008). Japan to rethink suicide-prevention policies. *The Lancet, 371*(9630), 2071. doi:10.1016/s0140-6736(08)60900-9.

Miyamoto, Y., & Ma, X. (2011). Dampening or savoring positive emotions: A dialectical cultural script guides emotion regulation. *Emotion, 11*(6), 1346–1357. doi:10.1037/a0025135.

Miyamoto, Y., & Ryff, C. D. (2011). Cultural differences in the dialectical and non-dialectical emotional styles and their implications for health. *Cognition and Emotion, 25*(1), 22–39. doi:10.1080/02699931003612114.

Morozink, J. A., Friedman, E. M., Coe, C. L., & Ryff, C. D. (2010). Socioeconomic and psychosocial predictors of interleukin-6 in the MIDUS national sample. *Health Psychology, 29*(6), 626–635. doi:10.1037/a0021360.

Murray, C. J. L., & Lopez, A. D. (1997). Alternative projection of mortality and disability by cause, 1990–2020: Global Burden of Disease study. *The Lancet, 349*, 1498–1504.

Peng, K., & Nisbett, R. E. (1999). Culture, dialectics, and reasoning about contradiction. *American Psychologist, 54*(9), 741–754. doi:10.1037/0003-066x.54.9.741.

Pressman, S. D., & Cohen, S. (2005). Does positive affect influence health? *Psychological Bulletin, 131*(6), 925–971. doi:10.1037/0033-2909.131.6.925.

Reynolds, D. K. (1976). *Morita psychotherapy*. Berkeley: University of California Press.

Reynolds, D. K. (1982). *The quiet therapies: Japanese pathways to personal growth*. Honolulu: University of Hawaii Press.

Ruini, C., & Fava, G. A. (2009). Well-being therapy for generalized anxiety disorder. *Journal of Clinical Psychology, 65*(5), 510–519.

Ruini, C., Ottolini, F., Tomba, E., Belaise, C., Albieri, E., Visani, D., Offidani, E., Caffo, E., & Fava, G. A. (2009). School intervention for promoting psychological well-being in adolescence. *Journal of Behavior Therapy and Experimental Psychiatry, 40*(4), 522–532.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology, 52*, 141–166. doi:10.1146/annurev.psych.52.1.141.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*(6), 1069–1081. doi:10.1037/0022-3514.57.6.1069.

Ryff, C. D., & Singer, B. H. (2008). Know thyself and become what you are: A eudaimonic approach to psychological well-being. *Journal of Happiness Studies, 9*(1), 13–39. doi:10.1007/s10902-006-9019-0.

Ryff, C. D., Love, G. D., Urry, H. L., Muller, D., Rosenkranz, M. A., Friedman, E. M., Davidson, R. J., & Singer, B. H. (2006). Psychological well-being and ill-being: Do they have distinct or mirrored biological correlates? *Psychotherapy and Psychosomatics, 75*, 85–95. doi:10.1159/000090892.

Schimmack, U., Oishi, S., & Diener, E. (2002). Cultural influences on the relation between pleasant emotions and unpleasant emotions: Asian dialectic philosophies or individualism-collectivism? *Cognition and Emotion, 16*(6), 705–719. doi:10.1080/02699930143000590.

Steptoe, A., Wardle, J., & Marmot, M. (2005). Positive affect and health-related neuroendocrine, cardiovascular, and inflammatory processes. *Proceedings of the National Academy of Sciences of the United States of America, 102*(18), 6508–6512. doi:10.1073/pnas.0409174102.

Steptoe, A., Gibson, E. L., Hamer, M., & Wardle, J. (2006). Neuroendocrine and cardiovascular correlates of positive affect measured by ecological momentary assessment and by questionnaire. *Psychoneuroendocrinology, 32*, 56–74. doi:10.1016/j.psyneuen.2006.10.001.

Suzuki, T., & Suzuki, R. (1977). *A follow-up of neurotics treated by Morita Therapy.* Paper presented at the 6th World Congress of Psychiatry, Honolulu.

Takeuchi, K. (1965). On *Naikan* method. *Psychologia, 8*, 2–8.

Tomba, E., Belaise, C., Ottolini, F., Ruini, C., Bravi, A., Albieri, E., Rafanelli, C., Caffo, E., & Fava, G. A. (2010). Differential effects of well-being promoting and anxiety-management strategies in a non-clinical school setting. *Journal of Anxiety Disorders, 24*(3), 326–333. doi:10.1016/j.janxdis.2010.01.005.

Tsai, J. L. (2007). Ideal affect: Cultural causes and behavioral consequences. *Perspectives on Psychological Science, 2*, 242–259.

Tsunetsugu, Y., Park, B. J., & Miyazaki, Y. (2010). Trends in research related to "Shinrin-yoku" (taking in the forest atmosphere or forest bathing) in Japan. *Environmental Health and Preventive Medicine, 15*, 27–37.

Uchida, Y., & Kitayama, S. (2009). Happiness and unhappiness in east and west: Themes and variations. *Emotion, 9*(4), 441–456.

Uchida, Y., Norasakkunit, V., & Kitayama, S. (2004). Cultural constructions of happiness: Theory and empirical evidence. *Journal of Happiness Studies, 5*(3, Special Issue), 223–239.

Wilson, W. R. (1967). Correlates of avowed happiness. *Psychological Bulletin, 67*(4), 294–306. doi:10.1037/h0024431.

WHO International Consortium in Psychiatric Epidemiology. (2000). Cross-national comparisons of the prevalences and correlates of mental disorders. *Bulletin of the World Health Organization, 78*, 413–426.

Yamamoto, H. (1972). *Naikan ryoho* [Naikan Therapy]. Tokyo: Igaku Shoin.

Chapter 2
The Individualized and Cross-Cultural Roots of Well-being Therapy

Chiara Ruini and Giovanni Andrea Fava

2.1 Introduction

In 1948 the World Health Organization defined health as a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO 1948). Further early experts in psychosomatics, such as Kissen (1963), Engel (1960, 1967), and Lipowski (1977) suggested the importance of evaluating the complexity of clinical phenomena in the equilibrium between health and disease (Fava and Sonino 2010). Kissen (1963) clarified that the relative weight of psychosocial factors may vary considerably from one individual to another within the same illness. Engel developed a biopsychosocial model of illness (1977) where the study of the diseases must include the individual, his/her body and his/her surrounding environment as essential components of the total system. In the same vein, Lipowski (1977) underlined the importance of studying the relationships of biological, psychological and social determinants of health and disease. Thus, researchers recognized the need for multiple indicators in evaluating well-being and treatment outcomes (Fava and Sonino 2010; Rafanelli and Ruini 2012).

Nevertheless, in almost all Western countries, a negativity bias that drives researchers and clinicians to attend to and be more affected by the negativity, such as symptoms and dysfunctions, has prevailed (Haizlip et al. 2012). This "negativity bias" is constantly reinforced starting from the educational background provided to clinicians and to students in medical schools, where many teaching methods and clinical reasoning are focused on a "negative approach" (Haizlip et al. 2012). Haizlip et al. (2012) suggested that this negativity bias is strictly linked to our Western culture that inadvertently emphasizes the tendency to recognize, to remember and to pay

C. Ruini, Ph.D. (✉) • G.A. Fava, M.D.
Department of Psychology, University of Bologna, Bologna, Italy
e-mail: chiara.ruini@unibo.it; giovanniandrea.fava@unibo.it

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_2, © Springer Science+Business Media Dordrecht 2014

attention to the negative aspects in human life. Thus, the negatively biased medical model embraced clinical practice, clinical research and general approach to illnesses and disease in Europe and North America.

Conversely, in Eastern countries, such as India, China and Japan, the traditional clinical models always involved a holistic approach to the individuals, their illnesses and other factors, such as energies, nature elements and spirituality (Hao et al. 2011). Even though they could be very differentiated, all eastern clinical models emphasize mind-body connections (Chan and Chow 2001) and are mainly focused on mobilizing human's capacity for self-adjustment and self-rehabilitation.

These concepts, however, also found some consideration in Western psychology and psychotherapy. For instance, since its early stages, clinical psychology research emphasized issues such as Jung's concept of individuation (1933), Frankl conceptualization of resilience and meaning (1959), and Jahoda criteria for positive mental health (1958). Similarly, humanistic psychology suggested concepts such as self-realization and self-actualization as final therapeutic goal (Maslow 1968; Rogers 1961). In 1954, Parloff, Kelman & Frank suggested that the goals of psychotherapy were increased personal comfort and effectiveness. For a long time these latter achievements were viewed only as by-products of the reduction of symptoms or as a luxury that clinical investigators could not afford. As a result, mental health research has been dramatically weighted on the side of psychological dysfunction and health was equated with the absence of illness, rather than the presence of wellness (Ryff and Singer 1996).

However, the inadequacy of this medical model applied to mental health domains has emerged. First of all, there is increasing awareness that the concept of recovery in clinical psychiatry and psychology cannot simply be confounded with response to treatment or limited to the abatement of certain symptoms. In fact, there is a growing body of literature on residual symptoms after apparently successful treatment in mood and anxiety disorders. Most residual symptoms also occur in the prodromal phase of illness and may progress to become prodromes of relapse (Fava et al. 2007a). The recognition of residual symptomatology has led to psychotherapeutic treatment specifically addressed to residual symptomatology, which was indeed found to improve long-term outcome of major depressive disorders (Fava et al. 2005a).

Further, partial remission after treatment was not found to be limited to negative affective symptoms. Remitted patients with mood and anxiety disorders displayed significantly lower levels of psychological well-being compared to healthy control subjects (Rafanelli et al. 2000). The question then arose as to whether also such impairment was amenable to amelioration upon psychological treatment.

Finally, clinicians working with patients with mood and anxiety disorders are often confronted with the unsatisfactory degree of remission that current therapeutic strategies yield and with the vexing problems of relapse and recurrence (Fava et al. 2007b). The need to develop intervention strategies and programs by including psychological well-being has then become manifest.

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 vs. languishing developed by Keyes (2002) 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 (Delle Fave and Fava 2011).

However, a basic problem to be addressed is the consensus on a definition of well-being, that may be used to plan interventions and set treatment outcomes.

2.2 The Concept of Psychological Well-being and Its Clinical Implications

Until now, well-being research has been grounded in the Western tradition, with its individualistic features shared by a minority of nations (Triandis 1995). For instance, research showed that the higher levels of subjective well-being (SWB) reported by European Americans compared with Eastern Asians are clearly grounded in cultural expectations and conceptualizations (Kitayama et al. 2000, 2004). However, all human cultures are concerned with well-being (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 (Delle Fave and Fava 2011).

2.2.1 The Concept of Well-being in Philosophy

A seminal review by Ryan and Deci (2001) examined the concept of well-being and described two main approaches, the hedonic and the eudaimonic one. According to the former, well-being consists of subjective happiness, pleasure and pain avoidance. Thus, the concept of well-being is equated with the experience of positive emotions versus negative emotions and with satisfaction in various domains of one's life. According to the eudaimonic perspective, well-being consists of fulfilling one's potential in a process of self-realization. Under this umbrella some researchers describe concepts such as fully functioning person, meaningfulness, self-actualization and vitality. Both concepts of well-being have specific philosophical background deriving from Greek traditions: the eudaimonic is certainly more linked to Aristotelian approach, whereas the hedonic is more linked to Aristippus and Epicurus theories (Ryff and Singer 2008). Thus, the interest in positivity and well-being is intrinsically grounded in European/Western culture. Nevertheless the negativity based medical model has guided mental health research so far.

Recently, with the diffusion of positive psychology movement, these two approaches have lead to different areas of research, but they complement each other

in defining the construct of well-being (Ryan and Deci 2001). Some Authors have also suggested that they can compensate each other; thus individuals may have profiles of high eudamonic well-being and low hedonic well-being, or vice versa. These profiles are also associated to sociodemographic variables, such as age, years of education and employment (Keyes et al. 2002) However, in this investigations, Authors underlined the fact that only a small proportion of individuals presents optimal well-being, that is high hedonic and eudemonic well-being, paving the way for possible psychosocial interventions.

Importantly, in describing optimal human functioning, Ryff and Singer (2008) emphasize Aristotele's admonishment to seek "that which is intermediate", avoiding excess and extremes. The pursuit of well-being may in fact be so solipsistic and individualistic to leave no room for human connection and the social good; or it could be so focused on responsibilities and duties outside the self that personal talents and capacities are neither recognized or developed (Ryff and Singer 2008). Other body of literature from 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).

Cross-cultural data collected in seven Western cultures by an international team (Delle Fave et al. 2010) confirmed the importance of harmony/balance as a component of well-being. The term "harmony" reflects more specifically the perception of inner peace, self-acceptance, 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 refers to harmony as mixing different things and balancing opposite elements into a whole, as in cooking and making music.

Several converging philosophical conceptualizations (Ryff and Singer 2008; Chenyang 2008) thus value the concept of balance, both as a theoretical guide and as an empirical reality that scholars of well-being need to appreciate.

2.2.2 The Concept of Well-being in Clinical Psychology

In clinical psychology the eudaimonic view has found much more feasibility, compared to the hedonic approach, because it concerns human potential and personal strength (Ryff and Singer 1996, 2008). Ryff's model of psychological well-being, encompassing autonomy, personal growth, environmental mastery, purpose in life, positive relations and self-acceptance (see Chap. 1 of this book) has been found to fit specific impairments of patients with affective disorders (Rafanelli et al. 2000, 2002; Fava et al. 2001; Ruini et al. 2002). Further, the absence of psychological well-being was found to be a risk factor for depression

(Wood and Joseph 2010). Thunedborg et al. (1995) observed that quality of life measurement, and not symptomatic ratings, could predict recurrence of depression. An increase in psychological well-being may thus protect against relapse and recurrence (Wood and Joseph 2010). Therefore an intervention that targets the positive may address an aspect of functioning and health that is typically left unaddressed in conventional treatments.

Even though there is overwhelming evidence of major cross-cultural differences in the definition and evaluation of both well-being and psychopathology (Massimini and Delle Fave 2000; Marsella and Yamada 2007), Ryff and Singer (1996) suggested that the route to enduring recovery lies not exclusively in alleviating the negative, but in engendering the positive. Certainly cultures shape individuals' behavior and conception of what a good life is, both providing a meaning-making system for daily events and interactions, and fostering/limiting opportunities for goal setting, personal growth and self-expression (Ryan and Deci 2001; Uchida et al. 2004). In any case Ryff and Singer (1996) underlined that interventions that bring the person out of the negative functioning are one form of success, but facilitating progression toward the restoration of positive is quite another. Early pioneer works in this research domain, can be considered Ellis and Becker's (1982) guide to personal happiness, Fordyce's (1983) program to increase happiness, Padesky's (1994) work on schema change processes, Frisch's (1998, 2006) quality of life therapy, and Horowitz and Kaltreider's (1979) work on positive states of mind. Again, by a cultural point of view, psychotherapeutic interventions addressed to positivity shared common Western cultural tradition.

2.2.3 The Concept of Well-being in Psychosomatics

Recently, many investigations in psychosomatic research provided confirmation to the protective role of well-being, both for mental and physical health. Positive emotions and well-being, with the contribution of other factors, can influence the healing process of various diseases and longevity (Chida and Steptoe 2008; Fava and Sonino 2010). Some Authors, such as Seeman et al. (2002), have investigated the role of social support and interpersonal relationships in psychosomatics. They concluded that the presence of positive relationships is associated with lower levels of allostatic load, which reflects the cumulative effects of stressful experiences in daily life (Fava et al. 2010; McEwen and Stellar 1993). As conditions of psychosocial distress and mental illness have been found to be associated with specific alterations of certain biological indicators of allostatic load (McEwen and Stellar 1993), Ryff and Singer (1996, 1998) therefore suggested that the presence of psychological well-being is a protective factor, that could be associated with variations in the same biological parameters of allostatic load. In the same line, research has indeed suggested the important role of positive affectivity (Fredrickson and Joiner 2002) in promoting resilience and growth.

Specific dimensions of positive functioning, namely autonomy and independence, have resulted to be related to increased level of noradrenaline (Seeman et al. 2002) and seem thus to be associated to in increased stress response. Similarly, excessively elevated levels of positive emotions can become detrimental and are more connected with mental disorders and impaired functioning (Fredrickson and Losada 2005). In 1991 Garamoni et al. suggested that healthy functioning is characterized by an optimal balance of positive and negative cognitions or affects, and that psychopathology is marked by deviations from the optimal balance.

Positive interventions, thus, should not be simply aimed to increase happiness and well-being, but should consider the complex balance between psychological well-being and distress (MacLeod and Moore 2000) and be targeted to specific and individualized needs. Wood and Tarrier (2010) emphasize that positive characteristics such as gratitude and autonomy often exist on a continuum. They are neither "negative" or "positive": their impact depends on the specific situation and on the interaction with concurrent distress and other psychological attitudes. All these elements should be taken into account in the psychotherapy process. The promotion of well-being should comprise the cultural competence of the patients, that is their optimal functioning contextualized in their daily cultural environment (Leong and Wong 2003).

An example of psychotherapeutic intervention that takes into consideration the above concepts for in achieving a balanced and individualized path to optimal functioning is Well-being Therapy (WBT) (Ruini and Fava 2012).

2.3 The Structure of Well-being Therapy

Well-being therapy is a short-term psychotherapeutic strategy, that extends over 8–12 sessions, which may take place every week or every other week (Fava 1999; Fava and Ruini 2003; Ruini and Fava 2012). The duration of each session may range from 30 to 50 min. It is a technique which emphasizes self-observation (Emmelkamp 1974), with the use of a structured diary, and interaction between patients and therapists. Well-being therapy is based on Ryff's cognitive model of psychological well-being (Ryff 1989), encompassing six dimensions of positive functioning and eudaimonic well-being: autonomy, environmental mastery, personal growth, purpose in life, self-acceptance and positive interpersonal relationships. The development of sessions is as follows.

2.3.1 Initial Sessions

These sessions are simply concerned with identifying episodes of well-being and setting them into a situational context, no matter how short lived they were. Patients are asked to report in a structured diary the circumstances surrounding their

episodes of well-being, rated on a 0–100 scale, with 0 being absence of well-being and 100 the most intense well-being that could be experienced.

Patients are particularly encouraged to search for well-being moments, not only in special hedonic–stimulating situations, but also during their daily activities. Several studies have shown that individuals preferentially invest their attention and psychic resources in activities associated with rewarding and challenging states of consciousness, in particular with optimal experience (Csikszentmihalyi 1990). This is characterized by the perception of high environmental challenges and environmental mastery, deep concentration, involvement, enjoyment, control of the situation, clear feedback on the course of activity and intrinsic motivation (Deci and Ryan 1985). Cross-sectional studies have demonstrated that optimal experience can occur in any daily context, such as work and leisure (Delle Fave and Massimini 2003). Patients are thus asked to report when they feel optimal experiences in their daily life and are invited to list the associated activities or situations.

This initial phase generally extends over a couple of sessions. Yet its duration depends on the factors that affect any homework assignment, such as resistance and compliance.

2.3.2 Intermediate Sessions

Once the instances of well-being are properly recognized, the patient is encouraged to identify thoughts and beliefs leading to premature interruption of well-being. The similarities with the search for irrational, tension-evoking thoughts in Ellis and Becker's rational-emotive therapy (1982) and automatic thoughts in cognitive therapy (Beck and Emery 1985; Beck et al. 1979) are obvious. The trigger for self-observation is, however, different, being based on well-being instead of distress.

This phase is crucial, since it allows the therapist to identify which areas of psychological well-being are unaffected by irrational or automatic thoughts and which are saturated with them. The therapist may also reinforce and encourage activities that are likely to elicit well-being and optimal experiences (for instance, assigning the task of undertaking particular pleasurable activities for a certain time each day). Such reinforcement may also result in graded task assignments (Beck et al. 1979), with special reference to exposure to feared or challenging situations, which the patient is likely to avoid. Over time patients may develop ambivalent attitudes toward well-being. They complain of having lost it, or they long for it, but at the same time they are scared when positive moments actually happen in their lives. These moments trigger specific negative automatic thoughts, usually concerning the fact that they will not last (i.e., it's too good to be true) or that they are not deserved by patients, or that they are attainable only by overcoming difficulties and distress. Encouraging patients in searching and engaging in optimal experiences and pleasant activities is therefore crucial at this stage of WBT.

This intermediate phase may extend over 2 or 3 sessions, depending on the patient's motivation and ability, and it paves the way for the specific well-being enhancing strategies.

2.3.3 Final Sessions

The monitoring of the course of episodes of well-being allows the therapist to realize specific impairments in well-being dimensions according to Ryff's conceptual framework. An additional source of information may be provided by Ryff's Scales of Psychological Well-being (PWB), an 84-item self-rating inventory (Ryff 1989). Ryff's six dimensions of psychological well-being are progressively introduced to the patients, as long as the material which is recorded lends itself to it. For example, the therapist could explain that autonomy consists of possessing an internal locus of control, independence and self-determination; or that personal growth consists of being open to new experience and considering self as expanding over time, if the patient's attitudes show impairments in these specific areas. Errors in thinking and alternative interpretations are then discussed. At this point in time the patient is expected to be able to readily identify moments of well-being, be aware of interruptions to well-being feelings (cognitions), utilize cognitive behavioral techniques to address these interruptions, and to pursue optimal experiences. Meeting the challenge that optimal experiences may entail is emphasized, because it is through this challenge that growth and improvement of self can take place.

2.4 Well-being Therapy: Clinical Framework

Cognitive restructuring in well-being therapy follows Ryff's conceptual framework (Ryff and Singer 1996). The 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. This means that patients are not simply encouraged pursing the highest possible levels in psychological well-being, in all dimensions, but to obtain a balanced functioning. This optimal-balanced well-being could be different from patient to patient, according to factors, such as personality traits, social roles and cultural and social contexts (Ruini et al. 2003; Ruini and Fava 2012).

The various dimensions of positive functioning can compensate each other (some being more interpersonally-oriented, some more personal/cognitive) and the aim of WBT, such as other positive interventions, should be the promotion of an optimal-balanced functioning between these dimensions, in order to facilitate individual flourishing (Keyes 2002). This means that sometimes patients should be encouraged to decrease their level of positive functioning in certain domains. Without this clinical framework, the risk is to lead patients at having too high levels of self-confidence, with unrealistic expectations that may become dysfunctional and/or stressful to individuals, as described in Table 2.1.

Environmental mastery (Table 2.1)

This is the most frequent impairment that emerges, that is felt by patients as a lack of sense of control. This leads the patients to miss surrounding opportunities, with

Table 2.1 Modifications of Well-being dimensions to achieve a balanced, optimal functioning

Dimensions	Low level	Balanced-functional level	High level
Environmental Mastery *Wisdom,* *Self determination* *Optimal experience*	The person feels difficulties in managing everyday affairs; feels unable to improve surrounding context; is unaware of surrounding opportunities; and lacks sense of control over external world.	The person has a sense of mastery and competence in managing the environment; makes effective use of surrounding opportunities; is able to choose contexts suitable to personal needs.	The person is unable to savoring positive emotions and hedonic pleasure.
Personal growth *Meaning* *Post-traumatic growth* *Benefit finding* *Intrinsic motivation*	The person has a sense of personal stagnation; lacks sense of improvement over time; feels bored and uninterested with life.	The person has a sense of continued development; sees self as growing and improving; is open to new experiences; has sense of realizing own potential.	The person is unable to process negativity, does not give enough emphasis to past negative experiences, cultivates benign illusions that do not fit with reality, sets unrealistic standards for overcoming adversities.
Purpose in life *Goals* *Hope* *Passion* *Optimism*	The person lacks a sense of meaning in life; has few goals or aims, lacks sense of direction.	The person has goals in life and feels there is meaning to present and past life; has aims and objectives for living.	The person has obsessional passions, is unable to admit failures. He/she manifests persistence and rigidity. Excessive hope is paralyzing and hampers facing negativity and failures.
Autonomy *Leadership,* *Locus of controls* *Self determination* *Bravery*	The person is overconcerned with the expectations and evaluation of others; relies on judgment of others to make important decisions.	The person is independent; able to resist to social pressures; regulates behavior from within; evaluates self by personal standards.	The person is unable to get along with other people, to work in team, to learn from others. Relies only on himself/herself for solving problems, and is unable to ask for advice or help.
Self-acceptance *Self-esteem* *Positive reframing*	The person feels dissatisfied with self; is disappointed with what has occurred in past life; wishes to be different than what he or she is.	The person has a positive attitude toward the self; accepts his/her good and bad qualities; feels positive about past life.	Narcissism, egocentrism, difficulties in admitting owns mistakes, rigidity
Positive relations *Empathy* *Generosity,* *Altruism* *Forgiveness* *Gratitude*	The person has few close, trusting relationships with others; finds difficult to be open and is isolated and frustrated in interpersonal relationship.	The person has warm and trusting relationships with others; is concerned about the welfare of others; capable of strong empathy affection, and intimacy; understands give and take of human relationships.	Due to exaggerated empathy, the person feels pain and distress of others. He/she sacrifices his/her needs and well-being for those of others. His/her extreme capacity to forgive and be grateful toward others could mask low self esteem and sense of wothlessness.

the possibility of subsequent regret over them. On the other hand, sometimes patients may require help because they are unable to enjoy and savoring daily life, as they are too engaged in work or family activities. Their abilities of planning and solving problems may lead others to constantly ask for their help, with the resulting feeling of being exploited and overwhelmed by requests. These extremely high levels of environmental mastery thus become a source of stress and allostatic load to the individual. Environmental mastery can be considered a key mediator or moderator of stressful life experiences (Fava et al. 2010). A positive characterization of protective factors converges with efforts to portray the individual as a psychological activist, capable of proactive and effective problem- solving, rather than passively buffeted by external forces (Ryff and Singer 1998), but also capable of finding time for rest and relaxing in daily life.

Personal growth (Table 2.1)

Patients often tend to emphasize their distance from expected goals much more than the progress that has been made toward goal achievement. A basic impairment that emerges is the inability to identify the similarities between events and situations that were handled successfully in the past and those that are about to come (transfer of experiences). On the other hand people with levels of personal growth that are too high tend to forget on do not give enough emphasis to past experiences because they are exclusively future-oriented. Negative or traumatic experiences could particularly be under-estimated (Held 2002; Norem and Chang 2002), as a sort of extreme defense mechanism (denial), i.e., "I just need to get over this situation and go on with my life". Dysfunctional high personal growth is similar to a cognitive benign illusion, or wishful thinking, which hinders the integration of past (negative) experiences and their related learning process.

Purpose in life (Table 2.1)

Patients may perceive a lack of sense of direction and may devalue their function in life. This particularly occurs when environmental mastery and sense of personal growth are impaired. On the other hand, many other conditions worthy of clinical attention may arise from too high levels of purpose in life. First of all individuals with a strong determination in realizing one (or more) life goal(s) could dedicate themselves fully to their activity, thereby allowing them to persist, even in the face of obstacles, and to eventually reach excellence. This again could have a cost in terms of allostatic load and stress. Further, Vallerand et al. (2003) have proposed the concept of obsessive passion for describing an activity or goal that becomes a central feature of one's identity and serves to define the person. Individuals with an obsessive passion come to develop ego-invested self-structures (Hodgins and Knee 2002) and, eventually, display a rigid persistence toward the activity thereby leading to less than optimal functioning. Such persistence is rigid because it not only occurs in the absence of positive emotions and sometimes of positive feedbacks, but even in the face of important personal costs such as damaged relationships, failed commitments and conflicts with other activities in the person's life (Vallerand et al. 2007). The individual

engagement for a certain goal could thus become a form of psychological inflexibility (Kashdan and Rottenberg 2010) which is more connected with psychopathology, than well-being. Some individuals, in fact, remains attached to their goals even when these seem to be unattainable, and keep believing that they would be happy pending the achievement of these goals. These mechanisms are associated with hopelessness (MacLeod and Conway 2007; Hadley and Macleod 2010) and parasuicidal behaviors (Vincent et al. 2004). Further, this confirms the idea that hope, another future-oriented positive emotion, can become paralyzing and hampers facing and accepting negativity and failures (Bohart 2002; Geraghty et al. 2010).

Autonomy (Table 2.1)

It is a frequent clinical observation that patients may exhibit a pattern whereby a perceived lack of self-worth leads to unassertive behavior. For instance, patients may hide their opinions or preferences, go along with a situation that is not in their best interests, or consistently put their needs behind the needs of others. This pattern undermines environmental mastery and purpose in life and these, in turn, may affect autonomy, since these dimensions are highly correlated in clinical populations. Such attitudes may not be obvious to the patients, who hide their considerable need for social approval. A patient who tries to please everyone is likely to fail to achieve this goal and the unavoidable conflicts that may result in chronic dissatisfaction and frustration. On the other hand, in Western countries particularly, individuals are culturally encouraged to be autonomous and independent. Certain individuals develop the idea that they should rely only on themselves for solving problems and difficulties, and are thus unable to ask for advice or help. Also in this case, an unbalanced high autonomy can become detrimental for social/interpersonal functioning (Seeman et al. 2002). Some patients complain they are not able to get along with other people, or work in team, or maintain intimate relationships, because they are constantly fighting for their opinions and independence.

Self-acceptance (Table 2.1)

Patients may maintain unrealistically high standards and expectations, driven by perfectionistic attitudes (that reflect lack of self-acceptance) and/or endorsement of external instead of personal standards (that reflect lack of autonomy). As a result, any instance of well-being is neutralized by a chronic dissatisfaction with oneself. A person may set unrealistic standards for her performance. On the other hand, an inflated self-esteem may be a source of distress and clash with reality, as was found to be the case in cyclothymia and bipolar disorder (Garland et al. 2010; Fava et al. 2011).

Positive relations with others (Table 2.1)

Interpersonal relationships may be influenced by strongly held attitudes of perfectionism which the patient may be unaware and which may be dysfunctional. Impairments in self-acceptance (with the resulting belief of being rejectable and unlovable, or others being inferior and unlovable) may also undermine positive

relations with others. There is a large body of literature (Uchino et al. 1996) on the buffering effects of social integration, social network properties, and perceived support. On the other hand, little research has been done on the possible negative consequences of an exaggerated social functioning. Characteristics such as empathy, altruism and generosity are usually considered universally positive. However, in clinical practice, patients often report sense of guilt for not being able to help someone, or to forgive an offence. An individual with a strong pro-social attitude can sacrifice his/her needs and well-being for those of others, and this in the long time becomes detrimental and sometimes disappointing. This individual can also become over-concerned and overwhelmed by others' problems and distress and be at risk for burn-out syndrome. Finally a generalized tendency to forgive others and be grateful toward benefactors could mask low self-esteem and low sense of personal worth.

2.5 WBT Validation Studies

Well-being therapy has been employed in several clinical studies. Other studies are currently in progress.

2.5.1 Residual Phase of Affective Disorders

The effectiveness of well-being therapy in the residual phase of affective disorders was first tested in a small controlled investigation (Fava et al. 1998a). Twenty patients with affective disorders who had been successfully treated by behavioral (anxiety disorders) or pharmacological (mood disorders) methods, were randomly assigned to either a well-being therapy or cognitive behavioral treatment (CBT) of residual symptoms. Both well-being and cognitive behavioral therapies were associated with a significant reduction of residual symptoms, as measured by the Clinical Interview for Depression (CID) (Guidi et al. 2011; Paykel 1985), and in PWB well-being. However, when the residual symptoms of the two groups were compared after treatment, a significant advantage of well-being therapy over cognitive behavioral strategies was observed with the CID. Well-being therapy was associated also with a significant increase in PWB well-being, particularly in the Personal Growth scale.

The improvement in residual symptoms was explained on the basis of the balance between positive and negative affect (Fava et al. 1998a). If treatment of psychiatric symptoms induces improvement of well-being, and indeed subscales describing well-being are more sensitive to drug effects than subscales describing symptoms (Kellner 1987; Rafanelli and Ruini 2012), it is conceivable that changes in well-being may affect the balance of positive and negative affect. In this sense, the higher degree of symptomatic improvement that was observed with well-being

therapy in this study is not surprising: in the acute phase of affective illness, removal of symptoms may yield the most substantial changes, but the reverse may be true in its residual phase.

2.5.2 Prevention of Recurrent Depression

Well-being therapy was a specific and innovative part of a cognitive behavioral package that was applied to recurrent depression (Fava et al. 1998b). This package included also CBT of residual symptoms and lifestyle modification. Forty patients with recurrent major depression, who had been successfully treated with antidepressant drugs, were randomly assigned to either this cognitive behavioral package including well-being therapy or clinical management. In both groups, antidepressant drugs were tapered and discontinued. The group that received cognitive behavioral therapy-WBT had a significantly lower level of residual symptoms after drug discontinuation in comparison with the clinical management group. Cognitive behavioral therapy-WBT also resulted in a significantly lower relapse rate (25 %) at a 2 year follow-up than did clinical management (80 %). At a 6 year follow-up (Fava et al. 2004) the relapse rate was 40 % in the former group and 90 % in the latter.

2.5.3 Loss of Clinical Effect During Drug Treatment

The return of depressive symptoms during maintenance antidepressant treatment is a common and vexing clinical phenomenon (Fava and Offidani 2011). Ten patients with recurrent depression who relapsed while taking antidepressant drugs were randomly assigned to dose increase or to a sequential combination of cognitive-behavior and well-being therapy (Fava et al. 2002). Four out of five patients responded to a larger dose, but all relapsed again on that dose by 1 year follow-up. Four out of the five patients responded to psychotherapy and only one relapsed. The data suggest that application of well-being therapy may counteract loss of clinical effect during long-term antidepressant treatment.

2.5.4 Treatment of Generalized Anxiety Disorder

Well-being Therapy has been applied for the treatment of generalized anxiety disorder (Fava et al. 2005b; Ruini and Fava 2009). Twenty patients with DSM-IV GAD were randomly assigned to eight sessions of CBT or the sequential administration of four sessions of CBT followed by other four sessions of WBT. Both treatments were associated with a significant reduction of anxiety. However, significant advantages of

the WBT-CBT sequential combination over CBT were observed, both in terms of symptom reduction and psychological well-being improvement. These preliminary results suggest the feasibility and clinical advantages of adding WBT to the treatment of GAD. A possible explanation to 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 (Ruini and Fava 2009).

2.5.5 Post-traumatic Stress Disorder

The use of WBT for the treatment of traumatized patients has not been tested in controlled investigations, yet. However, two cases were reported (Belaise et al. 2005) in which patients improved with WBT, 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 and warrant further investigation (Fava and Tomba 2009).

2.5.6 Cyclothymic Disorder

Well-being therapy was recently applied (Fava et al. 2011) in sequential combination with CBT for the treatment of cyclothymic disorder, that involves mild or moderate fluctuations of mood, thought, and behaviour without meeting formal diagnostic criteria for either major depressive disorder or mania (Baldessarini et al. 2011). Sixty-two patients with DSM-IV cyclothymic disorder were randomly assigned to CBT/WBT (n=31) or clinical management (CM) (n=31). An independent blind evaluator assessed the patients before treatment, after therapy, and at 1- and 2-year follow-ups. At post treatment, significant differences were found in all outcome measures, with greater improvements after treatment in the CBT/WBT group compared to the CM group. Therapeutic gains were maintained at 1- and 2-year follow-ups. The results of this investigation suggest that a sequential combination of CBT and WBT, which addresses both polarities of mood swings and comorbid anxiety, was found to yield significant and persistent benefits in cyclothymic disorder.

2.6 Conclusions

WBT was originally developed as a strategy for promoting psychological well-being which was still impaired after standard pharmacological or psychotherapeutic treatments in clinical populations. It was based on the assumption that these

impairments may vary from one illness to another, from patient to patient and even from one episode to another of the same illness in the same patient. These impairments represent a vulnerability factor for adversities and relapses (Fava and Tomba 2009; Ryff and Singer 1996; Wood and Joseph 2010).

Recently, other new psychotherapeutic strategies, summarized under the umbrella of third wave psychotherapies (Hofmann and Asmundson 2008), have been validated, enlarging their scopes to the improvement of patients' well-being. Their novelty consists of introducing Eastern techniques such as mindfulness meditation, love and kind meditation (Cohn and Fredrickson 2010) or Buddhist philosophy (see Chap. 3 of this book for a more complete review) combined with traditional CBT approach. It remains unclear if Western patients could fully understand and internalize their Eastern theoretical background, so different from their culture (Kohl et al. 2012). By a clinical point of view, the question is whether these new psychotherapies could really lead to patient's improvement and growth over time, or rather they constitute a series of good daily practices with positive effects on their quality of life and positive emotions (Cohn and Fredrickson 2010; Kohl et al. 2012).

WBT does not combine culturally different techniques, but unlike standard cognitive therapy which is based on rigid specific assumptions (e.g., the cognitive triad in depression), it is characterized by flexibility (Kashdan and Rottenberg 2010) and by an individualized approach for addressing psychological issues that other therapies have left unexplored, such as the promotion of eudaimonic well-being and optimal human functioning. We suggest that such functioning could be reached in some cases by diminishing some hedonic and eudaimonic dimensions when they impede flourishing (Keyes 2002). Individuals may be helped to move up form impaired low levels to optimal, but also to move down from high-dysfunctional to optimal-balanced levels. This diverse feasibility and flexibility of WBT is in line with the positive clinical psychology approach, which calls for a number of different interventions to be selected based on individual specific needs (Wood and Tarrier 2010).

References

Baldessarini, R. J., Vázquez, G., & Tondo, L. (2011). Treatment of cyclothymic disorder: Commentary. *Psychotherapy and Psychosomatics, 80*, 131–135.

Beck, A. T., & Emery, G. (1985). *Anxiety disorder and phobia*. New York: Basic Book.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.

Belaise, C., Fava, G. A., & Marks, I. M. (2005). Alternatives to debriefing and modifications to cognitive behavior therapy for posttraumatic stress disorder. *Psychotherapy and Psychosomatics, 74*, 212–217.

Bohart, A. C. (2002). Focusing on the positive, focusing on the negative: Implications for psychotherapy. *Journal of Clinical Psychology, 58*, 1037–1043.

Chan, C., & Chow, E. (2001). A body-mind-spirit model in health: An eastern approach. *Social Work in Health Care, 34*, 261–282.

Chenyang, L. (2008). The ideal of harmony in ancient Chinese and Greek philosophy. *Dao, 7*, 81–98.

Chida, Y., & Steptoe, A. (2008). Positive psychological well-being and mortality: A quantitative review of prospective observational studies. *Psychosomatic Medicine, 70*, 741–756.
Cohn, M. A., & Fredrickson, B. L. (2010). In search of durable positive psychology interventions: Predictors and consequences of long-term positive behavior change. *Journal of Positive Psychology, 5*(5), 355–366.
Csikszentmihalyi, M. (1990). *Flow: The psychology of optimal experience*. New York: Harper & Row.
Deci, E. L., & Ryan, R. M. (1985). *Intrinsic motivation and self-determination in human behavior*. New York: Plenum Press.
Delle Fave, A., & Fava, G. A. (2011). Positive psychotherapy and social change. In R. Biswas-Diner (Ed.), *Positive psychology as social change* (pp. 267–291). Berlin: Springer.
Delle Fave, A., & Massimini, F. (2003). Optimal experience in work and leisure among teachers and physicians. *Leisure Studies, 22*, 323–342.
Delle Fave, A., Brdar, I., Freire, T., Vella Brodrick, D. A., & Wissinig, M. P. (2010). The investigation of eudaimonic happiness: Qualitative and quantitative findings. *Social Indicators Research*. doi:10.1007/s1125-010-9632-5.
Ellis, A., & Becker, I. (1982). *A guide to personal happiness*. Hollywood: Melvin Powers Wilshire Book Company.
Emmelkamp, P. M. G. (1974). Self-observation versus flooding in the treatment of agoraphobia. *Behaviour Research and Therapy, 12*, 229–237.
Engel, G. L. (1960). A unified concept of health and disease. *Perspective in Biology and Medicine, 3*, 459–483.
Engel, G. L. (1967). The concept of psychosomatic disorder. *Journal of Psychosomatic Research, 11*, 3–9.
Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*, 129–136.
Fava, G. A. (1999). Well-being therapy. *Psychotherapy and Psychosomatics, 68*, 171–178.
Fava, G. A., & Offidani, E. (2011). The mechanisms of tolerance in antidepressant action. *Progress in Neuro-psychopharmacology & Biological Psychiatry, 35*(7), 1593–1602.
Fava, G. A., & Ruini, C. (2003). Development and characteristics of a well-being enhancing psychotherapeutic strategy: Well-being therapy. *Journal of Behavior Therapy and Experimental Psychiatry, 34*, 45–63.
Fava, G. A., & Sonino, N. (2010). Psychosomatic medicine. *International Journal of Clinical Practice, 64*, 1155–1161.
Fava, G. A., & Tomba, E. (2009). Increasing psychological well-being and resilience by psychotherapeutic methods. *Journal of Personality, 77*, 1903–1934.
Fava, G. A., Rafanelli, C., Cazzaro, M., Conti, S., & Grandi, S. (1998a). Well-being therapy. A novel psychotherapeutic approach for residual symptoms of affective disorders. *Psychological Medicine, 28*, 475–480.
Fava, G. A., Rafanelli, C., Grandi, S., Conti, S., & Belluardo, P. (1998b). Prevention of recurrent depression with cognitive behavioral therapy. *Archives of General Psychiatry, 55*, 816–820.
Fava, G. A., Rafanelli, C., Ottolini, F., Ruini, C., Cazzaro, M., & Grandi, S. (2001). Psychological well-being and residual symptoms in remitted patients with panic disorder and agoraphobia. *Journal of Affective Disorders, 31*, 899–905.
Fava, G. A., Ruini, C., Rafanelli, C., & Grandi, S. (2002). Cognitive behavior approach to loss of clinical effect during long-term antidepressant treatment. *American Journal of Psychiatry, 159*, 2094–2095.
Fava, G. A., Ruini, C., Rafanelli, C., Finos, L., Conti, S., & Grandi, S. (2004). Six year outcome of cognitive behavior therapy for prevention of recurrent depression. *American Journal of Psychiatry, 161*, 1872–1876.
Fava, G. A., Ruini, C., & Rafanelli, C. (2005a). Sequential treatment of mood and anxiety disorders. *Journal of Clinical Psychiatry, 66*, 1392–1400.
Fava, G. A., Ruini, C., Rafanelli, C., Finos, L., Salmaso, L., Mangelli, L., & Sirigatti, S. (2005b). Well-being therapy of generalized anxiety disorder. *Psychotherapy and Psychosomatics, 74*, 26–30.

Fava, G. A., Ruini, C., & Belaise, C. (2007a). The concept of recovery in major depression. *Psychological Medicine, 37*, 307–317.

Fava, G. A., Tomba, E., & Grandi, S. (2007b). The road to recovery from depression. *Psychotherapy and Psychosomatics, 76*, 260–265.

Fava, G. A., Guidi, J., Semprini, F., Tomba, E., & Sonino, N. (2010). Clinical assessment of allostatic load and clinimetric criteria. *Psychotherapy and Psychosomatics, 79*, 280–284.

Fava, G. A., Rafanelli, C., Tomba, E., Guidi, J., & Grandi, S. (2011). The sequential combination of cognitive behavioral treatment and well-being therapy in cyclothymic disorder. *Psychotherapy and Psychosomatics, 80*, 136–143.

Fordyce, M. W. (1983). A program to increase happiness. *Journal of Counseling Psychology, 30*, 483–498.

Frankl, V. E. (1959). *Man's search for meaning. An introduction to logotherapy*. Boston: Beacon Press.

Fredrickson, B. L., & Joiner, T. (2002). Positive emotions trigger upward spirals toward emotional well-being. *Psychological Science, 13*, 172–175.

Fredrickson, B. L., & Losada, M. F. (2005). Positive affect and the complex dynamics of human flourishing. *American Psychologist, 60*, 678–686.

Frisch, M. B. (1998). Quality of life therapy and assessment in health care. *Clinical Psychology: Science and Practice, 5*, 19–40.

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

Garamoni, G. L., Reynolds, C. F., Thase, M. E., Frank, E., Berman, S.-R., & Fasiczska, A. L. (1991). The balance of positive and negative affects in major depression. *Psychiatry Research, 39*, 99–108.

Garland, E. L., Fredrickson, B., Kring, A. M., Johnson, D., Meyer, P. S., & Penn, D. L. (2010). Upward spirals of positive emotions counter downspirals of negativity. Insights from the broaden-and-built theory and affective neuroscience on the treatment of emotion dysfunction and deficits in psychopathology. *Clinical Psychology Review, 30*, 849–864.

Geraghty, A. W. A., Wood, A. M., & Hyland, M. E. (2010). Dissociating the facets of hope: Agency and pathways predict dropout from unguided self-help therapy in opposite directions. *Journal of Research in Personality, 44*, 155–158.

Guidi, J., Fava, G. A., Bech, P., & Paykel, E. S. (2011). The clinical interview for depression: A comprehensive review of studies and clinimetric properties. *Psychotherapy and Psychosomatics, 80*, 10–27.

Hadley, S., & Macleod, A. K. (2010). Conditional goal-setting, personal goals and hopelessness about the future. *Cognition and Emotion, 24*, 1191–1198.

Haizlip, J., May, N., Schorling, J., Williams, A., & Plews-Ogan, M. (2012). Perspective: The negativity bias medical education, and the culture of academic medicine: Why culture change is hard. *Academic Medicine, 87*, 1205–1209.

Hao, Y., Liu, H., Yue, S., & Liu, X. (2011). Introducing traditional Chinese nursing: A review of concepts, theories and practices. *International Nursing Review, 58*, 319–327.

Held, B. S. (2002). The tyranny of positive attitude in America: Observation and speculation. *Journal of Clinical Psychology, 58*, 965–992.

Hodgins, H. S., & Knee, R. (2002). The integrating self and conscious experience. In E. L. Deci & R. M. Ryan (Eds.), *Handbook on self-determination research* (pp. 87–100). Rochester: University of Rochester Press.

Hofmann, S. G., & Asmundson, G. J. G. (2008). Acceptance and mindfulness-based therapy: New wave or old hat? *Clinical Psychology Review, 28*, 1–16.

Horowitz, M. J., & Kaltreider, N. B. (1979). Brief therapy of the stress response syndrome. *Psychiatric Clinics of North America, 2*, 365–377.

Jahoda, M. (1958). *Current concepts of positive mental health*. New York: Basic Books.

Jung, C. G. (1933). *Modern man in search of a soul* (W. S. Dell & C. F. Baynes, Trans.). New York: Harcourt, Brace & World.

Kashdan, T. B., & Rottenberg, J. (2010). Psychological flexibility as a fundamental aspect of health. *Clinical Psychology Review, 30*, 865–878.

Kellner, R. (1987). A symptom questionnaire. *Journal of Clinical Psychiatry, 48*, 269–274.
Keyes, C. L. (2002). The mental health continuum: Form languishing to flourishing in life. *Journal of Health and Social Behavior, 43*, 207–222.
Keyes, C. L. M., Shmotkin, D., & Ryff, C. D. (2002). Optimizing well-being: The empirical encounter of two traditions. *Journal of Personality and Social Psychology, 82*, 1007–1022.
Kissen, D. M. (1963). The significance of syndrome shift and late syndrome association in psychosomatic medicine. *Journal of Nervous and Mental Disease, 136*, 34–42.
Kitayama, S., Markus, H. R., & Kyurokawa, M. (2000). Culture, emotion and well-being: Good feelings in Japan and the United States. *Cognition and Emotion, 14*, 93–124.
Kitayama, S., Snibbe, A. C., Markus, H. R., & Suzuki, T. (2004). Is there any "free" choice? Self and dissonance in two cultures. *Psychological Science, 15*, 527–533.
Kohl, A., Rief, W., & Glombiewski, J. A. (2012). How effective are acceptance strategies? A meta-analytic review and experimental results. *Journal of Behavior Therapy and Experimental Psychiatry, 43*(4), 988–1001.
Leong, F. T. L., & Wong, P. T. P. (2003). Optimal human functioning from cross-cultural perspectives: Cultural competence as an organizing framework. In B. Walsh (Ed.), *Counseling psychology and optimal human functioning* (pp. 123–150). Mahwah: Erlbaum.
Lipowski, Z. J. (1977). Psychosomatic medicine in the seventies: An overview. *American Journal of Psychiatry, 134*, 233–244.
MacLeod, A. K., & Conway, C. (2007). Well-being and the anticipation of future positive experiences: The role of income, social networks and planning ability. *Cognition and Emotion, 18*, 357–374.
MacLeod, A. K., & Moore, R. (2000). Positive thinking revisited: Positive cognitions, well-being and mental health. *Clinical Psychology and Psychotherapy, 7*, 1–10.
Maddux, J. E. (2008). Positive psychology and the illness ideology: Toward a positive clinical psychology. *Applied Psychology: An International Review, 57*(Suppl 1), 54–70.
Marsella, A. J., & Yamada, A. M. (2007). Culture and psychopathology: Foundations, issues, and directions. In S. Kitayama & D. Cohen (Eds.), *Handbook of cultural psychology* (pp. 797–820). New York: Guilford Press.
Maslow, A. H. (1968). *Toward a psychology of being* (2nd ed.). New York: Van Nostrand.
Massimini, F., & Delle Fave, A. (2000). Individual development in a bio-cultural perspective. *American Psychologist, 55*, 24–33.
McEwen, B. S., & Stellar, E. (1993). Stress and the individual. *Archives of Internal Medicine, 153*, 2093–2101.
Norem, J. K., & Chang, E. C. (2002). The positive psychology of negative thinking. *Journal of Clinical Psychology, 58*, 993–1001.
Oishi, S. (2000). Goals as cornerstones of subjective well-being: Linking individuals and cultures. In E. Diener & E. M. Suh (Eds.), *Culture and subjective well-being* (pp. 87–112). Cambridge, MA: MIT Press.
Padesky, C. A. (1994). Schema change processes in cognitive therapy. *Clinical Psychology and Psychotherapy, 1*, 267–278.
Parloff, M. B., Kelman, H. C., & Frank, J. D. (1954). Comfort, effectiveness, and self-awareness as criteria of improvement in psychotherapy. *American Journal of Psychiatry, 11*, 343–351.
Paykel, E. S. (1985). The clinical interview for depression. *Journal of Affective Disorders, 9*, 85–96.
Rafanelli, C., & Ruini, C. (2012). The assessment of psychological well-being in psychosomatic medicine. *Advances in Psychosomatic Medicine, 32*, 182–202.
Rafanelli, C., Park, S. K., Ruini, C., Ottolini, F., Cazzaro, M., & Fava, G. A. (2000). Rating well-being and distress. *Stress Medicine, 16*, 55–61.
Rafanelli, C., Conti, S., Mangelli, L., Ruini, C., Ottolini, F., Fabbri, S., Tossani, E., Grandi, S., & Fava, G. A. (2002). Benessere psicologico e sintomi residui nei pazienti con disturbi affettivi. II. Confronto tra well-being therapy e terapia cognitivo-comportamentale. *Rivista di Psichiatria, 37*, 179–183.
Rogers, C. R. (1961). *On becoming a person*. Boston: Houghton Mifflin.

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

Ruini, C., & Fava, G. A. (2012). Role of well-being therapy in achieving a balanced and individualized path to optimal functioning. *Clinical Psychology and Psychotherapy, 19*, 291–304.

Ruini, C., Ottolini, F., Rafanelli, C., Tossani, E., Ryff, C. D., & Fava, G. A. (2003). The relationship of psychological well-being to distress and personality. *Psychotherapy and Psychosomatics, 72*, 268–275.

Ruini, C., Rafanelli, C., Conti, S., Ottolini, F., Mangelli, L., Tossani, E., Grandi, S., & Fava, G. A. (2002). Benessere psicologico e sintomi residui nei pazienti con disturbi affettivi. I. Rilevazioni psicometriche. *Rivista di Psichiatria, 37*, 171–178.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potential: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology, 52*, 141–166.

Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 6*, 1069–1081.

Ryff, C. D., & Singer, B. H. (1996). Psychological well-being: Meaning, measurement, and implications for psychotherapy research. *Psychotherapy and Psychosomatics, 65*, 14–23.

Ryff, C. D., & Singer, B. H. (1998). The contours of positive human health. *Psychological Inquiry, 9*, 1–28.

Ryff, C. D., & Singer, B. H. (2008). Know thyself and become what you are: A eudaimonic approach to psychological well-being. *Journal of Happiness Studies, 9*, 13–39.

Seeman, T. E., Singer, B. H., Ryff, C. D., Dienberg, L. G., & Levy-Storms, L. (2002). Social relationships, gender, and allostatic load across two age cohorts. *Psychosomatic Medicine, 64*, 395–406.

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

Thunedborg, K., Black, C. H., & Bech, P. (1995). Beyond the Hamilton depression scores in long-term treatment of manic-melancholic patients: Prediction of recurrence of depression by quality of life measurements. *Psychotherapy and Psychosomatics, 64*, 131–140.

Triandis, H. C. (1995). *Individualism and collectivism*. Boulder: Westview.

Uchida, Y., Norasakkunkit, V., & Kitayama, S. (2004). Cultural constructions of happiness: Theory and empirical evidence. *Journal of Happiness Studies, 5*, 223–239.

Uchino, B. N., Cacioppo, J. T., & Kiecolt-Glaser, J. V. (1996). The relationship between social support and physiological processes. *Psychological Bulletin, 119*, 488–531.

Vallerand, R. J., Blanchard, C. M., Mageau, G. A., Koestner, R., Ratelle, C., Leonard, M., Gagne, M., & Marsolais, J. (2003). Les passions de l'ame: On obsessive and harmonious passion. *Journal of Personality and Social Psychology, 85*, 756–767.

Vallerand, R. J., Salvy, S. J., Mageau, G. A., Elliot, A. J., Denis, P. L., Grouzet, F. M. E., & Blanchard, C. (2007). On the role of passion in performance. *Journal of Personality, 75*, 505–534.

Vincent, P. J., Boddana, P., & MacLeod, A. K. (2004). Positive life goals and plans in parasuicide. *Clinical Psychology and Psychotherapy, 11*, 90–99.

Wood, A. M., & Joseph, S. (2010). The absence of positive psychological (eudemonic) well-being as a risk factor for depression: A ten year cohort study. *Journal of Affective Disorders, 122*, 213–217.

Wood, A. M., & Tarrier, N. (2010). Positive clinical psychology: A new vision and strategy for integrated research and practice. *Clinical Psychology Review, 30*, 819–829.

World Health Organization. (1948). *World Health Organization constitution* (p. 28). Geneva: World Health Organization.

Chapter 3
The Place of Psychological Well-being in Cognitive Therapy

Andrew K. MacLeod and Olga Luzon

3.1 Introduction

Cognitive therapy is a therapeutic approach developed in the USA by Aaron Beck (1976). It integrates principles and practices from behaviour therapy, which predates it, and so the overall model and therapeutic approach is more typically called cognitive-behavioural therapy (CBT). This chapter is an attempt to explore whether well-being concepts are represented in CBT. The well-being literature and the CBT literature have largely followed independent paths, with very little overlap, despite some exceptions that have attempted to integrate them (see Fava et al. 1998; MacLeod and Moore 2000). Examining links is therefore exploratory and the ideas offered in this chapter are in the spirit of promoting discussion and further research rather than necessarily providing definitive answers. The chapter will first outline concepts of well-being, then provide an introduction to CBT, both as originally formulated and as represented in more recent developments. The place of well-being will be discussed in relation to the goals, the content and the philosophy associated with CBT in its various forms.

3.2 Well-being

3.2.1 Subjective and Objective

Well-being is not a concept that is easy to define and neither is there agreement about what it is. A first point of clarification is that well-being refers to a life that is good *for the person who is living that life*, what has been called prudential value

A.K. MacLeod (✉) • O. Luzon
Department of Psychology, Royal Holloway University of London, Surrey, UK
e-mail: A.Macleod@rhul.ac.uk

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_3, © Springer Science+Business Media Dordrecht 2014

(Sumner 1996). Lives can be good, or bad, in other ways, most notably moral ways. An overall evaluation of the goodness or value of a life would include those other aspects (Haybron 2008), but well-being refers to the aspect of a life that defines it as good for the person who is living it.

There are two broad ways of thinking about well-being (e.g., Brülde 2007; Varelius 2004). The most intuitive approach takes a subjective perspective where well-being is defined in terms of the experience of the person – essentially, well-being is about how a person feels and thinks about his or her life. People are high in well-being when they feel happy, experience lots of pleasure and not much pain, evaluate their lives favourably, feel satisfied with their lives, and so on. This is the approach that sits most comfortably with the everyday use of the term "happiness". Within this perspective the value of the desirable feeling states does not arise from the *source* of the feelings – what defines a life of well-being is the presence of desirable subjective states and the absence of undesirable ones.

Objectivism, in contrast, is the view that levels of well-being can be determined independently, or at least largely independently, of the subjective experience of the person under consideration. In this view, a person's level of well-being depends on the extent to which they have certain things in place in their lives that are more than feeling states. Objective approaches are often called list approaches because they draw up lists of what constitutes a life of well-being. The level of a person's well-being can then be calculated by how many of these "goods" are present and to what degree. At a cross-national level, the goods may be truly objective – the UN Human Development Index (United Nations 2010), consisting of income, longevity and years of education, would be a clear example, but most lists include psychological goods such as knowledge, friendships, attainment, aesthetic experience, and so on. An important point to remember is that the value of such goods does *not* lie in their ability to make someone happy even in the longer term (in the sense of producing a desirable or satisfactory experience, which they may well do); they are good as final ends in themselves whether they make someone happy or not. Subjectivists are also very likely to see these same goods as of value but see them as having instrumental value – they are good to the extent that they make someone feel happy.

As described in detail in the first two chapters of this book, the debate between these two approaches is ancient – stretching back at least to the Hellenistic period (Long and Sedley 1987). Within the recent psychological literature it has become fashionable to refer back to these roots and talk of hedonic and eudaimonic approaches to well-being (e.g., Kashdan et al. 2008; Ryan and Deci 2001). The hedonic approach is subjectivist, emphasising the value of subjective states, particularly feelings, whereas what have come to be referred to as eudaimonic approaches are essentially list approaches that see well-being as defined by something other than subjective states of happiness. Psychological theory and research have helped to flesh out the subjectivist perspective, which is frequently operationalised as subjective well-being. There have been several influential examples within the psychological literature of more objective (eudaimonic) approaches, with overlapping but different sets of goods proposed. There are likely to be cultural differences in the extent to which societies and cultures value subjectivist or objectivist aspects of well-being. For example, Diener et al. (2003) reported that, although all countries

value subjective feelings of happiness very highly, Latin American countries valued it more highly than did many Pacific Rim countries, who valued other goods such as achievement. However, as they point out it is not clear whether these other goods are seen as investments for higher levels of future happiness? thus consistent with a subjectivist approach.

3.2.2 Subjective Well-being (SWB)

SWB in the psychological literature is defined as the presence of positive affect, and the absence of negative affect, alongside the presence of life satisfaction. The measures that are most frequently used to operationalise the concepts are the Positive and Negative Affect Scale (PANAS; Watson et al. 1988), and the Satisfaction with Life Scale (SWLS; Diener et al. 1985). The PANAS provides a list of affective words (e.g., excited, interested, tense, worried) and respondents are asked to indicate the extent to which they have felt this way during a given period, for example, the past week. The SWLS asks respondents to indicate on a 7-point scale the extent to which they agree or disagree with five statements regarding their satisfaction with their life as a whole (for example, 'I am satisfied with my life'; 'the conditions of my life are excellent'). These three elements – NA, PA and SWLS – are either looked at separately or combined to form a unitary measure of subjective well-being (Pavot and Diener 2008).

3.2.3 Objective List Approaches

There are two particularly influential list approaches within the psychological literature. Carol Ryff (1989) proposed an account of well-being intended as an antidote to the prevailing view, as she saw it, of well-being as happiness. Drawing on various statements made about the nature of well-being, from Aristotle to Maslow, she proposed a six-dimensional scheme which she named Psychological Well-being (PWB).[1] The dimensions (with sample questions from the subscales developed to measure each dimension) were: positive relations with others ('I know that I can trust my friends and they know that they can trust me'); autonomy ('I have confidence in my own opinions even if they are contrary to the general consensus'); mastery of the environment ('I have been able to build a home and a lifestyle for myself that is much to my liking'); purpose in life ('I enjoy making plans for the future and working to make them a reality'); positive self-regard/self-acceptance ('I like most aspects of my personality'); and personal growth ('For me, life has been a continuous process of learning, changing and growth'). A person's overall

[1] It is worth noting that Ryff and colleagues use the term "Psychological Well-being" to describe their particular 6-dimensional scheme, and this should not be confused with the generic term "psychological well-being" which can be used to refer to the broader concept of psychological aspects of well-being, as distinct from physical well-being.

well-being depends on the extent to which they are high on the dimensions. Keyes et al. (2002) developed an approach that defines well-being in terms of the combination of SWB and PWB, with flourishing individuals being high in both and languishing individuals low in both.

The second influential example is the work of Martin Seligman. In his most recent formulation (Seligman 2011), Seligman lists positive emotions, engagement, relationships, meaning and accomplishment as the constituents of well-being. It is however, within the engagement aspect that Seligman's most original contribution lies. Engagement is absorption in activities but this is most clearly seen when people are engaged in activities that are related to their signature strengths. Seligman and Peterson have proposed a taxonomy of 24 strengths (Peterson and Seligman 2004), for example, love of learning, compassion curiosity, and leadership. Well-being arises when someone is actively engaged in exercising their particular strengths.

It is difficult to decide between subjectivist/hedonic and objectivist/eudaimonic views of well-being. There are no data that help because the debate is about what is of final value. If something is of final value there is nothing that can be appealed to in order to support it or give it legitimacy: it is essentially a value judgement. For the purposes of this chapter, it is enough to say that there is not agreement on what constitutes well-being but that there are broadly subjectivist/hedonic and objectivist/eudaimonic (list) approaches.

3.3 Well-being and Therapy

Therapy is obviously concerned with well-being. However, therapists and therapy researchers have typically not concerned themselves with concepts of well-being. As MacLeod (2012) has pointed out, most patients seen by therapists are experiencing low levels of well-being whatever definition is being used. Therapeutic outcomes typically consist of a mixture of subjective (feeling) and objective (functioning) states, with most therapeutic approaches having an understandable emphasis on reducing subjective distress. A detailed description of Well-being Therapy (WBT) is provided by Ruini and Fava in Chap. 2 of this book.

3.3.1 Well-being and Distress: One Dimension or Two?

An obvious question that arises when discussing the relationship of therapy to well-being is whether well-being and distress are opposite ends of the same continuum or whether they are best thought of as two different dimensions. Both views have been put forward (see MacLeod and Moore 2000). A full discussion is beyond the scope of this chapter, but whether they are best thought of as separate dimensions or two ends of the same dimension (or perhaps more likely, separate but correlated dimensions) does not affect the conclusions that will be drawn in this chapter. In the independent dimensions view, treating distress does not necessarily enhance well-being and therefore the case for enhancing well-being as separate

from reducing distress is clear. Within the continuum view, treating distress indirectly enhances well-being by moving someone along the continuum closer to the well-being end. To this extent, all therapies address well-being even if they are entirely focused on symptom reduction. But, even within the one-dimensional view there is a question that can be asked about whether a therapeutic approach has more than this minimal, indirect well-being element, that is, does it only address the half of the dimension that is below a neutral point or does it pay any attention to what is on the well-being half of the continuum? This is not simply a theoretical point. Given the relapsing, recurring and even chronic nature of a lot of psychological difficulties, enhancing well-being beyond the neutral point between well-being and distress may be of great value in preventing relapse/recurrence or improving people's lives in the face of some chronic symptoms (MacLeod 2012). The focus on this chapter will be to examine whether CBT approaches have a place for well-being beyond their indirect effect through reducing distress.

3.3.2 The Place of Well-being in Therapy

There are broadly three ways in which a therapeutic approach might have a direct place for well-being. First, the *goal* of the therapy might be to enhance well-being. All therapeutic approaches aim to reduce distress but they may also strive to improve aspects of the person's life and experience that go beyond simply the experience of distress. Second, the therapy might focus on aspects of well-being as part of its *content* – the sessions might discuss aspects of well-being, what it is that makes the person's life good and enjoyable and valuable for them, rather than simply spending time on distress – and techniques might be directly well-being focused. Finally, the therapy might have an overall, underlying *philosophy* of well-being within which it places its activity, even though the therapeutic activity might be problem- or distress-focused and the aims primarily symptom reduction. The remainder of this chapter will outline the main elements and approaches within CBT and discuss to what extent they reflect the three ways in which well-being might be present – in the goals, the content and the philosophy of the therapeutic approach. The discussion will cover both SWB and list approaches as different aspects well-being.

3.4 Cognitive Behavioural Therapy (CBT)

3.4.1 Basic Principles of CBT

People respond differently to similar events, indicating that it is not the event itself that simply determines a person's reaction to it but, rather, the meaning that is attached to the event. CBT is based on the idea that the way we feel (*emotions*) and what we do (*behaviours*) is strongly influenced by what we think (*cognitions*), and in turn what we do influences what we feel and think.

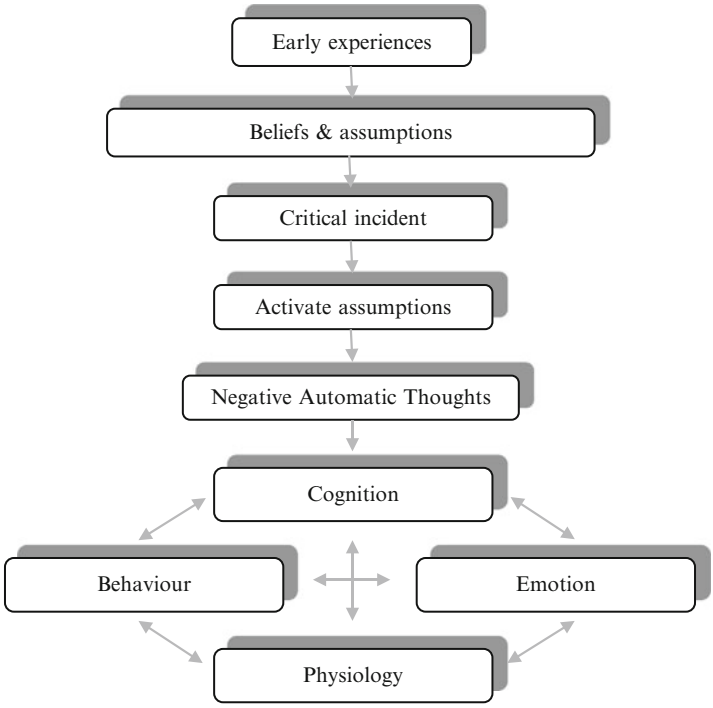

Fig. 3.1 Generic CBT model of emotional problems

Beck's (1976) original cognitive model of emotional difficulties proposes that early experience leads individuals to develop unhelpful beliefs and assumptions about themselves, others and the world, that later on influence the meaning they give to events, which in turn drives their actions. According to the model (see Fig. 3.1), certain situations (*critical incidents*) activate the already-formed unhelpful (*dysfunctional*) beliefs and assumptions, which then trigger *negative automatic thoughts* (NATs). These thoughts are associated with distressing emotions, physiological responses and maladaptive coping strategies, which are hypothesised to maintain psychological distress.

For example, if early experiences have led someone to believe that his or her self-worth depends on professional success, the person may have an assumptions such as *'If I am not successful all the time then I am a failure'*. Not getting a job offer or receiving criticism from a manager might then trigger negative thoughts (e.g., *'I'll never achieve my goals in life', 'My boss thinks I am a failure'*), which may lead to anxiety and/or low mood. As a result the person might engage in behaviours such as avoiding other job interviews, becoming defensive in meetings, working extra hours, or trying hard to avoid even small mistakes and further criticism.

The aim of CBT is to help people become aware of how the way they think and behave in a given situation might be contributing to their problems, and to help them

change unhelpful thoughts and behavioural patterns. What makes CBT unlike other types of therapy is its focus on the here and now, rather than what has happened in the past. CBT therapists use a collaborative and transparent style of treatment, regarding the individual as the expert of their own problems and their culture. Another distinctive feature of CBT is its use of *guided discovery,* a style of questioning to help individuals recognise and evaluate unhelpful patterns in order to develop an alternative, more helpful perspective. By fostering an inquisitive approach to one's own thinking and behavioural responses to a situation individuals learn to examine the evidence, consider alternatives and develop potential solutions. Therapy sessions are pragmatic, goal focused and structured; an agenda is agreed at the beginning of each session. CBT is an active therapy – individuals are expected to test out their predictions in between sessions through the use of *experiments* and/or practice alternative copying strategies, and these *homework* tasks are collaboratively agreed and reviewed at the next session.

Treatment is time limited (often between 8 and 20, 50 min weekly or fortnightly sessions) and can be delivered in a range of formats including individual, couple, group, guided self-help or computerised interventions. An intervention typically starts with an initial assessment of the individual's difficulties which leads to a shared understanding (*formulation*) of their difficulties. The formulation is informed by both empirical evidence from research studies and the individual's report of their problems, and is used to guide and adapt the individual treatment.

Recent years have seen the emergence of cognitive models and protocols for specific disorders. However, empirical research has also led to the identification of cognitive and behavioural processes that are thought to contribute to most psychological disorders, and these are commonly targeted during CBT treatment. Examples of these are reducing avoidance of feared situations/stimulus (*exposure*), reviewing and challenging beliefs and NATs, redirecting attention and reducing hypervigilance for danger, decreasing worry, dropping behaviours aimed at stopping a feared outcome, refraining from seeking reassurance, and increasing engagement on activities associated with pleasure and sense of achievement. A number of therapeutic techniques might be employed during the course of a CBT treatment to tackle the above processes including: (a) psychoeducation; (b) keeping records to identify and monitor NATs and their links with affect and behaviour; (c) reviewing the validity and usefulness of underlying assumptions (*cognitive restructuring*); (d) behavioural experiments to test out assumptions or gather evidence for alternative beliefs; (e) graded exposure to a fear situation; (f) activity scheduling; (g) breaking goals into manageable steps (*graded tasks assignments*); and (h) skills training (e.g., problem solving, assertiveness, social skills).

3.4.2 The Evidence Base for CBT

CBT is currently considered as the psychological therapy with the strongest evidence for its efficacy in research trials as well as effectiveness in routine clinical practice (Harvey et al. 2004). There is significant evidence from research studies

and systematic reviews supporting the effectiveness of CBT for most psychological problems (Roth and Fonagy 2004). CBT has been found to be effective for depression (e.g., Hollon et al. 2002); generalised anxiety (Hunot et al. 2007), health anxiety (Barsky and Ahern 2004), post-traumatic stress disorder (Mendes et al. 2008), obsessive compulsive disorder (Eddy et al. 2004), psychosis (Wykes et al. 2008), bulimia nervosa (Fairburn 2008) and chronic fatigue syndrome (Price et al. 2008), amongst other difficulties. Similar results have been reported across cultures, where CBT has been successfully adapted to the cultural context and values of very different Western and Asian societies (e.g., Hays and Iwamasa 2006; Rathod and Kingdon 2009). Nonetheless, most studies have compared CBT with either treatment as usual or waiting list and further evidence is required to establish its effectiveness over other types of active therapies.

3.4.3 Traditional CBT and Well-being

Traditional CBT does not contain strong elements of well-being, except in the minimal sense of indirectly influencing well-being through reducing distress. Clients set their own goals for therapy, so there is the possibility of some well-being related goals, but essentially the outcomes are about reducing distress, measured by change in symptom inventories. Sessions are spent talking about what is distressing for the person, although a notable exception to this is activity scheduling for pleasure and mastery experiences. Nor is there an underlying philosophy of well-being or living well that underpins CBT: it is a pragmatic approach to treating psychological problems that get in the way of a person living a good life, but there is no model of what that good life is. These points do not detract from the value of CBT in treating psychological distress but simply demonstrate that in its traditional form it is not a well-being focused approach.

3.4.4 Developments in CBT

A number of adaptations to traditional CBT treatments have emerged in recent years, sometimes referred to as ‘Third Wave Therapies’, with good empirical evidence. All of these therapies are CBT-based or CBT-influenced and part of the broad CBT church, both in philosophy and techniques, but they depart from traditional CBT in important ways.

3.4.5 Behavioural Activation (BA)

Activity scheduling to gain a sense of pleasure and a sense of mastery were described earlier as key pillars of behaviour therapy and later CBT. Those principles and techniques have been developed to form a therapeutic approach within its own

right – Behavioural Activation (Jacobson et al. 2001). Behavioural Activation (BA), initially developed to treat depression, assumes that in depression people often end up avoiding situations or not taking part in activities that could potentially be reinforcing through giving them pleasure or a sense of achievement. The therapy helps people to identify the activities or situations that they avoid, construct a hierarchy of what they would like to do but currently don't and start gradually to approach the things that they have identified. In this way, people will be introduced to positively reinforcing experiences which will diminish their experience of depression. BA is a straightforward, uncomplicated approach to treatment of depression that has a focus on increasing positive, rewarding experiences. A meta-analysis showed outcomes equivalent to full CBT for depression (Cuijpers et al. 2007).

BA is overtly well-being focused in aim and content. Not surprisingly, the principal aim is symptom reduction but this is achieved through increasing experiences of pleasure and mastery. Both SWB (pleasure) and broader well-being (mastery and achievement) are explicitly represented in the aims and content, although it is probably fair to say that there is not a strong well-being philosophy that underpins it. In addition, a further point in common with the well-being literature is the idea of engaging in positive experiences and activities which resonates with the concept of 'flow': a state of consciousness associated with happiness to which one can arrive by actively pursuing challenging but achievable goals, similar to what BA is aiming to achieve (Csikszentmihalyi 1998).

3.4.6 Schema Focused Therapy (SFT)

SFT integrates elements from CBT, gestalt, psychoanalytic and constructivist approaches. It was first developed by J. Young in the 1990s in response to the limited impact short-term CBT had with more complex and chronic patients, many with entrenched characterological problems or personality disorders (Young et al. 2003). SFT places a much greater emphasis on examining the origins of psychological difficulties in childhood and adolescence. It is based on the idea that unmet *childhood needs* (e.g., nurture, guidelines, limits) can lead to the development of *early maladaptive schemas* (e.g., dependence, incompetence) defined as pervasive and self-defeating patterns comprised of memories, emotions, thoughts, and body sensations regarding oneself and one's relationship with others. These schemas are associated with *dysfunctional copying styles* which are thought to reinforce the schemas and maintain the problem. The aim of SFT is to help individuals find healthier ways to meet their core emotional needs by breaking life-long behavioural patterns and meeting some of the unmet needs through the therapeutic relationship. Its focus on the origins of the problems, personality, relationships, use of experiential strategies, and view of the therapeutic relationship are significant departures from generic CBT.

SFT is also broadly distress focused. Problem reduction and spending the therapeutic time thinking about and discussing problems are characteristic of it, as they

are of traditional CBT, although positive data logs (see later section) are sometimes used. Arguably, there are elements of an underlying philosophy of a good life through highlighting patterns that are maladaptive, although the emphasis is strongly on what a life is like when these things are absent. This philosophy would fit most closely with a list-based approach to well-being that emphasised qualities of relationships, for example, and functioning well in a number of aspects of life.

There is limited but promising evidence for the effectiveness of SFT. Giesen-Bloo et al. (2006) carried out a randomised controlled trial of SFT compared to an active treatment (transference focused psychotherapy) with a sample of borderline personality disorder patients. The SFT group showed significantly greater improvement on a wide range of outcome measures. Similar results have been reported by a trial comparing group based SFT to treatment as usual (Farrell et al. 2009). However, it is early days to make firm statements about its effectiveness as evidence is only now emerging and further trails are currently underway.

3.4.7 Mindfulness Based Cognitive Therapy (MBCT)

One of the main developments in CBT in recent years has been the incorporation of Buddhist thought and practices. One example of this is MBCT, which blends aspects of cognitive therapy with mindfulness meditation practice. MBCT was first developed as a relapse prevention programme for major depression (Segal et al. 2002), but has since been applied to a wide range of psychological problems including psychosis (Chadwick et al. 2009), anxiety disorders (Evans et al. 2008) and medical conditions (Foley et al. 2010). A meta-analysis of 39 MBCT studies concluded that this approach appears to be effective for treating a range of psychological difficulties, and in particular anxiety and depression (Hofmann et al. 2010). Although, like most of the new developments described here, it remains to be shown whether it can be superior in its effects to standard CBT.

The goal of MCBT is to help individuals become aware of and detach from negative thought patterns which are associated with low mood and hypothesised to contribute to depressive relapse. MBCT encourages individuals to become aware of the links between thoughts, emotions and behaviours through the use of thought diaries in the same way as CBT does, and uses cognitive techniques to identify and challenge NATs when appropriate. This is coupled with mindfulness meditation which involves paying attention to the present moment purposely and in a non-judgemental way, becoming aware of and accepting one's thoughts and feelings without challenging them.

In terms of goals, the aim of MBCT is to reduce the impact of potentially distressing thoughts and feelings. Many of the techniques are traditional CBT techniques and therefore a lot of therapeutic time is spent discussing distress and how to minimise its impact through mindful acceptance. However, the approach introduces techniques such as mindful, non-judgemental attention, which are not problem-focused and are seen as universally important for achieving a good life, independently of any psychological distress someone is experiencing. MBCT is

built on an underlying Buddhist philosophy of a broader good life. This underlying good life model is not necessarily one in which SWB is the key ingredient; neither is it easily classified as an objective list approach. The good life that is aimed at is a very particular kind of subjective state involving non-attachment, but not necessarily experiencing states of high positive emotions and low negative emotions. So, in terms of aims, content, and philosophy, MBCT has some elements of well-being represented although those elements are not easy to classify simply in terms of subjective or objective aspects.

3.4.8 Acceptance and Commitment Therapy (ACT)

ACT is a second example of a Buddhist-influenced approach. This type of intervention integrates behavioural theories of change with mindfulness and acceptance strategies with the aim of promoting psychological flexibility, the lack of which is thought to be at the core of psychological distress (Hayes et al. 1999). ACT argues that attempts at changing difficult thoughts and emotions can be counterproductive and instead it encourages awareness and acceptance through mindfulness practice. ACT is additionally concerned with helping individuals become more aware of their personal values and to take steps towards important goals through a commitment to behavioural changes and actions in line with one's core values. A number of controlled trials published in recent years have yielded some support for the effectiveness of ACT over waiting list for a range of presentations including depression, anxiety disorders, chronic pain, psychosis, and substance misuse; however, its benefits over other established treatments are yet to be fully established (Powers et al. 2009; Ruiz 2010).

The conclusions about the place of well-being in ACT are similar to those already drawn for MBCT. However, ACT additionally has an explicit well-being element of identifying people's values and helping them to commit to actions that would bring about goals consistent with those values. As such, it has an explicitly well-being element that is central to the approach, both in terms of aims and therapy content. This would fit both with a subjective well-being approach and a more prescribed approach such as Ryff's where purpose and goal-directed behaviour along with autonomy are seen as key aspects of well-being. Both ACT and MBCT are interesting also from the point of view of bringing together eastern and western traditions, which typically have been conceptually and empirically separate.

3.4.9 Strengths-Based CBT

Christine Padesky (1994; Padesky and Mooney 2012) was one of the first within the cognitive therapy tradition to highlight the importance of positive thinking. This recognition arose from the realisation that within therapy, clients were often unable to correct their negative thinking as a result of being unable to process corrective positive experiences; positive experiences would easily be forgotten or explained

away. Padesky (1994) suggested that positive corrective experiences were important in challenging negative beliefs but clients would often need help in building up a positive self-schema that could assimilate and benefit from these positive experiences. Once a positive framework has been established the patient can work to collect examples of events that can build up the new idea. One way to aid this process is through patients keeping a positive data log, noting and logging specific examples of positive experiences that fit the new schema. Later developments of the ideas (Kuyken et al. 2009) shifted the emphasis to helping clients identify their strengths. Identifying strengths helps people to see that although their problems may feel overwhelming, there is more to them than their problems. This perspective helps to reduce distress by opening up positive, valued aspects of the person that may have been pushed to the back of their mind. Furthermore, a person's strengths can be used to develop resilience that will buffer against future difficulties. For example, someone may have very good social skills, which could be used in building friendships that will act as a resource should they encounter future difficulties. Finally, strengths can be used to help people identify life goals that they value and help them to move towards those goals, irrespective of their distress-reducing or resilience-building properties. The approach tends to be incorporated as an element within CBT rather than as an alternative stand-alone approach, hence there is no empirical evidence of its effectiveness to date. Future research could investigate it as part of a component analysis of treatment effectiveness.

Padesky's development of CBT certainly introduces elements of well-being. There is a focus on positive experiences and strengths. Again, the ultimate aim is to either reduce distress or to build resilience to reduce vulnerability to future problems, but that goal is achieved through a focus on positive experiences and building strengths as part of the therapy process. The importance of SWB is represented by the mood lifting properties of positive experiences and a more eudaimonic element is clearly represented by the emphasis on strengths, that bears a strong resemblance to the strengths-based model of Seligman (2011) which has also been applied to enhancing well-being (e.g., Park and Peterson 2008).

3.4.10 Well-being Therapy (WBT)

Perhaps the most explicit attempt to integrate well-being concepts into CBT comes from the work of Giovanni Fava and colleagues (e.g., Fava et al. 1998) in developing Well-being Therapy (WBT). WBT integrates the well-being model of Ryff into a CBT model and structure. The therapy is described in detail in the second chapter of this volume. WBT is the most overtly well-being focused development of CBT: there is a strong well-being content, its therapeutic goals have a well-being element-although like all therapies the key target is reduction of psychological disturbance; and it is linked strongly to an underlying model of what a good life is. It shares some elements of CBT but there is some question about whether it can still be thought of as CBT, given its departure from original model and its quite different focus.

3.5 CBT Practice in the UK

The UK National Institute for Clinical Excellence (NICE), responsible for evaluating and disseminating evidence-based treatments that should be available through the publicly-funded health service, recommends CBT as the treatment of choice for most common mental health problems (NICE 2008). In 2006, the UK government founded the Improving Access to Psychological Therapies (IAPT) programme with the aim of facilitating access in local health settings (general practice and health centres, libraries, sport and youth centres). This programme aims at not only disseminating best available psychological treatments, with a heavy emphasis on CBT, but also promoting broader well-being through establishing links with employment services, encouraging exercise and facilitating engagement with community based organisations. It is not difficult to see that, as well as tackling the affective and life satisfaction aspects of well-being through distress-reducing therapy, such an approach will foster purpose, engagement and other aspects of eudaimonic well-being through its broader focus. Whilst it is still early days to make firm conclusions, findings from pilot sites are very encouraging (Clark et al. 2009).

3.6 Summary and Conclusions

This chapter set out to examine the relationship between CBT and well-being. It has become clear that there is no simple answer to this question because there are different elements of CBT and there have been considerable developments within cognitive-behavioural therapies in the last 20 years. Furthermore, well-being is not a unitary concept with universally accepted definitions. Traditional CBT has little place for well-being, either in goals, content or underlying philosophy, although it increases the well-being potential of a person indirectly through reducing distress. Later developments have incorporated well-being elements either through explicit focus on well-being outcomes, spending time in the therapy on aspects of experience related to well-being rather than simply distress, or having an underlying philosophy that is well-being related. However, there remains a great deal of scope for increasing the place of well-being in CBT.

References

Barsky, A. J., & Ahern, D. K. (2004). Cognitive behavior therapy for hypochondriasis. A randomized trial. *Journal of the American Medical Association, 291*(12), 1464–1470.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International University Press.

Brülde, B. (2007). Happiness theories of the good life. *Journal of Happiness Studies, 8*(1), 15–49.

Chadwick, P., Hughes, S., Russell, D., Russell, I., & Dagnan, D. (2009). Mindfulness groups for distressing voices and paranoia: A replication and randomized feasibility trial. *Behavioural and Cognitive Psychotherapy, 37*(4), 403–412.

Clark, D. M., Layard, R., Smithies, R., Richards, D. A., Suckling, R., & Wright, B. (2009). Improving access to psychological therapy: Initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy, 47*(11), 910–920.

Csikszentmihalyi, M. (1998). *Finding flow: The psychology of engagement with everyday life*. New York: Basic Books.

Cuijpers, P., van Straten, A., & Warmerdam, L. (2007). Behavioral activation treatments of depression: A meta-analysis. *Clinical Psychology Review, 27*, 318–326.

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

Diener, E., Oishi, S., & Lucas, R. E. (2003). Personality, culture and subjective well-being: Emotional and cognitive evaluations of life. *Annual Review of Psychology, 54*, 403–425.

Eddy, K. T., Dutra, L., Bradley, R., & Westen, D. (2004). A multidimensional meta-analysis of psychotherapy and pharmacotherapy for obsessive–compulsive disorder. *Clinical Psychology Review, 24*, 1011–1030.

Evans, S., Ferrando, S., Findler, M., Stowell, C., Smart, C., & Haglin, D. (2008). Mindfulness-based cognitive therapy for generalized anxiety disorder. *Journal of Anxiety Disorders, 22*, 716–721.

Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders*. New York: Guilford.

Farrell, J. M., Shaw, I. A., & Webber, M. A. (2009). A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: A randomized controlled trial. *Journal of Behavior Therapy and Experimental Psychiatry, 40*, 317–328.

Fava, G. A., Rafanelli, C., Cazzaro, M., Conti, S., & Grandi, S. (1998). Well-being therapy: A novel psychotherapeutic approach for residual symptoms of affective disorders. *Psychological Medicine, 28*, 475–480.

Foley, E., Baillie, A., Huxter, M., Price, M., & Sinclair, E. (2010). Mindfulness-based cognitive therapy for individuals whose lives have been affected by cancer: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 78*(1), 72–79.

Giesen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W., Dirksen, C., van Asselt, T., et al. (2006). Outpatient psychotherapy for borderline personality disorder: A randomized clinical trial of schema focused therapy versus transference focused psychotherapy. *Archives of General Psychiatry, 63*, 649–658.

Harvey, A., Watkins, E., Mansell, W., & Shafran, R. (2004). *Cognitive behavioural processes across psychological disorders: A transdiagnostic approach to research and treatment*. Oxford: Oxford University Press.

Haybron, D. M. (2008). *The pursuit of unhappiness: The elusive psychology of well-being*. New York: Oxford University Press.

Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and commitment therapy: An experiential approach to behavior change*. New York: Guilford Press.

Hays, P. A., & Iwamasa, G. Y. (2006). *Culturally responsive cognitive-behavioral therapy: Assessment, practice and supervision*. Washington, DC: American Psychological Association.

Hofmann, S. G., Sawyer, A. T., Witt, A. A., & Oh, D. (2010). The effect of mindfulness-based therapy on anxiety and depression: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 78*(2), 169–183.

Hollon, S. D., Thase, M. E., & Markowitz, J. C. (2002). Treatment and prevention of depression. *Psychological Science in the Public Interest, 3*, 39–77.

Hunot, V., Churchill, R., Teixeira, V., & Silva de Lima, M. (2007). Psychological therapies for generalised anxiety disorder (Review). *Cochrane Database of Systematic Reviews*, Issue 1.

Jacobson, N. S., Martell, C. R., & Dimidjian, S. (2001). Behavioral activation treatment for depression: Returning to contextual roots. *Clinical Psychology: Science and Practice, 8*, 225–270.

Kashdan, T. B., Biswas-Diener, R., & King, L. A. (2008). Reconsidering happiness: The costs of distinguishing between hedonics and eudaimonia. *The Journal of Positive Psychology, 3*, 219–233.

Keyes, C. L. M., Shmotkin, D., & Ryff, C. D. (2002). Optimizing well-being: The empirical encounter of two traditions. *Journal of Personality and Social Psychology, 82*, 1007–1033.

Kuyken, W., Padesky, C. A., & Dudley, R. (2009). *Collaborative case conceptualization*. New York: Guilford Press.
Long, A. A., & Sedley, D. N. (1987). *The Hellenistic philosophers: Translations of the principal sources, with philosophical commentary*. Cambridge: CUP.
MacLeod, A. K. (2012). Well-being, positivity and mental health: An introduction. *Clinical Psychology and Psychotherapy, 19*, 279–282.
MacLeod, A. K., & Moore, R. (2000). Positive thinking revisited: Positive cognitions, well-being and mental health. *Clinical Psychology and Psychotherapy, 7*, 1–10.
Mendes, D. D., Mello, M. F., Ventura, P., Passarela, C. D. M., & Mari, J. D. J. (2008). A systematic review on the effectiveness of cognitive behavioral therapy for posttraumatic stress disorder. *International Journal of Psychiatry in Medicine, 38*(3), 241–259.
National Institute for Clinical Excellence. (2008). *Cognitive behavioural therapy for the management of common mental health problems*. Commissioning guide, Implementing NICE guidance, London.
Padesky, C. A. (1994). Schema change processes in cognitive therapy. *Clinical Psychology and Psychotherapy, 1*, 267–278.
Padesky, C. A., & Mooney, K. (2012). Strengths-based cognitive-behavioural therapy: A four step model to build resilience. *Clinical Psychology and Psychotherapy, 19*, 283–290.
Park, N., & Peterson, C. (2008). The cultivation of character strengths. In M. Ferrari & G. Potworowski (Eds.), *Teaching for wisdom* (pp. 57–75). Mahwah: Erlbaum.
Pavot, W., & Diener, E. (2008). The Satisfaction With Life Scale and the emerging construct of life satisfaction. *The Journal of Positive Psychology, 3*, 137–152.
Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. Oxford: Oxford University Press.
Powers, M. B., Zum Vörde Sive Vörding, M. B., & Emmelkamp, P. M. G. (2009). Acceptance and commitment therapy: A meta-analytic review. *Psychotherapy and Psychosomatics, 78*, 73–80.
Price, J. R., Mitchell, E., Tidy, E., & Hunot, V. (2008). Cognitive behaviour therapy for chronic fatigue syndrome in adults (Review). *Cochrane Database of Systematic Reviews*, CD001027, Issue 3.
Rathod, S., & Kingdon, D. (2009). Cognitive behaviour therapy across cultures. *Transcultural Psychiatry, 8*(9), 370–371.
Roth, A., & Fonagy, P. (2004). *What works for whom?: A critical review of psychotherapy research*. London: Guilford Press.
Ruiz, F. J. (2010). A review of Acceptance and Commitment Therapy (ACT) empirical evidence: Correlational, experimental psychopathology, component and outcome studies. *International Journal of Psychology and Psychological Therapy, 10*(1), 125–162.
Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology, 52*, 141–166.
Ryff, C. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*, 1069–1081.
Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford Press.
Seligman, M. E. P. (2011). *Flourish*. London: Nicholas Brealey.
Sumner, L. W. (1996). *Welfare, happiness and ethics*. New York: Oxford University Press.
United Nations. (2010). *Human Development Index and its components.* http://hdr.undp.org/en/media/HDR_2010_EN_Table1_reprint.pdf. Accessed July 2011.
Varelius, J. (2004). Objective explanations of individual well-being. *Journal of Happiness Studies, 5*, 73–91.
Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology, 54*, 1063–1070.
Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008). Cognitive behavior therapy for schizophrenia: Effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin, 34*(3), 523–537.
Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford Press.

Chapter 4
Posttraumatic Growth: Challenges from a Cross-Cultural Viewpoint

Carmelo Vázquez, Pau Pérez-Sales, and Cristian Ochoa

Recent studies have shown that both short- and long-term human responses to adversity are quite varied (Bonanno 2004). Symptoms and distress are expected and relatively frequent, yet traumatic experiences can also give rise to positive transformation. Though more research is needed to better understand the nature of those changes and the underlying processes, in this chapter we examine if the connection between psychological growth and trauma is universal or linked to a cultural viewpoint. We additionally make recommendations on how to stimulate growth processes through specific psychological interventions.

4.1 Trauma-Related Responses: From Vulnerability to Posttraumatic Growth

There have been three stages in the recent history of research on psychological trauma. The first, from 1980 to the early 1990s, was dominated by the definition of trauma in the DSM-III (APA 1980) that establishes universal vulnerability to the stressor that "would evoke significant symptoms of distress in *almost everyone*"

C. Vázquez (✉)
School of Psychology, Complutense University, 28223 Madrid, Spain
e-mail: cvazquez@psi.ucm.es

P. Pérez-Sales
Psychiatry Unit, Hospital Universitario La Paz, 28460 Madrid, Spain

Grupo de Accion Comunitaria (GAC)
www.psicosocial.net

C. Ochoa
Duran I Reynals Hospital, Psycho-Oncology Unit,
Catalonian Institute of Oncology (ICO), 08908 Hospitalet del Llobregat, Spain

School of Psychology, University of Barcelona, 08035 Barcelona, Spain

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_4, © Springer Science+Business Media Dordrecht 2014

(APA 1980, p. 236, italics added). In this stage, most research focused on the negative effects of trauma (McNally 2003; Bonanno et al. 2010).

The second stage arose in the mid 1980s when it was found that serious life events do not necessarily cause mental disorders. Epidemiological studies in the USA, Europe, and Australia showed that only a relatively small percent of the population—1.9 % in Europe to 8 % in the USA—have a life-time diagnosis of posttraumatic stress disorder (for a review, see Vázquez 2005), though at least two thirds suffer a potentially stressful life event, as defined in the DSM-IV (APA 2000). In other words, despite significant national differences still largely unexplained, most (35–65 %) show resilience when confronted with these events (Bonanno et al. 2011).

In the current third stage, researchers have focused their attention on positive aspects of traumatic experiences, expanding on the idea of resilience. Positive feelings are not excluded from the flow of emotions that a person may experience during and after trauma (Folkman 2008). For example, positive feelings and beliefs (e.g., feelings of solidarity) were found in community samples exposed to political violence (Vázquez et al. 2008), natural disasters (Vázquez et al. 2005), heart failure (Castilla and Vázquez 2011), and even in locked-in syndrome (Bruno et al. 2011). These findings are supported by the fact that positive and negative affect are relatively independent (Carver and Scheier 1990). This emotional architecture has deep implications for understanding trauma reactions as people can simultaneously value positive and negative effects of a traumatic experience even within the same domain (e.g., social relations). Consequently, we should develop assessment instruments that can gather this complex array of reactions (Baker et al. 2008; Cann et al. 2010; Pérez-Sales et al. 2012).

Furthermore, research in Western countries has shown that people exposed to traumatic events may experience positive changes as a result of those encounters. This phenomenon has been described as posttraumatic growth, thriving, stress-related growth, benefit finding, positive changes, and adversarial growth, among other names. Although there are significant epistemological and conceptual differences among these terms (see Park 2009), in this chapter we will use the generic term posttraumatic growth (PTG) as this expression, initially coined by Tedeschi and Calhoun (1996), is commonly used in the literature. It refers to positive cognitive and behavioral changes after trauma. PTG, or similar positive changes after suffering extreme adversities, has been found in events as diverse as natural disasters, cancer, community violence, terrorist attacks, and sexual assault (Linley and Joseph 2004; Joseph 2011). According to systematic reviews of the literature, as much as 50–60 % of survivors may display these changes (Linley and Joseph 2004; Helgeson et al. 2006).

Since there are no standard causal models, positive life changes after an adverse incident have been interpreted very heterogeneously (Zoellner and Maercker 2006; Sumalla et al. 2009; Tennen and Affleck 2009) such as: (1) adaptive (e.g., positive illusion) or disadaptive (e.g., denial, wishful thinking) distortions of reality; (2) coping strategies (e.g., positive reassessment or reframing of the event); (3) personality changes (e.g., optimism, resilience); (4) reflections of implicit theories on the possibility to change (Conway and Ross 1984; Tennen and Affleck 2002); (5)

self-enhancement through biased comparisons with the past or with others (Tennen and Affleck 2009); and (6) genuine changes of behavior and identity.

In what areas can change be expected? According to the influential assessment model of Tedeschi and Calhoun (1996), likely reflecting a Western worldview, positive changes can be observed in several domains: (a) self-concept (e.g., new valuation of one's own strength and resilience); (b) appreciation of new possibilities in life; (c) social relations (e.g., feeling emotionally closer to others, especially family and friends); (d) life philosophies (e.g., reordering of values and priorities); and (e) spiritually (e.g., increased participation in religious activities).

4.2 Posttrauma Reactions: From Symptoms to Shattered Core Beliefs

In current systems of psychiatric classification (i.e., DSM and ICD), there are detailed descriptions of certain characteristic symptoms of trauma (i.e., reexperiencing the event, avoidance, and hyperarousal). Although transcultural validity has not yet fully been demonstrated, these symptoms indicate that trauma can profoundly undermine the functioning and psychological integrity of the individual and the individual's identity (Walter and Bates 2012). However, the symptom list does not fully capture the profound psychological changes that trauma can produce and that partly explains the processes of PTG.

Prior to the first studies on PTG, Janoff-Bulman (1989, 1992) proposed a highly influential model to explain changes stemming from traumatic experiences. According to this author, trauma can shatter core beliefs (i.e., basic assumptions) about the world, others, and oneself. Recuperation, and possible growth, would consist of a laborious and possibly time-consuming process of accommodation to the new reality (Joseph 2009, 2011). For instance, traumatic events can ignite disbelief in God in previously religious people (Falsetti et al. 2003; Exline et al. 2011), or generate general distrust or feelings of living in a radically unjust world. This shattering of core beliefs (e.g., that we live in a just or predictable world, or that we are valuable in spite of our circumstances) can explain in many cases (Janoff-Bulman 2004) the profound emotional impact and existential crisis that extreme trauma can cause. Current models of PTG, from diverse theoretical realms, maintain that both the intensity of the traumatic response and the possibility of PTG are to a certain extent a consequence of the degree of shattering of those basic beliefs and the process of their reconstruction (Park 2010).

However, evidence that shattered beliefs are causally linked to severity of trauma responses and eventual PTG is very scarce. Support for the role of preexisting worldviews in the onset of psychological issues in the Western context basically comes from longitudinal studies of Bonanno et al. (2002) and Mancini et al. (2011), who found that pretrauma measures of beliefs (in justice or self-worth) predict PTSD symptoms. By contrast, there is minimal evidence that worldviews measured *after* a potentially traumatic event predict later adjustment. Studies conducted

with participants who suffered a spousal loss or heart attack found no relation between worldviews and severity of symptoms across time (see Bonanno et al. 2011). Most positive changes possibly arise from experiences in which the individual's global meaning is challenged but not extensively violated or deeply shattered.

4.3 Factors Associated with PTG

Although neither factors involved in PTG nor predictors that favor or hinder PTG are well understood (see Walter and Bates 2012), current research, including some metanalyses (Helgeson et al. 2006; Prati and Pietrantoni 2009), provide promising indices of variables significantly associated with PTG. In Table 4.1, we have summarized the most relevant findings. Therapeutic interventions should be guided or inspired by findings derived from research in ideal research translation. Nevertheless, there is still a lack of basic answers regarding PTG and even more so if we employ a transcultural viewpoint.

4.4 The Transcultural Perspective: An Epistemological Challenge to the Idea of Growth

All previous concepts originate from studies in an occidental cultural environment. Notions such as stress, trauma, and PTG are not perfectly transferred to other cultural settings. For example, Das (1995, 2006) developed an anthropological psychology of suffering considered a more accurate representation of the Indian concept of life. Compared with the common view of stress as perturbing to habitual homeostasis, the Indian concept of suffering refers to an intrinsic life condition; thus, human beings must develop detachment, immutability, and compassion to dominate it. As Das reflects, "at some point, all humans will suffer illness, bereavement, and death; most will suffer stress in their family, work, or spiritual lives; some will suffer from poverty, hunger, and torture. Suffering is not the extraordinary."

Thus, suffering must be seen "as a part of normal life" (Kleinman and Kleinman 1999). From this perspective, stressful or adverse life events may not be episodic or infrequent but continuous. Occidental academic models argue that trauma and growth are linked to discrete, identifiable traumatic events. Yet from a more holistic perspective, stress (and growth) can be linked to any life circumstance, discrete or continuous, that involves identity or existential issues, or that put into play the resources, and collective and individual abilities for survival.

4.5 The Limits of the Concepts of Trauma and PTG

Cultural context shapes experience and the *determinants of stress* (Pérez-Sales 2008), shaping the types of events that an individual is likely to experience as traumatic or stressful, the appraisal of stressfulness, and the unconscious emotions and

Table 4.1 Demographic, psychological, and contextual factors associated with facilitation or inhibition of PTG

Factor	Relation to PTG
Age	Younger people show greater probability of growth (Helgeson et al. 2006)
Sex	There is greater probability of PTG in women (Helgeson et al. 2006)
Time	There is greater probability of PTG if more time has passed since the trauma (Helgeson et al. 2006)
Severity of the event	There is a low correlation between severity of trauma and PTG (Helgeson et al. 2006; Butler et al. 2009)
	There is greater probability of PTG for intermediate severity of trauma than for very low or very high severity levels (Levine et al. 2008; Lechner et al. 2006; Kliem and Ehlers 2009)
Type of event	Some types of highly destructive experiences (e.g., torture) possibly make PTG difficult (Punamäki 2010)
	Threats of impending mortality are more likely to lead to positive changes (Stanton et al. 2006)
Community network	Maintaining the community structure favors PTG even in postwar scenarios (Arënliu and Landsman 2010)
Social support	Social support is positively associated with PTG (Prati and Pietrantoni 2009; Vázquez and Páez 2010)
Emotions	Positive emotions in the aftermath of trauma are associated with greater personal growth (Fredrickson et al. 2003; Vázquez and Hervás 2010)
	There is a low correlation between perception of benefits and negative emotions (Vázquez and Hervás 2010)
Coping (individual and community)	Active coping strategies are linked to PTG (Prati and Pietrantoni 2009)
	Participation in social rituals such as public demonstrations, political protests (Páez et al. 2007), or religious activities (Vázquez et al. 2005) may promote PTG
Appraisal	Positive reevaluation of the occurrence is linked to PTG (Helgeson et al. 2006; Prati and Pietrantoni 2009)
Cognitive factors	Rumination or brooding is associated with PTSD, whereas reflection (a ruminative style associated with deliberate attempts to make constructive meaning of an event's consequences) is associated with PTG (Stockton et al. 2011)
	Causal attributions (blaming others or oneself) may inhibit PTG processes (Van Loey et al. 2008)
Religiousness	Religiousness is positively associated with PTG (Helgeson et al. 2006; Prati and Pietrantoni 2009)
Optimism	A positive view of the world and the future increases the probability of PTG (Helgeson et al. 2006; Prati and Pietrantoni 2009)
Sense of control	A sense of responsibility may promote changes to reestablish a sense of control (Park 2009)

Note. PTG posttraumatic growth, *PTSD* posttraumatic stress disorder

coping strategies that individuals utilize in a situation. Culture also provides different institutional mechanisms by which an individual can cope with trauma or stress, and influence others' reactions in a situation. Thus, PTG and the associated processes very likely depend a great deal on cultural factors that surround the individual (Calhoun et al. 2010; Vázquez and Páez 2010).

A genuine transcultural view of PTG involves analyzing: (a) if a similar concept exists in most cultures; and (b) what its nature would be from *emic* (i.e., from within the culture) and *etic* (i.e., by observers outside of the culture) perspectives. A recent review (Splevins et al. 2010) showed that the majority of available information comes from etic studies based on the translation and reinterpretation of psychometric scales, essentially the Posttraumatic Growth Inventory (PTGI), devised and elaborated within the occidental culture. The review demonstrates the difficulties of the PTGI's use in the contexts of China, Japan, Turkey, and Palestine, and the necessity for significant conceptual adaptations. These studies run the risk of succumbing to what can be called the *categorical fallacy* in assuming that the construct measured by the instrument exists in a certain culture simply because the population can respond to and obtain a given score on the instrument. In an interesting linguistic work, Almedom et al. (2005) showed that the word "loser" (content in the Sense of Coherence Scale) was incomprehensible as a concept and did not have an equivalent for Eritreans. Therefore, the mental universes of cultures can be very different from one another.

A first conceptual limit is the nonuniversality of what we consider a *stressor*. Nancy Scheper-Hughes (1993) studied the reaction of Brazilian mothers of low socioeconomic status to the death of their children. The author was initially shocked to observe that after the death of a baby, there was no process of mourning. She concluded that spouses, partners, and babies are considered temporary commitments and are thus replaceable. A "test" period is established in which each pregnancy is welcomed ambivalently, and each newborn is adopted with caution and an apparent lack of empathy that increases in the following months if the child survives. Furthermore, the death of a child is not seen as traumatic. The dead child is believed to have guaranteed happiness in the other world. In sum, there is social modeling of feelings and emotions when facing extreme events that contrast with some of the preconceptions we may have from a universalist psychological approach. To automatically use concepts such as mourning, trauma, and PTG would be futile and inadequate.

Secondly, is the idea of *growth* transculturally valid? It may initially seem to underlie a notion of *overcoming* more suitable for individualistic cultures (Splevins et al. 2010). However, from a larger transcultural outlook, most groups establish life goals considered desirable and define a behavioral ideal that guides life reconstruction in adversity. A distinct issue is if these processes fit well with current explicative models of trauma and PTG (Weiss and Berger 2010).

We will present three examples that allow for reflection on the limits of these concepts when applied to diverse cultural and mental configurations:

4.5.1 The Mapuche Community: An Emic-Based Approach to PTG

The mapuche people, with a population of around two million, occupies the south of Chile and part of Argentina. Its inhabitants are of a native indigenous, collectivistic culture that has no assimilable concept of trauma in its ethnomedicine or language (Perez-Sales et al. 1999). They believe, as many other indigineous cultures, that

psychological illness is not inside (e.g., shattered beliefs destroyed by trauma) but outside, penetrating and affecting the whole person, and should be expelled. The impact of a traumatic event can be interpreted as disruption of a balanced system (e.g., with ancestors, oneself, the land, and supernatural forces) that allows illness to penetrate (Pérez-Sales 2006).

PTG presupposes progression toward "the correct way of living." In a certain sense, growth can be understood as a continuous process of gaining wisdom and an ideal identity as a human being in a series of dominions well guided by tradition (e.g., respect for the laws of nature or being fair), and that not all people are able to reach (Antona 2011).

4.5.2 Susto *as a Paradigm of "Pure" Trauma*

Psychological syndromes have been described in different cultures that are unleashed by unexpected events constituting threats to the physical or psychological integrity of a person (Simmons and Hughes 1985). A notable example for its frequency and characteristics is *susto* (fright sickness causing *soul loss*), present in almost all of Latin America (APA 2000). In the largest anthropological work published on susto to date and conducted in communities of southern Mexico (Chiapas, Oaxaca), a total of 47 cases diagnosed by traditional healers were studied with quantitative and qualitative methodologies, and followed over various years (Rubel et al. 1984). Causes of onset are triggering events such as a fire in which the house and all belongings are burned leaving the family unprotected, a child who is attacked by a dog, and a woman who falls from a tree and is carried away by a strong current. The appearance of *susto* symptoms (e.g., tiredness, lack of spirits, major depression, and loss of appetite, weight, and energy) can occur hardly hours after the triggering event to a few years later. In more than half of all cases, *susto* leads to isolation (especially of adults), detachment of trust-based ties with others, fear, and insecurity. The cure involves a complex healing process to extract the illness or make the lost soul return, and above all, to rebalance personal spaces in line with a typical mapuche healer's duties (e.g., family relationship issues, feelings of inability to confront daily suffering, lack of community support, or violation of norms in regard to relations with the land).

The endeavor to recuperate a person's *essence* and find equilibrium in personal spaces is what could be identified as psychotherapeutic work directed toward PTG with the person's individual and societal identities (i.e., valuing tradition, improving relationships, and respecting collective norms), though this might be a forced conceptual translation. *Susto* in reality is, as we saw, a person's suffering made physical in line with Das' theory.

4.5.3 *Extreme Trauma: Young Sudanese Refugees*

A good part of Euroamerican literature on growth originated from survivors of the Holocaust. A third way to find the limits of the concepts of trauma and growth is to analyze examples of extreme traumatization in the context of contemporary

holocausts, which have occurred in Arab and subsaharan countries, Rwanda, and Sudan. In an excellent ethnographic study, Goodman (2004) investigated the mechanisms of resistance and worldview of 14 Sudanese youth of the Dinka tribe aged 16–18 years who lived through absolute horror (years of being abandoned to their own devices, being victims of group assassinations, torture, acts of massacre and terror, persecution, and hunger and death of friends by starvation). In interviews 6–12 months after arriving in the USA, the youth participants expressed feelings of fellowship, benevolence, and hopefulness rather than victimization or resentment. Speaking primarily with the pronouns *we* and *us*, the participants identified themselves and recounted events as part of the refugee group. These Sudanese youth lived in the moment both individually, with strong cognitive and emotional detachment from facts, and collectively, encouraging one another to not think and remember. Their narratives of horror were unemotional and nonjudgmental. Through an unshakable faith in God's will and omnipotence (i.e., "God decides when you die"), the participants were able to steer clear of questioning their suffering and existence (Goodman 2004).

Was there PTG in this group of Sudanese youth? Their resilience, and perhaps growth (as their stories represent the path from hopelessness to hopefulness), is based on not looking for meaning, not questioning purpose or priorities, and not asking why and how they acted as they did. In fact, their spirituality is more a way to block thinking than true religiousness. This coping approach in certain ways violates the typical elaborative processes that survivors are supposed to follow to construe meaning and psychologically grow (Park 2010). Interestingly, Janoff-Bulman (2004) proposed different ways that lead to PTG and only one includes changes in basic beliefs through the reflective process. Thus, there is evidence that people can be strengthened by an adverse experience without even being aware of it.

The aforementioned examples span the continuum of human suffering and highlight cultural differences. This is exemplified by the Sudanese youth refugees who were born and enculturated in a context of extreme violence, possibly never developing excessive expectations of goodness and trust in humans, of predictability, of security, or of the idea that the world is fair and that everyone receives what they deserve (Janoff-Bulman 1992).

4.6 Facilitation of PTG: Strategic Approaches and Specific Techniques

PTG theorists place emphasis on a kind of cognitive restructuring after confrontation with extreme experiences. There are even initiatives to establish a PTG component in trauma prevention programs (Tedeschi and McNally 2011). Yet, deep positive changes are likely produced even without effort and are not necessarily linked to true insight (Zoellner and Maercker 2006). The survival experience of the

Sudanese youth supports the idea that life changes are not based on mere declarative statements (Johnson and Hobfoll 2007; Hobfoll et al. 2007). As taught in Buddhism, personal growth must be understood from a deep transpersonal level as an ongoing, holistic process of change (Wong and Wong 2006).

It should be emphasized that the majority of approaches and techniques we will present (see Table 4.2) have demonstrated potential in facilitating PTG in samples of occidental participants who have gone through adverse experiences in their own contexts (e.g., grave illnesses or accidents).

Calhoun and Tedeschi (1999), pioneers in creating a clinical guide to promote PTG, suggested that this new approach could be integrated by therapists of different psychotherapeutic orientations. Its goal would be to compensate for traditional clinical approaches more focused on the negative with greater inclusion and integration of positive elements of growth and personal development (Tedeschi and Kilmer 2005).

Caution should be taken when trying to stimulate PTG with people who have experienced a potentially traumatic event. First, they may not need help from health professionals. Most (50–60 %) spontaneously experience positive life changes after an adverse event (Linley and Joseph 2004; Helgeson et al. 2006), suggesting that this may be a natural process that does not require clinical intervention. Premature or forced intervention can interfere with natural recuperation, which can result in feelings of being misunderstood or in distancing from the therapist (Cordova 2008; Pérez-Sales 2008). Second, although there is increasing evidence on the adaptive value of growth (Sawyer et al. 2010), we still lack knowledge on how, when, and with whom it is therapeutic to promote the process more generally. Third, interventions are usually carried out with a culturally appropriate therapeutic framework given that the trauma-growth duo can have very different cultural variations as previously demonstrated.

4.7 Strategic Approaches

Curiosity Adverse effects are frequently considered strange, unknown, and alien in terms of a person's previous experiences, and difficult to understand and explain. Curiosity as a life attitude is a mechanism of survival that facilitates the development of new abilities and forms of understanding reality, and of definite growth. In fact, people rated high on personality dimensions such as *openness to experience* characterized by being imaginative, emotionally reactive, and intellectually curious, have a greater tendency to try PTG (Tedeschi and Calhoun 1996). This suggests that therapeutic intervention itself usually has an investigatory character that encourages openness and curiosity about the affected person's existential position in the world and relation with others posttrauma. The focus is normally on personal identity after the event (i.e., "Who am I after having gone through this?"), which promotes specification of internal dialogues about *the before* and *the now* to help recognize the adverse event's influence on life, a preliminary step in PTG (Cordova 2008).

Table 4.2 Strategies and techniques to promote PTG in clinical settings

Objective of the intervention	Strategies and techniques to facilitate PTG	Examples of cue questions
To generate a good attitude for change	1. Curiosity as a life attitude	Sometimes, investigating the effects difficult events have on people helps with recovery…what is your opinion on this?
	2. Realistic acceptance	What elements of the event would help you with acceptance without overthinking the event?
	3. Control and flexibility	What helps you maintain a certain sense of control, though minimal? Have you considered that there may be other forms of taking or facing what you have lived through?
	4. Promotion of optimism	If you could hope for an improvement in the future, what would be the most probable?
To work with strengths	1. Awareness	In spite of not being able to keep a job, it is also true that in just a few days you can get another. Could this perseverance be helpful with the rest of the problems you have?
	2. Learning of and search for exceptions	In this entire horrific week, has there been any day that you have surprised yourself doing something that has been impossible for you on the other days? What do you think was different on that occasion?
		If I could have a camera follow you around for 24 h but would only record moments when you are doing relatively well, what would you be doing? Would you be with someone?
To recall memories of success	Finding successful learning opportunities in other problematic situations	Focusing on the discomfort you are experiencing, have you felt like this in the past? How did you overcome it? What was helpful then? Would some of that be useful to you now?
To visualize a better future	Questioning on miracles	If a miracle occurred and solved your difficulty in handling what happened, how would we know that you are better? And the people around you? Whom and what would they notice?
To give meaning to the experience	1. Personal guidelines for fulfillment	(See in text)
	2. Positive autobiographical memories	
To promote relational growth	1. Arousal of interest in others	How do you think this has had an impact on others (family and other affected people)? What difficulties do they have to handle? What do they see in you that helps them recover?
	2. Positive models in adversity	Is there someone who has served as an example of how to overcome this or other difficult situations? What do you admire in that person? And if you could make that virtue yours, how would it help you?
	3. Gratitude and forgiveness	Before and after going through something like this, there are often things in life to be grateful for. In your case, what would they be? Have you expressed gratitude? What effect has it had?

Note. PTG posttraumatic growth

Realistic Acceptance As we have seen, research has shown a link between acceptance, coping, and PTG. The ability to accept and deal with situations that cannot be changed is crucial in facing adverse life situations, and is a prerequisite for working on complex emotions such as guilt (Pérez-Sales 2006) and for fostering personal growth (Calhoun et al. 2000). Be forewarned that the association is not linear, so more acceptance does not necessarily mean more growth; instead, acceptance facilitates growth.

Locus of Control and Flexibility Perception of the possibility, though small, to successfully cope is another relevant therapeutic factor. It is likely that those with more self-control are more flexible since they score higher on various psychological well-being dimensions and exhibit flexibility-related strengths such as curiosity and perseverance. This suggests that psychological flexibility may be key to well-being (Kashdan and Rottenberg 2010).

Promotion of Optimism Optimism is a general disposition or tendency to hope that good happens more often than bad. Several studies have shown a small-to-moderate correlation between optimism and PTG (Park et al. 1996; Tedeschi and Calhoun 1996), although there may be overlap between the concepts (Zoellner and Maercker 2006).

4.7.1 Specific Techniques: Exploration and Promotion of Positive Life Changes

Many techniques can be implemented in standard psychotherapeutic processes (Calhoun and Tedeschi 1999; Joseph 2011; Joseph and Linley 2006). In this chapter, we focus on some techniques that can facilitate long-term positive changes. Others (e.g., recalling memories of success, working with strengths, and visualizing a better future; see Table 4.2) can be used but will not be explained in detail due to space constraints.

Giving Meaning to the Experience A recent review (Park 2010) on the effects of meaning making in adjusting to stressful events attempts to integrate studies in a field that paradoxically lacks coherence. Models of dealing with traumatic situations examine ways to promote the construction of meaning posttrauma. Giving meaning to an adverse experience is a complex process. It may imply, on one hand, establishing continuity between the past, the traumatic experience, the present, and the capacity for future projection. On the other hand, it may also involve diminishing discrepancies between peritraumatic responses and coping (appraised meaning) and core beliefs (Joseph and Linley 2005), a process related to personal principles and life goals. Some approaches and techniques that facilitate PTG through meaning making are:

Fulfillment Patterns Versus Problem Patterns In psychotherapy, *problem patterns* connect events, people, and emotions in search of problematic patterns that

give sense to suffering or discomfort. Little attention is paid to establishing connections between elements that recur to our satisfaction, and that produce fulfillment and purpose in life. These connections between the past, present, and future that are positive and meaningful are called *personal guidelines for fulfillment* (Ochoa et al. 2010).

An adequate way to promote personal guidelines for fulfillment is to think of meaningful anchors that help maintain continuity after the event (e.g., "my family has always been there," "my partner still makes me feel loved," and "work makes me feel useful and worthy").

Positive Autobiographical Memories The role of traumatic memories in the psychological treatment of trauma has been the subject of much research (Leskin et al. 1998). Nevertheless, we only recently have data on the therapeutic ability of bringing positive biographical memories to the surface. The role of memory in achieving a sense of growth is very relevant. In fact, recalled growth rather than measured growth generates positive affect (Tennen and Affleck 2009). Carver and Scheier (1990) have also demonstrated that information about change over time gives rise to positive affect.

Recalling memories by writing or imagining, guided by positive autobiographical episodes (Serrano et al. 2004; Ochoa et al. 2010), can bring to mind what was lost or what happened (and associated negative emotions like nostalgia) but can also lead to reexperiencing pleasant sensations, construction of one's personal autobiography, a sense of progress, and probably PTG. Another therapeutic effect of bringing forward positive memories is that remembering these experiences makes more likely to promote behaviors associated to those positive states. In fact, Wirtz et al. (2003) showed that recalled experiences rather than objectives experiences predict interest in and willingness to repeat them.

Relational Growth A clinical indicator of improvement in mental health and of personal growth is the ability to transcend one's own "ego" (Joseph 2011). Relational growth involves the ability to take the focus away from oneself to be interested in, worry about, and commit to others, and in a more affective sense, to love and be loved, which seem key to facilitating PTG. If the deep desire for interpersonal relationships human beings show is a foundation of our psychological life, then we should regard personal growth as necessarily linked to the optimization of our interpersonal relationships (Fernández-Liria and Rodríguez Vega 2006).

Arousing Interest in Others In therapy, there are multiple interventions that attempt to improve communication and relationships with others for personal and relational growth, especially through a partner, family, and groups. In general, these interventions make it easier to develop a type of empathic or relational conscience. The objectives are to vicariously experience the emotions and intentions of others, to understand others' limitations, to discover the role of the affected person's own influence or responsibility in interactions, to be conscious of his or her own necessities, and to know how to communicate them. Procedures that favor a reduction of self-focus to develop interest in others likely promote relational PTG.

Positive Models in Adversity *W*hen going through potential trauma, many survivors search for information, references, and models to understand and face the adversity. Normally, coping models are others affected or meaningful personal references. People should also be conscious of how they can be coping models for others because there are data that indicate, for example, that PTG in breast cancer patients predicts PTG in their husbands (Weiss 2004a).

If personal growth or PTG can be understood as changes made that bring us closer to a preferred (or "ideal") version of ourselves in diverse areas, then in relational growth, the model (whether external and personified, or ideal and interiorized) would guide this process. Weiss (2004b) demonstrated the importance of this modeling in women who had contact with other breast cancer survivors who perceived benefits from their experience, noting significantly greater search for benefits (positive life changes) in contrast with women who did not have this contact. In PTG, corroboration of this growth or passing it on to meaningful people has been associated with true growth (Sumalla et al. 2009).

Gratitude and Forgiveness Adverse situations can affect how we view others and their kindness. In the case of man-made adverse events (e.g., rape or political violence), the potential for trauma may be even greater as the event undermines basic beliefs about the world and others, nurturing emotions such as anger (McHugh et al. 2012). In relation to attribution processes, blaming others has been linked to poor adjustment and may justify interventions based on forgiveness to alleviate PTSD and allow psychological growth (Van Loey et al. 2008).

However, personal relationships can still be affected by impersonal incidents (e.g., sickness or natural disaster). In these cases, affected people commonly undergo a process of selection between those who were at their side and supported them, and those who failed or disappointed them. Gratitude-based Interventions rely on increasing awareness of having externally received something positive (generally, from another person), and exploring the possibilities of identifying or recognizing it (e.g., letters of appreciation or public recognition).

4.8 Final Comments

The idea of perpetual possibilities of change underlying concepts such as PTG and flourishing is probably not universal despite being common in modern Western societies, or if universal, its magnitude and relative importance in our cultural scripts can be very different. Tennen and Affleck (2009) convincingly argued that this cultural bias may lead Americans to overestimate positive change from negative events, and to become frustrated and distressed if changes according to these expectations of psychological growth are not observed.

Values underlying the idea of human growth are likely not the same across cultures. Whereas some societies value change, others value constancy. There are societies that encourage self-examination, self-criticism, and self-correction in the

pursuit of an ideal (i.e., a fulfilled person) while others encourage inhibition or absence of conflict for the sake of personal or social harmony. Some societies value struggle and active coping, but others (usually labeled as fatalistic) have historically shown resistance through mechanisms of acceptance and continuity (Scott 1992; Martin-Baró 1996). In cultural environments where change is generally perceived to be distant, and fatalism and silence are forms of resistance, asking people if they can emerge strengthened by an experience is likely not understood because suffering is part of the processes and natural cycles of life.

We live in a world where human beings, in many low- and middle-income countries, cope daily with harsh conditions and the fight for survival. Concepts such as stress, trauma, and crisis are partial views of a more complex reality encompassed by the term *human suffering*, including individual and collective elements, and determined by the political and sociocultural context.

If we understand growth as the process of acquiring wisdom to live in society, then which is the kind of wisdom that each society finds desirable? Any intervention, societal or individual, must take into account the cultural and epistemological framework in which individuals live; otherwise, we would be imposing our worldview on others.

References

Almedom, A. M., Tesfamichael, B., Saeed Mohammed, Z., Muller, J., Mascie-Taylor, C. G. N., & Alemu, Z. (2005). "Hope" makes sense in Eritrean sense of coherence, but "loser" does not. *Journal of Loss and Trauma, 10*, 433–451.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed. Text Rev.). Washington, DC: Author.

Antona, J. (2011). *Etnografia de los derechos humanos. Etnoconcepciones de los pueblos indigenas de América: el caso mapuche.* Madrid: Universidad Complutense de Madrid.

Arënliu, A., & Landsman, M. S. (2010). Thriving in postwar Kosova. In T. Weiss & R. Berger (Eds.), *Posttraumatic growth and culturally competent practice: Lessons learned from around the globe* (pp. 65–72). New York: Wiley.

Baker, J. M., Kelly, C., Calhoun, L. G., Cann, A., & Tedeschi, R. G. (2008). An examination of posttraumatic growth and posttraumatic depreciation. *Journal of Loss and Trauma, 13*, 450–465.

Bonanno, G. A. (2004). Loss, trauma and human resilience. *American Psychologist, 59*, 20–28.

Bonanno, G. A., Wortman, C. B., Lehman, D. R., Tweed, R. G., Haring, M., Sonnega, J., Carr, D., & Neese, R. M. (2002). Resilience to loss and chronic grief: A prospective study from pre-loss to 18 months post-loss. *Journal of Personality and Social Psychology, 83*, 1150–1164.

Bonanno, G. A., Brewin, C. R., Kaniasty, K., & La Greca, A. M. (2010). Weighing the costs of disaster: Consequences, risks, and resilience in individuals, families, and communities. *Psychological Science in the Public Interest, 11*, 1–49.

Bonanno, G. A., Westphal, M., & Mancini, A. D. (2011). Resilience to loss and potential trauma. *Annual Review of Clinical Psychology, 7*, 511–535.

Bruno, M. A., Bernheim, J. L., Ledoux, D., Pellas, F., Demertzi, A., & Laureys, S. (2011). A survey on self-assessed well-being in a cohort of chronic locked-in syndrome patients: Happy majority, miserable minority. *BMJ Open, 1*, e000039. doi:10.1136/bmjopen-2010-000039.

Butler, L. D., Koopman, C., Azarow, J., Blasey, C. M., Magdalene, J. C., Dimiceli, S., et al. (2009). Psychosocial predictors of resilience after the September 11, 2001 terrorist attacks. *Journal of Nervous and Mental Disease, 197*, 266–273.

Calhoun, L. G., & Tedeschi, R. G. (1999). *Facilitating posttraumatic growth: A clinician's guide*. Mahwah: Lawrence Erlbaum Associates.

Calhoun, L. G., Cann, A., Tedeschi, R. G., & McMillan, J. (2000). A correlational test of the relationship between posttraumatic growth, religion, and cognitive processing. *Journal of Traumatic Stress, 13*, 521–527.

Calhoun, L. G., Cann, A., & Tedeschi, R. G. (2010). The posttraumatic growth model. In T. Weiss & R. Berger (Eds.), *Posttraumatic growth and culturally competent practice: Lessons learned from around the globe* (pp. 1–14). New York: Wiley.

Cann, A., Calhoun, L. G., Tedeschi, R. G., & Solomon, D. T. (2010). Posttraumatic growth and depreciation as independent experiences and predictors of well-being. *Journal of Loss and Trauma, 15*, 151–166.

Carver, C. S., & Scheier, M. F. (1990). Origins and functions of positive and negative affect: A control process view. *Psychological Review, 97*, 19–35.

Castilla, C., & Vázquez, C. (2011). Stress-related symptoms and positive emotions after a myocardial infarction: A longitudinal analysis. *European Journal of Psychotraumatology, 2*, 8082. DOI: 10.3402/ejpt.v2i0.8082

Conway, M., & Ross, M. (1984). Getting what you want by revising what you had. *Journal of Personality and Social Psychology, 47*, 738–748.

Cordova, M. J. (2008). Facilitating posttraumatic growth following cancer. In S. Joseph & A. Linley (Eds.), *Trauma, recovery, and growth: Positive psychological perspectives on posttraumatic stress* (pp. 185–207). New York: Lawrence Erlbaum Associates.

Das, V. (1995). *Critical events. An anthropological perspective on contemporary India*. Delhi: Oxford University Press.

Das, V. (2006). *Life and words: Violence and the descent into the ordinary*. Berkeley: University of California Press.

Exline, J. J., Park, C. L., Smyth, J. M., & Carey, M. P. (2011). Anger toward God: Five foundational studies emphasizing predictors, doubts about God's existence, and adjustment to bereavement and cancer. *Journal of Personality and Social Psychology, 100*, 129–148.

Falsetti, S. A., Resick, P. A., & Davis, J. L. (2003). Changes in religious beliefs following trauma. *Journal of Traumatic Stress, 16*, 391–398.

Fernández-Liria, A., & Rodríguez Vega, B. (2006). *Habilidades de entrevista para psicoterapeutas*. Bilbao: Desclee de Brouwer.

Folkman, S. (2008). The case for positive emotions in the stress process. *Anxiety, Stress, and Coping, 21*, 3–14.

Fredrickson, B. L., Tugade, M. M., Waugh, C. E., & Larkin, G. R. (2003). What good are positive emotions in crisis? A prospective study of resilience and emotions following the terrorist attacks on the United States on September 11th, 2001. *Journal of Personality and Social Psychology, 84*, 365–376.

Goodman, J. H. (2004). Coping with trauma and hardship among unaccompanied refugee youths from Sudan. *Qualitative Health Research, 14*, 1177–1196.

Helgeson, V. S., Reynolds, K. A., & Tomich, P. L. (2006). A meta-analytic review of benefit finding and growth. *Journal of Consulting and Clinical Psychology, 74*, 797–816.

Hobfoll, S. E., Hall, B. J., Canetti-Nism, D., Galea, S., Johnson, R. J., & Palmieri, P. A. (2007). Refining our understanding of traumatic growth in the face of terrorism: Moving from meaning cognitions to doing what is meaningful. *Applied Psychology: An International Review, 56*, 345–366.

Janoff-Bulman, R. (1989). Assumptive worlds and the stress of traumatic events: Applications of the schema construct. *Social Cognition, 7*, 113–136.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: The Free Press.

Janoff-Bulman, R. (2004). Posttraumatic growth: Three explanatory models. *Psychological Inquiry, 15*, 30–34.

Johnson, R., & Hobfoll, S. (2007). Posttraumatic growth: Action and reaction. *Applied Psychology, 56*(3), 428–436.

Joseph, S. (2009). Growth following adversity: Positive psychological perspectives on posttraumatic stress. *Psychological Topics, 18*, 335–344.

Joseph, S. (2011). *What doesn't kill us: The new psychology of posttraumatic growth*. New York: Basic Books.

Joseph, S., & Linley, P. A. (2005). Positive adjustment to threatening events: An organismic valuing theory of growth through adversity. *Review of General Psychology, 9*, 262–280.

Joseph, S., & Linley, P. A. (2006). Growth following adversity: Theoretical perspectives and implications for clinical practice. *Clinical Psychology Review, 26*, 1041–1053.

Kashdan, T. B., & Rottenberg, J. (2010). Psychological flexibility as a fundamental aspect of health. *Clinical Psychology Review, 30*, 865–878.

Kleinman, A., & Kleinman, J. (1999). The moral, the political and the medical: A sociosomatic view of suffering. In Y. Otsuka, S. Shizu, & S. Kuriyama (Eds.), *Medicine and the history of the body*. Tokyo: Ishiyaku Euroamerica.

Kliem, B., & Ehlers, A. (2009). Evidence for a curvilinear relationship between posttraumatic growth and posttrauma depression and PTSD in assault survivors. *Journal of Traumatic Stress, 22*, 45–52.

Lechner, S. C., Carver, C. S., Antoni, M. H., Weaver, K. E., & Phillips, K. M. (2006). Curvilinear associations between benefit finding and psychosocial adjustment to breast cancer. *Journal of Consulting and Clinical Psychology, 74*, 828–840.

Leskin, G. A., Kaloupek, D. G., & Keane, T. M. (1998). Treatment for traumatic memories: Review and recommendations. *Clinical Psychology Review, 18*, 983–1001.

Levine, S. Z., Laufer, A., Hamama-Raz, Y., Stein, E., & Solomon, Z. (2008). Posttraumatic growth in adolescence: Examining its components and relationship with PTSD. *Journal of Traumatic Stress, 21*(5), 492–496.

Linley, P. A., & Joseph, S. (2004). Positive change following trauma and adversity: A review. *Journal of Traumatic Stress, 17*, 11–21.

Mancini, A. D., Prati, G., Bonanno, G. A. (2011). Do shattered worldviews lead to complicated grief? Prospective and longitudinal analyses. *Journal of Social and Clinical Psychology, 30*(2), 184–215.

Martin-Baró, I. (1996). *Writings for a liberation psychology*. New York: Harvard University Press.

McHugh, T., Forbes, D., Bates, G., Hopwood, M., & Creamer, M. (2012). Anger in PTSD: Is there a need for a concept of PTSD-related posttraumatic anger? *Clinical Psychology Review, 32*, 93–104.

McNally, R. J. (2003). Progress and controversy in the study of posttraumatic stress disorder. *Annual Review of Psychology, 54*, 229–252.

Ochoa, C., Sumalla, E. C., Maté, J., Castejón, V., Rodriguez, A., Blanco, I., & Gil, F. (2010). Psicoterapia positiva grupal. Hacia una atención psicosocial integral del superviviente de cáncer. *Psicooncologia, 7*, 7–34.

Páez, D., Basabe, N., Ubillos, S., & González, J. L. (2007). Social sharing, participation in demonstrations, emotional climate, and coping with collective violence alter the March 11th Madrid bombings. *Journal of Social Issues, 63*, 207–323.

Park, C. L. (2009). Overview in theoretical perspectives. In C. Park, S. Lechner, A. L. Stanton, & M. H. Antoni (Eds.), *Medical illness and positive life change: Can crisis lead to personal transformation?* (pp. 11–30). Washington, DC: American Psychological Association.

Park, C. L. (2010). Making sense of the meaning literature: An integrative review of meaning making and its effects on adjustment to stressful life events. *Psychological Bulletin, 136*, 257–301.

Park, C. L., Cohen, L., & Murch, R. (1996). Assessment and prediction of stress-related growth. *Journal of Personality, 64*, 71–105.

Pérez-Sales, P. (2006). *Trauma, culpa y duelo: Hacia una psicoterapia integradora*. Bilbao: Desclée De Brower.

Pérez-Sales, P. (2008). Psicoterapia positiva en situaciones adversas. In C. Vázquez & G. Hervás (Eds.), *Psicología Positiva Aplicada* (pp. 155–190). Bilbao: Desclée De Brouwer.

Perez-Sales, P., Bacic, R., & Durán-Perez, T. (1999). *Muerte y desaparición forzada en la Araucania: Una aproximación étnica*. Santiago de Chile: Ediciones LOM.

Pérez-Sales, P., Eiroa-Orosa, F. J., Olivos, P., Barbero-Val, E., Fernández-Liria, A., & Vergara, M. (2012). Vivo Questionnaire: A measure of human worldviews and identity in trauma, crisis, and loss—validation and preliminary findings. *Journal of Loss and Trauma, 17*, 236–259.

Prati, G., & Pietrantoni, L. (2009). Optimism, social support, and coping strategies as factors contributing to posttraumatic growth: A meta-analysis. *Journal of Loss and Trauma, 14*, 364–388.

Punamäki, R. (2010). Posttraumatic growth in Middle Eastern context: Expression and determinants among Palestinians. In T. Weiss & R. Berger (Eds.), *Posttraumatic growth and culturally competent practice: Lessons learned from around the globe* (pp. 31–48). New York: Wiley.

Rubel, A. J., O'Nell, C. W., & Collado, R. (1984). *Susto. A folk illness*. Berkeley: University of California Press.

Sawyer, A., Ayers, S., & Field, A. P. (2010). Posttraumatic growth and adjustment among individuals with cancer and HIV/AIDS: A meta-analysis. *Clinical Psychology Review, 30*, 436–447.

Scheper-Hughes, N. (1993). *Death without weeping: The violence of everyday life in Brazil*. Berkeley: University of California Press.

Scott, J. C. (1992). *Domination and the arts of resistance: Hidden transcripts*. New Haven: Yale University Press.

Serrano, J. P., Latorre, J. M., Gatz, M., & Montanes, J. (2004). Life review therapy using autobiographical retrieval practice for older adults with depressive symptomatology. *Psychology and Aging, 19*, 272–277.

Simmons, R., & Hughes, C. (Eds.). (1985). *The culture-bound syndromes. Folk illnesses of psychiatric and anthropological interest*. Boston: Reidel.

Splevins, K., Cohen, K., Bowley, J., & Joseph, S. (2010). Theories of posttraumatic growth: Cross-cultural perspectives. *Journal of Loss and Trauma, 15*, 259–277.

Stanton, A. L., Bower, J. E., & Low, C. A. (2006). Posttraumatic growth after cancer. In L. G. Calhoun & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research and practice* (pp. 138–175). Mahwah: Lawrence Erlbaum Associates.

Stockton, H., Hunt, N., & Joseph, S. (2011). Cognitive processing, rumination, and posttraumatic growth. *Journal of Traumatic Stress, 24*, 85–92.

Sumalla, E. C., Ochoa, C., & Blanco, I. (2009). Posttraumatic growth in cancer: Reality or illusion? *Clinical Psychology Review, 29*, 24–33.

Tedeschi, R. G., & Calhoun, L. G. (1996). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress, 9*, 455–471.

Tedeschi, R. G., & Kilmer, R. P. (2005). Assessing strengths, resilience, and growth to guide clinical interventions. *Professional Psychology: Research and Practice, 36*, 230–237.

Tedeschi, R. G., & McNally, R. J. (2011). Can we facilitate posttraumatic growth in combat veterans? *American Psychologist, 66*, 19–24.

Tennen, H., & Affleck, G. (2002). Benefit-finding and benefit-reminding. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 584–597). New York: Oxford University Press.

Tennen, H., & Affleck, G. (2009). Assessing positive life change: In search of meticulous methods. In C. Park, S. Lechner, A. L. Stanton, & M. H. Antoni (Eds.), *Medical illness and positive life change: Can crisis lead to personal transformation?* (pp. 31–49). Washington, DC: American Psychological Association.

Van Loey, N. E., van Son, M. J., van der Heijden, P. G., & Ellis, I. M. (2008). PTSD in persons with burns: An explorative study examining relationships with attributed responsibility, negative and positive emotional states. *Burns, 34*, 1082–1089.

Vázquez, C. (2005). Stress reactions of the general population after the terrorist attacks of S11 (USA) and M11 (Madrid, Spain): Myths and realities. *Annuary of Clinical and Health Psychology, 1*, 9–25.

Vázquez, C., & Hervás, G. (2010). Terrorist attacks and benefit finding: The role of positive and negative emotions. *Journal of Positive Psychology, 5*, 154–163.

Vázquez, C., & Páez, D. (2010). Posttraumatic growth in Spain. In T. Weiss & R. Berger (Eds.), *Posttraumatic growth and culturally competent practice: Lessons learned from around the globe* (pp. 97–112). New York: Wiley.

Vázquez, C., Cervellón, P., Pérez Sales, P., Vidales, D., & Gaborit, M. (2005). Positive emotions in earthquake survivors in El Salvador (2001). *Journal of Anxiety Disorders, 19*, 313–328.

Vázquez, C., Pérez-Sales, P., & Hervás, G. (2008). Positive effects of terrorism and posttraumatic growth: An individual and community perspective. In S. Joseph & A. Linley (Eds.), *Trauma, recovery, and growth: Positive psychological perspectives on posttraumatic stress* (pp. 63–91). New York: Lawrence Erlbaum Associates.

Walter, M., & Bates, G. (2012). Posttraumatic growth and recovery from post traumatic stress disorder. In V. Olisah (Ed.), *Essential notes in psychiatry* (pp. 143–186). Rijeka, Croacia: InTech. Available at: http://www.intechopen.com/books/essential-notes-in-psychiatry

Weiss, T. (2004a). Correlates of posttraumatic growth in husbands of breast cancer survivors. *Psycho-Oncology, 12*, 260–268.

Weiss, T. (2004b). Correlates of posttraumatic growth in married breast cancer survivors. *Journal of Social and Clinical Psychology, 23*, 733–746.

Weiss, T., & Berger, R. (2010). *Posttraumatic growth and culturally competent practice: Lessons learned from around the globe*. New York: Wiley.

Wirtz, D., Kruger, J., Scollon, C. N., & Diener, E. (2003). What to do on spring break? The role of predicted, online, and remembered experience in future choice. *Psychological Science, 14*, 520–524.

Wong, P. T. P., & Wong, L. C. J. (2006). *Handbook of multicultural perspectives on stress and coping*. New York: Springer.

Zoellner, T., & Maercker, A. (2006). Posttraumatic growth in clinical psychology: A critical review and introduction of a two component model. *Clinical Psychology Review, 26*, 626–653.

Chapter 5
Promoting Resilience and Well-being with Wisdom and Wisdom Therapy

Michael Linden

5.1 Burdens in Life

It is part of every human existence since ancient times, that life is full of burdens and negative events, be it hunger, poverty, illness, war, death of beloved ones, marital discord, or failure in one's aspirations. And human beings are well equipped to cope with such negative events. They live in the face of all miseries, they marry or bring forth children during war times, they revel and strive for a better life. It can even be argued that hardship is in fact to some degree needed for psychological well-being, similar to physical challenges and exercise for somatic health. The psychological properties which help to cope with adversities are called "coping repertoire" or "resilience" (Lazarus 1999; Johnson and Baker 2004; Kalra et al. 2012; Pejušković et al. 2011; Herrman et al. 2011). People who are confronted with burdens and are able to master them experience eustress. As described in details in Chap. 4 of this volume by Vazquez et al., there is even the concept of posttraumatic development which says that demands can lead to personal growth and development, e.g. in the form of better appreciation of life, intensifying of personal relations, appreciation of personal strength or development of new perspectives in life (Tedeshi and Calhoun 2004). Only if somebody cannot cope with his or her environment distress develops leading to psychological problems and maladjustment. Whether one or the other happens is depending on the degree of resilience of a person. Resilience can be defined as the ability to stand up against burdens in life and to make a positive development in spite of a negative environment. It is a

M. Linden (✉)
Research Group Psychosomatic Rehabilitation, Charité University Medicine, Berlin, Germany

Department of Behavioural and Psychosomatic Medicine, Rehabilitation Center Seehof, Lichterfelder Allee 55, 14513 Teltow/Berlin, Germany
e-mail: michael.linden@charite.de

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_5, © Springer Science+Business Media Dordrecht 2014

multidimensional construct including personality, environmental support, or coping repertoire (Herrman et al. 2011). One psychological dimension of special interest for the mastery of life and managing adversities is wisdom, which has found much scientific attention in recent years.

5.2 Definition of Wisdom

Wisdom has been defined by Baltes and coworkers (Baltes and Smith 1990; Staudinger and Baltes 1996; Staudinger and Glück 2011) as expertise in dealing with difficult questions of life, like life planning. Baumann and Linden (2008) have specified this global definition in seeing wisdom as capacity, like assertiveness or others, which is given to everybody and needed "to solve unsolvable problems" in life.

There are many and daily unsolvable, ambiguous, or difficult problems in life. This starts with important decisions like to marry or not this or that person, to have children, to start this or that career, to go on after the infidelity of the partner, to overcome the death of a beloved one, or to accept guilt. But there are also daily demands like either to stay with the sick child at home this morning or go to work. There is no easy way out. All options have positive and negative consequences alike. Wisdom is needed to act in spite of these double-bind situations, not to fall in inactivity or worrying, and to find the best solution under the given possibilities. According to Sternberg (1990) there are three major scientific approaches to define wisdom: philosophical, implicit, and explicit theories.

5.2.1 Philosophical Understanding of Wisdom

Under a philosophical perspective wisdom is understood as a special form of knowledge. The opposite is stupidity, vice, or foolishness. A criterion of wisdom is comfort and contentment (Panikkar 2002). Human beings are never wise or not but may be wise in different degrees and also in some aspects and not in others. Only few humans are explicitly called wise although all are able to behave in a wise manner. It is typically not the person him- or herself but the others who make a judgement, whether some behaviour was wise or not. According to Assmann (1994) four aspects of wisdom can be discriminated under a philosophical perspective, i.e. (1) scope, (2) depth, (3) accessibility, and (4) usefulness:

Scope

In ancient times wisdom was seen as a comprehensive and integrated knowledge. A wise man knew more than others. The roman philosopher Cicero defined wisdom as knowledge about human and divine issues: "sapienta est rerum divinarum et humanarum scientia" (De Officiis, II, ii, 5). This concept of wisdom was the same in Renaissance and seen as the opposite of specialized and fragmented knowledge as it is learned from books.

Depth

In an educated and specialized society the question is not so much the quantity of knowledge but rather it's depth. Wisdom can help to learn about the important aspects of life, to look under the surface and ask for the essentials. In this sense, the Roman poet Vergil did not go to the works or schools to acquire knowledge about the world but engaged in the muses to learn about the deep and hidden questions of life (rerum cognoscere causas).

Accessibility

As wisdom cannot be taken from instruction manuals it is mysterious, esoteric and not open to everybody. But, it is not exclusive. It does not require formal training but experience in life. An illustration for this is given be the fotographer August Sander (2002) in his book on "Persons of the 19. Century", in which he contrasts pictures of a simply dressed "wise man" with those of a "philosopher".

Usefulness

Wisdom is knowledge about what is good for oneself or others. Only good goal oriented actions can be called wise and the degree of wisdom is in part measured by the outcome. It is a practical capacity. "The truth of wisdom is in probation". It is neither fair (like art) nor good (like moral), nor interesting (like science). Wisdom means knowledge about how to master one's life, given the imperfectness and frailty or human existence. Wisdom is there to help to solve problems, be it on a practical, motivational or value level (Assmann 1991).

Under a transcultural perspective also different bearers of wisdom can be discriminated which at the same time point to important facets of wisdom (Assmann 1991). There is the wisdom of the sovereign. He is the one who has the overview, foresight, and the resources to look after the welfare of all community members. The wisdom of the magician, be it sorcerers, shamans, or astrologers, encompasses insight in a hidden order of the world. The wisdom of the father is guided by knowledge about traditions and experience in life. He gives advice and guidance without prescriptions. The wisdom of the skeptic knows about the vanity in our life. This gives distance to all what on the first sight seems to be important, but does not on the second.

5.2.2 Implicit Theories of Wisdom

An important approach for the understanding of wisdom are common-sense-concepts which are held in daily life by ordinary persons. Clayton and Birren (1980) made persons say on a list of adjectives what characterizes wisdom. Three basic dimensions emerged: (1) cognitive (experienced, knowledgeable, intelligent, pragmatic, attentive), (2) reflective (introspective, intuitive) and (3) emotional (understanding,

empathic, peaceful, and gentle). There are similar studies which all come to comparable results (Brent and Watson 1980; Holliday and Chandler 1986; Bluck and Glück 2004) and which show that there is a general consensus about what people understand when talking about wisdom. This can also be seen when students are asked to name persons which they consider to be especially wise. There is a big overlap in the names which are given, like: Gandhi, Konfuzius, Christus, M. L. King, Sokrates, Mutter Teresa, Salomon, Buddha, the pope, the Dalai Lama, or Nelson Mandela (Bluck and Glück 2004).

5.2.3 Explicit Theories of Wisdom

There is ample scientific research on wisdom for some decades, mostly stimulated by developmental psychologists (Erikson 1959; Baltes and Staudinger 2000; Staudinger and Glück 2011) which resulted in several elaborated scientific theories. Erikson et al. (1986) conceived human development in eight steps. The highest is to accept the finiteness of life, which helps to develop meaning in life, serenity and acceptance of death. Brent and Watson (1980) see wisdom as an age dependent form of adaptive intelligence. It is characterized by specific communicative capacities, with high sensibility for verbal and nonverbal cues, empathy, and humor. The development of wisdom is fostered by misery, resulting in a new and complex inner balance. Meacham (1990) sees wisdom as a form of dealing with the limitations of all knowledge which leads to sepsis, uncertainty, and by this to critical reflections. Kramer (2000) defines wisdom as a special expertise in relation to life situations, allowing multiple responses and a pattern of individual properties, with the sense of cognitive, emotional, and behavioral maturity, resulting in openness for new experiences, dialectic thinking, empathy, and reduced despair or unhappiness in negative situations of life. Important is insight for the present situation with the ability to understand their background, the ability to look at problems from different perspectives and to put it in a universal context and integrate one's own wants in the context of social requirements. Achenbaum and Orwoll (1991) and McKee and Barber (1999) see wisdom as the capacity to accept reality as it is and to recognize and resist illusions in life in respect to intra-, inter-, and transpersonal experiences.

Sternberg (1998) developed the balance theory of wisdom. It implies a balance of cognitive, emotional, and cognitive functions of a person, as well as a balance between the individual and the environment. This requires empathy for the needs of others. This means that wisdom is not only an individual but also social phenomenon. An important capacity to achieve this goal is tacit knowledge about oneself, others and the context. It can be understood as a form of practical intelligence which allows to adapt at the environment and also to change it. Tacit knowledge can better predict success in the job than conventional intelligence tests. In summary, wisdom is defined by Sternberg (1998) as the use of tacit knowledge and general values to reach a general good by balancing intra-, inter-, and extrapersonal interests, and environmental demands.

Baltes and Staudinger (2000) define wisdom as a form of crystallized intelligence (in contrast to fluid intelligence) which can be described on five dimensions: (1) knowledge of facts, (2) procedural knowledge, (3) lifespan-contextualism, (4) value relativism, and (5) uncertainty tolerance. Lyster (1996) enlarged the concept of Baltes by adding emotional aspects, i.e. "affect-cognition" and "generativity". Similarly Ardelt (2003, 2004, 2005) pointed to the importance of emotional features in the understanding of wisdom. Referring to implicit wisdom concepts, they define wisdom as a three dimensional construct including (1) a cognitive component (a deep and clear understanding of life and a desire to know the truth, i.e., to comprehend the significance and deeper meaning of phenomena and events, particularly with regard to intrapersonal and interpersonal matters, conditio humana), (2) a reflective component (a perception of phenomena and events from multiple perspectives, including self-awareness and self critique), and (3) an emotional component (sympathetic and compassionate love for others and empathy).

Several psychological concepts such as cognitive intelligence and problem solving capacities, emotional intelligence, attributions, morality, or forgiveness share common characteristics with the concept of wisdom. Intelligence can be defined as the capacity to cope with new situations and problems without referring to earlier experiences. As to cognitive intelligence, a distinction is made between inborn or "fluid" intelligence and learned or "crystalline" intelligence (Cattell 1963, 1971). Research has shown that cognitive intelligence and mastery of life are only marginally correlated. Better correlations are found with practical intelligence or the ability of complex problem solving, which uses procedural knowledge, i.e. knowledge about the functioning of processes, evaluation of past experiences before going on to the next step or reevaluation of up to now decisions (Dörner and Schölkopf 1991). A different aspect is emotional intelligence (Mayer et al. 2004) which is the ability to recognize, control, and use own feelings, and to show empathy and interpersonal connection. Emotional and cognitive intelligence are seen as independent of each other.

An interesting concept in the context of wisdom is coming from Carol Ryff (1989; Ryff and Singer 1996). She defined psychological well-being as encompassing autonomy, personal growth, environmental mastery, purpose in life, positive relations and self-acceptance. These dimensions come from research on optimal human functioning and positive mental health. In part they can be understood as competencies to create and maintain positive health. Although this concept has not been developed in the context of wisdom but of well-being, the resemblance to some of the explicit wisdom strategies is obvious. This approach is even more interesting as it has been translated in therapeutic strategies, i.e. well-being therapy by Fava (Fava et al. 1998; Fava and Ruini 2003).

Interpretation of events and attributions are also important processes in the evaluation of events and guiding of reactions (Peters et al. 2011). In the "transactional stressmodel" of Lazarus (1999) stress is defined as the discrepancy between demand, coping repertoire and anticipation of negative consequences. Interpretations and attributions are a core feature in explaining how a person reacts to demands or burdens, with special importance of control attributions (Seligman 1995). An important

approach in such control attributions, e.g. in the mastery of psychological traumata, is to give sense to what happened. This can even have a preventive effect and is described as "psychological preparedness" (Basoglu and Mineka 1992). A similar concept is Antonovsky's "sense of coherence" (1997). This means a sense of comprehensibility, i.e. to understand and integrate new experiences in a coherent way, sense of manageability, i.e. to have the feeling that one has the resources to manage the problem, and sense of meaningfulness, i.e. the feeling that there is meaning to what happens and that it makes sense to invest effort. A high rate of sense of coherence is correlated with resilience, i.e. the capacity to withstand negative events and burdens in life.

Moral can similarly be seen as a set of rules which give meaning and even more give rules on how to cope with life. It includes judgments on what is right or wrong and often advices to keep impulses and emotions under control (Sachdeva et al. 2011). Moral allows to bring negative events in life in a broader context, adopt a view beyond the present problem and refer to general modes of coping. One response to severe life events, which is guided by moral, is forgiveness. Forgiveness has found ample attention in the frame of positive psychology. It does not so much mean to excuse or justify what has happened but to restructure emotions and letting go negative attitudes toward a received offense (Wade 2005; Bradfield and Aquino 1999; Enright and Fitzgibbons 2000; Worthington 1998, 2001). In this sense, forgiveness is a way of self control, the ability to integrate what has happened in one's biography, to give sense to an event, to change perspectives, to reframe attributions, to show empathy and the ability not to be overwhelmed by events.

The discussion of moral in the context of wisdom raises the question, if wisdom is a universal or culturally bound phenomenon. There are two answers (Linden 2012). The basic psychological processes seem to be universal, i.e. change of perspective, empathy, contextualism etc. It is also interesting that there seems to be a universal consensus who should be called a wise person. Dalai Lama, Nelson Mandela, some Greek philosophers etc. are prototypes. On the other hand, there is a cultural part, in respect to what is considered to be just, or right, or a problem and therefore activates and needs wisdom. A partner who has sexual intercourse with somebody else or joblessness can cause a major problem in one society and none in another.

5.3 Multidimensional Operationalization of Wisdom

All these theories and empirical results show that wisdom is a complex multidimensional capacity, associated with a broad range of different psychological processes. In this respect it is similar e.g. to assertiveness, which is also constituted by different competencies, like how to speak to others, eye contact, posture, etc.. Still, all scientific theories of wisdom point to similar features. Table 5.1 gives an overview on these dimensions which will in the following be explained in greater detail.

Table 5.1 Wisdom dimensions

• Change of perspective	Does the person look at events from different perspectives?
• Empathy	Does the person recognize emotions of others
• Acceptance of emotions	Does the persons recognize and accept the own emotions?
• Serenity and humor	Does the person control negative emotions and react with humor in the face of adversities?
• Factual knowledge	Does the person hold general and specific knowledge about life matters
• Procedural knowledge	Does the person know strategies of decision making (e.g., cost-benefit analysis), and problem solving?
• Contextualism	Does the person consider past, current, and possible future contexts of life and the many circumstances in which life is embedded?
• Value relativism	Does the person accept values and life priorities of other persons
• Uncertainty acceptance	Does the person accept the inherent uncertainty in life (in terms of interpreting the past, predicting the future, managing the present) and use effective strategies for dealing with uncertainty?
• Long-term perspective	Does the person consider that each behavior can have positive and negative, as well as short- and long-term consequences, which can also contradict themselves?
• Self distance	Does the person accept that he or she is not the center of the world and does not appraise modesty as a degradation?
• Relativation of aspiration	Does the person consider that aspirations are no rights, but relative to comparisons with others or the past

Change of perspective

Several of the aforementioned authors list, as an essential element of wisdom, "change of perspective", i.e. the capacity to look at problems from multiple points of view. This competency allows a better understanding of the causes of a problem and especially the views of others. It is a prerequisite to balance one's own wishes with the expectations of others. In psychotherapy it is well established to use role change in order to teach patients new ways of how to approach and solve a problem (Ullrich de Muynck and Ullrich 2011).

Empathy

Empathy is another central part in many theories of wisdom. It allows to feel what others feel. It is one dimension of emotional competency and a prerequisite to include feelings of others as an important factor in the planning of one's own behavior and to find a balance between oneself and others.

Perception and acceptance of emotions

Coping with problems requires amongst others to master or tolerate one's own emotions. Especially negative emotions, as they are typically connected to negative

life events, tend to be suppressed or externalized or result in thoughtless actions. The identification and acceptance of such emotions is therefore an important step towards control and modification of own emotions. This is part of emotional intelligence (Salovey and Mayer 1990).

Serenity and humor

Emotions do not only pilot one's own behaviour but do also influence partners. Uncontrolled, excessive or inadequate emotions are therefore dysfunctional with negative consequences for all involved (Fiedler 2001; Linden 2006). The concept of serenity can be defined as the capacity to keep negative emotions under control, so that they take not over one's thinking and behaving. One way to overcome and contain negative emotions is humor. It allows accepting negative emotions while at the same time downplaying them. Also, humor does modify one's emotional expression and stimulate positive emotions in others.

Factual and procedural knowledge

Knowledge can be divided into "epistemic knowledge", i.e. facts about reality, and "heuristic knowledge", i.e. what to do (Dörner and Schölkopf 1991). A similar distinction is "assimilation", i.e. the application of known schemata, versus "accommodation", i.e. the development of new schemata (Piaget 1948). Based on such concepts Baltes and Staudinger (2000) discriminate (1) "knowledge about facts in fundamental aspects of life", and (2) "knowledge about strategies in fundamental aspects of life". Knowledge about facts refers to general (conditio humana) as well as situational information about what constitutes problems in life. Strategy knowledge refers to the availability of decision strategies.

Contextualism

All events are embedded in a situational and temporal context. The question is to which degree a person takes into account that the meaning of an event can change over the life span or in different contexts. Contextualism allows to accept determinants of events which are independent of the person and to adopt a new view (Newell and Simon 1972). Contextualism is a trait which many persons have in respect to their own behavior (I am late because the bus was late) while this is less so when it comes to other persons (this person is late because he is unpunctual).

Value relativism

Convictions and values require to be defended and often tend to separate oneself from others that don't share them. Value relativism means to stand for one's own values and at the same time accept that others are right in holding different views. This is the opposite of rigidity, bigotry and narrow-mindedness. Value relativism allows accepting other point of views, without considering them as a personal attack.

Uncertainty Acceptance

Life is characterized by the fact that the future is unpredictable. This causes uncertainty and insecurity. Wisdom is the capacity to accept this and still not refrain from going forward. Uncertainty acceptance not only refers to the future but also the past, when it comes to memories and their interpretation. This is the capacity to go on even when not knowing what has happened or what the outcome may be. It means courage to face life while accepting the possibility of failure.

Long-Term Perspective

Shoda et al. (1990) demonstrated in an experiment, that it is an important step in the development of humans to postpone wants. Four year old children who were able to do so for 10 min were 10 years later more stress tolerant, sociable, or successful in school than those who were not able to delay their immediate desires. This is a better predictor for school success than the classic IQ tests and is an indicator of how persons can use their other mental capacities (Goleman 1999). This is related to will, self control and the ability to orient oneself towards long term goals. It also implies to accept that all behavior has positive and negative consequences alike, be it now or later, which must be taken into account when making choices.

Self distance and relativation

Every person has to accept that the world goes on without caring about oneself or one's wishes. This includes nature, health, the fate of the company, or behavior of children and spouses. There are also values of higher order than the own personal well-being. Every person is part of a complex system of the universe and therefore has to integrate and subordinate. One is not so important as one might wish to be. Most events on earth happen without regard for oneself and most of the time nothing can be done about it. Therefore, one has to accept what cannot be changed.

Relativation of aspirations

It is highly dysfunctional to suffer from one's own unmet aspirations (e.g. not enjoying a theater performance because one did not get a seat in the front row). Research has shown that levels of aspiration are relative to what others have or what oneself had in earlier times (Heckhausen 2006). Aspirations in relation to others are enviousness. A way to overcome dysfunctional aspirations is reframing (Stoeber and Janssen 2011).

There are several scales which aim at measuring wisdom at large or some subdimensions. Examples are the "Three-Dimensional Wisdom Scale (3D-WS)" which measures cognitive, emotional and reflective components of wisdom (Ardelt 2003, 2005), the "Self-Assessed Wisdom Scale" which measures regulation of emotions, humor, reflection, openness for new ideas and life experience (Webster 2003), the "Reflective Judgement Interview (RJI)" which measures wisdom related problem solving using dilemmata situations (Kitchener and Brenner 1990), and the method

of "Tinking aloud" which measures the factual knowledge, strategy knowledge, value relativism, and life span contextualism (Ericson and Simon 1984; Staudinger et al. 1994). Based on the Baltes paradigm Baumann and Linden (2008) developed a rating of the beformentioned wisdom competencies. Unsolvable problems of life are presented and the subjects are then asked to comment on them. Their responses and suggestions for solutions are then rated in respect to the dimensions of the multiple wisdom competency paradigm.

5.4 Wisdom, Resilience, and Well-being

Wisdom is given to everybody, while explicitly "wise persons" seem to be the exception (Baltes and Smith 1990). Empirical studies have shown that wisdom is a psychological dimension which is more or less independent of personality traits. Staudinger et al. (1997) found only marginal correlations between wisdom and 33 personality dimension from different tests, including cognitive and social intelligence. There are some correlations with the ability of dialectic thinking (see Chap. 1 of this book, Oser and Reich 1987), practical intelligence and creativity (Sternberg 1985), humor und empathy (Brent and Watson 1980), autonomy and growth orientation (Baltes and Staudinger 2000), personal suffering (Brent and Watson 1980), positive models (Sternberg 1998), and openness for new experiences (Kramer 2000; Lyster 1996). Some professionals who have to deal with problem solving, like lawyers, psychologists, or priests, show higher rates of wisdom than other persons (Baltes and Staudinger 2000). There was no correlation between wisdom and the wish to be wise (Baltes et al. 2002), formal education (Sternberg 1998), and extraversion or neuroticism (Lyster 1996).

Research on wisdom was stimulated by research on the aged with the assumption that in old age many capacities decline while wisdom could be an example for gains in old age. Empirical results are discrepant (Baltes and Staudinger 2000; Sternberg 1985; Erikson 1959). Life span observations suggest that wisdom develops in the age between 15 and 25 (Pasupathi et al. 1999) and remains constant from there on (Baltes et al. 2002; Kramer 2000).

An important correlate of wisdom is life satisfaction (Ardelt 1997). Wisdom can in this respect compensate negative factors of ageing and is more important than health, socioeconomic status, money, environment or social engagement (Johnson 1995). Wisdom is more important for life satisfaction than objective living conditions (Lyster 1996; Baclear 1998).

When comparing persons with high and low scores in wisdom, Ardelt (2005) found that those with higher wisdom scores on the three dimensional wisdom scale were better able to distance oneself from burdensome events, had better abilities to cope with such event, were able to adopt new views, could use earlier life experiences in new situations, and were less able to remember negative events from the past. Similarly Tausch (2004) suggested that feelings like helplessness, powerlessness,

anger, and aggressivity are caused by failing to understand why something negative has happened. People who are able to cope with negative events did not so much ask why and rather looked forward. According to Ardelt (2005) acceptance of what has happened and cannot be changed is a good mode of coping if it is coming along with the ability to see that oneself is responsible for one's well-being, and an orientation towards others rather than oneself. Wise persons can be characterized by leadership ability, knowledge, experience morality, empathy, and future orientation (Montgomery et al. 2002).

5.5 Improvement of Wisdom

Wisdom is sometimes seen as something mysterious, which is given to a person or not. The idea that one could learn wisdom is almost a paradox, since it has often been shown that wisdom is not correlated with formal education. Still, it seems to be very simple to improve wisdom competencies. A first hint in this direction came from Baltes and co-workers (Baltes et al. 2002; Böhmig-Krumhaar et al. 2002). They showed that one can improve wisdom by (1) taking 5 min to think about a problem before starting to comment on it, (2) talking about the problem with another person, (3) talking about the problem in sensu with another person and asking what this person might say or do, (4) putting the problem in a different context, be it across cultures or the life span. This shows that the balancing of pros and cons and context relativization are core wisdom capacities which can be very easily triggered.

Wisdom can be considered under a structural perspective as similar to assertiveness. Both are complex and multidimensional psychological capacities. Still, assertiveness can be trained in a formal and structured way (Ullrich de Muynck and Ullrich 2011). Similarly wisdom can be trained and learned. This has been summarized under the heading of wisdom therapy (Baumann and Linden 2008; Linden 2008; Linden et al. 2011). It is conceived as a form of cognitive psychotherapy. There is a general part which refers to conventional cognitive-behavioral strategies like analyzing problems, changing attitudes and perspectives or helping with problem solving. This includes methods of reframing, change of dysfunctional cognitions, exposition, activity training, etc. (Linden and Hautzinger 2011).

Additionally, there is a new technique which is especially geared towards teaching and learning wisdom competencies, i.e. the method of unsolvable life problems. Patients do not get direct help in coping with their present problem, as it is done in problem solving therapy, but learn new competencies, as it is done in assertiveness training.

To do this, little vignettes are used that describe severe, unsolvable problems in life, which can happen to everybody, like divorce, death, loss of job, infidelity etc. These problem vignettes involve three main characters: (1) the victim, (2) the offender, (3) a third person that has become part of the situation without being intentionally involved.

Examples are:

Mr. A has given everything for the company, has put aside his family life and even relinquished to ask for a pay increase, because the company is financially in trouble. One day his boss tells him that he is fired and instead a "real" manager has been engaged.

Ms. B has lived with a man for years and cared for him in his last year when he was seriously sick and in need of help. After he died she learned that he had bequeathed all his assets to his wife, to whom he still had been married.

Examples are selected with no immediate reference to the patient. If the patient is a man, a female is used as victim, if the problem reported by the patient is at work, a family example is used. This is done to steer free of present problems and allow the patient to find some cognitive and emotional distance when thinking about problem solutions. Patients are then asked to comment on what happened from the perspective of the victim, to express their views and emotions and explain what they would do in a case like that. In the next step they are asked to tell the same story, but this time they are the offender, or the third party. This approach teaches patients to monitor one's own emotions, cognitions and values, to change perspective, accept contextualism, learn empathy etc.

The next step is the introduction of models with different goals in order to enhance value relativism, factual and procedural knowledge, or contextualism. For example: What would a lawyer say, who wants as much money as possible? What would a grandmother say, who has survived wars and looks back on life? How would you like to present your experience when you are 70 and writing your biography for your grandchildren? What would a priest say, who wants you to go to heaven? What would a psychologist say who understands why persons do queer things? The use of paradoxes is also encouraged, i.e.: What should the victim do in order to worsen the problem and make the situation even more troublesome ?

Finally, one can also introduce a more general "frame of reference" by referring to aphorisms. These are wisdom knowledge in a very condensed form. As they are known to most people they also have some face validity and credibility. This can be combined with the analysis of the unsolvable problems. Examples are:

- Reflection of the episodic character of events: "After rain comes sunshine"
- Time projection: "Time heals wounds".
- Reflection of the dialectic of fortune: "Hardship teaches happiness".
- Relativation of earlier problems: "Nothing is better than pain that is fading away".
- Relativation of the present problem: "If you think that this is the worst what can happen, wait for the next step".
- Problems as chance for a new start: "There is a chance in any crisis"
- Focussing on new goals: "There are many mothers with pretty girls"
- Dealing with aspirations: "Better a sparrow in your hand than a dove on the roof"
- Reflection of ambiguity: "There are two sides to every coin"
- Reflection of gains: "Per aspera ad astra"
- Problem as challenge: "God tests steadfastyness"
- Acceptance of one's misconduct: "Nobody is perfect"

5.6 Conclusions

Burdens and hardships are inevitable in every life. Therefore, resilience towards burdens is needed. Different persons react very differently to the same event. Some reactions help to solve or overcome the problem, in other cases the reaction causes more problems than the original event. There are many psychological skills which can be summarized under the heading of problem solving. But, there are some negative life events for which there is no unambiguous solution, which are irreversible or cannot be made undone. This can be everyday problems or severe and life changing events. In such cases wisdom is needed. It is the capacity to cope with such situations or to "solve unsolvable problems". Wisdom is an important resilience factor. High scores in wisdom competencies are related to higher well-being and success in life.

Wisdom can be learned and trained, even by simple strategies. When life events have become overwhelming, structured "wisdom therapy" can be used to help patients find their way out. It is a form of cognitive behavior therapy enriched by special techniques to teach wisdom competencies. There is initial evidence that it may ameliorate persisting adjustment disorders.

References

Achenbaum, A. W., & Orwoll, L. (1991). Becoming wise: A psycho-gerontological interpretation of the book of job. *International Journal of Aging and Human Development, 32*, 21–39.

Antonovsky, A. (1997). *Salutogenese – Zur Entmystifizierung der Gesundheit*. Tübingen: Deutsche Gesellschaft für Verhaltenstherapie.

Ardelt, M. (1997). Wisdom and life satisfaction in old age. *Journal of Gerontology, 52B*, 15–27.

Ardelt, M. (2003). Empirical assessment of a three-dimensional wisdom scale. *Research on Ageing, 25*(3), 275–324.

Ardelt, M. (2004). Wisdom as expert knowledge system: A critical review of a contemporary operationalization of an ancient concept. *Human Development, 47*, 257–285.

Ardelt, M. (2005). How wise people cope with crises and obstacles in life. *ReVision: A Journal of Consciousness and Transformation, 28*(1), 7–19.

Assmann, A. (Hrsg.). (1991). *Weisheit*. München: Fink.

Assmann, A. (1994). Wholesome knowledge: Concepts of wisdom in a historical and cross-cultural perspective. In D. L. Featherman, R. M. Lerner, & M. Perlmutter (Eds.), *Life-span development and behavior* (Vol. 12, pp. 187–224). New York: Academic.

Baclear, W. T. (1998). *Age differences in adult cognitive complexity: The role of life experiences and personality*. Doctoral Dissertation. New Brunswick: Rutgers University.

Baltes, P. B., & Smith, J. (1990). Weisheit und Weisheitsentwicklung: Prolegomena zu einer psychologischen Weisheitstheorie. *Zeitschrift für Entwicklungspsychologie und Pädagogische Psychologie, 22*, 95–135.

Baltes, P. B., & Staudinger, U. M. (2000). Wisdom: A metaheuristic (pragmatic) to orchestrate mind and virtue toward excellence. *American Psychologist, 55*, 122–136.

Baltes, P. B., Glück, J., & Kunzmann, U. (2002). Wisdom: Its structure and function in regulating successful life span development. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 327–347). Oxford: Oxford University Press.

Basoglu, M., & Mineka, S. (1992). The role of uncontrollable and unpredictable stress in posttraumatic stress responses in torture survivors. In M. Basoglu (Ed.), *Torture and its consequences: Current treatment approaches* (pp. 182–225). Cambridge: Cambridge University Press.

Baumann, K., & Linden, M. (2008). *Weisheitskompentenzen und Weisheitstherapie*. Lengerich: Pabst.

Bluck, S., & Glück, J. (2004). Making things better and learning a lesson: Experiencing wisdom across lifespan. *Journal of Personality, 72*, 3.

Böhmig-Krumhaar, S. A., Staudinger, U. M., & Baltes, P. B. (2002). Mehr Toleranz tut Not: Lässt sich wert-relativierendes Wissen und Urteilen mit Hilfe einer wissensaktivierenden Gedächtnisstrategie verbessern? *Zeitschrift für Entwicklungspsychologie und Pädagogische Psychologie, 34*, 30–43.

Bradfield, M., & Aquino, K. (1999). The effects of blame attributions and offender likeableness on forgiveness and revenge in the workplace. *Journal of Management, 25*, 607–631.

Brent, O. G., & Watson, D. (1980). *Aging and wisdom: Individual and collective aspects*. San Francisco: Meetings of the Gerontological Society of America.

Cattell, R. B. (1963). Theory of fluid and crystallized intelligence. *Journal of Educational Psychology, 54*, 1–22.

Cattell, R. B. (1971). *Abilities – Their structure, growth and action*. Boston: Houghton Mifflin.

Clayton, V. P., & Birren, J. E. (1980). The development of wisdom across the life-span: A reexamination of an ancient topic. In P. B. Baltes & O. G. Brim Jr. (Eds.), *Life-span development and behavior* (Vol. 3, pp. 103–135). New York: Academic.

Dörner, D., & Schölkopf, J. (1991). Controlling complex systems: Or Expertise als "grandmother's know-how". In K. A. Ericsson & J. Smith (Eds.), *Toward a general theory of expertise: Prospects and limits*. New York: Cambridge University Press.

Enright, R. D., & Fitzgibbons, R. P. (2000). *Helping clients forgive: An empirical guide for resolving anger and restoring hope*. Washington, DC: American Psychological Association.

Ericson, K. A., & Simon, H. A. (1984). *Protocol analysis: Verbal reports as data*. Cambridge, MA: MIT Press.

Erikson, E. (1959). *Identity in the life cycle. Psychological issues*. New York: International Universities Press.

Erikson, E. H., Erikson, J. M., & Kivnick, H. Q. (1986). *Vital involvement in old age: The experience of old age in our time*. New York: Norton.

Fava, G. A., & Ruini, C. (2003). Development and characteristics of a well-being enhancing psychotherapy strategy: Well-being therapy. *Journal of Behavior Therapy and Experimental Psychiatry, 34*, 45–63.

Fava, G. A., Rafanelli, C., Cazzaro, M., Conti, S., & Grandi, S. (1998). Well-being therapy. *Psychological Medicine, 28*, 475–480.

Fiedler, P. (2001). *Persönlichkeitsstörungen* (5 Aufl). Weinheim: Beltz.

Goleman, D. (1999). *Emotional intelligence*. New York: Bantam Books; deutsch. (1999). *Emotionale Intelligenz* (10 Aufl). München: Deutscher Taschenbuch Verlag.

Heckhausen, H. (2006). *Motivation und Handeln. Lehrbuch der Motivationspsychologie*. Berlin: Springer.

Herrman, H., Stewart, D. E., Diaz-Granados, N., Berger, E. L., Jackson, B., & Yuen, T. (2011). What is resilience? *Canadian Journal of Psychiatry, 56*, 258–265.

Holliday, S. G., & Chandler, M. J. (1986). Wisdom: Explorations in adult competence. In J. A. Meacham (Ed.), *Contributions to human development* (Vol. 17, pp. 1–96). Basel: Karger.

Johnson, T. F. (1995). Aging well in contemporary society. *American Behavioral Scientist, 39*, 120–130.

Johnson, M. P., & Baker, S. R. (2004). Implications of coping repertoire as predictors of men's stress, anxiety and depression following pregnancy, childbirth and miscarriage: A longitudinal study. *Journal of Psychosomatic Obstetrics & Gynaecology, 25*, 87–98.

Kalra, G., Christodoulou, G., Jenkins, R., Tsipas, V., Christodoulou, N., Lecic-Tosevski, D., Mezzich, J., & Bhugra, D. (2012). Mental health promotion: Guidance and strategies. *European Psychiatry, 27*(2), 81–86.

Kitchener, K. S., & Brenner, H. G. (1990). Wisdom and reflective judgment: Knowing in the face of uncertainty. In R. J. Sternberg (Ed.), *Wisdom: Its nature, origins, and development*. Cambridge: Cambridge University Press.

Kramer, D. A. (2000). Wisdom as a classical source of human strength: Conceptualization and empirical inquiry. *Journal of Social and Clinical Psychology, 19*, 83–101.
Lazarus, R. S. (1999). *Stress and emotion: A new synthesis*. London: Free Association Books.
Linden, M. (2006). Minimal emotional dysfunctions (MED) in personality disorders. *European Psychiatry, 21*, 325–332.
Linden, M. (2008). Posttraumatic embitterment disorder and wisdom therapy. *Journal of Cognitive Psychotherapy, 22*, 4–14.
Linden, M. (2012). Embitterment in a cultural context. In S. Barnow (Ed.), *Cultural variations in emotion regulation and treatment of psychiatric patients*. Stuttgart: Hogrefe Publishers.
Linden, M., & Hautzinger, M. (Eds.). (2011). *Verhaltenstherapie. Techniken, Einzelverfahren und Behandlungsanleitungen*. Berlin: Springer.
Linden, M., Baumann, K., Lieberei, B., Lorenz, C., & Rotter, M. (2011). Treatment of posttraumatic embitterment disorder with cognitive behaviour therapy based on wisdom psychology and hedonia strategies. *Psychotherapy and Psychosomatics, 80*, 199–205.
Lyster, T. L. (1996). *A nomination approach to the study of wisdom in old age*. Doctoral Dissertation, Concordia University, Montreal, Quebec, Canada.
Mayer, J. D., Salovey, P., & Caruso, D. R. (2004). Emotional intelligence: Theory, findings, and implications. *Psychological Inquiry, 3*, 197–215.
McKee, P., & Barber, C. (1999). On defining wisdom. *International Journal of Aging and Human Development, 49*, 149–164.
Meacham, J. A. (1990). The loss of wisdom. In R. J. Sternberg (Ed.), *Wisdom, its nature, origins, and development* (pp. 181–212). Cambridge: Cambridge University Press.
Montgomery, A., Barber, C., & McKee, P. (2002). A phenomenological study of wisdom in later life. *International Journal of Aging and Human Development, 54*, 139–159.
Newell, A., & Simon, H. A. (1972). *Human problem solving*. Englewood Cliffs: Prentice Hall.
Oser, F., & Reich, K. H. (1987). The challenge of competing explanations: The development of thinking in terms of complementarity of "theories". *Human Development, 30*, 178–186.
Panikkar, R. (2002). *Einführung in die Weisheit*. Freiburg: Herder.
Pasupathi, M., Staudinger, U. M., & Baltes, P. B. (1999). *The emergence of wisdom-related knowledge and judgement during adolescence*. Berlin: Max Planck Institute for Human Development.
Pejušković, B., Lečić-Toševski, D., Priebe, S., & Tošković, O. (2011). Burnout syndrome among physicians – The role of personality dimensions and coping strategies. *Psychiatria Danubina, 23*, 389–395.
Peters, K. D., Constans, J. I., & Mathews, A. (2011). Experimental modification of attribution processes. *Journal of Abnormal Psychology, 120*, 168–173.
Piaget, J. (1948). *Psychologie der Intelligenz*. Zürich: Rascher.
Ryff, C. D. (1989). Happiness is everything, or is it? Exploration on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 57*, 1069–1083.
Ryff, C. D., & Singer, B. (1996). Psychological well-being: Meaning, measurement and implication for psychotherapy research. *Psychotherapy and Psychosomatics, 65*, 14–23.
Sachdeva, S., Singh, P., & Medin, D. (2011). Culture and the quest for universal principles in moral reasoning. *International Journal of Psychology, 46*, 161–176.
Salovey, P., & Mayer, J. D. (1990). Emotional intelligence. *Imagination, Cognition, and Personality, 9*, 185–211.
Sander, A. (2002). Menschen des 20. Jahrhunderts. Werkausgabe in 7 Bänden. Hrsg.: Die Photographische Sammlung/SK Stiftung Kultur, Köln, bearbeitet von Susanne Lange, Gabriele Conrath-Scholl und Gerd Sander. München: Schirmer/Mosel.
Seligman, M. E. P. (1995). *Helplessness*. San Francisco: Freeman.
Shoda, Y., Mischel, W., & Peake, P. K. (1990). Predicting adolescent cognitive and self-regulatory competencies from preschool delay of gratification. *Developmental Psychology, 26*(6), 978–986.
Staudinger, U. M., & Baltes, P. B. (1996). Weisheit als Gegenstand psychologischer Forschung. *Psychologische Rundschau, 47*, 57–77.

Staudinger, U. M., & Glück, J. (2011). Psychological wisdom research: Commonalities and differences in a growing field. *Annual Review of Psychology, 62*, 215–241.
Staudinger, U. M., Smith, J., & Baltes, P. B. (1994). *Handbuch zur Erfassung von weisheitsbezogenem Wissen* (Materialien aus der Bildungsforschung Nr. 46). Berlin: Max-Planck-Institut für Bildungsforschung.
Staudinger, U. M., Lopez, D., & Baltes, P. B. (1997). The psychometric location of wisdom-related performance: Intelligence, personality, and more? *Personality and Social Psychology Bulletin, 23*, 1200–1214.
Sternberg, R. J. (1985). Implicit theories of intelligence, creativity, and wisdom. *Journal of Personality and Social Psychology, 49*, 607–627.
Sternberg, R. J. (Ed.). (1990). *Wisdom, its nature, origins, and development*. New York: Cambridge University Press.
Sternberg, R. J. (1998). A balance theory of wisdom. *Review of General Psychology, 2*(4), 347–365.
Stoeber, J., & Janssen, D. P. (2011). Perfectionism and coping with daily failures: Positive reframing helps achieve satisfaction at the end of the day. *Anxiety, Stress, and Coping, 24*, 477–497.
Tausch, R. (2004). Sinn in unserem Leben. In A. E. Auhagen (Hrsg.), *Positive Psychologie*. Weinheim: Beltz.
Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth, conceptual foundations and empirical evidence. *Psychological Inquiry, 15*, 1–18.
Ullrich de Muynck, R., & Ullrich, R. (2011). Aufbau sozialer Kompetenz. In M. Linden & M. Hautzinger (Hrsg.), *Verhaltenstherapie*. Berlin: Springer.
Wade, N. G. (2005). In search of a common core: A content analysis of interventions to promote forgiveness. *Psychotherapy, 42*(2), 160–177.
Webster, J. D. (2003). An exploratory analysis of a self-assessed wisdom scale. *Journal of Adult Development, 10*, 13–22.
Worthington, E. L. (Ed.). (1998). *Dimensions of forgiveness: Psychological research and theological perspectives*. Philadelphia: Templeton Press.
Worthington, E. L. J. R. (2001). *Five steps to forgiveness: The art and science of forgiving*. New York: Crown Publishers.

Chapter 6
Increasing Psychological Well-being Through Hypnosis

Tharina Guse

6.1 Contextualizing Hypnosis

From its earliest beginnings hypnosis was associated with promoting health and well-being because trance states have been utilized to facilitate healing since ancient times (Lynn and Kirsch 2006; Sthalekar 2000). The development of modern hypnosis is mostly associated with the work of Franz Anton Mesmer, an eighteenth century Viennese physician who introduced hypnosis to the medical community. He theorized that illness, both physical and psychological, was caused by an imbalance of an invisible fluid in the body, which he referred to as animal magnetism. Mesmer's treatment involved passing magnetic rods slowly over patients' bodies to redistribute this fluid and thereby restore balance. Although Mesmer successfully treated many patients for whom traditional methods did not work, he soon fell into disrepute. Interest in hypnosis waxed and waned for several decades afterwards (see Lynn and Kirsch 2006, for a review of the early history). Freud was also trained in hypnosis, but eventually rejected its use, with the result that hypnosis was again marginalized in medicine and psychology.

In the twentieth century scientific and practical explorations of hypnosis were revived by scholars such as Clark Hull, Milton Erickson (Lynn and Kirsch 2006) and John Watkins (Emmerson 2006). Since the 1950s hypnosis has received more research attention and the field is now firmly established in mainstream psychology (Lynn and Kirsch 2006). Research on hypnosis and its clinical application has proliferated internationally. According to the International Society of Hypnosis (ISH), it has more than 1,600 members from 40 countries (ISH n.d.). A triennial conference has been held since 1965, focusing on research and workshops to

T. Guse (✉)
Department of Psychology, University of Johannesburg,
P O Box 524, Auckland Park, 2006 Johannesburg, South Africa
e-mail: tguse@uj.ac.za

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_6, © Springer Science+Business Media Dordrecht 2014

enhance clinical skills. It is evident that hypnosis as scientific field continues to evolve across nations and cultures.

Research findings confirmed that hypnosis is valuable as adjunct treatment for various medical conditions, most notably for the reduction of pain (Mendoza and Capofons 2009; Stoelb et al. 2009) as well as for reducing distress related to medical procedures (Schnur et al. 2008). When implemented in the framework of cognitive therapy, hypnosis has further been found effective for the treatment of depression (Alladin and Alibhai 2007). The use of hypnosis is often associated with the reduction of psychological distress and increasing feelings of well-being (Alladin 2008a). Further, Jensen et al. (2006, p. 432) reported that hypnosis, when applied for pain reduction, can have "beneficial side-effects". This included an increased sense of relaxation and well-being and decreased distress. However, it is only recently that positive psychology principles and practices started to be explicitly incorporated in this treatment modality. This chapter has two aims: (a) to describe the mechanisms of hypnosis that could contribute to increased psychological well-being and (b) to review interventions and research findings related to enhancing psychological well-being through hypnosis.

6.2 Hypnosis Defined

Hypnosis suffers from a lack of consensual definition. Several definitions exist, which are often based on different theoretical frameworks. Further, there is as yet no single unifying theory of hypnosis, partly because of the complexity and multidimensionality of hypnosis (Yapko 2012). For the purposes of simplifying the discussion of hypnosis here, a working definition will be presented.

Hypnosis involves a specific procedure of suggesting changes in subjective experience, perceptions, thoughts, emotions and behaviour to a client (Green et al. 2005) that may lead to hypnotic responses as well as enhanced and focused attention and internal concentration (Lankton 2008). The experience of hypnosis is further accompanied by a relative suspension of peripheral awareness (Spiegel and Spiegel 2004). Hypnosis can be facilitated by an introduction to the experience as well as by providing initial suggestions. Experiencing hypnosis and hypnotic responses are enhanced by the motivation of the person being hypnotized and possibly his ability to enter trance (Barrett 2010). Suggestions are central to hypnosis (Mende 2009; Kihlstrom 2010) and it is generally accepted that an individual is in hypnosis when he responds to hypnotic suggestions (Barrett 2010). Clinicians seem less concerned about whether hypnotic trance exists, or whether an induction to trance is necessary and are more focused on maximizing therapeutic gains in the clinical context (Alladin 2008a).

Once an individual is in hypnosis, further suggestions are provided based upon therapeutic goals. These suggestions can be viewed as a specific form of influential communication from the clinician (cf. Yapko 2012), because hypnosis itself

does not lead to therapeutic change (Nash 2008; Yapko 2012). Rather, specific therapeutic skills, often those used in other therapeutic modalities, are used in the context of hypnosis. Hypnosis should therefore be viewed as a therapeutic tool that can be integrated into existing therapeutic and conceptual frameworks, and not a specific school of therapy (Yapko 2012). Hypnosis as vehicle of therapeutic change can thus also be implemented in the context of positive psychology interventions, with the goal being to increase psychological well-being.

Hypnosis should be distinguished from interventions such as mindfulness meditation and relaxation training. During mindfulness meditation, the aim is to non-judgmentally pay attention to experiences in the here and now (Kabat-Zinn 2003) and to increase voluntary control over mental processes (Walsh and Shapiro 2006). In hypnosis, there may be a focus on past, present or future, depending on the therapeutic plan. Relaxation training is focused on contracting and relaxing specific muscle groups progressively and ultimately relax the whole body. While relaxation often occurs during hypnosis, it only serves to facilitate more complex hypnotic experiences and to access unconscious resources more easily (Yapko 2012).

6.3 Promoting Psychological Well-being Through Hypnosis: Mechanisms and Frameworks

Long before the advent of positive psychology writers in the field of hypnosis have indirectly referred to the potential of hypnosis to enhance well-being. Heap (1988, p. 297) suggested that hypnosis should be aligned with "growth psychology" rather than "sickness psychology" due to its potential to enhance psychological well-being. Cardena (2001) argued that mesmerism, often mentioned as precursor of hypnosis, intended to increase human potentials. More recently literature on specific hypnosis interventions, based on positive psychology assumptions, started to emerge (e.g. Burns 2010; Guse 2012; Guse et al. 2006a; Ruysschaert 2009; Yapko 2012). These interventions could be explained in terms of the mechanisms of hypnosis that may enhance well-being and in terms of therapeutic approaches to hypnosis that can be aligned with positive psychological interventions.

6.3.1 Mechanisms of Hypnosis in the Enhancement of Psychological Well-being

The nature of hypnosis and the mechanisms inherent in the process of hypnosis itself can contribute to increased well-being in various ways. Yapko (2007, p. 16) described hypnosis as "an approach that emphasizes the importance of understanding the

structure of and pathways into the best and most adaptive aspects of human experience". Specifically, hypnosis provides a specific way of focusing awareness or attention, which leads to specific facets of experience being amplified, including client strengths (Mende 2009; Yapko 2012). Evidence from cognitive psychology indicated that hypnosis can modulate attention, or what is focused on, specifically when post-hypnotic suggestions are provided (Raz and Campbell 2011). Hypnosis therefore provides the opportunity to enhance facets of positive psychological functioning through focusing awareness on specific aspects such as client strengths, positive affect and meaningfulness related to particular experiences, for example. Moreover, by providing post-hypnotic suggestions to further strengthen these facets, the impact of these suggestions may be prolonged. Thus, because hypnosis allows for a narrowed and amplified focus of attention, it has the ability to enhance well-being through focusing on and amplifying aspects of client functioning that are related to psychological well-being.

Another mechanism through which hypnosis may facilitate psychological well-being is by providing the opportunity for experiential learning which could fast-track therapeutic results (Mende 2009; Yapko 2012). Specifically, hypnosis is a process in which clients are active participants who attend to, integrate and apply suggestions offered to them (Yapko 2010). The value of intentional activities in promoting psychological well-being is well-documented (e.g. Sin and Lyubomirsky 2009), and the hypnotic context provides opportunities for experiencing these activities in another modality, often more intensely. Further, hypnosis allows for the rapid building of a strong therapeutic alliance (Alladin 2008b) as well as access to emotions and fantasies (Brown and Fromm 1986) which could focus on accessing positive emotions and experiences. Since the experience of positive emotions are associated with enhanced psychological well-being as postulated by Fredrickson's (1998, 2001) Broaden and Build theory these processes inherent to hypnosis could be applied in interventions to enhance well-being.

Finally, Mende (2006) argued that hypnosis provides a specific context for therapeutic change through addressing the basic needs of autonomy, competence and relatedness. Specifically, through accessing unconscious resources, "…the most autonomous inner authority of an individual is addressed" (Mende 2006, p. 177). Relatedness is facilitated through rapport, while competence is enhanced through the discovery of as yet unknown possible resources. The importance of these needs in facilitating positive functioning is central to self-determination theory (SDT) (Deci and Ryan 2000; Ryan and Deci 2000). Further, meeting these needs may be one way to effect therapeutic change (Ryan and Deci 2008). Moreover, since Ryan et al. (2006) presented a model of psychological well-being based on self-determination theory, meeting the needs of autonomy, competence and relatedness through hypnosis, suggest that this therapeutic approach is well-suited to enhance psychological well-being.

In summary, the nature and mechanisms of hypnosis, including focusing attention on positive experiences and perceptions, enhanced experiential learning and facilitating basic needs as defined by SDT, may serve as vehicle to enhance psychological well-being.

6.3.2 *Theoretical Approaches to Hypnosis and the Promotion of Psychological Well-being*

There are no explicit theoretical models on the promotion of psychological well-being through hypnosis. However, two therapeutic approaches have previously been put forward as implicit frameworks to enhance well-being and can be aligned with positive psychology. These are Ericksonian approaches to hypnosis, and ego state therapy approaches (see Guse and Fourie 2013, for an overview). Ericksonian approaches to hypnosis explicitly acknowledge the resourcefulness and strengths of clients, hold a non-pathological view of clients, are future orientated and are focused on solutions rather than problems (Lankton 2008). Ego state therapy approaches propose the existence of different "parts" or sub selves of the personality (Emmerson 2003), including resourceful parts (Frederick and McNeal 1999), which can be mobilized in the therapeutic process and could contribute to enhanced well-being. Specifically, through the technique of ego-strengthening (McNeal and Frederick 1993) these resourceful facets of the self could be accessed and utilized according to therapeutic goals. Both approaches therefore provide theoretical and practical frameworks to develop interventions to increase well-being.

6.4 Hypnotherapeutic Interventions for the Promotion of Psychological Well-being

Using hypnosis to facilitate psychological well-being has steadily gained momentum. Whereas some authors (e.g. Burns 2010; Ruysschaert 2009; Yapko 2012) presented general strategies to enhance the experience of psychological well-being, others formulated interventions based on specific theoretical approaches (e.g. Fourie and Guse 2011; Guse 2009, 2012; Guse and Fourie 2013) or aimed to enhance specific facets of psychological well-being (Casula and Inbar 2009; Guse et al. 2006a; Guse and Fourie 2008).

6.4.1 *Interventions Based on the Mechanisms and Nature of Hypnosis*

Hypnosis interventions to enhance well-being have been proposed for various populations and in various contexts. Ruysschaert (2009) stated that hypnosis, and in particular, self-hypnosis, could be useful to prevent compassion fatigue and burnout in mental health professionals, as well as to increase flourishing and flow. She provided various examples of hypnotic suggestions to this effect, including suggestions to develop resilience and to access internal resources.

Casula and Inbar (2009) explained how hypnosis could be used to access positive emotions they referred to as "happiness", in the past, present and future. For example, they used age regression suggestions, asking the client to go back to a past memory of experiencing satisfaction, contentment, gratitude and fulfilment, among others. Their aim was to amplify these good memories through utilizing the context of hypnosis. Casula and Inbar (2009) further provided metaphors, to be presented while the client is in hypnosis, to increase gratitude and hope. The authors provided practical hypnotic strategies to enhance well-being.

Burns (2010) described how hypnosis could be implemented as part of the management of chronic pain, yet he expanded on existing interventions by also exploring possibilities for increasing happiness. Specifically, Burns (2010) described how the recall of past positive experiences, while the client is in hypnosis, could contribute to enhanced happiness, which share some similarity with Casula and Inbar's (2009) approach. Burns' proposed intervention suggests that enhancing psychological well-being need not be limited to individuals without serious distress.

Further, Yapko (2012) suggested that well-known positive psychology exercises, as reported by Seligman et al. (2005), could be enhanced through their application in the context of hypnosis. Accordingly, Yapko (2012) provided several detailed suggestions as to how three exercises (gratitude visit, counting blessings, using signature strengths in a new way) could be enhanced by preceding these exercises with hypnosis sessions. During hypnosis specific suggestions to enhance clients' receptiveness for these exercises and to maximize the therapeutic benefits gained can be included. Yapko (2012) particularly stressed the importance of focusing clients' attention to be receptive to the exercises and to increase the possibility of them becoming integrated in clients' daily lives. However, these interventions still need to be evaluated empirically to ascertain its effect on psychological well-being if applied in the context of hypnosis.

6.4.2 Interventions Based on Therapeutic Approaches

Several interventions based on Ericksonian and ego state therapy approaches have been proposed and described. Guse and Fourie (2008) presented a set of hypnosis suggestions that could enhance psychological well-being. This contained suggestions for the enhancement of specific psychological strengths, including a sense of inner strength, wisdom, inner love, spirituality and hope. The aim of this set of suggestions was to instil a sense of resourcefulness, consisting of various individual strengths, within clients. Ego state therapy approaches were also proposed to enhance flourishing in therapists (Guse 2009). Specific hypnosis interventions could enhance hope and gratitude in therapists, as these strengths are generally accepted to be strongly related to psychological well-being. Therapist burnout remains a concern in the profession of psychology (e.g. D'Souza et al. 2011) and promoting flourishing by means of hypnosis may be one way to counter the negative effects of being a therapist.

More recently Guse (2012) provided an outline of how the use of signature strengths, as identified through the Values-In-Action inventory (VIA) (Peterson and Seligman 2004) could be enhanced through ego state therapy approaches. Specifically, Guse suggested that, after completing the VIA and identifying strengths, these strengths can be enhanced and mobilized through working with them as different "parts" of the personality in hypnosis.. Since using strengths use seem to be more strongly related to well-being that that identifying strengths only (Wood et al. 2011), posthypnotic suggestions regarding using specific strengths could be beneficial in integrating strengths use in clients' everyday lives.

These proposed interventions provide various avenues to enhance psychological well-being, but substantiating evidence on the effectiveness thereof is still lacking.

6.4.3 Hypnosis Scripts

The development and implementation of specific scripts often form part of hypnosis interventions. Most hypnosis scripts include suggestions to increase relaxation, calm and peacefulness, which in itself may increase a sense of well-being. Some scripts contain specific suggestions to increase well-being or facets or positive functioning, although these have not been articulated as positive interventions or well-being interventions. For example, Walters and Havens (1993) published scripts based on principles from Ericksonian therapy, aimed at increasing optimism, altruism, connectedness and savouring. Earlier Gibbons (1990, p. 263) provided a script to enhance "aesthetic enhancement and enjoyment", which could be considered a script to enhance the character strength of appreciation of beauty and excellence. Direct suggestions to enhance well-being were presented in a script by Barber (1990, p. 114), such as "…enjoy every aspect of every day, as you feel peaceful and calm, and at ease, with energy, with vitality…" These could be viewed as suggestions to enhance positive emotions. Finally, Frederick and McNeal (1999) offered various scripts to access what they refer to as inner resources or inner strengths, based on ego state therapy. Guidelines on how to develop hypnosis scripts based on specific therapeutic goals have been offered (e.g. Havens and Walters 2002; Walters and Havens 1993), thus it is possible to create specific suggestions aimed at increasing psychological well-being. However, it remains to be seen whether specific scripts do significantly enhance well-being as empirical studies on its effectiveness are scarce.

6.5 The Effect of Hypnosis on Psychological Well-being

As previously stated, various interventions to increase psychological well-being through hypnosis have been proposed, but empirical studies are limited. Further, several existing studies have conceptualized well-being only as the reduction of distress in the context of medical conditions. For example, Bakke et al. (2002)

determined the effect of hypnosis on the affective states of women diagnosed with breast cancer, but their definition of well-being was limited to a decrease in negative mood. Similarly, Willemsen et al. (2011) reported that hypnosis can increase well-being of patients with dermatological problems, but conceptualized psychological well-being only as by-product of symptom reduction. In an exception to this trend in research, Schnur et al. (2009) determined the effect of hypnosis on both negative effect and positive affect in patients receiving radiotherapy for breast cancer. They reported that hypnosis, combined with cognitive behavioural therapy, led to an increase in positive affect and a decrease in negative affect. Therefore, there is some evidence that hypnosis could contribute to facets of well-being.

Only three studies, done in South Africa, on hypnosis as intervention from a positive psychology perspective, could be found. First, Guse et al. (2006b) developed and evaluated the effect of a prenatal hypnosis programme on the postnatal psychological well-being of first time mothers. The aim was to enhance psychological strengths and resources through specific hypnotic strategies, with the expectation that this intervention may prepare participants psychologically for the transition to motherhood and increase various facets of psychological well-being. The programme was based on Ericksonian and ego state therapy approaches, consisting of six sessions. Women in the third trimester of pregnancy participated in the programme and attended prenatal classes ($N=23$) while a control group ($N=23$) attended prenatal classes only. The facets of psychological well-being measured in the study were sense of coherence, positive affect, negative affect, affect balance, life satisfaction, general symptoms of psychopathology and postpartum depression. The results suggested that women who received the hypnosis intervention experienced increased psychological well-being 2 weeks after giving birth, when compared to the control group. At 10 weeks postpartum, mothers who attended the programme showed fewer symptoms of psychopathology and postpartum depression than mothers in the control group. Guse et al. (2006b) concluded that the programme was successful in the promotion of psychological well-being in this group of first time mothers. However, the study had several limitations, including small sample size and lack of randomization of participants. It also does not provide evidence that hypnosis intervention would continue to have a long term effect on psychological well-being.

Second, Fourie and Guse (2011) described a case study based on an integrated hypnotherapeutic model for the treatment of an adult female survivor of childhood sexual abuse. This model integrated the utilization model of ego state therapy (Hartman 2002), which include principles of Ericksonian approaches, and the SARI model (Frederick and McNeal 1999; Phillips and Frederick 1995) which is a hypnosis model for dealing with trauma. Hypnosis was implemented with a specific focus on mobilizing strengths and inner resources. Psychological well-being was evaluated through measuring sense of coherence, positive affect, negative affect, satisfaction with life, symptoms of pathology and symptoms of trauma before and after the hypnosis intervention. Fourie and Guse (2011) reported that applying the integrated hypnosis model seemed to have increased all facets of psychological well-being for the client.

Finally, Guse and Fourie (2013) elaborated on the abovementioned intervention. The authors described the experience of psychological well-being of five women

who endured childhood sexual abuse, as it unfolded in the context of the hypnosis intervention. A multiple case study design was implemented and qualitative as well as quantitative methods were used. For the quantitative component of the study, participants completed a set of questionnaires evaluating psychological well-being (sense of coherence, positive affect, negative affect, satisfaction with life, symptoms of pathology and symptoms of trauma) before and after the hypnosis intervention. Data for the qualitative component of the study consisted of three interviews and the therapeutic process. Three participants experienced an increase in most facets of psychological well-being at the conclusion of the intervention. For two participants symptoms of psychopathology and distress decreased but relatively low levels of psychological well-being persisted. Guse and Fourie (2013) concluded that hypnosis interventions to enhance well-being for clients who are experiencing more severe distress, and in several areas of functioning, may need to be implemented over a longer time period to contribute to increased well-being. Due to the methodology followed, findings are limited to the participants.

Taken together, these studies suggest that hypnosis, practiced from the perspective of positive psychology, could increase psychological well-being for both clients who are not presenting with clinical syndromes (Guse et al. 2006b) and clients experiencing distress (Fourie and Guse 2011; Guse and Fourie 2013). However, all three studies have methodological flaws and limitations which need to be addressed in subsequent research. Evidence for increasing well-being through hypnosis is sparse but promising, and warrants further research attention.

6.6 Concluding Comments

Increasing well-being through hypnosis has a long history, but its role in the context of positive psychology interventions is still in its infancy. Hypnosis is a valuable therapeutic tool to access, mobilize and optimize facets of positive psychological functioning. Internationally, interventions to enhance well-being through hypnosis were proposed by clinicians in Europe (Casula and Inbar 2009; Ruysschaert 2009), Israel (Casula and Inbar 2009), Australia (Burns 2010) and the USA (Yapko 2012). Yet, more research is needed to confirm and expand the application of hypnosis to increase psychological well-being. It is hoped that, across cultures, clinicians and researchers will continue to explore these possibilities.

References

Alladin, A. (2008a). *Cognitive hypnotherapy: An integrated approach to the treatment of emotional disorders*. Chichester: Wiley.

Alladin, A. (2008b). *Hypnotherapy explained*. Oxon: Radcliff.

Alladin, A., & Alibhai, A. (2007). Cognitive hypnotherapy for depression: An empirical investigation. *International Journal of Clinical and Experimental Hypnosis, 55*(2), 147–166.

Bakke, A. C., Purtzer, M. Z., & Newton, P. (2002). The effect of hypnotic-guided imagery on psychological well-being and immune function in patients with prior breast cancer. *Journal of Psychosomatic Research, 53*, 1131–1137.

Barber, T. X. (1990). Positive suggestions for effective living. In D. C. Hammond (Ed.), *Handbook of hypnotic suggestions and metaphors* (pp. 113–118). New York: W.W. Norton.

Barrett, D. (2010). Introduction. In D. Barrett (Ed.), *Hypnosis and hypnotherapy. Vol. 1: History, theory and research* (pp. i–xv). Santa Barbara: ABC-CLIO.

Brown, P. D., & Fromm, E. (1986). *Hypnotherapy and hypnoanalysis*. Hillsdale: Erlbaum.

Burns, G. (2010). Can you be happy in pain? Applying positive psychology, mindfulness and hypnosis to chronic pain management. In G. W. Burns (Ed.), *Happiness, healing, enhancement: Your casebook collection for applying positive psychology in therapy* (pp. 202–213). Hoboken: Wiley.

Cardena, E. (2001, August). *What is hypnosis good for, anyway?* Presidential address for Division 30, 103rd annual meeting of the American Psychological Association, San Francisco, CA.

Casula, C., & Inbar, J. (2009, September). *Hypnosis and happiness: Hypnotherapy's contribution to enhance happiness.* Workshop presented at presented at the 18th International Society of Hypnosis Congress, Rome, Italy.

Deci, E. L., & Ryan, R. M. (2000). The "what" and "why" of goal pursuits: Human needs and the self-determination of behavior. *Psychological Inquiry, 11*, 227–268.

D'Souza, F., Egan, S. J., & Rees, C. S. (2011). The relationship between perfectionism, stress and burnout in clinical psychologists. *Behaviour Change, 28*(1), 17–28.

Emmerson, G. (2003). *Ego state therapy*. Williston: Crown House Publishing.

Emmerson, G. (2006). *Advanced skills and interventions in therapeutic counselling*. Camarthen: Crown House Publishing.

Fourie, G., & Guse, T. (2011). An integrated hypnotherapeutic model for the treatment of childhood sexual trauma: A case study. *The American Journal for Clinical Hypnosis, 53*(3), 193–205.

Frederick, C., & McNeal, S. (1999). *Inner strengths: Contemporary psychotherapy and hypnosis for ego-strengthening*. Mahwah: Lawrence Erlbaum Associates.

Fredrickson, B. L. (1998). What good are positive emotions? *Review of General Psychology, 2*, 300–319.

Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American Psychologist, 56*, 218–226.

Gibbons, D. E. (1990). Suggestions for aesthetic refinement and enjoyment. In D. C. Hammond (Ed.), *Handbook of hypnotic suggestions and metaphors* (p. 462). New York: W.W. Norton.

Green, J. B., Barabasz, A., Barrett, D., & Montgomery, G. H. (2005). Forging ahead: The 2003 APA Division 30 definition of hypnosis. *International Journal of Clinical and Experimental Hypnosis, 53*, 259–264.

Guse, T. (2009, September). *Facilitating flourishing in therapists by using psychological strengths in ego state therapy*. Paper presented at the 18th International Society of Hypnosis Congress, Rome, Italy.

Guse, T. (2012). Enhancing lives: A positive psychology agenda for hypnosis. *South African Journal of Psychology, 42*, 214–223.

Guse, T., & Fourie, G. (2008, July). *Eliciting psychological strengths through hypnosis: An experiential introduction.* Workshop presented at the 4th European conference on positive psychology, Opatija, Croatia.

Guse, T., & Fourie, G. (2013). Facilitating psychological well-being through hypnotherapeutic interventions. In M. P. Wissing (Ed.), *Well-being research in South Africa* (pp. 539–555). Dordrecht: Springer.

Guse, T., Wissing, M. P., & Hartman, W. (2006a). A hypnotherapeutic programme to facilitate postpartum psychological well-being. *Australian Journal for Clinical and Experimental Hypnosis, 34*, 27–40.

Guse, T., Wissing, M. P., & Hartman, W. (2006b). The effect of a prenatal hypnotherapeutic programme on postnatal psychological well-being. *Journal of Reproductive and Infant Psychology, 24*, 163–177.

Hartman, W. (2002). Ego state therapy then and now: Towards a naturalistic utilization approach. *Hypnos: Swedish Journal of Hypnosis in Psychotherapy and Psychosomatic Medicine, 29*(2), 52–58.

Havens, C., & Walters, R. A. (2002). *Hypnotherapy scripts: A Neo-Ericksonian approach to persuasive healing* (2nd ed.). New York: Routledge.

Heap, M. (1988). *Hypnosis: Current clinical, experimental and forensic practices*. London: Croom Helm.

International Society for Hypnosis. (n.d.). *The history of ISH*. Retrieved from http://ish-hypnosis.org/ish-history.htm

Jensen, M. P., McArthur, K. D., Barber, J., Hanley, M. A., Engel, J. M., Romano, J. M., Cardenas, D. D., Kraft, G. H., Hoffman, A. J., & Patterson, D. J. (2006). Satisfaction with, and the beneficial side effects of hypnotic analgesia. *International Journal of Clinical and Experimental Hypnosis, 54*(4), 432–447.

Kabat-Zinn, J. (2003). Mindfulness-based interventions in context: Past, present, and future. *Clinical Psychology: Science and Practice, 10*, 144–156.

Kihlstrom, J. (2010). The domain of hypnosis revisited. In M. R. Nash & A. J. Barnier (Eds.), *Oxford handbook of hypnosis* (pp. 19–52). New York: Oxford University Press.

Lankton, S. (2008). An Ericksonian approach to clinical hypnosis. In M. R. Nash & A. J. Barnier (Eds.), *Oxford handbook of hypnosis* (pp. 467–486). New York: Oxford University Press.

Lynn, S. J., & Kirsch, I. (2006). *Essentials of clinical hypnosis: An evidence-based approach*. Washington, DC: American Psychological Association.

McNeal, S., & Frederick, C. (1993). Inner strength and other techniques for ego-strengthening. *American Journal of Clinical Hypnosis, 35*, 170–178.

Mende, M. (2006). The special effects of hypnosis and hypnotherapy: A contribution to an ecological model of therapeutic change. *Journal of Clinical and Experimental Hypnosis, 54*(2), 167–185.

Mende, M. (2009). Hypnosis: State of the art and perspectives for the twenty-first century. *Contemporary Hypnosis, 26*(3), 179–184.

Mendoza, M. E., & Capofons, A. (2009). Efficacy of clinical hypnosis: A summary of its empirical evidence. *Papeles del Psicólogo, 30*(2), 98–116.

Nash, M. (2008). Foundations of clinical hypnosis. In M. R. Nash & A. J. Barnier (Eds.), *Oxford handbook of hypnosis* (pp. 487–502). New York: Oxford University Press.

Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. New York: Oxford University Press.

Phillips, M., & Frederick, C. (1995). *Healing the divided self: Clinical and Ericksonian hypnotherapy for post-traumatic and dissociative conditions*. New York: Norton.

Raz, A., & Campbell, N. K. J. (2011). Can suggestion obviate reading? Supplementary primary stroop evidence with exploratory negative priming analysis. *Cognition and Consciousness, 20*, 312–320.

Ruysschaert, N. (2009). (Self) hypnosis in the prevention of burnout and compassion fatigue for caregivers: Theory and induction. *Contemporary Hypnosis, 26*(3), 159–172.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist, 55*, 68–78.

Ryan, R. M., & Deci, E. L. (2008). A self-determination theory approach to psychotherapy: The motivational basis for effective change. *Canadian Psychology, 49*(3), 186–193.

Ryan, R. M., Huta, V., & Deci, E. L. (2006). Living well: A self-determination theory perspective on eudaimonia. *Journal of Happiness Studies, 9*, 139–170.

Schnur, J. B., Kafer, I., Marcus, C., & Montgomery, G. H. (2008). Hypnosis to manage distress related to medical procedures: A meta-analysis. *Contemporary Hypnosis, 21*(3–4), 114–128.

Schnur, J. B., David, D., Kangas, M., Green, S., Bovberg, D. H., & Montgomery, D. H. (2009). A randomized trial of a cognitive-behavioral therapy and hypnosis intervention on positive and negative affect during breast cancer radiotherapy. *Journal of Clinical Psychology, 65*(4), 443–455.

Seligman, M., Steen, T., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist, 60*(5), 410–421.

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

Spiegel, H., & Spiegel, D. (2004). *Trance and treatment: Clinical uses of hypnosis*. Arlington: American Psychiatric Publishing.

Sthalekar, H. (2000). Hypnosis in the past, present and in the new millennium. *Australian Journal of Clinical Hypnotherapy & Hypnosis, 21*(2), 65–80.

Stoelb, B. L., Molton, I. R., Jensen, M. P., & Patterson, D. R. (2009). The efficacy of hypnotic analgesia in adults: A review of the literature. *Contemporary Hypnosis, 26*(1), 24–39.

Walsh, R., & Shapiro, S. L. (2006). The meeting of meditative disciplines and Western Psychology: A mutually enriching dialogue. *American Psychologist, 61*(3), 227–239.

Walters, C., & Havens, R. A. (1993). *Hypnotherapy for health, harmony and peak performance*. New York: Brunner/Mazel.

Willemsen, R., Haentjes, P., Roseeuw, D., & Vanderlinden, J. (2011). Hypnosis and alopecia areata: Long-term beneficial effects on psychological well-being. *Acta Dermato-Venereologica, 91*, 35–39.

Wood, A. M., Linley, P. A., Maltby, J., Kashdan, T. B., & Hurling, R. (2011). Using personal and psychological strengths leads to increases in well-being over time: A longitudinal study and the development of the strengths use questionnaire. *Personality and Individual Differences, 50*(1), 15–19.

Yapko, M. (2007, December). *What positive psychology can learn from hypnosis.* Keynote address at the 10th International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy, Phoenix, AZ.

Yapko, M. (2010). Hypnotically catalyzing experiential learning across treatments for depression: Actions speak louder than moods. *International Journal for Clinical and Experimental Hypnosis, 58*(2), 186–201.

Yapko, M. (2012). *Trancework: An introduction to the practice of clinical hypnosis* (4th ed.). New York: Routledge.

Chapter 7
The Role of Motivation in Cognitive Behavioural Psychotherapy for Anxiety Disorders

Elizeth Heldt, Carolina Blaya, and Gisele Gus Manfro

7.1 Introduction

Cognitive-behavioral therapy (CBT) is known to be efficacious for anxiety disorders, however the vast majority of suffering people does not receive adequate treatment. A recent study has reported that only 6 % of patients seeking treatment at an obsessive-compulsive disorder clinic had received CBT (Denys et al. 2002). Many reasons have been discussed to understand treatment underutilization as ambivalence about seeking treatment and catastrophic misinterpretation. Ambivalence in anxiety disorder can result from avoidant behavior component (Mcmanus et al. 2008; Starcevic et al. 2011), which is common characteristic to anxiety cognitive models. Whereas the impaired quality of life (Watson et al. 2011) may motivate anxiety-disordered patients to seek and follow treatment, the fear of anxiety usually discourage them to do so. This chapter aims to review the role of motivation in the process of CBT for anxiety disorders, considering the cultural and individual characteristics.

7.2 Anxiety Disorders and Diagnosis Consideration Across Cultures

Anxiety can be recognized as an alarm that occurs as a response to a dangerous situation. This alarm is composed by somatic and psychic symptoms as palpitation, chest discomfort, dizziness, dyspnea, tension, apprehension and fear. Anxiety is

E. Heldt (✉) • C. Blaya • G.G. Manfro
Psychiatry Service – Hospital de Clinicas de Porto Alegre,
Rua Ramiro Barcelos, 2350 – Room 400N, 90035-903 Porto Alegre, RS, Brazil

Universidade Federal do Rio Grande do Sul.,
Rua Ramiro Barcelos, 2350 – Room 400N, 90035-903 Porto Alegre, RS, Brazil
e-mail: eliz.h@globo.com; eliz@dualnet.com.br; cblaya@terra.com.br; gmanfro@gmail.com

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_7, © Springer Science+Business Media Dordrecht 2014

characterized as an anxiety disorder when the symptoms are more intense, more frequent and longer, causing significant distress. According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision – DSM-IV-TR* (APA 2002), anxiety disorders are characterized by intense fear and discomfort in response to adverse stimulus. They are accompanied by physical and emotional symptoms, especially catastrophic thoughts that cause significant distress. These symptoms can be followed by anticipatory anxiety and avoidance that can interfere with daily routine. The DSM-IV-TR (APA 2002) classified the anxiety disorders in (1) panic disorder (PD) with or without agoraphobia, (2) specific phobia (SP), (3) social anxiety disorder (SAD), (4) generalized anxiety disorder (GAD), (5) obsessive-compulsive disorder (OCD), (6) post traumatic stress disorder (PTSD) and (7) acute stress disorder (ASD). The central cognition distortion in all anxiety disorders is catastrophizing the risk and minimizing the resources to deal with the situation. Therefore, anticipatory anxiety and avoidance contribute to the maintenance of symptoms and are considered the most important risk factors for relapses (Manfro et al. 2008).

A review of epidemiologic studies of anxiety disorders across different cultures showed the 1-year and lifetime prevalence rates for all anxiety disorders to be 10.6 % and 16.6 %, respectively (Somers et al. 2006). However, anxiety disorders are usually under diagnosed (Wittchen et al. 2002). These disorders are associated to increased psychiatry and medical comorbidities, suicide thoughts and attempts, substance abuse (Conway et al. 2006; Nock et al. 2010) and higher rates of using medical services and visiting emergency rooms (Roy-Byrne 1996).

Studies have shown some variation in the prevalence and phenomenology of anxiety disorders across cultural and ethnic groups (Marques et al. 2011). For instance, in Caucasian countries, the prevalence of GAD, PD and SAD is considerable higher than in Asian and Latin American countries (Marques et al. 2011). On the other hand, the prevalence of anxiety disorder did not differ among ethnic minorities in the same country (Tarricone et al. 2012). It is possible that the questions and concepts used in diagnostic assessments derived from the DSM-IV and International Classification of Diseases-10 may not have comparable words or ideas in different languages and cultures. Furthermore, the presentation of psychopathology may itself differ across cultures. For example, Cambodian refugees often report worry and anxiety about the spiritual well-being of relatives who had passed away during the Cambodian genocide and could not receive a proper burial (Marques et al. 2011). Also, individuals from non-Western cultures are significantly more likely to report somatic (e.g., dizziness or indigestion) rather than psychological symptoms (e.g., scared or nervous) (Marques et al. 2011; Zhou et al. 2011). Consequently, extant diagnostic criteria may fail to capture culturally shaped presentations of anxiety disorders, leading to an underestimation of the prevalence of these disorders in non-Western cultures.

In order to contemplate these cultural idiosyncrasies, the recommendations for the new DSM-V include the revision of some of the anxiety diagnostic criteria. For example, it has been suggested the addition of four culturally specific

symptoms to improve identification of panic attacks cross-culturally. These symptoms are: tinnitus, neck soreness, headache, and uncontrollable screaming or crying (Lewis-Fernandez et al. 2010).

A well-known example of cultural variation in the presentation of SAD is Taijin kyofusho (TKS), a clinical syndrome literally meaning 'fear of interpersonal relations' that is observed in Japan and in South Korea. There are two subtypes of TKS, one that is focused on personal shame and embarrassment, much like the DSM-IV diagnosis of SAD, and another that is characterized by a fear that one's flawed social presentations will offend others (Marques et al. 2011). The allocentric focus of this subtype of TKS distinguishes it from the more egocentric focus in the DSM-IV diagnostic criteria for SAD (Russell 1989).

The etiology of anxiety disorders is multifactorial, which means that different aspects may equally contribute to illness development. The hereditability of anxiety is around 40 %, but it is not considered disorder specific. On the other hand, it is suggested that this hereditability may increase to up to 90 % if temperament is considered (Smoller et al. 2009). Therefore, the presence of a specific type of temperament like behavior inhibition, neuroticism or harm avoidance may interact with environmental factors developing the anxiety disorder. Lower family income and school levels, as well as stressors in childhood like trauma, neglect and abuse are considered environmental factors associated to the development of anxiety disorders (Cougle et al. 2010). Moreover negative life event are also consistent associated to the onset of these disorders (Beesdo et al. 2009). Furthermore individuals with these disorders usually describe their parents as more authoritarian and less affective as compared to non-anxious individuals.

The anxiety disorders are considered chronic conditions characterized by periods of remissions and relapses (Colman et al. 2007). These relapses are usually associated to the presence of life event stressors or the presence of residual symptoms (Heldt et al. 2011). It is also known that anxiety disorders are associated to worse quality of life and well-being as compared to non-anxious controls (Candilis et al. 1999; Heldt et al. 2003), even in remitted stages of the disorder (Candilis et al. 1999; Heldt et al. 2006). The assessment of psychological well-being is similar to the quality of life evaluation and both have been used as important tools to evaluate outcome after clinical trials with different treatment modalities.

Cognitive-Behavior therapy (CBT) is considered the first line of treatment for anxiety disorders and may be used alone (Manfro et al. 2008), in combination to pharmacotherapy (Candilis et al. 1999; Heldt et al. 2003) or in addition with others psychotherapeutic strategies, like well-being therapy (see Chap. 2 of this book) (Fava et al. 2005). According to Ryff's conceptual model for psychological well-being, panic disordered patients in remission had shown difficulty in managing everyday affairs (environmental mastery). They also tend to have a sense of personal stagnation (personal growth), to lack a sense of direction (purpose in life) and to feel dissatisfied with self (self-acceptance) (Ryff and Keyes 1995).

7.3 Cultural Aspects of CBT for Anxiety Disorders

'Culture' is used to refer to a system of common beliefs and values that characterize a group of people (Marques et al. 2011). Culture beliefs and values are dynamically changing and are influenced by the contexts of time and place. The cultural aspects of health and illness are determinate by how it is cognitively understood for each individual.

According to World Health Organization (WHO), quality of life (QoL) is characterized as "the individual's perception of their position in life, in the context of culture and value systems in which they live, and in relation to their goals, expectations, standards and concerns" (Anonymous 1995). Considering that subjects with anxiety disorder have worse QoL as compared to general population (Candilis et al. 1999; Quilty et al. 2003), this measure can provide an accurate and comprehensive assessment of health outcomes to treatment (Cordioli et al. 2003; Heldt et al. 2006; Watanabe et al. 2010). It is also important because it takes into consideration the cultural beliefs.

Regarding anxiety symptoms, it seems that the efficacy of CBT does not depend on cultural aspects of the sample. For instance, studies that evaluated efficacy of CBT for PD found similar response among subjects in Brazil and in North America (Heldt et al. 2003; Otto et al. 1999; Pollack et al. 1994). Moreover, it seems that CBT had similar response rates in other different cultural minorities. Otto et al. have shown CBT efficacy for PTSD in Cambodian refugees that live in the United States. In this study, CBT provided substantial additional benefit relative to treatment with sertraline alone (Otto et al. 2003). Barlow et al. conducted one review of self-management interventions for PD, OCD and phobias and included studies conducted in a range of countries (Australia, Brazil, Spain, Sweden, the UK and the USA). They found that these strategies are effective and the authors did not report significant differences in response among samples with different cultural background (Barlow et al. 2005).

7.4 Predictors Associated to CBT Response

Baseline QoL is a predictor of outcome and symptoms remission (Fava et al. 2001), but few studies have systematic evaluate this dimension across different cultures. Despite the growing importance of QoL as a valid outcome in measuring response to different treatments in anxiety disorders, there are some barriers that hinder progress. The most obvious concern is related to understanding the meaning and associations between "health" and QoL (Zubaran et al. 2009). Studies usually evaluate the "quality of life related to health" (Cummins et al. 2004; Moons et al. 2006), which reflects the paradigm focused on the effects of the disease in the individual's functional capacity in daily living activities, with special attention to the physical, psychological and social limitations. However, actually the new concept of QoL reflects the paradigm centered on the subjective well-being (Mooney 2006).

This conceptualization includes subjective satisfaction in general life or on specific life domains (Cummins et al. 2004).

The studies concerning CBT evaluate patient's motivation as a state of readiness for change prior to the treatment, and also as patient's participation and compliance to different techniques throughout the course of therapy (Keithly et al. 1980). Nevertheless, it seems that prior motivation can mediate compliance during treatment. In fact, either patient's motivation, or the psychotherapy process as an open system are subject to high fluctuations that can be influenced by the patient's own personality characteristics (Rosenbaum and Horowitz 1983).

A recent randomized study comparing adding CBT to pharmacotherapy treatment in PD patients suggested that high levels of anxiety sensitivity and high scores on neuroticism are independent predictors of poor response to CBT (Chavira et al. 2009). Furthermore, personality characteristics and temperament have also been associated to relapse after pharmacological treatment. A 2-year follow-up study with PD panic patients treated with sertraline described that high levels in temperamental characteristics as novelty seeking and harm avoidance were associated with poorer outcome, while the character trait of self-directedness was higher in patients who remitted (Kipper et al. 2009). Furthermore, self-directedness and persistence are now considered traits connected to positive functioning (Cloninger 2004). Recent study has described that anxious patients present lower self-directedness as compared to mood disorder patients. Moreover anxious patients present higher persistence which is associated to greater health and happiness (Cloninger et al. 2012).

7.5 Motivation and CBT

Since the 1970s, instruments to assess patient's motivations to psychotherapy have been developed to establish the relationship between motivation and treatment outcome. Some criteria to evaluate motivation were defined: desire to change, degree of autonomy, introspection and readiness to make some sacrifices (Keithly et al. 1980). However, the instruments used to assess treatment motivation reflect the psychological well-functioning, which demonstrate that motivation needs to be considered in a multifaceted construct (Rosenbaum and Horowitz 1983).

Despite the efficacy of CBT for anxiety disorders, some patients do not have enough motivation for treatment. For example, a naturalistic study showed that from 120 OCD patients to whom CBT have been recommended, only 61 attended CBT sessions and from those, 26 (13 % of the total sample) got a recommended 'dose' of CBT (Mancebo et al. 2011). Naturalistic studies reported lower rates of patients' adherence to CBT as compared to the ones in clinical trials. This difference may be associated to the use of an intensive and time-limited approach in clinical trials that may select patients that are more motivated. Reasons for dropout include not having time to attend the sessions, and fear of the tools used in CBT, especially exposure and ritual prevention (ERP). In order to improve adherence to CBT, the authors suggested emphasizing cognitive techniques prior to EPR methods (Mancebo et al. 2011).

Measures of motivation can predict treatment dropout (Dozois et al. 2004) but data concerning its relation to treatment outcome has been controversial in the literature (Westra 2011). Westra (2011) showed that early resistance for modification has been associated to lower homework compliance and lower clinical response in CBT for GAD. Furthermore the same study demonstrated that patients which received motivational interview had lower early resistance to treatment (Westra 2011).

The use of homework is a hallmark of CBT approaches. Completion of extra session homework is hypothesized to be a critical mechanism for skill consolidation and generalization (Gaynor et al. 2006). Predictors to compliance in CBT with adolescents with depression are initial motivation to reduce symptoms, positive outcome expectancies for completing homework, and avoidance of potential social consequences for noncompliance. However, the relationship between homework compliance and improvement is not conclusive. Whereas studies in adulthood had suggested a strong relationship between homework compliance and improvement (Anand et al. 2011; De Araujo et al. 1996), some authors have failed to demonstrate a significant association between the amounts of homework completed during the Adolescent Coping with Depression Course (CWD-A) and depressive symptoms (Gaynor et al. 2006). The adolescents usually completed only about half of the homework assignments. Moreover, homework compliance is likely to decline across treatment. There are some hypothesis concerning why adolescent patients decline to complete the homework or decrease compliance over the treatment, such as: the difficulties to follow rules, the delayed response between homework completion and practical results and also clinical improvement (Gaynor et al. 2006).

Although studies in different countries have shown similar response for CBT treatment, a few have evaluated homework compliance. It is possible that cultural aspects regarding how important is to follow a rule may influence on compliance. For example, in Brazil people have raised strategies not to follow a rule in order to deal with bureaucratize (Almeida 2007). On the other hand, children in China and Japan usually spent more time doing school homework than does American children (Chen and Stevenson 1989), which may contribute for homework compliance in CBT. Thus, Brazilian patients doing CBT may need additional strategies in order to increase homework compliance.

Then, motivation could be considered a way of directing attention to elicit the patient's desire for their behavior changes in the interest of their health. The patient-centered approach is what allows exploring and changing the ambivalence that may be present during the process of engaging in treatment that leads to behavioral change (Fig. 7.1).

7.6 Strategies to Increase Motivation

Since different factors mediate motivation to CBT, strategies must focus not only in the beginning but also during the course of the therapeutic process. Strategies focusing on increase homework compliance include adding another outcome that is more

Fig. 7.1 Core skills of motivation to CBT for anxiety disorders (Adapted by Rollnick et al. 2008)

immediate, sizable, and probable, such as monetary reward for drug abstinence (Gaynor et al. 2006). For instance, the Kendall's Coping Cat program (Kendall and Hedtke 2006) developed to treat anxiety disorder in childhood include positive reward for each homework completed. Examples include collectable cards (e.g., Pokémon cards), stickers, and small prizes that can be purchased in bulk (Beidas et al. 2010). Unfortunately, the applicability of this positive reinforcement for adult is not well established. Another strategy is to provide psychoeducation on the importance of homework compliance to prevent relapses and the use of motivation strategies to enhance adherence. For example, the therapist might doubt whether the patient can sustain homework adherence in the absence of symptoms or provide a challengeable counterargument against continued adherence (e.g., "maybe you don't need additional practice such as homework"). These motivation strategies put the patient in the position of arguing for additional adherence, so it is the patients decision to do so (Gaynor et al. 2006).

Considering these difficulties, Motivational Interviewing (MI) was developed to understand and to explore the patient's own motivations, and to help a therapist to promote collaboration and reduce ambivalence about changing a particular behavior. In fact, MI helps the therapist and patient to achieve a common understanding about the patient's awareness of change. MI considers five guiding principles: (1) express empathy and acceptance (i.e., empathy means acceptance and understanding another's perspective and feelings neutrally, without judging or evaluating in any way); (2) develop discrepancy (i.e., perceive differences between a current situation and hope for the future); (3) avoid argumentation (i.e., when the patient refuses to complete a task, it is time to stop forcing the point and to modify the strategy); (4) work with resistance (i.e., when the patient is ambivalent to modify some behavior, he will tend to argue against the change), and (5) support self-efficacy (i.e., a person's belief in his or her ability to carry out a specific behavior) (Rollnick et al. 2008).

Another strategy designed to increase motivation is the Thought Mapping (TM). Elaborated by Leukefelt and cols (Leukefeld et al. 2000), TM is a visual technique

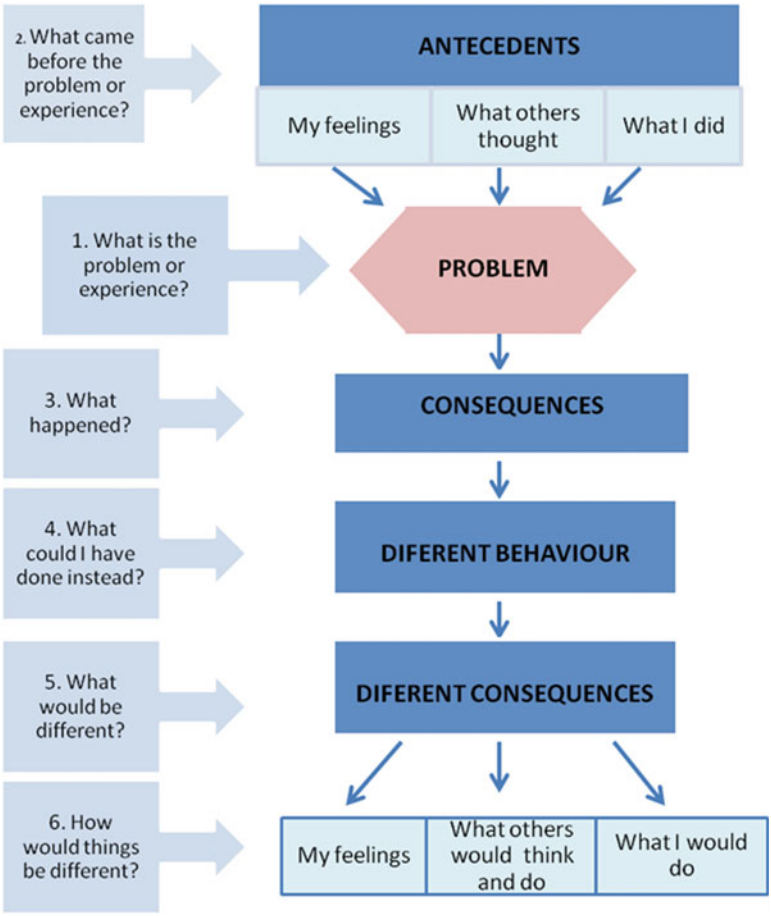

Fig. 7.2 Thought Mapping (Adapted by Meyer et al. 2010)

that uses a personal thought map, for dysfunctional thoughts and behaviors. The first part of the map (questions 1–3) was used to facilitate problem recognition and identification – antecedents. The second part (questions 4–6) was for problem solutions – consequences (Fig. 7.2).

The aim of TM is to organize the patient's thoughts and connections between behavior and feelings. It can also help to recognize where changes need to take place, to explore behavioral choices and subsequent results, and to consider solutions to the present problem. The results of a study which combines the techniques of MI and TM in two individual sessions before starting a group CBT for OCD showed significant changes at the endpoint and decrease the scores in different obsessive-compulsive symptom dimensions scales (Meyer et al. 2010).

MI strategies have been systematically evaluated for addictive disorders; however there are only few studies that evaluated these strategies for anxiety

disorders. A randomized clinical trial included patients with a primary diagnosis of PD, GAD and SAD who received three MI sessions prior to CBT. These add on group was compared to a control group that received CBT alone. The results showed that even though both sets improved in anxiety symptoms, the improvement in MI plus CBT group was higher as compared to the control group (Westra and Dozois 2006). MI seems to add benefits for GAD patients with higher baseline worry severity and for those that are less responsive to CBT (Westra et al. 2009). Besides this, a recent study showed that adding two sessions of motivational interviewing and thought mapping in group CBT was more effective than group CBT alone for OCD patients (Meyer et al. 2010). Indeed, adding three sessions of motivation interviewing increased CBT utilization among social anxiety patients (Buckner and Schmidt 2009). Thus, adding this psychotherapeutic technique may enhance CBT outcomes. On the other hand, adding pre-treatment interoceptive exposure (asking to imagine attending therapy sessions) did not improve compliance to CBT sessions neither improve symptoms among social anxiety disordered patients (Buckner et al. 2009).

According to some authors, hope is also associated to psychotherapy motivation (Snyder et al. 2000) and can be understood as a cognitive nature. It is associated with operationalized goals and to the capacity to generate strategies. CBT interventions (e.g., cognitive restructuring, interoceptive exposure, programmed re-entry into avoided situations, etc.) may be an interesting pathway to achieve hope which is an important element in motivation and in the success of anxiety disorders treatment (Snyder et al. 2000).

7.7 Conclusions

CBT is not only efficacious for anxiety disorder, but it can also improve quality of life in patients with different cultural backgrounds. However, a few patients are motivated enough for the psychotherapeutic treatment. It seems that factors that influence this state of readiness for change depend on psychological idiosyncrasies, such as personality characteristics, anxiety sensitivity, absence of well-being and hope for the future, but not on cultural aspects. Besides this, motivation has a high fluctuation and could decrease with clinical improvement. Thus, strategies tools should focus on improving patients' motivation, such as MI and TM, and emphasis cognitive techniques in order to increase CBT response rates and consequently improving patient's quality of life.

References

Almeida, A. C. (2007). Corrupção: com jeitinho parece que vai. In E. Record (Ed.), *A cabeça do brasileiro*. Rio de Janeiro.

Anand, N., Sudhir, P. M., Math, S. B., et al. (2011). Cognitive behavior therapy in medication non-responders with obsessive-compulsive disorder: A prospective 1-year follow-up study. *Journal of Anxiety Disorders, 25*, 939–945. doi:10.1016/j.janxdis.2011.05.007.

Anonymous. (1995). The World Health Organization Quality of Life assessment (WHOQOL): Position paper from the World Health Organization. *Social Science & Medicine, 41*, 1403–1409. doi:10.1016/0277-9536(95)00112-K.

APA. (2002). *Manual Diagnóstico e Estatístico de Transtornos Mentais (DSM-IV-TR)*. Porto Alegre: Artmed.

Barlow, J. H., Ellard, D. R., Hainsworth, J. M., et al. (2005). A review of self-management interventions for panic disorders, phobias and obsessive-compulsive disorders. *Acta Psychiatrica Scandinavica, 111*, 272–285. doi:10.1111/j.1600-0447.2005.00499.X.

Beesdo, K., Knappe, S., & Pine, D. S. (2009). Anxiety and anxiety disorders in children and adolescents: Developmental issues and implications for DSM-V. *The Psychiatric Clinics of North America, 32*, 483–524. doi:10.1016/j.psc.2009.06.002.

Beidas, R. S., Benjamin, C. L., Puleo, C. M., et al. (2010). Flexible applications of the coping cat program for anxious youth. *Cognitive and Behavioral Practice, 17*, 142–153. doi:10.1016/j.cbpra.2009.11.002.

Buckner, J. D., & Schmidt, N. B. (2009). A randomized pilot study of motivation enhancement therapy to increase utilization of cognitive-behavioral therapy for social anxiety. *Behaviour Research and Therapy, 47*, 710–715. doi:10.1016/j.brat.2009.04.009.

Buckner, J. D., Cromer, K. R., Merrill, K. A., et al. (2009). Pretreatment intervention increases treatment outcomes for patients with anxiety disorders. *Cognitive Therapy and Research, 33*, 126–137. doi:10.1007/s10608-007-9154-x.

Candilis, P. J., Mclean, R. Y., Otto, M. W., et al. (1999). Quality of life in patients with panic disorder. *Journal of Nervous and Mental Disease, 187*, 429–434.

Chavira, D. A., Stein, M. B., Golinelli, D., et al. (2009). Predictors of clinical improvement in a randomized effectiveness trial for primary care patients with panic disorder. *Journal of Nervous and Mental Disease, 197*, 715–721. doi:10.1097/NMD.0b013e3181b97d4d.

Chen, C. S., & Stevenson, H. W. (1989). Homework: A cross-cultural examination. *Child Development, 60*, 551–561.

Cloninger, C. R. (2004). *Feeling good: The science of well-being*. New York: Oxford University Press.

Cloninger, C. R., Zohar, A. H., Hirschmann, S., et al. (2012). The psychological costs and benefits of being highly persistent: Personality profiles distinguish mood disorders from anxiety disorders. *Journal of Affective Disorders, 136*, 758–766. doi:10.1016/j.jad.2011.09.046.

Colman, I., Ploubidis, G. B., Wadsworth, M. E., et al. (2007). A longitudinal typology of symptoms of depression and anxiety over the life course. *Biological Psychiatry, 62*, 1265–1271. doi:10.1016/j.biopsych.2007.05.012.

Conway, K. P., Compton, W., Stinson, F. S., et al. (2006). Lifetime comorbidity of DSM-IV mood and anxiety disorders and specific drug use disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinical Psychiatry, 67*, 247–257.

Cordioli, A. V., Heldt, E., Bochi, D. B., et al. (2003). Cognitive-behavioral group therapy in obsessive-compulsive disorder: A randomized clinical trial. *Psychotherapy and Psychosomatics, 72*, 211–216. doi:10.1159/000070785.

Cougle, J. R., Timpano, K. R., Sachs-Ericsson, N., et al. (2010). Examining the unique relationships between anxiety disorders and childhood physical and sexual abuse in the National Comorbidity Survey-Replication. *Psychiatry Research, 177*, 150–155. doi:10.1016/j.psychres.2009.03.008.

Cummins, R. A., Lau, A. L., & Stokes, M. (2004). HRQOL and subjective well-being: Noncomplementary forms of outcome measurement. *Expert Review of Pharmacoeconomics & Outcomes Research, 4*, 413–420. doi:10.1586/14737167.4.4.413.

De Araujo, L. A., Ito, L. M., & Marks, I. M. (1996). Early compliance and other factors predicting outcome of exposure for obsessive-compulsive disorder. *British Journal of Psychiatry, 169*, 747–752.

Denys, D., Van Megen, H., & Westenberg, H. (2002). The adequacy of pharmacotherapy in outpatients with obsessive-compulsive disorder. *International Clinical Psychopharmacology, 17*, 109–114.

Dozois, D. J., Westra, H. A., Collins, K. A., et al. (2004). Stages of change in anxiety: Psychometric properties of the University of Rhode Island Change Assessment (URICA) scale. *Behaviour Research and Therapy, 42*, 711–729. doi:10.1016/S0005-7967.

Fava, G. A., Rafanelli, C., Ottolini, F., et al. (2001). Psychological well-being and residual symptoms in remitted patients with panic disorder and agoraphobia. *Journal of Affective Disorders, 65*, 185–190. PII: S0165-0327(00)00267-6.

Fava, G. A., Ruini, C., Rafanelli, C., et al. (2005). Well-being therapy of generalized anxiety disorder. *Psychotherapy and Psychosomatics, 74*, 26–30. doi:10.1159/000082023.

Gaynor, S. T., Lawrence, P. S., & Nelson-Gray, R. O. (2006). Measuring homework compliance in cognitive-behavioral therapy for adolescent depression: Review, preliminary findings, and implications for theory and practice. *Behavior Modification, 30*, 647–672. doi:10.1177/0145445504272979.

Heldt, E., Manfro, G. G., Kipper, L., et al. (2003). Treating medication-resistant panic disorder: Predictors and outcome of cognitive-behavior therapy in a Brazilian public hospital. *Psychotherapy and Psychosomatics, 72*, 43–48. doi:10.1159/000067188.

Heldt, E., Blaya, C., Isolan, L., et al. (2006). Quality of life and treatment outcome in panic disorder: Cognitive behavior group therapy effects in patients refractory to medication treatment. *Psychotherapy and Psychosomatics, 75*, 183–186. doi:10.1159/000091776.

Heldt, E., Kipper, L., Blaya, C., et al. (2011). Predictors of relapse in the second follow-up year post cognitive-behavior therapy for panic disorder. *Revista Brasileira de Psiquiatria, 33*, 23–29. doi:10.1590/S1516-44462010005000005.

Keithly, L. J., Samples, S. J., & Strupp, H. H. (1980). Patient motivation as a predictor of process and outcome in psychotherapy. *Psychotherapy and Psychosomatics, 33*, 87–97.

Kendall, P. C., & Hedtke, K. A. (2006). *The coping cat workbook*. Ardmore: Workbook Publishing.

Kipper, L., Wachleski, C., Salum, G. A., et al. (2009). Can psychopharmacological treatment change personality traits in patients with panic disorder? *Revista Brasileira de Psiquiatria, 31*, 307–313. doi:10.1590/S1516-44462009000400005.

Leukefeld, C., Brown, C., Clark, J., et al. (2000). *Behavioral therapy for rural substance abusers*. Lexington: University of Kentucky Press.

Lewis-Fernandez, R., Hinton, D. E., Laria, A. J., et al. (2010). Culture and the anxiety disorders: Recommendations for DSM-V. *Depression and Anxiety, 27*, 212–229. doi:10.1002/da.20647.

Mancebo, M. C., Eisen, J. L., Sibrava, N. J., et al. (2011). Patient utilization of cognitive-behavioral therapy for OCD. *Behavior Therapy, 42*, 399–412. doi:10.1016/j.beth.2010.10.002.

Manfro, G. G., Heldt, E., Cordioli, A. V., et al. (2008). Cognitive-behavioral therapy in panic disorder. *Revista Brasileira de Psiquiatria, 30*(Suppl 2), s81–87. doi:10.1590/S1516-44462008000600005.

Marques, L., Robinaugh, D. J., Leblanc, N. J., et al. (2011). Cross-cultural variations in the prevalence and presentation of anxiety disorders. *Expert Review of Neurotherapeutics, 11*, 313–322. doi:10.1586/ern.10.122.

Mcmanus, F., Sacadura, C., & Clark, D. M. (2008). Why social anxiety persists: An experimental investigation of the role of safety behaviours as a maintaining factor. *Journal of Behavior Therapy and Experimental Psychiatry, 39*, 147–161. doi:10.1016/j.jbtep.2006.12.002.

Meyer, E., Shavitt, R. G., Leukefeld, C., et al. (2010). Adding motivational interviewing and thought mapping to cognitive-behavioral group therapy: Results from a randomized clinical trial. *Revista Brasileira de Psiquiatria, 32*, 20–29. doi:10.1590/S1516-44462010000100006.

Mooney, A. (2006). Quality of life: Questionnaires and questions. *Journal of Health Communication, 11*, 327–341. doi:10.1080/10810730600614094.

Moons, P., Budts, W., & De Geest, S. (2006). Critique on the conceptualisation of quality of life: A review and evaluation of different conceptual approaches. *International Journal of Nursing Studies, 43*, 891–901. doi:10.1016/j.ijnurstu.2006.03.015.

Nock, M. K., Hwang, I., Sampson, N. A., et al. (2010). Mental disorders, comorbidity and suicidal behavior: Results from the National Comorbidity Survey Replication. *Molecular Psychiatry, 15*, 868–876. doi:10.1038/mp.2009.29.

Otto, M. W., Pollack, M. H., Penava, S. J., et al. (1999). Group cognitive-behavior therapy for patients failing to respond to pharmacotherapy for panic disorder: A clinical case series. *Behaviour Research and Therapy, 37*, 763–770. doi:10.1016/S0005-7967(98)00176-4.

Otto, M. W., Hinton, D., Korbly, N. B., et al. (2003). Treatment of pharmacotherapy-refractory posttraumatic stress disorder among Cambodian refugees: A pilot study of combination

treatment with cognitive-behavior therapy vs sertraline alone. *Behaviour Research and Therapy, 41*, 1271–1276. doi:10.1016/S0005-7967(03)00032-9.
Pollack, M. H., Otto, M. W., Kaspi, S. P., et al. (1994). Cognitive behavior therapy for treatment-refractory panic disorder. *Journal of Clinical Psychiatry, 55*, 200–205.
Quilty, L. C., Van Ameringen, M., Mancini, C., et al. (2003). Quality of life and the anxiety disorders. *Journal of Anxiety Disorders, 17*, 405–426. doi:10.1016/S0887-6185(02)00225-6.
Rollnick, S., Miller, W. R., & Butler, C. C. (2008). *Motivational interviewing in health care: Helping patients change behavior* (Applications of motivational interviewing). New York: The Guilford Press.
Rosenbaum, R. L., & Horowitz, M. J. (1983). Motivation for psychotherapy: A factorial and concept analysis. *Psychotherapy: Theory, Research and Practice, 20*, 346–354.
Roy-Byrne, P. P. (1996). Generalized anxiety and mixed anxiety-depression: Association with disability and health care utilization. *Journal of Clinical Psychiatry, 57*(Suppl 7), 86–91.
Russell, J. G. (1989). Anxiety disorders in Japan: A review of the Japanese literature on shinkeishitsu and taijinkyofusho. *Culture, Medicine and Psychiatry, 13*, 391–403.
Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology, 69*, 719–727.
Smoller, J. W., Block, S. R., & Young, M. M. (2009). Genetics of anxiety disorders: The complex road from DSM to DNA. *Depression and Anxiety, 26*, 965–975. doi:10.1002/da.20623.
Snyder, C. R., Stephen, S. I., Cheavens, J., et al. (2000). The role of hope in cognitive-behaviour therapies. *Cognitive Therapy and Research, 24*, 747–762.
Somers, J. M., Goldner, E. M., Waraich, P., et al. (2006). Prevalence and incidence studies of anxiety disorders: A systematic review of the literature. *Canadian Journal of Psychiatry, 51*, 100–113.
Starcevic, V., Berle, D., Brakoulias, V., et al. (2011). The nature and correlates of avoidance in obsessive-compulsive disorder. *The Australian and New Zealand Journal of Psychiatry, 45*, 871–879. doi:10.3109/00048674.2011.607632.
Tarricone, I., Stivanello, E., Poggi, F., et al. (2012). Ethnic variation in the prevalence of depression and anxiety in primary care: A systematic review and meta-analysis. *Psychiatry Research, 195*, 91–106. doi:10.1016/j.psychres.2011.05.020.
Watanabe, N., Furukawa, T. A., Chen, J., et al. (2010). Change in quality of life and their predictors in the long-term follow-up after group cognitive behavioral therapy for social anxiety disorder: A prospective cohort study. *BMC Psychiatry, 10*, 81. doi:10.1186/1471-244X-10-81.
Watson, H. J., Swan, A., & Nathan, P. R. (2011). Psychiatric diagnosis and quality of life: The additional burden of psychiatric comorbidity. *Comprehensive Psychiatry, 52*, 265–272. doi:10.1016/j.comppsych.2010.07.006.
Westra, H. A. (2011). Comparing the predictive capacity of observed in-session resistance to self-reported motivation in cognitive behavioral therapy. *Behaviour Research and Therapy, 49*, 106–113. doi:10.1016/j.brat.2010.11.007.
Westra, H. A., & Dozois, D. J. (2006). Preparing clients for cognitive behavioral therapy: A randomized pilot study of motivational interviewing for anxiety. *Cognitive Therapy and Research, 30*, 481–498.
Westra, H. A., Arkowitz, H., & Dozois, D. J. (2009). Adding a motivational interviewing pretreatment to cognitive behavioral therapy for generalized anxiety disorder: A preliminary randomized controlled trial. *Journal of Anxiety Disorders, 23*, 1106–1117. doi:10.1016/j.janxdis.2009.07.014.
Wittchen, H. U., Kessler, R. C., Beesdo, K., et al. (2002). Generalized anxiety and depression in primary care: Prevalence, recognition, and management. *Journal of Clinical Psychiatry, 63*(Suppl 8), 24–34.
Zhou, X., Dere, J., Zhu, X., et al. (2011). Anxiety symptom presentations in Han Chinese and Euro-Canadian outpatients: Is distress always somatized in China? *Journal of Affective Disorders, 135*, 111–114. doi:10.1016/j.jad.2011.06.049.
Zubaran, C., Foresti, K., Thorell, M. R., et al. (2009). Portuguese version of the Quality of Life Enjoyment and Satisfaction Questionnaire: A validation study. *Revista Panamericana de Salud Pública, 25*, 443–448. doi:10.1590/S1020-49892009000500010.

Chapter 8
The Role of Psychological Well-being in Childhood Interventions

Elisa Albieri and Dalila Visani

8.1 Mental Health in Developmental Age

A number of studies have documented the high prevalence of psychological difficulties in children and adolescents. Currently available epidemiological data suggest a worldwide prevalence of child and adolescent mental disorders of approximately 20 %. Of this 20 %, from 4 to 6 % of children and adolescents are in need of a clinical intervention for an observed significant mental disorder (WHO 2001). Anxiety disorders such as generalized anxiety disorder (GAD), separation anxiety disorder (SAD), social phobia (SOC) and other phobic disorders are estimated to represent the largest class of childhood emotional problems with prevalence rates ranging between 2 and 24 % (Kessler et al. 2005; Costello et al. 2005; Merikangas et al. 2009; Tsuchiya et al. 2009). Depression tends to affect a smaller number of youth, wherein 1–2 % of children (ages 6–12) and 4–8 % of adolescents (ages 12–18) meet criteria for a depressive disorder at any point in time (Elmquist et al. 2010). In an international meta-analysis of population-based studies, it was found that in all cultures depressive disorders were higher for adolescents than children and for adolescent girls than boys (Costello et al. 2006). Prevalence of depression increases with age and more than doubles at puberty. Nearly 20 % of youth may experience a depressive disorder by the end of adolescence. Further, depression ranks as one of the most disabling disease worldwide, as measured by its impact on quality of life (WHO 2004). Many affective disorders in adults have their onset in early-to-late childhood and symptoms/syndromes of anxiety seem to be the earliest of all forms of psychopathology (Beesdo et al. 2009, 2010; Rapee et al. 2009). However, most of these data are referred to children and adolescents living in

E. Albieri (✉) • D. Visani
Department of Psychology, University of Bologna, Bologna, Italy
e-mail: elisa.albieri3@unibo.it

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_8, © Springer Science+Business Media Dordrecht 2014

Western societies, whereas a paucity of studies are concerned with children living in the Third World or developing countries, where most of the world's young generations actually live (Benjet 2010). According to available data, several epidemiological reports identified that in resources-poor countries the types of disorders were generally no different from those encountered in industrialized countries (Belfer and Nurcombe 2007) and similar prevalence levels have been reported both in Western societies and in developing countries such as Nigeria, Arab Emirates, Sudan, Philippines, India and Colombia (Fayyad et al. 2001).

Another crucial issue in children mental health research lies in the fact that, in addition to official epidemiological data, approximately 5 % of children present sub-threshold symptoms, which equally produce a significant effect on their daily life (Gerber et al. 2010). Longitudinal studies suggest that affective disorders during youth may have a chronic course and also predict a variety of subsequent problems in adulthood connected with greater risk for more severe anxiety, major depression, dystymia, substance abuse (Kendall et al. 2003; Bittner et al. 2007; Beesdo et al. 2009) and educational underachievement (Beesdo et al. 2007; Sakolsky and Birmaher 2008). Youth depression is linked to suicide (Gould et al. 2004), which is the third most common cause of death among adolescents (Arias et al. 2003).

In spite of their high prevalence in the community, affective disorders in children and adolescents are under-recognized and remain untreated, even in medical settings (Chavira et al. 2004; James et al. 2005; Watanabe et al. 2004). Physical symptoms, a frequent feature of anxiety disorders, may be mistaken for medical illnesses or misinterpreted. Similarly, depressed children are more likely to show irritable mood (rather than sad mood as in depressed adults) and could be defined simply as ill-mannered instead of depressed. Moreover, inadequacy of formal diagnostic classifications for assessing children and adolescents' affective disorder, complicates the possibility to make a correct diagnoses or to give the right attention to sub-threshold symptoms (Rutter 2003; Angst 2007; Bittner et al. 2007).

Cross-sectional and longitudinal studies in different cultural contexts have suggested a developmental relationship between the disorders (Flament et al. 2007). Early diagnosis and treatment are essential, but recent data show that, even in developed countries with well-organized health care systems, there is a significant gap between the number of children who need mental health services and those who actually receive professional help (WHO 2003). In many countries mental health services for youth represent a subset of adult services rather than a distinct category and 10–20 % of kids who suffer from a psychiatric disorder are identified by primary health workers, suggesting that those children do not receive proper diagnosis and care (WHO 2004; Flament et al. 2007; Latzman et al. 2011). Child and teenager mental disorders, more than many other illnesses, have longstanding costs to society both in terms of healthcare utilization and social services. An improvement in identification and treatment of them would therefore have important public health implications (Layard 2006; Patel et al. 2007).

8.2 Treatment for Emotional Problems in Youth

The majority of data on the treatment of the main emotional problems in youth are based on studies in Europe and United States, which then are used for the planning of effective interventions and services in all other area of the world. Even though most evidence-based interventions were developed in western societies, several investigations show that many therapeutic principles and procedures are appropriate also for different countries. Nevertheless, important adaptations are necessary and further data with local studies that reflect cultural dimension are needed (ISP Task Force 2007). The most of treatment studies have not generally examined the extent to which age, gender, race, and ethnicity moderate the efficacy of psychosocial interventions and pharmacotherapy for children and adolescents with depressive disorders. Finally, a paucity of data concerning the efficacy for specific racial or ethnic groups have been available, despite evidence that drug adherence and metabolism are affected by ethno-cultural issues (Lin et al. 1993; Muñoz and Hilgenberg 2005; Canino and Alegría 2008) and that minorities are much less likely to seek mental health treatment than non-minorities (Muñoz and Hilgenberg 2005).

Moreover, the paucity of clinical trials involving long-term evaluation of depressed/anxious children patients is a specific weakness in the pediatric psychopathology research. More than one third of the investigations did not include follow-up assessment (Weisz et al. 2006). Indeed, results about pharmacotherapy are complicated by the concerns derive from long-term outcomes and the potentially serious side-effects (Whittington et al. 2004; Weisz et al. 2006; Walkup et al. 2008; Ipser et al. 2009; Vitiello 2009).

8.2.1 Psychotherapy

Randomized Controlled Trials concerning psychotherapies for affective disorders in youth are relatively limited compared to studies on adult samples, but a growing number of meta-analyses and systematic reviews consider Cognitive-Behavioral Therapy (CBT) the recommended treatment for many childhood disorders, including emotional and behavioral problems (Compton et al. 2004; James et al. 2005; Weisz et al. 2006; In-Albon and Schneider 2007; Eyberg et al. 2008; Toplak et al. 2008; Benjamin et al. 2011). The American Psychological Association Task Force on Promotion and Dissemination of Psychological Procedures (APA Task Force 1995) established criteria for use in determining whether treatments can be considered empirically effective and CBT has emerged as the treatment with the most empirical support for numerous internalizing disorders in youth (Benjamin et al. 2011). A number of individual CBT programs for affective disorders meet criteria as "probably efficacious" using APA guidelines (Ollendick and King 2004; David-Ferdon and Kaslow 2008), including:

- the Coping Cat Program, in its different format (children aged 8–13, adolescents, group, family-based and computerized) for anxiety and phobic disorders (Khanna and Kendall 2007; Kendall and Hedtke 2006; Kendall et al. 2002; Flannery-Schroeder and Kendall 2000);
- the FRIENDS for Life Program for Children (Barrett 2004) and for Youth (Barrett 2005), a family-based group CBT, resulted effective in reducing anxiety both at post treatment and 12-month follow-up (Shortt et al. 2001);
- the Social Effectiveness Therapy for Children (SET-C) (Beidel et al. 2000) a structured behavioral therapy for the treatment of social anxiety;
- some CBT-based specific programs for depressed youth (Harington et al. 1998; Reinecke et al. 1998; Lewinsohn and Clarke 1999; Michael and Crowley 2002);

In addition to CBT, the efficacy of Interpersonal Psychotherapy for depressed adolescents (IPT-A) (Mufson et al. 1994, 1999; Mufson and Fairbanks 1996; Rossellò and Bernal 1999) is also well-established. Currently, IPT-A has evidence for short-term effect, but its long-term effectiveness and compared or in combination with antidepressant medication is still under evaluation (Brunstein Klomek and Stanley 2007). Moreover, the evidence for the use of this approach in preadolescents is extremely limited, in fact, IPT-A was modified specifically as a therapy for adolescents.

8.2.2 Combination Therapy

Treatment effect of antidepressant medications and psychotherapy is, on average, more modest than expected, showing small effect sizes when used as monotherapy (Weisz et al. 2006; Bridge et al. 2007; Dubicka et al. 2010), and still leave between one-third and one-half of the patients insufficiently improved or still depressed. Thus, increasing the level of remission appears to be a crucial point in obtaining a more effective treatment outcome. As Fava (1996) suggested, there are two main strategies for going beyond current, unsatisfactory levels of remission: one is provided by augmentation and combination treatments, the other by sequential strategies.

Considering adolescent depression, Treatment for Adolescents with Depression Study (TADS; TADS Team 2004) compared the effectiveness of fluoxetine, CBT, and their combination (COMB) with clinical management with pill placebo. At the end of the acute phase treatment, COMB was superior in inducing remission of depression, decreasing suicidal ideation, and improving general functioning, global health, and feelings of well being (Kennard et al. 2006; Vitiello et al. 2004). At the end of the maintenance phase, the rate of clinical response was similar across fluoxetine, CBT, and COMB, indicating that COMB benefit consists in accelerating the improvement process (TADS Team 2007).

The Adolescent Depression and Psychotherapy Trial (ADAPT) is a randomized controlled trial which compared SSRI, CBT and or combined treatment

(Goodyer et al. 2007). No differences between monotherapy and combination of SSRI plus CBT emerged in terms of symptom reduction, remission, or incidence of suicidal behavior (Goodyer et al. 2007).

Treatment of Resistant Depression in Adolescents (TORDIA; Brent et al. 2008) is a multisite trial focused on a second-step treatment, for depressed adolescents who had been unsuccessfully treated with SSRI (Brent et al. 2008). They were randomly assigned to receive a different antidepressant medication either alone or together with CBT. At the end of the acute phase of treatment, combined intervention was superior to monotherapy in terms of responses rate (Brent et al. 2008), but at the end of continuation phase, rates and times of remission were similar for both groups (SSRI+CBT and SSRI alone) (Emslie et al. 2010; Vitiello et al. 2011).

Patients who participated in TORDIA and ADAPT presented a more severe symptomatology at the intake, due to comorbidity, suicidality, or previous treatment resistance. Not surprisingly, these studies do not lead to a univocal interpretation about the superiority of combined treatments (pharmacotherapy and psychotherapy), also because they do not include a psychotherapy plus pharmacological arm.

Considering anxiety disorders, the Child/Adolescent Multimodal Study (CAMS; Compton et al. 2010) showed that children who received combination of pharmacotherapy and psychotherapy had significantly higher rates of remission compared to monotherapies (Ginsburg et al. 2011). On the contrary, results of Pediatric OCD Treatment Study (POTS; Pediatric OCD Treatment Study Team 2004) indicated that remission rates for combined treatment (sertraline plus CBT) did not differ from CBT alone and both arms resulted superior to sertraline alone and placebo after 12-weeks treatment (Pediatric OCD Treatment Study POTS Team 2004).

8.2.3 Sequential Strategies

Studies concerning different sequential strategies of treatment mainly pertain to depression. Compared to adult, considerably less is known about continuation and maintenance phase treatments in pediatric depression and anxiety. A preliminary study of continuation phase treatment with fluoxetine found that 34 % of those children and adolescents who continued with fluoxetine relapsed, compared to 60 % of those placed on the placebo condition (Emslie et al. 2004). In a pilot study, Kroll and colleagues (1996) found that 6 months of continuation phase CBT following acute phase CBT significantly lowered relapse rates compared to controls (6 % vs. 50 %). Clarke et al. (1999) reported that booster sessions did not reduce relapse rates, but did accelerate remission in patients with depression at the end of acute phase CBT. The relatively low number of booster sessions, along with poor attendance rates of these sessions, may account for the significant relapse rates.

Kennard and colleagues (2008) evaluated the feasibility and efficacy of a sequential treatment strategy using continuation phase cognitive-behavioral therapy (CBT) to prevent relapse in youths with major depressive disorder (MDD) who have

responded to acute phase pharmacotherapy. The addition of continuation phase CBT lengthened time to relapse. Adolescents who did not receive continuation phase CBT had an eightfold greater risk for relapse than those who received CBT. Results suggested that medication alone may not be sufficient in reducing relapse in adolescent depression.

Data on the sequential use of different type of psychotherapy, specifically addressed to different stages of affective disorders are still missing and further studies are needed.

8.3 The Concept of Recovery in Childhood

A neglected area in the studies on children psychopathology is the concept of remission and recovery. A commonly considered index of outcome in randomized controlled trials (RCTs) for affective disorders is the response rate, defined as a meaningful improvement in symptoms (Frank et al. 1991). Remission is considered a more stringent criterion than response: it is a relatively brief period during which an improvement of sufficient magnitude is observed and the individual no longer meets syndromal criteria for the disorder (Frank et al. 1991). Identifying remission rates in RCTs is thus an important index of treatment outcome. Nowadays there is no consensus on an operational definition of remission for affective disorders in youth and in particular, on its difference with response rate. Concerning the criteria to define symptoms remission, pharmacological trials often consider a rating scale cut-off point (such as Children's Depression Rating Scale-Revised, CDRS-R; Poznanski and Mokros 1996), whereas studies about psychotherapy show more variability in the evaluation of treatment outcomes, using different criteria mainly based on diagnostic criteria (Compton et al. 2004). Both measurement methods are grounded on Frank and colleagues' (1991) set of definitions described above, which distinguish response, remission and recovery on a basis of the number and severity of symptoms and a temporal criterion only, without taking into account some specific developmental age features. First, fears and worries are common in youth and may represent a normal developmental transition. As a consequence, clinicians need to distinguish normal, developmentally appropriate worries, fears, and shyness from anxiety disorders that significantly impair a child's functioning, in terms of severity, intensity and duration of symptoms rather than their presence. Second, the clinical presentation of affective disorders in youth evolves according to the child's physical, emotional, cognitive, and social developmental stages (e.g. significant separation anxiety may represent a precursor of a social anxiety disorder). Moreover, in children of preschool age, different subtypes of anxiety may be less differentiated than in primary school children, but the clinical impact of these anxiety symptoms may be significant even if full criteria are not met (Spence 2001). As Fava and Kellner (1993) suggested, a longitudinal consideration of the development of disorders (staging method) may be more suitable for

clinical decision making and treatment planning than a flat, cross-sectional approach based on diagnostic criteria only. Third, the majority of trials accounts for the effect of both pharmacological and psychotherapeutic interventions in reducing symptoms, whether the effect of treatment in terms of improvement in quality of life and psychological well-being is less well documented (Sin and Lyubomirsky 2009). Fava (1996) suggested a new set of criteria for defining recovery, that specify the quality of residual symptoms and encompass the presence of psychological well-being. According to this conceptualization, not all residual symptoms are equally important (e.g., the persistence of depressed mood is different from lack of concentration in an improved depressed patient) and need to be carefully assessed considering their longitudinal development. Moreover, the key criteria of this new conceptualization of recovery is the focus on patient's psychological well-being. In fact, the absence of well-being creates conditions of vulnerability, therefore the route to recovery lies not exclusively in the absence of symptomatology, but also in the presence of specific well-being dimensions (Fava et al. 1998, 2007; Fava 1999). Nevertheless, we may assume that, as for adults, psychological well-being is impaired in children and adolescents with affective disorders who remitted upon standard treatment (Fava 2012). Impaired school performance, the absence or paucity of positive interpersonal relationships and low self-esteem are some of the most common residual symptoms (Tao et al. 2010) and can be considered as factors predicting absence of full recovery or presence of future relapse (Emslie et al. 2008). This residual symptomatology may be re-interpreted as the lack of psychological well-being in one of six areas described by Ryff's model (1989), such as environmental mastery, personal growth, positive relation with other, self-acceptance, purpose in life and autonomy (see Chaps. 1 and 2 of this book for further details). Nowadays, child psychiatry suggest to focus on child's competencies and enhance growth in psychological domains (Caffo et al. 2008), in line with the concept of flourishing, a global health status which combines high levels of emotional, psychological and social well-being, buffering the effect of psychological distress (Keyes 2007). Thus, a multidimensional definition of recovery, which should not be limited to symptomatic assessment, is more than ever needed also in pediatric settings and should involve psychological well-being and positive functioning. Little is known on the relationship between subclinical symptoms and well-being in the residual phase of pediatric affective disorders.

8.4 The Role of Well-being in Clinical Practice with Children and Adolescents

Traditional therapeutic protocols share common ingredients, with the aim to modify dysfunctional cognitions and attitudes, increasing new coping skills strategies and changing unrewarding or avoidant behavioral patterns through both cognitive and behavioral techniques. Cognitive ingredients comprise psycho-education,

self-monitoring (somatic reactions included), general modification of dysfunctional thinking; coping skills strategies. Behavioral techniques may be used to correct misperceptions and maladaptive cognitions through modeling, exposure, relaxation training and role-playing. The specific target of cognitive restructuring may vary across disorders but replacing maladaptive thoughts with more functional thinking is a common goal (Kendall et al. 2003; Clarke et al. 2003; Chu and Harrison 2007; Spielmans et al. 2007). Thus, successful CBT would be expected to engender positive change in cognitive processing including the decrease of negative automatic thoughts, maladaptive attitudes and assumptions, and threat interpretations. Relapse prevention is another important issue taken into account during the final phases of the therapy, but it seems to be accomplished only promoting the generalization of reached goals to different situations and encouraging to continue with self-observation, exposure and auto-therapy. Also when considering IPT-A protocol for depressed adolescent (where relapse and recurrence are frequent), the therapy ends with the generalization of skills to future situations, in order to reduce possible risks of relapses.

In spite of the encouraging outcomes of evidence-based CBT protocols, literature shows also other important issues: a large percentage of children treated with psychotherapy (especially depressed children) do not respond to the treatment; within responders a significant percentage does not achieve remission or reports residual symptomatology (impaired school performance insomnia, irritability, low self-esteem, and appetite changes; Tao et al. 2010). Cross-cultural investigations also reported relapse rates ranging from 12 % within 1 year and 33 % within 4 years (Lewinsohn et al. 1994; Stewart et al. 2004). APA Working Group (2006) reports that the specific advantages of available treatments (psychosocial or psychopharmacological), especially for depressed youth, are small compared with the non-specific effects of placebo and other supportive comparison treatments. These unsatisfactory outcomes suggest that mental illness has to be considered and treated in a more complex manner, particularly in pediatric setting, addressing specifically psychological well-being and positive functioning, essential factors in determining remission of affective disorders (Fava 1996; Fava et al. 2007). The integration of approaches meets the growing trends aimed to a sequential implementation of different active psychotherapeutic ingredients (Karwoski et al. 2006), in different moments of the therapy (e.g. CBT precedes WBT) (Fava et al. 2005; Fava and Tomba 2010), going over the old concept of "monotherapy", which results simplistic and insufficient to lead to a complete remission of symptoms (Fava et al. 2008). Studies suggest that specific treatment of residual symptoms may improve the longitudinal development of the disorder by acting on the potential prodromes of relapse (Fava 1999) and strengthen youth's psychological well-being could be a good strategy to this end. Younger individuals should be encouraged to devote more effort and commitment in order to build up positive psychological functioning, therefore, practitioners should be encouraged to incorporate elements of positive psychology into their clinical work (Joseph and Linley 2006).

8.4.1 Positive Interventions

In recent years several studies has documented the effect of new therapeutic approaches in the treatment of affective disorders in adults, which aim to cultivate positive cognitions, feelings, behaviors, and to build strengths, where happiness is an explicit goal of the therapy (Seligman et al. 2006; Rashid 2009) and the outcomes are even more encouraging (Joseph and Linley 2006). The key features of all these so called Positive Psychology Interventions (PPIs) include positive behaviors (like engaging in enjoyable activities and using personal strengths in new ways), cognitive strategies (such as replaying positive experiences and self-monitoring instances of well-being) and the practice of emotional skills. Because of the relatively recent development of Positive Psychology, the majority of investigations were conducted on adult population and only few studies analyzed the effects of PPI in youth. A recent meta-analysis (Sin and Lyubomirsky 2009) of 51 interventions was carried out with the aim to verify if PPI could enhance well-being and ameliorate depressive symptoms. The results revealed that positive psychology interventions do indeed significantly enhance well-being and decrease depressive symptoms with medium-sized effects. However, analyzing the studies considered in the meta-analyses, only 3 of them pertained to child and adolescent up to 17 years old (Rashid et al. 2006; Ruini et al. 2006; Froh et al. 2008) and two of them were performed in school settings (Ruini et al. 2006; Froh et al. 2008). Actually, the majority of positive interventions for children has a preventive purpose and is addressed to a non-clinical population, particularly in school settings (Tomba et al. 2010; Brunwasser et al. 2009; Ruini et al. 2006, 2009; Wyman et al. 2004, 2010; McGrath and Noble 2003; Patton et al. 2003; Shochet et al. 2001; Greenberg et al. 1995). These school interventions are analyzed in details in the subsequent chapters of this book (Chaps. 9, 10, 11, 12 and 13). All other positive interventions for children and adolescents resulted from recent literature, pertained to preventive interventions (see Merry et al. 2011 for a review) or specific for high risk teens (Campbell-Heider et al. 2009). To date, there is still a paucity of studies on the treatment of psychological disturbances in youth from a positive psychology perspective. As for adults, recent trends in youth psychotherapy emphasize the role of mindfulness (a non-judgmental awareness of the present moment), acceptance (the ability to view previously inacceptable thoughts, emotions and behaviors as valid, given a particular context) and values as basic ingredients of new psychotherapeutic approaches (Hayes et al. 2004; Burke 2009). The goal of these techniques is not only the change of problematic thoughts and emotions (as in traditional CBT), but rather the acceptance of them for what they are. According to this approach, patients could improve their feelings because they may change their relation to their thoughts, balancing acceptance and change, in a dialectical way (Linehan 1993; O'Brien et al. 2008). Conceptual and empirical researches suggest that this new line of intervention can be adapted for children and adolescents in a variety of populations and settings, in effective ways (Semple et al. 2005; Murrell and Scherbarth 2006; Greco and Hayes 2008; Saltzman and Goldin 2008; Liehr

and Diaz 2010). However, studies are only in their early stage and much work remain to be done in empirically evaluating the effectiveness of these new approaches with youth, particularly in clinical settings.

8.5 A Sequential Treatment Strategy for Youth: *Child-Well-being Therapy*

According to recent findings about the superiority of sequential treatments compared to monotherapy or combination therapy for affective disorders, a conceptual innovation in the treatment of affective disorders has been proposed: Well-being Therapy (WBT), an innovative psychotherapeutic strategy for enhancing well-being in addition to cognitive-behavioral packages (for a complete description of the sequential model and WBT see Chap. 2 in this book, Fava and Ruini 2003; Fava et al. 2005; Ruini and Fava 2009). Recently a modified form of WBT has been developed for being applied in pediatric clinical setting and its feasibility has been tested in an open clinical trial (Albieri et al. 2009, 2011) with encouraging outcomes.

Starting from the WBT-School Program protocol (described in Chap. 11), Child-WBT has been developed and tested on a small sample of patients (Albieri et al. 2009, 2011). Considering the specific features of the protocol, positive and negative emotions are discussed from the beginning, but in the first sessions more attention was given to negative emotions, whereas in the remaining sessions the focus was upon the enhancement of psychological well-being, according to Ryff's model (1989) and proposed in a sequential format (Fava et al. 2005).

Successively, the preliminary version of the protocol was refined (as illustrated in Box 8.1) and tested on a small sample of young patients reporting affective disorders and behavioral problems. Children (14 male and 2 female) were referred to a Neuropsychiatric Service in the North-East of Italy. The age ranged from 7 to 14 years (M = 10,13; DS = 1,784). None of them were receiving pharmacological treatment. At the intake, diagnoses and symptoms severity were established by two clinical psychologists, who were not involved in the treatment, using the Schedule for Affective Disorders and Schizophrenia for School Age Children -Present and Lifetime Version (K-SADS-PL) (Kaufman et al. 1997) and the Kellner's global rating scales for illness severity (GSIS) (Kellner 1972).

The protocol consisted of 12, 1-h sessions, once a week. Two additional sessions were addressed to parents immediately before and after the intervention, therefore the clinical psychologists who performed the therapy met the patients' family in order to explain the aims of the intervention and underline the importance of parents' support and collaboration during all the time of the therapy. Then, at the end of the therapy, parents received a feed-back from the therapist about the whole experience and some important advices on how to help the child to keep the reached

Box 8.1 Protocol of Well-being Therapy for Children

The protocol consists of 12, 1-h sessions, which were held once a week. Child-WBT was based on the interaction between child and therapist using games, role-playing and involved the use of a diary during each session with specific homework assignments. Two sessions were also addressed to parents (at the beginning and at the end of child's therapy).

Parent training

Sessions

1–2. Child- Assessment

3. The child is trained to identify, recognize and express a wide variety of emotions, both positive and negative, by face expressions or body gestures. Through role-playing the child is encouraged to communicate his/her emotions to the therapist in an assertive way.

4. Focus on the link between emotions and behaviours, including physical symptoms for facilitating considerations on how all these feelings could influence our behaviors.

5. Relationship between thoughts and emotions, according to the cognitive model. Child is trained to the self-observation in a diary and is asked to report his/her daily situations (at school, with friends, with parents) for helping him/her realize that the way he/she interprets situations can influence his/her emotions.

6. Cognitive restructuring according to CBT model. Child learns how to identify and differentiate negative/dysfunctional thoughts and helpful ones, taking examples from his/her daily activities. Finally child is instructed to recognize cognitive errors and correct them with alternative, more positive and realistic interpretations.

7–8. Focus on Self-Acceptance and Positive Relations: child is asked to recognize his/her positive and negative personal characteristics and to consider that everyone has virtues and faults. Then child is invited to remember and report in the diary some compliments received in the past and is encouraged to pay compliment to friends (homework). This allowed child to reflect on how could be difficult to be nice with someone, but also how receiving an unexpected compliment could be gratifying.

9–10. Autonomy (perception of one's skills and abilities) and Purpose in Life (objectives to be reached in the future): child is asked to reflect both on abilities he already possess and the ones he would like to develop. Child is also invited to write down a story about future plans (social activities, school, sports and leisure time) reflecting on how to reach those goals learning easy problem-solving strategies. Furthermore, child is helped to recognize some personal strengths he possess and he could rely on.

(continued)

Box 8.1 (continued)

11. Happiness and emotional well-being: child is asked to think and share with the therapist some important and positive moments he/she has experienced during the life. Child is also trained to recognize daily moments of well-being, writing them on the diary.
12. Assessment and final general advices about how to make children's life happier.

Parent training

goals were also provided. Children have shown to appreciate the proposed activities a lot, suggesting a good feasibility of the protocol. Only 3 patients dropped-out from treatment after few sessions, because of families' difficulties.

After Child-WBT intervention and at 1-year follow-up, children were reassessed using K-SADS-PL and patients' treatment response was evaluated using Kellner's global rating scale for change after treatment (GSC) (Kellner 1972). Pre-post and follow-up data showed a change in children's clinical status during the time. According to clinicians' evaluations, symptoms severity significantly improved both at post-treatment and at 1-year follow-up, in fact K-SADS criteria were no more satisfied in the 62 % of completers. Even when residual symptoms were still present, relevant positive changes were noticed and reported also by parents and teachers in terms of school performances, social functioning and interpersonal behaviors and competences.

Further studies with adequate controls, more appropriate and sensitive assessment tools and long-term follow-up are now under evaluation by the Italian research group. This is the first study targeted to the improvement of optimal functioning in children, according to a eudaimonic perspective. As in adults, cultivating positive emotions, latent strengths and competencies seems to produce promising results also in young patients. Important clinical implications are emerging and the feasibility of the children version of WBT, if confirmed by the studies, might represent a very useful tool for pediatric settings.

8.6 Conclusions

Rates of remission and recovery in children and adolescents with affective disorders call for a more accurate definition, taking into account also subclinical symptomatology and encompassing psychological well-being, with important implications for clinical treatment and long-term outcomes (Fava 1999).

Recently, researchers in pediatric settings have called for a shift toward positive experiences, positive individual traits and eudaimonic well-being, examining also the mediators, moderators and predictors of treatment outcomes.

This approach, goes beyond the evaluation of the degree to which a treatment works and moves toward the examination of when, why and for whom it works (Weisz and Jensen 1999; Benjamin et al. 2011), considering also cultural differences (Canino and Alegría 2008). Positive characteristics as life satisfaction and strengths of character vary little across gender, ethnicity, and social class, as well as the prevalence of psychological disorders varies considerably as a function of these contrasts, which means that they cannot be neglected in future research. Promoting optimal human and social functioning with children and adolescents could be particularly feasible, promising and may entail long term benefits (Joseph and Wood 2010), developing important protective factors in the face of future challenges and adversities.

References

Albieri, E., Visani, D., Offidani, E., Ottolini, F., & Ruini, C. (2009). Well-being therapy in children with emotional and behavioral disturbances: A pilot investigation. *Psychotherapy and Psychosomatics, 78*, 387–390.

Albieri, E., Visani, D., Ottolini, F., Vescovelli, F., & Ruini, C. (2011). The use of well-being therapy in childhood: Clinical cases [Article in Italian]. *Rivista di Psichiatria, 46*, 265–272. doi:10.1708/931.10207.

Angst, J. (2007). The bipolar spectrum. *British Journal of Psychiatry, 190*, 189–191.

APA – American Psychological Association Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically validated psychological treatments: Report and recommendations. *Clinical Psychology, 48*, 3–23.

APA – Working Group on Psychoactive Medications for Children and Adolescents. (2006). *Report of the working group on psychoactive medications for children and adolescents. Psychopharmacological, psychosocial, and combined interventions for childhood disorders: Evidence base, contextual factors, and future directions*. Washington, DC: American Psychological Association. http://www.apa.org/pi/cyf/childmeds.pdf

Arias, E., MacDorman, M. F., Strobino, D. M., & Guyer, B. (2003). Annual summary of vital statistics-2002. *Pediatrics, 112*, 1215–1230.

Barrett, P. M. (2004). *FRIENDS for life program_group leaders workbook for children* (4th ed.). Brisbane: Australian Academic Press.

Barrett, P. M. (2005). *FRIENDS for life program_group leaders workbook for youth* (4th ed.). Brisbane: Australian Academic Press.

Beesdo, K., Bittner, A., Pine, D. S., Stein, M. B., Höfler, M., Lieb, R., et al. (2007). Incidence of social anxiety disorder and the consistent risk for secondary depression in the first three decades of life. *Archives of General Psychiatry, 64*, 903–912.

Beesdo, K., Knappe, S., & Pine, D. S. (2009). Anxiety and anxiety disorders in children and adolescents: Developmental issues and implications for DSM-V. *Psychiatric Clinics of North America, 32*, 483–524.

Beesdo, K., Pine, D. S., Lieb, R., & Wittchen, H. U. (2010). Incidence and risk patterns of anxiety and depressive disorders and categorization of generalized anxiety disorder. *Archives of General Psychiatry, 67*, 47–57.

Beidel, D. C., Turner, S. M., & Morris, T. L. (2000). Behavioral treatment of childhood social phobia. *Journal of Consulting and Clinical Psychology, 68*, 1072–1080.

Belfer, M. L., & Nurcombe, B. (2007). The epidemiology and burden of child and adolescents mental disorders. In H. Remschmidt, B. Nurcombe, M. L. Belfer, N. Sartorius, & A. Okasha (Eds.), *The mental health of children and adolescents: An area of global neglect* (pp. 27–42). Chichester: Wiley.

Benjamin, C. L., Puleo, C. M., Settipani, C. A., Brodman, D. M., Edmunds, J. M., Cummings, C. M., et al. (2011). History of cognitive-behavioral therapy in youth. *Child and Adolescent Psychiatric Clinics of North America, 20*, 179–189.

Benjet, C. (2010). Childhood adversities of populations living in low-income countries: Prevalence, characteristics, and mental health consequences. *Current Opinion in Psychiatry, 23*(4), 356–362.

Bittner, A., Egger, H. L., Erkanli, A., Jane Costello, E., Foley, D. L., & Angold, A. (2007). What do childhood anxiety disorders predict? *Journal of Child Psychology and Psychiatry, 48*, 1174–1183.

Brent, D., Emslie, G., Clarke, G., Wagner, K. D., Asarnow, J. R., Keller, M., et al. (2008). The treatment of adolescents with SSRI-resistant depression (TORDIA): A comparison of switch to venlafaxine or to another SSRI, with or without additional cognitive behavioral therapy. *Journal of the American Medical Association, 299*, 901–913.

Bridge, J. A., Iyengar, S., Salary, C. B., Barbe, R. P., Birmaher, B., Pincus, H. A., et al. (2007). Clinical response and risk for reported suicidal ideation and suicide attempts in pediatric antidepressant treatment: A meta-analysis of randomized controlled trials. *Journal of the American Medical Association, 297*, 1683–1696.

Brunstein Klomek, A., & Stanley, B. (2007). Psychosocial treatment of depression and suicidality in adolescents. *CNS Spectrums, 12*(2), 135–144.

Brunwasser, S. M., Gillham, J. E., & Kim, E. S. (2009). A meta-analytic review of the Penn Resiliency Program's effect on depressive symptoms. *Journal of Consulting and Clinical Psychology, 77*, 1042–1054.

Burke, A. C. (2009). Mindfulness-based approaches with children and adolescents: A preliminary review of current research in an emergent field. *Journal of Child and Family Studies*. doi:10.1007/s10826-009-9282-x.

Caffo, E., Belaise, C., & Forresi, B. (2008). Promoting resilience and psychological well-being in vulnerable life stages. *Psychotherapy and Psychosomatics, 77*, 331–336.

Campbell-Heider, N., Tuttle, J., & Knapp, T. R. (2009). The effect of positive adolescent life skills training on long term outcomes for high-risk teens. *Journal of Addictions Nursing, 20*, 6–15.

Canino, G., & Alegría, M. (2008). Psychiatric diagnosis – Is it universal or relative to culture? *Journal of Child Psychology and Psychiatry, 49*(3), 237–250.

Chavira, D. A., Stein, M. B., Bailey, K., & Stein, M. T. (2004). Child anxiety in primary care: Prevalent but untreated. *Depression and Anxiety, 20*, 155–164.

Chu, B. C., & Harrison, T. L. (2007). Disorder-specific effects of CBT for anxious and depressed youth: A meta-analysis of candidate mediators of change. *Clinical Child and Family Psychology Review, 10*, 352–372.

Clarke, G. N., Rohde, P., Lewinsohn, P. M., Hops, H., & Seeley, J. R. (1999). Cognitive-behavioral treatment of adolescent depression: Efficacy of acute group treatment and booster sessions. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 272–279.

Clarke, G. N., Debar, L. L., & Lewinsohn, P. M. (2003). Cognitive–behavioral group treatment for adolescent depression. In A. E. Kazdin (Ed.), *Evidenced-based psychotherapies for children and adolescents* (pp. 120–134). New York: Guilford Press.

Compton, S. N., March, J. S., Brent, D., Albano, A. M., Weersing, V. R., et al. (2004). Cognitive-behavioral psychotherapy for anxiety and depressive disorders in children and adolescents: An evidence-based medicine review. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 930–959.

Compton, S. N., Walkup, J. T., Albano, A. M., Piacentini, J. C., Birmaher, B., Sherril, J. T., et al. (2010). Child/adolescent anxiety multimodal study (CAMS): Rationale, design, and methods. *Child and Adolescent Psychiatry and Mental Health, 4*, 1–15.

Costello, J., Egger, H., & Angold, A. (2005). A 10-year research update review: The epidemiology of child and adolescent psychiatric disorders: Methods and public health burden. *Journal of the American Academy of Child and Adolescent Psychiatry, 44*, 972–986.

Costello, J., Erkanli, A., & Angold, A. (2006). Is there an epidemic of child or adolescent depression? *Journal of Child Psychology and Psychiatry, 47*, 1263–1271.

David-Ferdon, C., & Kaslow, N. J. (2008). Evidence-based psychosocial treatments for child and adolescent depression. *Journal of Clinical Child and Adolescent Psychology, 37*, 62–104.

Dubicka, B., Elvins, R., Roberts, C., Chick, G., Wilkinson, P., & Goodyer, I. M. (2010). Combined treatment with cognitive-behavioural therapy in adolescent depression: Meta-analysis. *British Journal of Psychiatry, 197*, 433–440.

Elmquist, J. M., Melton, T. K., Croarkin, P., & McClintock, S. M. (2010). A systematic overview of measurement-based care in the treatment of childhood and adolescent depression. *Journal of Psychiatric Practice, 16*, 217–234.

Emslie, G. J., Heiligenstein, J. H., Hoog, S. L., Wagner, K. D., Findling, R. L., McCracken, J. T., et al. (2004). Fluoxetine treatment for prevention of relapse of depression in children and adolescents: A double-blind, placebo controlled study. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 1397–1405.

Emslie, G. J., Kennard, B. D., Mayes, T. L., et al. (2008). Fluoxetine versus placebo in preventing relapse of major depression in children and adolescents. *American Journal of Psychiatry, 165*, 459–467.

Emslie, G. J., Mayes, T., Porta, G., Vitiello, B., Clarke, G., Wagner, K. D., et al. (2010). Treatment of resistant depression in adolescents (TORDIA): Week 24 outcomes. *American Journal of Psychiatry, 167*, 782–791.

Eyberg, S. M., Nelson, M. M., & Boggs, S. R. (2008). Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child & Adolescent Psychology, 37*, 215–237.

Fava, G. A. (1996). The concept of recovery in affective disorders. *Psychotherapy and Psychosomatics, 65*, 2–13.

Fava, G. A. (1999). Subclinical symptoms in mood disorders: Pathophysiological and therapeutic implications. *Psychological Medicine, 29*, 47–61.

Fava, G. A. (2012). The clinical role of psychological well-being. *World Psychiatry, 11*(2), 102–103.

Fava, G. A., & Kellner, R. (1993). Staging: A neglected dimension in psychiatric classification. *Acta Psychiatrica Scandinavica, 87*, 225–230.

Fava, G. A., & Ruini, C. (2003). Development and characteristics of a well-being enhancing psychotherapeutic strategy: Well-being therapy. *Journal of Behavior Therapy and Experimental Psychiatry, 34*, 45–63.

Fava, G. A., & Tomba, E. (2010). New modalities of assessment and treatment planning in depression: The sequential approach. *CNS Drugs, 24*, 453–465.

Fava, G. A., Rafanelli, C., Cazzaro, M., Conti, S., & Grandi, S. (1998). Well-being therapy. A novel psychotherapeutic approach for residual symptoms of affective disorders. *Psychological Medicine, 28*, 475–480.

Fava, G. A., Ruini, C., & Rafanelli, C. (2005). Sequential treatment of mood and anxiety disorders. *Journal of Clinical Psychiatry, 66*, 1392–1400.

Fava, G. A., Ruini, C., & Belaise, C. (2007). The concept of recovery in major depression. *Psychological Medicine, 37*, 307–317.

Fava, G. A., Park, S. K., & Dubovsky, S. L. (2008). The mental health clinic: A new model. *World Psychiatry, 7*, 177–181.

Fayyad, J. A., Jahshan, C. S., & Karam, E. G. (2001). Systems development of child mental health services in developing countries. *Child and Adolescent Psychiatric Clinics of North America, 10*, 745–763.

Flament, M. F., Nguyen, H., Furino, C., Schachter, H., MacLean, C., Wasserman, D., et al. (2007). Evidence-based primary prevention programmes for the promotion of mental health in children and adolescents: A systematic worldwide review. In H. Remschmidt, B. Nurcombe, M. L. Belfer, N. Sartorius, & A. Okasha (Eds.), *The mental health of children and adolescents: An area of global neglect* (pp. 65–135). Chichester: Wiley.

Flannery-Schroeder, E. C., & Kendall, P. C. (2000). Group and individual cognitive-behavioral treatment for youth with anxiety disorders: A randomized control trial. *Cognitive Therapy and Research, 24*, 251–278.

Frank, E., Prien, R. F., Jarret, R. B., Keller, M. B., Kupfer, D. J., Lavori, P. W., et al. (1991). Conceptualization and rationale for consensus definitions of terms in major depressive disorder. *Archives of General Psychiatry, 48*, 851–855.

Froh, J. J., Sefick, W. J., & Emmons, R. A. (2008). Counting blessings in early adolescents: An experimental study of gratitude and subjective well-being. *Journal of School Psychology, 46*, 213–233.

Gerber, W. D., Petermann, F., Gerber-Von Müller, G., Dollwet, M., Darabaneanu, S., Niederberger, U., et al. (2010). MIPAS-family—evaluation of a new multi-modal behavioral training program for pediatric headaches: Clinical effects and the impact on quality of life. *The Journal of Headache and Pain, 11*, 215–225. doi:10.1007/s10194-010-0192-5.

Ginsburg, G. S., Kendall, P. C., Sakolsky, D., Compton, S. N., Piacentini, J., Albano, A. M., et al. (2011). Remission after acute treatment in children and adolescents with anxiety disorders: Findings from the CAMS. *Journal of Consulting and Clinical Psychology, 79*, 806–813.

Goodyer, I., Dubicka, B., Wilkinson, P., Kelvin, R., Roberts, C., Byford, S., et al. (2007). Selective serotonin reuptake inhibitors (SSRIs) and routine specialist care with and without cognitive behaviour therapy in adolescents with major depression: Randomized controlled trial. *British Medical Journal, 335*, 142–146. doi:10.1136/bmj.39224.494340.55.

Gould, M. S., Velting, D., Kleinman, M., Lucas, C., Thomas, J. G., & Chung, M. (2004). Teenagers' attitudes about coping strategies and help-seeking behavior for suicidality. *Journal of the American Academy of Child and Adolescent Psychiatry, 43*, 1124–1133.

Greco, L. A., & Hayes, S. C. (2008). *Acceptance and mindfulness interventions for children adolescents and families*. Oakland: Context Press/New Harbinger.

Greenberg, M. T., Kusche, C. A., Cook, E. T., & Quamma, J. P. (1995). Promoting emotional competence in school-aged children: The effects of the PATHS curriculum. *Development and Psychopathology, 7*, 17–136.

Harington, R., Whittaker, J., & Shoebridge, P. (1998). Psychological treatment of depression in children and adolescents: A review of treatment research. *British Journal of Psychiatry, 173*, 291–298.

Hayes, S. C., Masuda, A., Bissett, R., Luoma, J., & Guerrero, L. F. (2004). DBT, FAP and ACT: How empirically oriented are the new behavior therapy technologies? *Behavior Therapy, 35*, 35–54.

In-Albon, T., & Schneider, S. (2007). Psychotherapy of childhood anxiety disorders: A meta-analysis. *Psychotherapy and Psychosomatics, 76*, 15–24.

Ipser, J. C., Stein, D. J., Hawkrldge, S., & Hoppe, L. (2009). Pharmacotherapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews, 3*, Art. no. CD005170.

ISP – The Integrated Services Programme Task Force. (2007). Disseminating child and adolescents mental health treatment methods: An international feasibility study. In H. Remschmidt, B. Nurcombe, M. L. Belfer, N. Sartorius, & A. Okasha (Eds.), *The mental health of children and adolescents: An area of global neglect* (pp. 43–50). Chichester: Wiley.

James, A., Soler, A., & Weatherall, R. (2005). Cognitive behavioural therapy for anxiety disorders in children and adolescents. *Cochrane Database of Systematic Reviews, 4*, CD004690. doi:10.1002/14651858.CD004690.pub2.

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

Joseph, S., & Wood, A. (2010). Assessment of positive functioning in clinical psychology: Theoretical and practical issues. *Clinical Psychology Review, 30*, 830–838.

Karwoski, L., Garratt, G. M., & Ilardi, S. S. (2006). On the integration of cognitive-behavioral therapy for depression and positive psychology. *Journal of Cognitive Psychotherapy, 20*, 159–170.

Kaufman, J., Birmaher, B., Brent, D., Rao, U., Flynn, C., Moreci, P., et al. (1997). Schedule for affective disorders and schizophrenia for school-age children – present and lifetime version (KSADS-PL): initial reliability and validity data. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 980–988.

Kellner, R. (1972). Improvement criteria in drug trials with neurotic patients. Part 2. *Psychological Medicine, 2*, 73–80.

Kendall, P. C., & Hedtke, K. A. (2006). *Coping cat workbook* (2nd ed.). Ardmore: Workbook.

Kendall, P. C., & Pimental, S. S. (2003). On the psychological symptom constellation in youth with Generalized Anxiety Disorder (GAD). *Journal of Anxiety Disorders, 17*, 211–221.

Kendall, P. C., Choudhury, M. S., Hudson, J. L., & Webb, A. (2002). *The C.A.T. project*. Ardmore: Workbook.

Kennard, B., Silva, S., Vitiello, B., Curry, J., Kratochvil, C., Simons, A., et al. (2006). Remission and residual symptoms after short-term treatment in the Treatment of Adolescents with Depression Study (TADS). *Journal of the American Academy of Child and Adolescent Psychiatry, 45*, 1404–1411.

Kennard, B. D., Emslie, G. J., Mayes, T. L., Nightingale-Teresi, J., Nakonezny, P. A., Hughes, J. L., et al. (2008). Cognitive-behavioral therapy to prevent relapse in pediatric responders to pharmacotherapy for major depressive disorder. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*, 1395–1404.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age of-unset of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593–602.

Keyes, C. L. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American Psychologist, 62*, 95–108.

Khanna, M., & Kendall, P. C. (2007). New frontiers: Computer technology in the treatment of anxious youth. *Behavior Therapy, 30*, 22–25.

Kroll, L., Harrington, R., Jayson, D., Fraser, J., & Gowers, S. (1996). Pilot study of continuation cognitive-behavioral therapy for major depression in adolescent psychiatric patients. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1156–1161.

Latzman, R. D., Naifeh, J. A., Watson, D., Vaidya, J. G., Heiden, L. J., Damon, J. D., et al. (2011). Racial differences in symptoms of anxiety and depression among three cohorts of students in the southern United States. *Psychiatry, 74*, 332–348.

Layard, R. (2006). The case for psychological treatment centres. *British Medical Journal, 332*, 1030–1032.

Lewinsohn, P. M., & Clarke, G. N. (1999). Psychosocial treatments for adolescent depression. *Clinical Psychology Reviews, 19*, 329–342.

Lewinsohn, P. M., Clarke, G. N., Seeley, J. R., & Rohde, P. (1994). Major depression in community adolescents: Age at onset, episode duration, and time to recurrence. *Journal of the American Academy of Child and Adolescent Psychiatry, 33*, 809–818.

Liehr, P., & Diaz, N. (2010). A pilot study examining the effect of mindfulness on depression and anxiety for minority children. *Archives of Psychiatric Nursing, 24*, 69–71.

Lin, K. M., Poland, R. E., & Nakasaki, G. (1993). *Psychopharmacology and psychobiology of ethnicity*. Washington, DC: American Psychiatric Press.

Linehan, M. M. (1993). *Cognitive behavioral treatment of borderline personality disorder*. New York: Guilford.

McGrath, H., & Noble, T. (2003). *BOUNCE BACK! A classroom resiliency program for schools*. Sydney: Pearson Education.

Merikangas, K. R., Nakamura, E. F., & Kessler, R. C. (2009). Epidemiology of mental disorders in children and adolescents. *Dialogues in Clinical Neuroscience, 11*, 7–20.

Merry, S. N., Hetrick, S. E., Cox, G. R., Brudevold-Iversen, T., Bir, J. J., & McDowell, H. (2011). Psychological and educational interventions for preventing depression in children and adolescents. *Cochrane Database Systematic Review,* CD003380.

Michael, K. D., & Crowley, S. L. (2002). How effective are treatments for child and adolescent depression? A meta-analytic review. *Clinical Psychology Reviews, 22*, 247–269.

Mufson, L., & Fairbanks, J. (1996). Interpersonal psychotherapy for depressed adolescents: A one-year naturalistic follow- up study. *Journal of the American Academy of Child and Adolescent Psychiatry, 35*, 1145–1155.

Mufson, L., Moreau, D., Weissman, M. M., Wickramaratne, P., Martin, J., & Samoilov, A. (1994). Modification of interpersonal psychotherapy with depressed adolescents (IPT-A):

Phase I and II studies. *Journal of the American Academy of Child and Adolescent Psychiatry, 33*, 695–705.

Mufson, L., Weissman, M. M., Moreau, D., & Garfinkel, R. (1999). Efficacy of interpersonal psychotherapy for depressed adolescents. *Archives of General Psychiatry, 56*, 573–579.

Muñoz, C., & Hilgenberg, C. (2005). Ethnopharmacology. *American Journal of Nursing, 105*, 40–48. Report of the Working Group on Psychotropic Medications.

Murrell, A., & Scherbarth, A. (2006). State of the research & literature address: Act with children, adolescents and parents. *International Journal of Behavioral Consultation and Therapy, 2*, 13.

O'Brien, K. M., Larson, C. M., & Murrell, A. R. (2008). Third-wave behavior therapies for children and adolescents: Progress, challenges, and future directions. In L. A. Greco & S. C. Hayes (Eds.), *Acceptance & mindfulness interventions for children & adolescents* (pp. 15–35). Oakland: New Harbinger Publications, Inc.

Ollendick, T. H., & King, N. J. (2004). Empirically supported treatments for children and adolescents: Advances toward evidence-based practice. In P. M. Barrett & T. H. Ollendick (Eds.), *Handbook of interventions that work with children and adolescents: Prevention and treatment* (pp. 3–25). West Sussex: Wiley.

Patel, V., Flisher, A. J., Hetrick, S., & Mcgorry, P. (2007). Mental health of young people: A global public-health challenge. *Lancet, 369*, 1302–1313.

Patton, G., Franz, M. D., Bond, L., Butler, H., & Glover, S. (2003). Changing schools, changing health? Design and implementation of the gatehouse project. *Journal of Adolescent Health, 33*, 231–239.

Pediatric OCD Treatment Study (POTS) Team. (2004). Cognitive-behavior therapy, sertraline, and their combination for children and adolescents with obsessive-compulsive disorder: The pediatric OCD treatment study (POTS) randomized controlled trial. *Journal of the American Medical Association, 292*, 1969–1976.

Poznanski, E., & Mokros, H. (1996). *Children's Depression Rating Scale-Revised (CDRS-R)*. Los Angeles: Western Psychological Services.

Rapee, R. M., Schniering, C. A., & Hudson, J. L. (2009). Anxiety disorders during childhood and adolescence: Origins and treatment. *Annual Review of Clinical Psychology, 5*, 311–341.

Rashid, T. (2009). Positive interventions in clinical practice. *Journal of Clinical Psychology, 65*, 461–466.

Rashid, T., Anjum, A., & Lennox, C. (2006). Positive psychotherapy for middle school children. Unpublished manuscript, Toronto District School Board. Results presented in: Rashid, T., & Anjum, A. (2008). Positive psychotherapy for young adults and children. In J. R. Z. Abela & B. L. Hankin (Ed.), *Handbook of depression in children and adolescents* (pp. 250–287). New York: Guilford Press.

Reinecke, M. A., Ryan, N. E., & DuBois, D. L. (1998). Cognitive-behavioral therapy of depression and depressive symptoms during adolescence: A review and meta-analysis. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*, 26–34.

Rossellò, J., & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal treatments for depression in Puerto Rican adolescents. *Journal of Consulting and Clinical Psychology, 67*, 734–745.

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

Ruini, C., Belaise, C., Brombin, C., Caffo, E., & Fava, G. A. (2006). Well-being therapy in school settings: A pilot study. *Psychotherapy and Psychosomatics, 75*, 331–336.

Ruini, C., Ottolini, F., Tomba, E., Belaise, C., Albieri, E., Visani, D., et al. (2009). School intervention for promoting psychological well-being in adolescence. *Journal of Behavior Therapy and Experimental Psychiatry, 40*, 522–532.

Rutter, M. J. (2003). Categories, dimensions, and the mental health of children and adolescents. *Annals of the New York Academy of Sciences, 1008*, 11–21.

Ryff, C. D. (1989). Happiness is everything, or is it? Exploration on the meaning of psychological well-being. *Journal of Personality and Social Psychology, 6*, 1069–1081.

Sakolsky, D., & Birmaher, B. (2008). Pediatric anxiety disorders: Management in primary care. *Current Opinion in Pediatrics, 20*, 538–543.

Saltzman, A., & Goldin, P. (2008). Mindfulness based stress reduction for school-age children. In S. C. Hayes & L. A. Greco (Eds.), *Acceptance and mindfulness interventions for children adolescents and families* (pp. 139–161). Oakland: Context Press/New Harbinger.

Seligman, M. E. P., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist, 61*, 774–788.

Semple, R. J., Reid, E. F. G., & Miller, L. (2005). Treating anxiety with mindfulness: An open trial of mindfulness training for anxious children. *Journal of Cognitive Psychotherapy, 19*, 379–392.

Shochet, I. M., Dadds, M. R., Holland, D., Whitefield, K., Harnett, P. H., & Osgarby, S. M. (2001). The efficacy of a universal school-based program to prevent adolescent depression. *Journal of Clinical Child Psychology, 30*, 303–315.

Shortt, A. L., Barrett, P. M., & Fox, T. L. (2001). Evaluating the FRIENDS program: A cognitive-behavioral group treatment for anxious children and their parents. *Journal of Clinical Child Psychology, 30*, 525–535.

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

Spence, S. H. (2001). Prevention strategies. In M. W. Vasey & M. R. Dadds (Eds.), *The developmental psychopathology of anxiety*. New York: Oxford University Press.

Spielmans, G. I., Pasek, L. F., & McFall, J. P. (2007). What are the active ingredients in cognitive and behavioral psychotherapy for anxious and depressed children? A meta-analytic review. *Clinical Psychology Review, 27*, 642–654.

Stewart, S. M., Kennard, B. D., Lee, P. W., Hughes, C. W., Mayes, T. L., Emslie, G. J., et al. (2004). A cross-cultural investigation of cognitions and depressive symptoms in adolescents. *Journal of Abnormal Psychology, 113*, 248–257.

TADS Team. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association, 292*, 861–863.

TADS Team. (2007). The Treatment for Adolescents with Depression Study (TADS): Long-term effectiveness and safety outcomes. *Archives of General Psychiatry, 64*, 1132–1144.

Tao, R., Emslie, G. J., Mayes, T. L., Nakonezny, P. A., & Kennard, B. D. (2010). Symptom improvement and residual symptoms during acute antidepressant treatment in pediatric major depressive disorder. *Journal of Child and Adolescent Psychopharmacology, 20*, 423–430.

Tomba, E., Belaise, C., Ottolini, F., Ruini, C., Bravi, A., Albieri, E., et al. (2010). Differential effects of well-being promoting and anxiety-management strategies in a non-clinical school setting. *Journal of Anxiety Disorders, 24*, 326–333.

Toplak, M. E., Connors, L., Shuster, J., Knezevic, B., & Parks, S. (2008). Review of cognitive, cognitive-behavioral, and neural-based interventions for Attention-Deficit/Hyperactivity Disorder (ADHD). *Clinical Psychology Review, 28*, 801–823.

Tsuchiya, M., Kawakami, N., Ono, Y., Nakane, Y., Nakamura, Y., Tachimori, H., et al. (2009). Lifetime comorbidities between phobic disorders and major depression in Japan: Results from the World Mental Health Japan 2002–2004 survey. *Depression and Anxiety, 26*, 949–955.

Vitiello, B. (2009). Treatment of adolescent depression: What we have come to know. *Depression and Anxiety, 26*, 393–395.

Vitiello, B., & Swedo, S. (2004). Antidepressant medications in children. *New England Journal of Medicine, 350*, 1489–1491.

Vitiello, B., Emslie, G., Clarke, G., Wagner, K. D., Asarnow, J. R., Keller, M. B., et al. (2011). Long-term outcome of adolescent depression initially resistant to selective serotonin reuptake inhibitor treatment: A follow-up study of the TORDIA sample. *Journal of Clinical Psychiatry, 72*, 388–396.

Walkup, J. T., Albano, A. M., Piacentini, J., Birmaher, B., Compton, S. N., Sherrill, J. T., et al. (2008). Cognitive behavioral therapy, sertraline, or a combination in childhood anxiety. *New England Journal of Medicine, 359*, 2753–2766.

Watanabe, N., Churchill, R., Hunot, V., & Furukawa, T. A. (2004). Psychotherapy for depression in children and adolescents. *Cochrane Database of Systematic Reviews*, (4), Art. No.: CD005334. doi:10.1002/14651858.CD005334.

Weisz, J. R., & Jensen, P. S. (1999). Efficacy and effectiveness of child and adolescent psychotherapy and pharmacotherapy. *Mental Health Services Research, 1*, 125–157.

Weisz, J. R., McCarty, C. A., & Valeri, S. M. (2006). Effects of psychotherapy for depression in children and adolescents: A meta-analysis. *Psychological Bulletin, 132*, 132–149.

Whittington, C. J., Kendall, T., Fonagy, P., Cottrell, D., Cotgrove, A., & Boddington, E. (2004). Selective serotonin reuptake inhibitors in childhood depression: Systematic review of published versus unpublished data. *Lancet, 363*, 1341–1345.

WHO – The World Health Organization. (2001). *The world health report 2001: Mental health: New understanding, new hope*. http://www.who.int/whr/2001/en/whr01_en.pdf

WHO – The World Health Organization. (2003). *Investing in mental health*. http://www.who.int/mental_health/en/investing_in_mnh_final.pdf

WHO – The World Health Organization. (2004). Annex table 3 burden of disease in DALYs by cause, sex and mortality stratum in WHO Regions, a estimates for 2002. The World Health report.

Wyman, P. A., Cross, W., & Barry, J. (2004). Translating research on resilience into school-based prevention: Program components and preliminary outcomes from the Promoting Resilient Children Initiative (PRCI). In M. Weist & C. Clauss-Ehlers (Eds.), *Community planning to foster resilience in children*. New York: Kluwer Academic/Plenum Publishers.

Wyman, P. A., Cross, W., Hendricks Brown, C., Yu, Q., Tu, X., & Eberly, S. (2010). Intervention to strengthen emotional self-regulation in children with emerging mental health problems: Proximal impact on school behavior. *Journal of Abnormal Child Psychology, 38*, 707–720.

Chapter 9
Well-being and Resilience in School Settings

Toni Noble and Helen McGrath

9.1 Introduction

Many of the challenges that young people face today are much the same as those experienced by previous generations. These challenges include their search for identity and independence as they develop and grow from childhood, to adolescence and into adulthood. However young people today also face new challenges such as: higher levels of family break-up; family relocation and blended families; more pressure to complete higher levels of education; managing social media and cybersafety issues and for many in urbanised societies less connection or sense of belonging to their local community.

Over the last decade many countries have also experienced an increase in both natural and man-made disasters. Illustrative of these disasters is the 2001 terrorist attacks on the USA, the 2011 Japanese earthquake and tsunami, the 2011 New Zealand and Turkish earthquakes and a series of catastrophic bushfires and floods in Australia between 2009 and 2011. There have also been ongoing civil wars and conflicts in the Middle East, Africa and in other parts of the world and a worldwide global financial crisis that that began in 2008 and continues today. These challenges place great pressure on governments and their capacity to meet the needs of their people. There is a strong likelihood that many of these national and international events and circumstances will be either repeated or ongoing and significantly impact on every nation. This chapter explores the implications of these events on the well-being and resilience of young people.

T. Noble (✉)
School of Educational Leadership, Faculty of Education,
Australian Catholic University, Sydney, Australia
e-mail: Toni.noble@acu.edu.au

H. McGrath
School of Education, RMIT University, Melbourne, Australia
e-mail: helen.mcgrath@rmit.edu.au

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_9, © Springer Science+Business Media Dordrecht 2014

Recent statistics indicate that approximately one quarter of young people aged 16–24 in Australia experience mental health problems (ABS 2008) and these figures are similar to those identified in other Western democracies such as the USA (US Department of Health and Human Services 1999) and the UK (Weare 2009). The World Health Organization has estimated that neuropsychiatric disorders contribute to 13 % of the global burden of disease. In particular, depression is the third leading cause of disability among young people aged 15 years and over (WHO 2008, 2011). (see Chap. 8 of this book for more details on affective disturbances in developmental settings.)

These challenges and data have led to a widespread global interest from Governments in how educational policy and school practices can help children and young people develop resilience and a sense of well-being.

9.2 What Is Resilience?

Nearly all definitions of resilience refer to the capacity of the individual to demonstrate the personal strengths that are needed to cope with difficulties, hardship, challenge or adversity. Resilience has been described as *'the ability to persist, cope adaptively and bounce back after encountering change, challenges, setback, disappointments, difficult situations or adversity and to return to a reasonable level of well-being'* (McGrath and Noble 2003). It is also the *capacity to respond adaptively to difficult circumstances and still thrive* (McGrath and Noble 2011; NSSF 2011). A similar definition by (Ryff 2012) is that resilience is the maintenance, recovery or improvement in mental or physical health following challenge. To achieve psychological well-being and resilience Ryff strongly advocates the importance of an individual's capacity to successfully balance life's negatives with the positives; a message that underpins all of her six dimensions of well-being.

Fava and Sonino (2008) favour Ryff's definition because of its focus on health as more than the absence of disease and on wellness within a bio-psychosocial context. As described in Chap. 2 of this book, Fava's model of Well-being Therapy (Fava and Tomba 2009) is an intervention based on Ryff's model. It incorporates working with individuals to enhance self-regard, sense of purpose and autonomy, environmental mastery, quality relationships and personal growth. Of interest, Carver distinguishes between resilience and thriving, defining resilience as a homeostatic return to earlier levels of functioning whereas thriving is the capacity of an individual to function at a continuing higher level than before the adverse event (Carver 1968).

The construct of 'resilience' in childhood was identified more than four decades ago as a result of longitudinal research studies of 'at risk' children living under adverse conditions. Despite encountering many major life stressors and/or deprivation and hardship during their childhood and early teenage years, some children not only survived but, in many cases, actually thrived (Rutter 1985; Garmezy 1992; Werner and Smith 1992). The adoption of the resilience construct in schools

represents a significant shift from a deficit model of young people 'at risk' to prevention initiatives. A preventative approach focuses on teaching the personal skills of resilience to all students and developing in schools the school-based factors that are 'protective' and can help young people develop resilience.

Resilience is not only about dealing with major stressors or adversity. All young people require the attitudes and skills of 'bouncing back' to successfully manage everyday challenges. For school children this might be persevering on a difficult academic task, having the courage despite feeling anxious to tackle a typical school challenge such as presenting to the class for the first time, adapting to a step-family, resolving a fall-out with a friend, coping with not getting into a sporting team or relocating to a new house or school. Being resilient is also demonstrated by being proactive such as seeking new experiences and opportunities and taking well-considered risks. Risk taking is likely to mean some failures, setbacks and rejections but it also creates more opportunities for successes and the development of self respect and confidence.

9.3 What Is Student Well-being?

Governments or school systems that undertake initiatives in relation to student well-being need a robust and evidence-based definition of the construct to effectively guide educational policy and school practices. Naturally a child's family, home and community all significantly impact on a young person's well-being. However an educational perspective focuses on the actions that schools and teachers can take to enhance student well-being within a school context.

Although there are many definitions of well-being per se, a literature search revealed only three definitions of *student well-being* (Noble et al. 2008). One definition perceived student well-being as "a positive emotional state that is the result of a harmony between the sum of specific context factors on the one hand and the personal needs and expectations towards the school on the other hand" (Engels et al. 2004, p. 128); another simply defined student well-being as *"the degree to which a student feels good in the school environment"* (De Fraine et al. 2005); and the third definition focused on student well-being as "*the degree to which a student is functioning effectively in the school community*" (Fraillon 2004). None of these definitions provide specific guidelines for school practices.

In order to develop an operational definition of student well-being 26 key people working in the field of well-being and/or student well-being from a range of countries including Australia, Denmark, United Kingdom, Italy, New Zealand, Portugal and the USA were invited to give feedback on a proposed definition of student well-being using Delphi methodology. There was significant but not total agreement amongst the experts on the final definition (Noble et al. 2008) which is:

> Optimal (or desirable) well-being is characterised by (predominantly) positive feelings and attitude, positive relationships with other students and teachers, resilience, self optimisation, and a high level of satisfaction with their learning experiences at school.

The constructs of well-being and resilience are closely linked and bi-directional. Most definitions of well-being incorporate some reference, either explicit or implied, to the capacity of the individual to be resilient and resilient students are more likely to have optimal levels of well-being. Research indicates that a student with an optimal level of well-being is more likely to have higher levels of school attendance, demonstrate age-appropriate academic skills, more pro-social behaviour and be less likely to bully others (Noble et al. 2008).

9.4 What Works?

School systems, governments and policy makers are increasingly focusing on the role of coordinated educational initiatives in promoting mental health and well-being in young people and preventing mental health problems. A meta-analysis undertaken by the Collaborative for Academic and Social and Emotional (CASEL) of 213 research studies into the effectiveness of school-based social and emotional programs identified that there were significant improvements in students' social-emotional skills and their sense of feeling more connected to their school (Durlak et al. 2011). The participating schools also documented a 44 % decrease in suspensions and a 27 % decrease in other disciplinary actions. Academic achievement scores improved by 11–17 percentiles that illustrates the strong interdependence of student well-being with student learning. The school-based programs were also most effective at increasing academic achievement when taught by the classroom teacher, rather than a visiting specialist. A classroom teacher can embed the program into their classroom and school practices, and integrate the social-emotional learning with the academic curriculum. The teacher can also customise the program for individual student's needs or the class as a whole.

Diekstra (2008) has drawn the following conclusions based on his meta-analysis of worldwide research studies into the effectiveness of school-based social and emotional learning programs:

- Enhanced social & emotional development is the key to the overall development of students in terms of personality, academic progress, school career and societal functioning
- Universal school-based social and emotional learning programs are highly beneficial for children and adolescents, especially those implemented with students aged between 5 and 13 (i.e. in primary/elementary schools)
- Young people from low socio-economic status and different ethnic backgrounds benefit at least as much as other young people (and often more) from social and emotional programs.

9.5 Positive Education

School-based social-emotional learning programs align with the vision of Positive Education. Positive Education is a new term (Seligman et al. 2009) that applies the core principles of positive psychology in educational contexts and focuses on student resilience, well-being and accomplishment. Positive education adopts the focus of positive psychology that focuses on strengths rather than deficits, on positive experiences rather than difficulties, on competency building rather than pathology and on what is going well rather than what is not working (Seligman and Csikszentmihalyi 2000). We define positive education as *the scientific inquiry of the social-emotional skills, relationships, strengths and behaviours that contribute to student well-being and resilience in the school context and the school and classroom practices that contribute to positive, safe and supportive teaching and learning communities.*

The key role of positive education for the future of all countries was recognised in an international meeting of 800 participants at United Nations Headquarters in New York hosted by the Royal Government of Bhutan (2012). The UN Recommendation is that "Constructive and positive education is an important facilitator of the mindsets necessary to support an economic paradigm based on well-being and happiness. In this context, a broad-based learning platform is needed to identify, study and discuss best practices targeted to promote well-being and happiness" (Royal Government of Bhutan 2012, p. 84). The authors' model of Positive Education (Noble and McGrath 2008) is based on the following six foundations:

- Social and emotional competencies
- Positive emotions
- Positive relationships
- Strengths-based approaches
- Positive purpose
- Optimal learning environments that facilitate achievement

These foundations are similar to Seligman's (2011) pillars of positive psychology as described in his acronym PERMA: **P**ositive emotion, **E**ngagement, **R**elationships, **M**eaning and **A**ccomplishment but are more specifically linked to school-based pedagogy and practices that enhance student well-being, resilience and achievement.

9.5.1 Foundation One: Social and Emotional Competencies

Helping students to develop competencies in the social and emotional skills and attitudes related to resilience and well-being is the core of the first foundation. These include pro-social values, social skills, resilience skills (including

helpful thinking skills and optimistic thinking skills) and skills for managing uncomfortable emotions.

- *Pro-social values* are the principles or standards that guide young peoples' behaviour and choices. The most significant values are: respect for self and others, fairness, cooperation, acceptance of differences, compassion, honesty, and friendliness/inclusion. The importance of acting in accord with one's pro-social values for mental health and well-being is illustrated by a longitudinal study that tracked high school students over 50 years into late adulthood. The students were interviewed every 10 years and the results demonstrated that 'giving' adolescents became both psychologically and physically healthier adults (Wink et al. 2007).
- *Social skills:* Key social skills in school settings include: sharing resources and workload, cooperating, respectfully disagreeing, negotiating, making and keeping friends, having an interesting conversation, presenting to an audience, and managing conflict well. Social skills have also been described as 'academic enablers'. A student's level of social competence and their friendship networks have been found to be predictive of their academic achievement (Caprara et al. 2000; Wentzel and Caldwell 1997). Friendships provide students with intimacy, a sense of belonging, security, validation and affirmation and social and academic support. Friendships also offer students opportunities to practise and refine their social skills and discuss moral dilemmas in a way that enhances the development of empathy and socio-moral reasoning (Hodges et al. 1999; Schonert-Reichel 1999; Thoma and Ladewig 1993). Having the social competencies to develop high-quality friendships, or at least one best friend, can also help prevent children and young people from being bullied (Bollmer et al. 2005; Fox and Boulton 2006).
- *Resilience skills:* Some of the core skills that enable a young person to cope with difficult times and challenges are: optimistic thinking skills, helpful thinking skills, adaptive distancing skills, using humour and seeking assistance when needed.
  - Optimistic thinking: In their review of the construct of optimism, MacLeod and Moore (2000) conclude that an optimistic way of interpreting and adjusting to negative life events is an essential component of coping. The following four components to optimism are a useful focus for school-based resilience and well-being programs:
  - *Positivity*: finding the positives in negative situations, however small
  - *Mastery*: feeling some sense of control and competence in school work and in other aspects of one's life.
  - *Hope*: having a disposition or tendency to *expect* things to work out, to be forward looking and proactive and to have the confidence to persist when faced with setbacks or adversity; (Carver and Scheier 1999; Masten 2004); and believing that failures and setbacks will happen but that things will get better and you can try again (Benard 2004).
  - *An optimistic explanatory style*: believing that bad situations are temporary, acknowledging that bad situations are usually not all your fault, and believing that bad situations are specific, and don't affect everything else or necessarily flow over into all aspects of your life (Seligman 1998; Gillham and Reivich 2004; Seligman et al. 1995)

- Helpful thinking is always rational (i.e. reflects how things really are rather than how they should be or how an individual would like them to be) and helps an individual to calm down, feel more emotionally in control and hence be more able to solve problems (Werner and Smith 1992; Ellis 1997). It derives from the original Cognitive Behaviour Therapy model (CBT) (Beck 1979) based on the understanding that how you think affects how you feel which in turn influences how you behave.
- Adaptive distancing encompasses a range of skills such as: being able to detach from individuals whose influence is negative; withdrawing from family members who are enmeshed in anti-social or dysfunctional behaviour (Werner and Smith 1992); emotionally distancing oneself from distressing and unalterable situations instead of constantly immersing oneself in a negative situation and continually thinking about it.
- Humour. Individuals are less likely to succumb to feelings of depression and helplessness if they are able to find something humorous, even if only small, in an adverse situation (Benard 2004; Wolin and Wolin 1993). Lefcourt (2001) has argued that humour enables individuals to live in what are often unbearable circumstances. Humour can also be seen as a form of optimism that helps to keep things in perspective.
- *Skills for managing emotions:* Skills for handling one's emotions are important components of resilience and well-being (Masten 2004; Masten and Coatsworth 1998). These skills include: calming oneself down; managing uncomfortable feelings such as anger, fear and disappointment, recognising and understanding the feelings of others, and showing empathy and support towards others.
- *Self management and self-discipline.* These skills include: a willingness to plan and set both personal and academic goals and be prepared to strive, persist and work hard towards achieving those goals (Vaillant 2003; Werner and Smith 1992; Dweck 2006); a preparedness to tolerate frustration and delay short-term gratification in order to achieve longer term outcomes (Masten and Obradović 2008; Vaillant 2003; Werner and Smith 1992); time management and organisational and planning skills. Baumeister et al. (2007) highlight the importance of self control and willpower as critical to school and life success and Hattie (2009) highlights the importance of self-regulation for school success.

9.5.2 Foundation Two: Positive Emotions

Being able to identify and amplify positive emotions is also an important skill for students to learn. Over time, the ongoing experience of positive emotions contributes to a sense of optimism that 'life can be good again' (even if things are difficult at the time). Positive emotions at school can include feelings such as: belonging, feeling safe, feeling satisfied with their learning, pride, curiosity, excitement and enjoyment.

The broaden-and-build theory of positive emotions (Fredrickson and Tugade 2004; Fredrickson and Joiner 2002) proposes that the ongoing experience of these positive emotions helps to extend one's awareness of options for problem solving and coping. For example experiencing feelings of closeness and satisfaction when working with others to accomplish a shared goal can become valuable knowledge about how to get along with others and access support from others in difficult times. Having fun through playing games, singing and dancing together at school can contribute to creative thinking, physical fitness and better health. The joy and fun that occurs during social play can build bonds, highlight the importance of humour and teach and encourage empathy and perspective taking. These 'assets' can be drawn on if needed and can help young people to deal with distressing events that are temporarily occurring in their life and 'bounce back' rather than break. Learning how to amplify positive emotions also 'undoes' the effects of stress more quickly (Fredrickson and Tugade 2004). In contrast, experiencing predominantly negative emotions such as anxiety, anger and disappointment are more likely to prompt narrow attention on survival-oriented behaviors such as avoidance, running away or fighting.

9.5.3 Foundation Three: Positive Relationships

A positive school culture is characterised by both positive peer relationships and positive teacher-pupil relationships. Students are more likely to be engaged in learning and achieve academic success if they experience positive relationships at school (Hattie 2009; Marzano et al. 2003). Teacher-student relationships are also the foundation of effective classroom management. A meta-analysis by Marzano et al. (2003) found that, on average, teachers who had high-quality relationships with their students had 31 % fewer discipline and related problems in a given year than did teachers with poorer relationships with their students. Having a relationship with a caring adult other than or in addition to a parent has also been shown to be a significant protective factor in helping young people be resilient (Garmezy 1992; Werner and Smith 1992). This person is often their teacher (Benard 2004).

When a school works to facilitate positive school-based relationships through the use of 'pro-social architecture' bullying is less likely to thrive, student well-being is enhanced and there is a greater likelihood of higher student engagement with school (Blum and Libbey 2004; Galloway and Roland 2004; Schaps and Lewis 1999; McGrath and Noble 2003). Pro-social architecture refers to planned structures and activities that enhance social interaction such as peer support initiatives, cooperative learning, educational games and rotating classroom seating. Schaps (2003a, b) has also argued that this type of positive school culture predisposes students to adopt the goals and values of the school, demonstrate more compassion and concern for others, be more prepared to resolve conflicts fairly, engage in more pro-social behavior and adopt an inclusive rather than exclusive attitude toward other students.

9.5.4 Foundation Four: Strengths-Based Approaches

Positive Education stresses the importance of identifying, building and finding genuine ways to engage the individual strengths of students. A 'strength' can be a specific ability (e.g. playing music, swimming, cartooning, using spread-sheets) or a character trait (e.g. persistence, kindness to others, leadership skills). Gardner's (1999) theory of multiple intelligences for ability strengths and Peterson and Seligman's (2004) model for character strengths are both useful frameworks for educators to utilise in school settings and have been applied in class and school settings (e.g. see Kornhaber et al. 2003; McGrath and Noble 2005, 2011; Chen et al. 2009; Petersen and Seligman 2004; Yeager et al. 2011). The benefit of a strengths-based approach in teaching young people is illustrated in the following two studies. Using Gardner's framework of multiple intelligences (with Bloom's taxonomy of thinking) helped teachers in two schools identify academic and other strengths in their students and increased the teachers' confidence and skills in diversifying their curriculum tasks to effectively engage different students in learning (Noble 2004). Applying their new knowledge of character strengths to character analyses in English literature helped secondary students to significantly improve their essay writing skills (White 2012).

9.5.5 Foundation Five: Positive Purpose

Young people have a sense of *'meaning and purpose'* in their lives when they pursue what they perceive as worthwhile goals (e.g. working on an entry for a short story competition). This sense of meaning and purpose is facilitated when they use their strengths to investigate issues of real concern to them. For example they take action to bring about change in their school or community such as forming a student action team campaign to reduce school bullying (Holdsworth 2002; Chapman et al. 2007) or are involved in peer support initiatives such as buddy systems where older children become mentors for younger children. Helping young people to use their strengths to achieve a sense of meaning and/or purpose is especially likely to promote their sense of well-being and develop resilience skills.

9.5.6 Foundation Six: Optimal Learning Environments That Facilitate Achievement

An optimal experience or 'flow' has been described as a state in which a person is totally absorbed in a task for its own sake, time passes very rapidly, the individual experiences enjoyment, feels in control, is intrinsically motivated and gains clear-cut feedback on their progress (Csikszentmihalyi 2002). Cross-cultural studies have demonstrated that an optimal experience can occur in any daily context such as work or leisure (Delle Fave and Massimini 2003). An optimal learning environment

provides opportunities for students to be involved in a learning activity that utilises their strength(s) and has a degree of challenge that requires a reasonably high level of skill (for example building a complex model, playing a musical instrument, writing a poem or mentoring a younger child). Such learning can increase young people's satisfaction with their learning (from the completion of a task or the creation of a product or performance). An optimal learning environment addresses all the positive educational foundations of student well-being i.e. it enhances positive relationships, positive feelings, explicitly teaches social-emotional competencies, adopts strengths-based approaches and encourages a sense of purpose.

Effective teaching is at the heart of the development of an optimal learning environment as demonstrated in the largest conducted research meta-analyses on factors influencing student learning (Hattie 2009). The essence of effective teaching focuses on a teacher's capacity to adapt their teaching to meet their students' social-emotional and learning needs. Effective teachers provide optimal learning environments by having high expectations of their students and intellectually challenge them in activities that promote critical and creative thinking, problem solving, ethical decision making, social and personal competencies, cooperative learning with clear criteria for social-emotional and academic success (McGrath and Noble 2010).

9.6 Australian Initiatives Related To Student Well-being and Resilience

The health-promoting schools model has been widely adopted in Europe and other countries such as Australia to help schools combine a focus on mental health, well-being and education. A health-promoting school is defined as one that *is constantly strengthening its capacity as a healthy setting for living, learning and working (WHO 2013)*. Two Australian mental health and well-being initiatives (MindMatters for secondary students and KidsMatter for primary students) are based on the global model of health-promoting schools.

9.6.1 KidsMatter

KidsMatter (kidsmatter.org.au) is supported by a partnership between the Commonwealth Department of Health and Ageing, Beyond Blue (A National Depression initiative), The Australian Psychological Society, Principals Australia and Australian Rotary Club. It aims to improve the mental health and well-being of primary school students, reduce mental health problems and achieve greater support for students experiencing mental health problems.

Funds were provided to 101 primary schools to implement a social and emotional learning (SEL) program over a 2-year period. Schools were guided in their choice

of a program by the evaluation by the Australian Psychological Society of existing SEL programs using CASEL criteria. The evaluation of the effectiveness of the KidsMatter initiative indicated that there were significant and positive changes in the schools, teachers, parents/caregivers, and students over the 2-year trial. In particular there were statistically and practically significant improvements in students' measured mental health in terms of both reduced mental health difficulties and increased mental health strengths. The impact of KidsMatter was especially apparent for students who were rated as having higher levels of mental health difficulties at the start of the trial (Dix et al. 2009). The program is continuing and the KidsMatter website contains a selection of useful information for schools and parents on social and emotional skills and mental health.

9.6.2 An Example of a School-Based Student Well-being and Resilience Program Based on Positive Education

The Bounce Back Well-being and Resilience program (McGrath and Noble 2003, 2011) was selected by 64 % of the KidsMatter schools that chose to implement a whole school well-being program. Cross-cultural feasibility of the program is illustrated in its successful implementation in 16 primary schools in the Perth-Kinross area in Scotland where it has been shown to enhance students' personal resilience skills, social skills and class connectedness, as well as teacher well-being and to create a positive school culture (Axford et al. 2010, 2011). Of interest in terms of it's possible cross-cultural applicability for school systems, the program is recommended to all UK schools in the 2012 UK National Final Report on the Riots.

The Bounce Back! Program has been developed for children from kindergarten (5 years old) to early adolescence (14 years old) and has three levels of age-appropriate curriculum resources. The program integrates the use of CBT principles for teaching resilience with the aforementioned foundations of positive education. It is a whole-school universal program that uses evidence-based pedagogy and children's literature to teach well-being and resilience in the following nine curriculum units:

- The *Core Values* unit encourages children to be honest, fair, kind, cooperative, respectful of self and others and accepting of differences.
- The *People Bouncing Back* unit incorporates the Bounce Back acronym of 10 coping statements based on cognitive behavioural and counselling principles
- *Looking on the Bright Side* teaches optimistic thinking and gratitude
- The *Courage* unit discriminates between 'everyday' courage of having a go at something that is challenging for you despite experiencing fear or anxiety and heroism or foolhardy behaviour.
- The *Emotions* unit teaches children ways to amplify positive emotions, to have empathy for others as well as ways to manage strong negative emotions
- The *Relationships* unit teaches strategies for making and keeping friends as well as managing conflict

- The *Humour* unit incorporates ideas for building class fun through a giggle gym and other strategies and explains the differences between humour that is helpful and humour that is hurtful or trivialises a difficult situation
- The *No Bullying* unit helps children discriminate between bullying behaviour and other kinds of anti-social behaviour and teaches skills in acting confidently and assertively as well as skills in supporting others who are being bullied
- The *Success* unit helps children to identify their character and ability strengths, to set and maintain realistic goals and to gain a sense of meaning and purpose through class and community activities.

9.6.3 The Australian Curriculum

The Australian Curriculum has been developed over the last 2 years to establish a common curriculum across all Australian states and territories (ACARA 2012). The Australian Educational Goals outline the responsibility of educators to develop successful learners, confident and creative individuals and active and informed citizens, the same goals shared by the Scottish Government. The goals state that:

> Schools play a vital role in promoting the intellectual, physical, social, emotional, moral, spiritual and aesthetic development and well-being of young Australians….

The Australian curriculum sets out the core knowledge, understandings and skills in specific curriculum areas (e.g. English, Science, Mathematics etc.) that are deemed to be important for all students. In addition it identifies seven 'general capabilities' to action the educational goals, to assist students to live and work successfully in the twenty-first century and to contribute to the creation of a more productive, sustainable and just society. It is expected that schools will 'infuse' these general capabilities throughout all curriculum subjects and across all aspects of schooling. The seven general capabilities are: literacy, numeracy, information and communication technology competence, critical and creative thinking, personal and social competence, ethical behaviour and intercultural understanding. Schools are required to report on the progress of students (at different year levels) in developing these capabilities as well as their progress in specific curriculum areas. The general capability of 'personal and social competence' encompasses four elements: self awareness, self-management, social awareness and social management.

9.6.4 The National Safe Schools Framework (NSSF)

A national school policy that focuses the attention of both Government ministers and school leadership to the crucial role of schools in promoting student well-being and resilience is illustrated by the Australian Government's (2011) National Safe Schools Framework; a framework endorsed by all State Ministers of Education and distributed to all schools in the nation. This policy appears to be a world first in

guiding all schools' curriculum and practices and highlights the Australian Government's endorsement of the important role of student well-being for learning and achievement. A safe and supportive school is described in the following way:

> In a safe and supportive school, the risk from all types of harm is minimised, diversity is valued and all members of the school community feel respected and included and can be confident that they will receive support in the face of any threats to their safety or well-being.

The Framework identifies the following nine elements to assist schools in fulfilling this vision:

1. Leadership commitment to a safe school
2. Supportive and connected school culture
3. Policies & procedures
4. Professional learning
5. Positive behaviour management approaches
6. Engagement, skill development and a safe school curriculum
7. A focus on student well-being and student ownership
8. Early intervention and targeted student and family support
9. Partnerships with families, community agencies and the justice system.

Schools are encouraged to conduct an online audit of their school's strengths and limitations based on these nine elements. The Framework provides many evidence-based practices and resources for enhancing their school's capabilities for whole school, staff and student well-being.

9.6.5 The Bushfire Recovery Project

Australia is one of many countries prone to repeated natural disasters and, in particular, to bushfires and floods. In 2009 the state of Victoria experienced the worst bushfires in the history of Australia with great loss of life and homes. In some parts of the country whole communities were destroyed. The Bushfire Psychosocial Recovery Unit of the Victorian Education and Early Childhood Department (DEECD) took several steps to enhance the resilience and well-being of these communities and the students in their schools. One of their initiatives was the provision of training workshops on the Bounce Back! Program for the teachers and community support staff in the seven regions most affected by these devastating fires. The goal was to develop teachers' skills in firstly supporting their students and secondly teaching their students the skills of resilience to help them recover from the trauma that many of them had experienced and to enhance the capacity of all students to cope with any such future disasters.

Data were collected after the implementation of Bounce Back! over two school terms in 18 sample schools affected by the Victorian bushfires (Vic. DEECD 2010). Teachers completed an online survey about their perceptions of the success of the program and their observations of student behaviour in response to the program. Teachers and students also participated in focus group discussions in four

participating schools. The findings indicated that participation in the Bounce Back! program had enhanced the capacity of many students to cope more effectively with their experiences during the bushfires and, in general, to behave more confidently, resiliently and pro-socially.

In the online survey:

- All of the (teacher) respondents (100 %) endorsed the relevance and usefulness of the program for their classroom
- Respondents indicated that they had observed students using skills or behaviours that reflected their participation and learning in the *Bounce Back!* program either 'often' or 'sometimes' during class discussions (73 %), when working in class (70 %) and in the playground (65 %).
- The majority (76 %) of the teachers also indicated that they had used key resilience messages from the program in their own lives

Some typical teacher responses in the focus group discussions and in the open-ended survey questions were:

- *In the aftermath of the fires we found the activities and themes embodied in the Bounce Back! program really helped us to get our students expressing and dealing with their emotions.*
- *Bounce Back has allowed us to talk usefully about some very sad things*
- *We have students with high anxiety levels (as a result of the fires) and Bounce Back has helped them to put things into perspective*
- *Bounce Back has given us a common name for feelings and reactions. It has given the children permission to feel and to share their feelings.*
- *We have seen a real turn around in the attitude and approach of several of our Year 5 and 6 students – they are now much more optimistic and logical in their response to setbacks.*
- *We have observed children using language and skills from the program particularly at camp e.g. encouraging others to stick with it, keep going, supporting others when a challenge was started.*
- *We have had fewer problems in the playground since we introduced it. The children are using language from the program to solve playground problems*

Examples of typical comments from students in the focus groups included:

- *I know now what to do when something goes wrong*
- *I focus more on positives and I don't think the worst now*
- *I have learned how to cope and how to get over bad times*
- *You feel better about the day after Bounce Back lessons*
- *It helps you get all your thoughts out and share them with others who understand.*
- *I talked with my family about what we learnt and now my parents say it back to me – it's not the end of the world, bad times don't last etc.*

These data demonstrate that the *Bounce Back!* program enhanced teachers' skills in supporting primary school aged children to discuss issues that caused them

concern and in explicitly teaching them the skills, behaviours and attitudes associated with resilience and well-being. Providing support and teaching skills for coping and resilience have been identified as critical to helping children and young people to cope better in life, especially when faced with adversity. This study illustrates the benefits for children and young people in resourcing and skilling teachers to implement a well-being and resilience initiative. These findings have relevance for all schools as all children and young people experience setbacks, difficulties and failure. Such initiatives are particularly relevant for those school communities experiencing any kind of trauma.

9.7 Conclusion

Today's children and young people will become tomorrow's citizens, workers and parents. Schools play a crucial role in enhancing their mental health, well-being and resilience. The six foundations of positive education outlined in this chapter are (i) social-emotional competencies that include prosocial values, social skills, resilience skills, skills for managing strong emotions, and skills for self-management and self discipline; (ii) positive emotions; (iii) positive relationships; (iv) strengths-based approaches (v) positive purpose and (vi) an optimal learning environment. The integration of student well-being and resilience initiatives into the academic curriculum is more likely to develop resilient and effective learners as well as productive, caring, achieving, healthy and responsible adults with sound levels of well-being. An investment in positive education at the school, system and national level, and in educational policies and practices for student well-being produce long-term benefits for individual students, for school communities and for the whole of society.

References

ACARA. (2012). The Australian Curriculum Information Sheet. http://www.australiancurriculum.edu.au/Australian%20Curriculum.pdf?type=0&x=0

Australian Bureau of Statistics. (2008). *2007 National survey of mental health and wellbeing: Summary of results (4326.0)*. Canberra: ABS.

Axford, S., Blythe, K., & Schepens, R. (2010). *Can we help children learn coping skills for life? A study of the impact of the Bounce Back programme on resilience, connectedness and wellbeing of children and teachers in sixteen primary schools in Perth and Kinross, Scotland*. Report is available from http://www.pkc.gov.uk/CHttpHandler.ashx?id=10321&p=0

Axford, S., Schepens, R., & Blyth, K. (2011). Did introducing the Bounce Back programme have an impact on resilience, connectedness and well-being of children and teachers in 16 primary schools in Perth and Kinross, Scotland? *Educational Psychology in Scotland, 12*(1), 1–4.

Baumeister, R. F., Vohs, K. D., & Tice, D. M. (2007). The strength model of self-control. *Current Directions in Psychological Science, 16*(6), 351–355.

Beck, A. T. (1979). *Cognitive therapy and the emotional disorders*. New York: Penguin.

Benard, B. (2004). *Resiliency: What we have learned*. San Francisco: WestEd.

Blum, R. W., & Libbey, H. P. (2004). Executive summary. *Journal of School Health, 74*, 231–232.
Bollmer, J. M., Milich, R., Harris, M. J., & Maras, M. (2005). A friend in need: Friendship quality, internalizing/externalizing behavior, and peer victimization. *Journal of Interpersonal Violence, 20*, 701–712.
Caprara, G. V., Barbaranelli, C., Pastorelli, C., Bandura, A., & Zimbardo, P. G. (2000). Prosocial foundations of children's academic achievement. *Psychological Science, 11*(4), 302–306.
Carver, C. S. (1968). Resilience & thriving: Issues, models and linkages. *Journal of Social Issues, 54*, 245–266.
Carver, C. S., & Scheier, M. E. (1999). Optimism. In C. R. Snyder (Ed.), *Coping: The psychology of what works* (pp. 182–204). New York: Oxford University Press.
Chapman, J., Cahill, S., & Holdsworth, R. (2007). Student action teams, values education and quality teaching and learning. In T. J. Lovat & R. Toomey (Eds.), *Values education and quality teaching: the double helix effect* (pp. 28–48). Sydney: David Barlow Publishing.
Chen, J., Moran, S., & Gardner, H. (Eds.). (2009). *Multiple intelligences around the world*. San Francisco: Jossey-Bass.
Csikszentmihalyi, M. (2002). *Flow: The classic work on how to achieve happiness*. London: Rider.
De Fraine, B., Van Landeghem, G., & Van Damme, J. (2005). An analysis of well-being in secondary school with multilevel growth curve models and multilevel multivariate models. *Quality & Quantity, 39*, 297–316.
Delle Fave, A., & Massimini, F. (2003). Optimal experience in work and leisure among teachers and physicians. *Leisure Studies, 22*, 323–342.
Diekstra, R. (2008). Effectiveness of school-based social and emotional education programmes worldwide (Part One and Part Two). In *Social and emotional education: An international analysis* (pp. 285–312). Santander: Fundacion Marcellino Botin.
Dix, K. L., Owens, L., Skrzypiec, G., & Spears, B. (2009). *KidsMatter evaluation executive summary*. Beyond Blue, Downloaded 7th January 2010 from www.kidsmatter.edu.au/wp/wp-content/uploads/2009/10/kidsmatter-executive-summary
Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82*(1), 405–432.
Dweck, C. S. (2006). *Mindset: The new psychology of success*. New York: Random House.
Ellis, A. (1997). *The practice of rational emotive behaviour therapy*. New York: Springer.
Engels, N., Aelterman, A., Van Petegem, K., & Schepens, A. (2004). Factors which influence the well-being of pupils in Flemish secondary schools. *Educational Studies*, *30*(2), 127–143. Englewood Cliffs: Prentice-Hall.
Fava, G. A., & Sonino, N. (2008). The bio-psychosocial model thirty years later. *Psychotherapy and Psychosomatics, 77*, 1–2.
Fava, G. A., & Tomba, E. (2009). Increasing psychological well-being and resilience by psychotherapeutic methods. *Journal of Personality, 77*, 1903–1934.
Fox, C., & Boulton, M. J. (2006). Friendship as a moderator of the relationship between social skills problems and peer victimization. *Aggressive Behaviour, 32*(2), 110–121.
Fraillon, J. (2004). *Measuring student wellbeing in the context of Australian schooling: Discussion paper.* Commissioned by the South Australian department of Education and Children's services as an agent of the Ministerial Council on Education, Employment, Training and Youth Affairs. Retrievable from: http://www.mceecdya.edu.au/verve/_resources/Measuring_Student_Well-Being_in_the_Context_of_Australian_Schooling.pdf
Fredrickson, B., & Joiner, T. (2002). Positive emotions trigger upward spirals toward emotional well-being. *Psychological Science, 13*, 172–175.
Fredrickson, B., & Tugade, M. (2004). Resilient individuals use positive emotions to bounce back from negative emotional experiences. *Journal of Personality and Social Psychology, 86*(2), 320–333.
Galloway, D. M., & Roland, E. (2004). Is the direct approach to bullying always best? In P. K. Smith, D. Pepler, & K. Rigby (Eds.), *Bullying in schools: How successful can interventions be?* (pp. 37–53). Cambridge: Cambridge University Press.

Gardner, H. (1999). *Intelligence reframed: Multiple intelligences for the 21st century*. New York: Basic Books.
Garmezy, N. (1992). Resiliency and vulnerability to adverse developmental outcomes associated with poverty. In T. Thompson & S. C. Hupp (Eds.), *Saving children at-risk: Poverty and disabilities* (pp. 45–60). Newbury Park: Sage.
Gillham, J., & Reivich, K. (2004). Cultivating optimism in childhood and adolescence. *The Annals of the American Academy of Political and Social Science, 591*, 146–163.
Hattie, J. (2009). *Visible learning: A synthesis of over 800 meta-analyses relating to achievement*. London: Routledge.
Hodges, E. V. E., Boivin, M., Vitaro, F., & Bukowski, W. M. (1999). The power of friendship: Protection against an escalating cycle of peer victimization. *Developmental Psychology, 35*, 94–101.
Holdsworth, R. (2002). *Student action teams: What do we learn?* Paper presented at the role of schools in Crime Prevention conference, Melbourne. http://192.190.66.70/media_library/conferences/schools/holdsworth.pdf
Lefcourt, H. M. (2001). *Humor: The psychology of living buoyantly*. New York: Plenum Publishers.
Kornhaber, M., Fierros, E., & Veenema, S. (2003). *Multiple intelligences: Best ideas from research and practice*. Boston/New York: Allyn & Bacon.
MacLeod, A. K., & Moore, R. (2000). Positive thinking revisited: Positive cognitions, well-being and mental health. *Clinical Psychology & Psychotherapy, 7*, 1–10.
Marzano, R. J., Marzano, J. S., & Pickering, D. (2003). *Classroom management that works: Research-based strategies for every teacher*. Alexandria: Association for Supervision and Curriculum Development.
Masten, A. S. (2004). Regulatory processes, risk and resilience in adolescent development. *Annals of the New York Academy of Sciences, 1021*, 310–319.
Masten, A., & Coatsworth, J. (1998). The development of competence in favorable and unfavorable environments: Lessons from research on successful children. *American Psychologist, 53*, 205–220.
Masten, A. S., & Obradović, J. (2008). Disaster preparation and recovery: Lessons from research on resilience in human development. *Ecology and Society, 13*(1), 9.
McGrath, H., & Noble, T. (2003). *BOUNCE BACK! A classroom resiliency program.* (Teacher's handbook. Teacher's resource books, Level 1: K-2; Level 2: Yrs 3–4; Level 3: Yrs 5–8). Sydney: Pearson Education.
McGrath, H., & Noble, T. (2005). *Eight ways at once. Book one: Multiple intelligences+Bloom's revised taxonomy=200 differentiated classroom strategies*. Sydney: Pearson Education.
McGrath, H., & Noble, T. (2010). *HITS and HOTS. Teaching+thinking+social skills*. Melbourne: Pearson Education.
McGrath, H., & Noble, T. (2011). *BOUNCE BACK! A wellbeing & resilience program* (Lower primary K-2; Middle primary: Yrs 3–4; Upper primary/Junior secondary: Yrs 5–8). Melbourne: Pearson Education.
National Safe Schools Framework. (2011). http://www.safeschoolshub.edu.au
Noble, T. (2004). Integrating the revised Bloom's taxonomy with multiple intelligences: A planning tool for curriculum differentiation. *Teachers College Record, 106*(1), 193–211.
Noble, T., & McGrath, H. (2008). The positive educational practices framework: A tool for facilitating the work of educational psychologists in promoting pupil wellbeing. *Educational and Child Psychology, 25*(2), 119–134.
Noble, T., McGrath, H., Roffey, S., & Rowling, L. (2008). *A scoping study on student wellbeing*. Canberra: Australian Government Department of Education, Employment & Workplace Relations.
Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. Oxford: Oxford University Press.
Royal Government of Bhutan. (2012). *The report of the high-level meeting on wellbeing and happiness: Defining a new economic paradigm*. New York/Thimphu: The Permanent Mission of the Kingdom of Bhutan to the United Nations/ Office of the Prime Minister. This report is available electronically at http://sustainabledevelopment.un.org/content/documents/617BhutanReport_WEB_F.pdf

Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry, 147*, 598–611.
Ryff, C. (2012). *Contradiction at the core of positive psychology: The essential role of the negative in adaptive human functioning. Keynote address*. European Positive Psychology Conference, Moscow.
Schaps, E. (2003a). Creating a school community. *Educational Leadership, 60*(6), 31–33.
Schaps, E. (2003b). *The role of supportive school environments in promoting academic success*. Sacramento: California Department of Education Press.
Schaps, E., & Lewis, C. (1999). Perils on an essential journey: Building school community. *Phi Delta Kappan, 81*(3), 215.
Seligman, M. E. P. (1998). *Learned optimism*. New York: Pocket Books (Simon & Schuster).
Seligman, M. E. P. (2011). *Flourish: A visionary understanding of happiness and well-being*. New York: Simon & Schuster Inc.
Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*, 5–14.
Seligman, M. E. P., Reivich, K., Jaycox, L., & Gillham, J. (1995). *The optimistic child*. New York: Houghton Mifflin.
Seligman, M. E. P., Ernst, R. M., Gillham, J., Reivich, K., & Linkins, M. (2009). Positive education: Positive psychology and classroom interventions. *Oxford Review of Education, 35*(3), 293–311.
Thoma, S. J., & Ladewig, B. H. (1993). *Moral judgment development and adjustment in late adolescence.* Paper presented to the American Educational Research Association, Atlanta, GA.
U.S. Department of Health and Human Services. (1999). *Mental health: A report of the Surgeon General*. Rockville: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Service.
UK National Final Report on the Riots, Communities and Victims Panel. (2012). http://webarchive.nationalarchives.gov.uk/20121003195935/http://riotspanel.independent.gov.uk/news/riots-communities-and-victims-panel-publishes-final-report/
Vaillant, G. (2003). *Aging well: Surprising guideposts to a happier life from the landmark Harvard study of adult development*. New York: Little Brown.
Victorian Department of Education & Early Childhood. (2010). *Report on the evaluation of the impact of training teachers in Bushfire-affected schools to use the Bounce Back Classroom Resilience Program in their Schools*. Unpublished Report.
Weare, K. (2009). In P. Aggleton, C. Dennison, & I. Warwick (Eds.), *Promoting health and wellbeing through schools*. London: Routledge.
Wentzel, K. R., & Caldwell, K. (1997). Friendships, peer acceptance, and group membership: Relations to academic achievement in middle school. *Child Development, 68*, 1198–1209.
Werner, E., & Smith, R. (1992). *Overcoming the odds: High risk children from birth to adulthood*. New York: Adams, Bannister, Cox.
White, M. (2012, June). *Positive humanities- integrating positive psychology & teaching of English literature*. European conference on positive psychology, Moscow.
WHO. (2008). *World Health Organization. The global burden of disease – 2004 update.* Retrieved December 1, 2011 from http://www.who.int/healthinfo/global_burden_disease/GBD_report_2004update_full.pdf
WHO. (2011). *Mental health atlas.* Department of Mental Health and Substance Abuse Department of Mental Health and Substance Abuse. Retrieved December 1, 2011 from http://apps.who.int/globalatlas/predefinedReports/MentalHealth/Section_One_Mental_Health_Atlas_2005.pdf
WHO. (2013). *What is a health promoting school?* http://www.who.int/school_youth_health/gshi/hps/en/
Wink, P., Ciciolla, L., Dillon, M., & Tracy, A. (2007). Religiousness, spiritual seeking and personality. Findings from a longitudinal study. *Journal of Personality, 75*(5), 1051–1070.
Wolin, S. J., & Wolin, S. (1993). *The resilient self*. New York: Villard Books.
Yeager, J., Fisher, S., & Shearon, D. (2011). *Smart strengths: Building character, resilience and relationships in youth*. New York: Kravis Publishing.

Chapter 10
Strength Based Resilience: Integrating Risk and Resources Towards Holistic Well-being

Tayyab Rashid, Afroze Anjum, Ron Chu, Suzanna Stevanovski, Anosha Zanjani, and Carolyn Lennox

10.1 Introduction

We begin with a story of H'Sien Hayward, a close friend of the first and second authors.

We were like a photograph and its negative – Rishi, my big brother, was tall for his age, I was short; he was athletic, I was academic; he was extroverted and social, I was shy. He was, throughout my childhood, the most important person in my life. We were only 18 months apart in age, and I wanted to be just like him. I was a tomboy, wore his hand-me-down clothes, and even had my hair cut short like his. People would often mistake us for twins (they thought I was a little boy) and I remember feeling so proud. He was my protector. He would not let older kids pick on me at recess, checked on me first if fighting broke out and, at bedtime, would listen to all of my worries and tell me that everything was okay so I could fall asleep.

And then he was gone. In one day, one afternoon really, when he was 10 and I 9, Rishi was killed in an accident and I never saw him again. I was not there when he died and I did not see his body before he was cremated. He was not there to dig trenches in the driveway with me after it rained, or to sit next to me on the school bus, and his bed remained empty at night.

T. Rashid (✉)
Health and Wellness Centre, University of Toronto Scarborough,
SL-270, 1265 Military Trail, Toronto, ON M1C 1A4, Canada
e-mail: trashid@utsc.utoronto.ca

A. Anjum • C. Lennox
Toronto District School Board, Psychological Services, South-West Education Office,
1 Civic Centre Court, Toronto, ON M9C 2B3, Canada
e-mail: Afroze.Anjum@tdsb.on.ca; Carolyn.Lennox@tdsb.on.ca

R. Chu • S. Stevanovski • A. Zanjani
University of Toronto Scarborough, 1265 Military Trail, Toronto, ON M1C 1A4, Canada
e-mail: s.stevanovski@mail.utoronto.ca; ron.chu@utoronto.ca; anosha.zanjani@utoronto.ca

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_10, © Springer Science+Business Media Dordrecht 2014

My memory of the moment when I was told he was dead is so clear it seems like someone drew it on the inside of my skull with a permanent marker. In the memory I am sitting on the burgundy futon couch watching Liz, an adult friend of our family, put down the phone and walk toward me. She had been talking to my parents who were at the hospital with Rishi because he had been hurt in a tractor accident earlier that day. I knew he would be fine because he was always fine. He was rambunctious and outdoorsy and loved being around large farm machinery, and always came home with big scrapes and bruises and even bigger stories about how he got the scrapes and bruises. And then I saw the expression on Liz's face and in the second before she spoke I remember everything in the room, and everything in the world, slowing down. It was like right before a car crash when everything around you seems to slow down and become very quiet. I didn't know then that that was what a car crash was like, but I would find out later.

Because I was a kid, logic and causality got all twisted up; I didn't know if something I had done, or had not done, had caused him to die. I remember feeling terribly, terribly alone in the world. It was as if a big part of me had died with him; I didn't know who I was when I wasn't Rishi's little sister. I rebelled the year after his death; I dyed my hair green and then pink, hung out with the older "bad kids" at recess, shoplifted, and tried smoking cigarettes. But what I remember most clearly from that time was a deep sense of existential embarrassment; that is, I felt profoundly embarrassed to be alive because I was sure that everyone would have preferred it to have been me that died. Accompanying this was a world-sized sense of anxiety that I somehow had to prove my worth or my right to exist – so after my rebellion phase, I got to work. I became a competitive four-sport athlete, got perfect grades, and became extroverted – I was prom queen and dated the quarterback (or the starting center, or pitcher, depending on the season).

Seven years after my brother's death, when I was 16, I was in a near-fatal automobile accident that left me in a coma and paralyzed from the chest down. Several friends and I were driving to the beach to celebrate winning the state track championship. I was riding in the back seat as we came down a winding mountain road, and the last thing I remember is begging the driver to slow down. When I woke up from the coma, my parents, paragons of resilience, banded together and surrounded me with love and hope. Though they had divorced after my brother's death, they had remained a unified supportive force when it came to me. The example they provided, of finding good even in things that seemed very bad, sustained me through 4 months of hospitalization, 4 more months of outpatient physical therapy, and when I returned to my senior year of high school in a wheelchair. Contrary to the recurrent bouts of depression and pernicious suicidal ideation that I was told to expect upon awakening from the coma, life had never been more beautiful, nor I more grateful. Having experienced my brother's accident and subsequent death, made life, whether spent standing or sitting, feel precious.

Now, after almost 18 years of using a wheelchair, and 24 since my brother's death, I maintain a deep inner commitment to helping others whose lives have been touched by severe loss or adversity to find the beauty in these challenges. As a sophomore at Stanford University I was exposed to the power of scientific inquiry to systematically challenge and offer alternatives to prevailing perceptions

of life experience, and have now returned to academic study at Harvard and close to completing my doctoral degree in psychology. Resilience, in my belief, is one of the most powerful concepts I can use to understand why some rise and others fall when tragedy hits. As a doctoral student and afterwards, as a scholar and researcher, I hope to contribute to a base of knowledge that may ultimately help enhance resilience and increase well-being for people who are living with great challenges.

The resources that supported me in my personal experience of growth through loss and adversity, including hope, meaning, and relationships with others, are among those that a growing body of research has identified as important for understanding the full range of potential responses to loss and adversity.

10.1.1 Introduction

H'Sien's story, distills resilience poignantly. Although her specific experiences are rare, the resilience she displayed is not. In pages to follow, we unpack this ordinary magic of resilience from scientific and application perspectives and explore which strengths enabled H'Sien to not to give up and create her happiness. We begin with definition of resilience. As described in the previous chapter, resilience is the ability to bounce back effectively in the face of adversities, challenges, traumas and setbacks. It is to persevere, adapt and make sense of trauma or loss (Masten 2001; Brooks and Goldstein 2004). Resilience is also defined as reduced vulnerability to environmental risk experiences, the overcoming of a stress or adversity, or a relatively good outcome despite risk experience (Rutter 2006). Resilience is not entirely fixed but is an ability that can be acquired – a central theme of this chapter. While the role of school system in promoting resilience was analyzed in the previous chapter of this book, we present a brief summary of the current literature on resilience among children and adolescents and highlight a predominant focus on the role of resilience in protecting against risk factors. While the protective factors have long been explored in unpacking resilience, the role of character strengths among these protective factors has not received much attention. We propose an alternative model of resilience called a Strength-Based Resilience (SBR), which incorporates character strengths in enhancing resilience.

We posit that by meaningfully incorporating the complex yet critical interplay of negative risks and positive resources, that is, character strengths we can enrich our scientific understanding of resilience, and can make it more accessible to non-western cultures which do not fully subscribe to pathologically-oriented risk factors such as vulnerabilities, deficits, dysfunctions and disorders (Wallace and Shapiro 2006; Joseph and Wood 2010). Resilience, we believe is not only surviving but also thriving. H'Sien didn't only survive but she continues to strive. To make our case, we present converging lines of evidence that support this approach. We also present results of our initial studies with culturally diverse students and teachers based on a SBR approach. We conclude the chapter with implications for future applications of a strength-based resilience.

For more than three decades individual, familial, communal, and broader ecological correlates of resilience have been examined through multiple lines of research (e.g., Garmezy 1990; Luthar and Cicchetti 2000; Masten 2001; Liebenberg and Ungar 2009; Rutter 2012). These lines of research suggest that resilience, conceptualized either as an outcome or intervening factor, acts as a buffer against previously identified risk factors for psychopathology in children and adolescents. Broadly these factors can be parsed in poverty and violence. Poverty is manifested through poor nutrition, lower educational achievement, lack of inadequate caregiving and insufficient medical care whereas violence often entails physical, sexual, emotional, psychological and financial abuse (Brackenreed 2010).

Fortunately, not all children and adolescents develop psychopathology as a consequence of exposure to aforementioned risk factors. Instead, they respond to adversities, setbacks, risks and vulnerabilities adaptively (Masten 2001; Cicchetti 2010). Research, broadly construes these factors under the umbrella of resilience which enables adaptive response (Rutter 1985; Masten 2001; Bonanno et al. 2011). As such, an important goal is to find methods to further enhance resilience through the complex interplay of risk and protective factors that are often moderated by cultural context.

Specific individual and social factors have been demonstrated to enhance resilience; such factors include optimism, autonomy, effective problem solving, faith, sense of meaning, self-efficacy, flexibility, impulse control, empathy, close relationships and spirituality. We believe that these protective factors, despite the presence of risk factors, help individuals negotiate and navigate stressful situations and setbacks adaptively.

10.1.2 Resilience as a Developmental Process

Resilience-enhancing protective factors have been conceptualized into two broad categories: *environmental protective factors,* like good schools and supportive families, and *personal strengths* such as, social competency, autonomy, problem solving skills. Critically, these personal and environmental factors interact dynamically. For example, strong association has been found between temperament and resilience (Derauf et al. 2011; Kesebir et al. 2013). In a study conducted by Hass and Graydon (2009), it was demonstrated that foster children who sought social support, were engaged with their community, and had interactions with members of the foster family were more likely to help others, participate in activities and were also, more cognitively stable. Critically, such positive factors were associated with the development of resilience among the foster youth.

In understanding resilience as a developmental process, the role of positive attributes is also critical. For example, experimental and applied lines of research have demonstrated that positive emotions build resilience by "undoing" the effects of negative emotions (Fredrickson et al. 2003; Lyubomirsky et al. 2005). Peterson and colleagues (2008) have found that gratitude, love, and hope facilitate recovery from trauma.

Resilience and Culture

Michael Unger's research (2008) has highlighted that resilience has mostly focused on Eurocentric notions of healthy functioning (staying in school, attachment to a parent or caregiver, forming secure attachments and stable intimate relationships, non-delinquent forms of adaptation, etc. Unger notes that these notions of functioning lack sensitivity to community and cultural factors that help in contextualizing how resilience is defined by various populations and is manifested in daily living. As a result, there is paucity of cross-cultural validation of findings. Furthermore, culturally determined outcomes that might be associated in non-western cultures and contexts are poorly understood. Therefore, we don't know what does resilience means to someone is Syria, Haiti. Unger (2008) has studied more than 1,500 youth in 14 mixed sites and has found out that culturally and contextually specific aspects facilitate resilience among youth.

10.1.3 Why Focus or Incorporate Strengths in Boosting Resilience?

Clearly, several factors that influence resilience have already been identified in the literature (Larsen et al. 2003). However, we believe that one very critical factor has been not been systematically explored is that of character strengths. Reflecting back to H'Sien's story, we would posit that despite very challenging circumstances, it was her character strengths which kept her psychological immunity robust. We acknowledge that character strengths are morally desired traits which are, at the same time, descriptive traits open to empirical examination. In fact, emerging research demonstrates that character strengths can play a critical role, not only in the cultivation of well-being but also in boosting resilience (Peterson et al. 2008; Bonanno 2004; Cacioppo et al. 2011). Following are some important reasons, in our view, to keep character strengths, front and centre of any resilience intervention. Critically, these reasons are grounded on the basis that *remediation or management of deficits alone will not make adolescents more resilient* (Masten 2001).

- ***Building strengths is necessary***: Being symptom-free is not synonymous with fulfillment and flourishing (Seligman 2011). Character strengths are linked to lower levels of depression and higher levels of well-being (Rust et al. 2009; Seligman et al. 2006; Proctor et al. 2009). In fact, increased use of specific character strengths is associated with fewer symptoms of depression and anxiety (Gillham et al. 2011; Park and Peterson 2008), greater life satisfaction (Antaramian et al. 2008), fewer externalizing problems (Park and Peterson 2008), and a lower internalizing problems (Beaver 2008).
- ***Using strengths helps to reinterpret and reframe problems adaptively:*** Using strengths increases children's self-efficacy and confidence in ways focusing on weakness cannot. Being aware of strengths, in addition to weaknesses, helps

children to reinterpret and reframe problems from strength's perspective rather than from a deficit perspective. Specifically, Maddi et al. (2009) have explored patterns of attitudes and skills, which foster resilience under adverse circumstance. For example, it appears that H'Sien reframed a very stressful situation into an opportunity to further develop her strengths and turned her stressful situation into an adaptive and advantageous one.

- ***Using strengths to promote resilience.*** Knowing and using strengths, in good times helps participants to learn strategies, which, they can use in turn, during tough times. Being aware of and using strengths not only promotes resilience but also prepares participants to encounter challenges adaptively.
- ***Using of strengths to find balance in daily interactions and manage relational challenges.*** As for adults (see Chap. 2 of this book,) a balanced approach to foster resilience, in our view, should focus equally on criticism as well on complements, on eliciting and savouring positive memories as well as recalling resentments, on self-centeredness as well as empathy. This will likely lessen interpersonal tension and create opportunities to resiliently adjust these interactions.
- ***Ubiquity of Character Strengths:*** Resilience is about bringing the best out of people at times when they really need it. We believe that character strengths, not vulnerabilities, symptoms or weaknesses, are those innate and best resources which can help individual to navigate tough terrain resiliently. Character strengths are ubiquitous traits, which are better suited to promote inclusion and harmony in increasingly pluralistic cultural contexts. Character strengths are closely related to notion of flourishing (Seligman 2011; Fowers and Davidov 2006). Character strengths such as open-minded, curiosity, perspective and love of learning can help to understand and appreciate various dimensions of cultural diversity. Likewise, the character strength of openness to others enables us to develop cultural sensitivity and competence.

10.1.4 Strengths and Their Relationship with Well-being, Academic Performance and Psychopathology

In the following section we summarize literature demonstrating that character strengths can facilitate, well-being, and academic performance as well as buffer against psychopathology among adolescents. As mentioned above, the current literature has demonstrated that character strengths are strongly correlated with several indices of well-being such as fewer symptoms of depression and anxiety (Gillham et al. 2011; Park and Peterson 2008; Waters 2012), greater life satisfaction (Antaramian et al. 2008), fewer externalizing problems (Park and Peterson 2008) and a lower probability for mental illness (Richards and Huppert 2011). However, two notable studies (Schmid et al. 2011; Richards and Huppert 2011) with very large samples accentuate the role of character strengths and well-being. Schmid et al. (2011) studied 1,273 adolescents and found that character strengths were predictive of positive youth development and less depressive symptoms was predicted.

Richards and Huppert (2011) analyzed data from 1964 British birth control cohort, which began with 563 teens. Children rated as "positive" by their teachers at age 13 or 14 were significantly more likely to report satisfaction with their work, midlife, and have had stronger social ties. Prosocial behavior such as volunteering, buffered against emotional exhaustion, while positive emotions increased helping and citizenship.

Researchers have demonstrated a strong correlation between character strengths and factors that influence academic performance. Studies have demonstrated that academic achievement, leadership (Bundick 2011; Durlak et al. 2011), well-being (Govindji and Linley 2007), motivation (Lopez and Louis 2009) were each strongly correlated with specific character strengths. Furthermore, even after controlling for IQ, character strengths of perseverance, fairness, honesty, hope and perspective predicted grade point average (GPA) (Park and Peterson 2008). Furthermore, the use of student's inbuilt character strengths has been shown to enhance motivation, keep positive mood, broaden attention, and expand creative and flexible thinking (Fredrickson 2009; Ouweneel et al. 2011; Yeager et al. 2011). Proctor and colleagues (2011) examined the impact of *Strengths Gym*, a character strength-based positive psychological intervention program, on adolescent life satisfaction, positive and negative affect, and character strength-based exercises in the school curriculum. Adolescents ($n = 208$) who participated in the program experienced significant increases in life satisfaction compared to adolescents ($n = 101$) who did not participate. For further details on life satisfaction in youth, see Chap. 13 of this book.

Researchers have also clearly demonstrated that resilience is the key to maintaining mental health. Corey Keyes (2006) posits that absence of symptoms of mental health does not necessarily mean presence of mental health. Using a categorical diagnosis, Keyes terms the presence of mental health as *flourishing*, and the absence of mental health as *languishing*. Keyes has examined the flourishing and languishing of more than 1,200 nationally representative adolescents between ages 12 and 18. Keyes found that approximately 38 % of adolescents were flourishing, 56 % were moderately mentally healthy, and 6 % were languishing.

Critically, depressive symptoms decreased as mental health increased; on average languishing youth reported 10.9, moderately mentally healthy youth reported 3.4, while flourishing youth reported 1.4 depressive symptoms. The languishing adolescents also reported more conduct problems (arrests, skipped school, alcohol use, cigarette smoking, and marijuana use) while flourishing adolescents reported better psychosocial functioning (global self concept, self-determination, closeness to others, and school integration). Thus, the evidence clearly suggests the flourishing adolescents are well buffered against mental illness. Yet, depression interventions do not systematically and deliberately focus on flourishing. In the following section we will outline various programs which explicitly focus on positive emotions, character strengths, sense of purpose and positive relationships to undo depression. Next, we present three illustrative programs which foster well-being and resilience by tapping into positive resources: The Penn Resiliency Program, Positive Youth Development and Positive Psychotherapy.

10.1.5 Illustrations of Well-being Interventions

The *Penn Resiliency Program (PRP)* is a Cognitive-behavioural intervention designed to target cognitive and behavioral risk factors, to help youth learn optimistic thinking, which in turn boosts resilience. It was originally designed to prevent symptoms of depression in early adolescence (Gillham et al. 1995) but currently many of its exercises have been adapted to boost strengths like optimism and perspective. It is designed for children between the ages of 10 and 14 years of age. By targeting the early adolescents it is hoped to prevent the steep increase in depression that occurs just a few years later. Early adolescence is an important developmental period, at this age adolescents make important cognitive gains that may enable them to learn cognitive and problem solving skills that can increase their resilience. Compared to children, adolescents can reflect on their beliefs and engage in hypothesis testing by examining evidence and considering alternatives (development of meta cognitive skills) (Inhelder and Piaget 1958). The PRP has two major components: a cognitive component and social problem-solving component. It is comprised of twelve 90–120 min group sessions. It is most often delivered by teachers and counselors in schools, but can also be delivered in clinic or other community settings. A group leader manual provides a detailed outline for each lesson and step-by-step instructions. Students receive an illustrated notebook with in-class activities and homework assignments for each lesion. It is structured in a manner intended to make abstract cognitive behavioral concepts both accessible and relevant to children between the ages of about 10 and 14. Three major steps are involved in PRP; first one is to establish a conceptual framework for each skill. Once the children have firm grasp on these concepts the group tackles hypothetical examples that demonstrate how the skills are useful to real world experiences. Finally students apply the skills to their own lives. The children are then encouraged to share personal experiences of times when they used or could have used the skills in question. Research examined PRP's effect on depressive symptoms by comparing the intervention to control groups. In a recent meta-analyses of depression prevention and treatment programs in children and adolescence found that PRP has a significant effect; this indicates the reduction and prevention of symptoms of depression (Brunwasser et al. 2009). However, not all studies showed significant improvement, some studies have failed to find positive effects. Previous studies have shown beneficial effects of PRP on automatic thoughts, explanatory style, hopelessness and self-esteem which some research suggests mediate PRP effects on depressive symptoms (Cardemil et al. 2007). The intervention has also examined the potential of including parent in the intervention with promising results (Gillham et al. 2007). This makes the intervention more effective in addressing family factors that increase children's risk of depression. PRP effects may also be enhanced by tailoring the intervention to the subgroup of children in question (all girls format, all boys format). Girls and boys experience different stressors therefore it may be necessary to cater the program accordingly for optimal outcomes (Petersen et al. 1991; Chaplin et al. 2006).

The *Positive Youth Development (PYD)* programs are developmentally appropriate diverse programs designed to prepare children and adolescents for productive

adulthood. The programs provide opportunities and support to help children and adolescents gain the competencies and knowledge needed to meet the increasing challenges they will face as they mature (*For reviews please see:* Kia-Keating et al. 2011; McWhinnie et al. 2008). PYD programs focus on multiple targets; such multidimensional approach has been found to be associated with positive outcomes at both the broad based and depression specific levels especially in universal populations. These multiple domains include community, family, and school settings. This program tends to be conducted over several months if not years.

The programs, include a wide-range of approaches but most include well-defined developmental but achievable goals. Most of these goals focus on building strengths and competencies of children and adolescents as well as focusing on youth's interests and talents while helping them make full use of their potential. Most PYDs emphasize the development of competencies to counteract risk factors and enhance protective factors in order to increase the likelihood of positive outcomes. Five constructs that are focused on in most PYDs include: (1) building academic social and vocational competence (2) building confidence (3) strengthening connection to family community and peers (4) building character (5) strengthening caring and compassion (Roth and Brooks-Gunn 2003).

PYD does not intentionally target depression or depressive symptoms. However, many of the attitudinal (self concept, self efficacy, prosocial beliefs etc.) and behavioral (i.e., problem solving, decision making, conflict resolution etc.,) targets of such programs are implicated in the etiology and maintenance of depression. No formal meta analysis has been conducted however previous studies have found that programs lead to positive changes in behavior, problem solving, improved interpersonal skills, quality of peer and adult relationships, self control, problem solving, cognitive competencies, self-efficacy and commitment to school and academic achievements. These findings also included an increase in factors thought to buffer against depression. The combined findings related to PYD program outcome reveal the potentially effective nature of strength-based interventions. PYD are likely to be effective in invoking change in many psychosocial variables implicated in the development of and resistance to depression.

Positive Psychotherapy (PPT) is a strength-based intervention within positive psychology to broaden the scope of traditional deficit-oriented interventions. It is primarily a therapeutic approach, offered as individual and groups therapy. However, its exercises have been adapted to school setting, offered as a psychoeducational intervention. Its central hypothesis is that building positive emotions, strengths and meaning, in addition to undoing symptoms, is efficacious in the treatment of psychological challenges. Positive emotions and strengths are especially helpful to youth when they are challenged by depression or anxiety. Resorting to inbuilt positive resources can be very effective in managing face-to-face and virtual interpersonal challenges faced by children and adolescents (Rashid and Seligman 2013).

To balance the inherent negativity bias, children and adolescents in PPT are encouraged to discuss transgressions as well as acts of kindness, competition as well as cooperation, criticism as well complements, hubris as well as humility.

PPT believes that amidst obvious symptoms of psychopathology tucked somewhere are also strengths of children and adolescents. For a distressed adolescent who often finds herself enveloped in ambivalence and helplessness, an emphatic reassurance from an adult and peers about his or her strengths can be reassuring, empowering and motivating. PPT is, in this way is, a resilience boosting approach based on *"build-what's-strong"* supplement to the traditional *"fix-what's-wrong"* approach (Duckworth et al. 2005, p. 631). Initial validation of PPT is primarily based on Seligman's authentic happiness theory (2002), which decomposes happiness in three lives, the pleasant life, the engaged life and the meaningful life. More recently Seligman (2011) has expanded his theory adding two more elements, positive relationships and accomplishment.

PPT's theoretical foundations are well rooted in ancient wisdom and rich psychological traditions. To begin with, much like humanistic psychotherapies (Maslow 1970; Rogers 1951), PPT rests on this fundamental belief that individuals have inherent capacity for growth and resilience. The window of opportunity for growth is wider and more flexible for children and adolescents. Psychopathology occurs when cognitive, interpersonal, or socio-cultural frames become narrow, essentially thwarting client's capacity to respond adaptively. PPT is flexibly structured procedure and an interpersonal process to widen these frames. Relatedly, PPT, unlike traditional therapeutic paradigms, purports that problems do not necessarily reside entirely inside participants. Hence, it is not in favor of the New Age mantra: *To Change Life, Change Your Attitude.* Instead, PPT acknowledges that well-being and depression are engendered and maintained by complex interactions between individuals and their environments. PPT doesn't purport to oversimplify this complexity. It weighs symptoms and strengths, vulnerabilities and opportunities, skills and deficits realistically – without minimizing or ignoring either. In this regard, Positive Psychotherapy is a misnomer; we would prefer to call it a balanced therapy – but it is far less appetizing than PPT.

In striking the balance, PPT, equally considers positive emotions and strengths and negative symptoms and disorders. PPT regards positive emotions and strengths of children and adolescents as authentic and values them in their own right. Because, repairing weaknesses doesn't make participants stronger but enhancing their strengths and abilities does (Govindji and Linley 2007). Therefore, the function of psychotherapy is not only to help children and adolescents eliminate or manage symptoms but also to restore and nurture courage, kindness, modesty, perseverance, and emotional and social intelligence. The former may make life less painful, but the latter are what make it fulfilling.

10.2 Strength-Based Resilience – Pilot Studies

Over the past eight years, we (Rashid and Anjum) along with our graduate students have devised and refined three strength-based interventions, which first assess and then systematically attempt to build strengths in children and adolescents. Next we present brief summaries of these studies.

10.2.1 Description of the Interventions

The study was conducted in compliance with the Research Services of the Toronto District School Board. Informational sessions (i.e., presentations during the staff meeting for teachers, and a presentation for parents at the parent evening) were conducted to inform participants. If parents were willing to participate, they completed the consent and permission forms. They were also informed about parent measures to be completed once study commenced. We later obtained assent from students.

The PPT included following exercises: Positive Introduction, Using Signature Strengths, Three Blessings, Savoring, and Family Tree of Strengths. (See Table 10.1 for brief description of exercises). PPT was an 8-week, 1½ hour per week intervention administered first two authors of the present paper. After the first orientation session, the children completed online the Values in Action Inventory of Strengths (VIA-Youth) in a group format. Each was then asked to imagine him- or herself to be a better person at the end of the intervention by undertaking a signature strength project. In the following three sessions, the children were extensively coached about ways of using their top strengths, also known as *signature strengths* to devise a practical behavioral project. Legends, real-life narratives, and popular films such as *Pay It Forward, Billy Elliot, Forest Gump, Life Is Beautiful, and My Left Foot* illustrated the use of strengths. Parents and teachers in both groups were requested to complete the SSIS before and after the treatment. From session three to seven, participants were extensively taught about a strength-based problem solving approach which entailed understanding and appreciating the context and fit between situation and intended use of the character strength.

In the final session, each of 11 participants described their experience of using their signature strengths. One participant, who had experienced bullying, utilized her social intelligence to team up with a friend and performed a small skit illustrating impact of bullying. The skit was done well to an extent that school principal requested the student to do the skit at a school assembly. Another student who constantly argued with her mother, utilized her gratitude and started expressing her thanks towards her mother – even for small favors. Another student whose signature strength wasn't self-regulation, nonetheless, used it to stop saying impolite and unkind words towards his younger sibling. As children discussed their use of signature strengths within the group, we noticed a synergistic contagion, which motivated other group members.

10.2.2 Outcome Measures

Both our pilot studies used the following outcome measures to assess well-being, life satisfaction, depression, character strengths and social skills:

- **Depression:** Children's depression was measured by Children Depression Inventory (CDI; Kovacs 1981). The CDI is a 27-item self-report measure that assesses the affective, cognitive and behavioral symptoms of depression with a

Table 10.1 Strength-based resilience: session-by-session description

Session # & topic		Description
1	Your story of resilience	Ground rules, roles and responsibilities are discussed, along with the importance of completing homework.
		Homework: Participants write a positive, real life story about themselves about their resilience. The story has a beginning, middle, and conclusion, and has an uplifting end.
2	Positive emotions	The role of positive emotion as buffers is discussed.
		Character strengths are introduced.
	Character strengths	Homework: Participants start a Gratitude Journal to record three good things every night (big or small).
		Participants complete the on-line *Values in Action* (VIA) questionnaire.
3	Signature strengths	Signature strengths are discussed.
		Homework Participants are coached to devise specific, measurable and achievable goals targeting specific problems which undermine their resilience.
4	Good vs. bad memories	The role of bad memories is discussed in terms of how they undermine one's resilience. The role of good memories is also highlighted.
		Homework: Participants write about feelings of anger and bitterness and their impact in perpetuating depression.
5	Grudge/Forgiveness	The consequences of holding on to a grudge are discussed.
		Forgiveness is introduced as a tool to transform anger and bitterness and to cultivate neutral or positive emotions.
		Homework: grudge exercise.
		Forgiveness Letter. Participants describe a transgression, its related emotions and pledges to forgive the transgressor. Do not deliver the letter.
6	Gratitude	Gratitude is discussed as an enduring thankfulness. The roles of good and bad memories are discussed again, with an emphasis on Gratitude.
		Homework: Participants write and delivers in person a Gratitude letter to someone they never properly thanked.

7	Mid-intervention check	The Grudge/forgiveness and gratitude assignments are followed up. Experiences related to the signature strengths and Blessing Journal activities discussed. Check in with client about any therapeutic gains
		Participants discuss their progress and experience of completing the Grudge/Forgiveness & Gratitude assignments.
8	Satisficing vs. maximizing	Concepts of satisficing (good enough) and maximizing are discussed.
		Homework: Participants review ways to increase satisficing. Devises personal action plan.
9	Hope and optimism	Optimism and hope are discussed in detail. Participants are helped to think of times when important things were lost but other opportunities opened up.
		Homework Participants reflect and write about three doors that closed and then reflect and write, what doors opened?
10	Positive communication	Discussion about Active-Constructive – a technique of positive communication.
		Participants look for active-constructive responding opportunities.
11	Signature strengths of others	The significance of recognizing and associating through character strengths of family members is discussed.
		Homework Participants ask family members to take the VIA. A family tree of strengths is drawn up and discussed at a gathering.
12	Savoring	Savouring is discussed, along with techniques and strategies to safeguard against adaptation.
		Homework Participants plans a savoring activity using specific techniques.
13	Gift of time	The therapeutic benefits of helping others are discussed.
		Homework: Participants plan to give the gift of time doing something that also use their signature strengths.
14	The full life	Well-being and Resilience is discussed as the integration of positive emotions, engagement, positive relationships, meaning and accomplishment (PERMA).
		Therapeutic gains and experiences are discussed and ways to sustain positive changes are devised.

score range of 0–52. The psychometric properties of CDI have been well-established (Nelson and Politano 1990; Saylor et al. 1984). Adult depression was measured by Beck Depression Inventory-II (BDI; Beck and Steer 1992). With a score range of 0–63, BDI is the one of the most widely used, reliable, and valid self-report measure of depression for both psychiatrically diagnosed clients and normal populations (Nezu et al. 2002).

- **Social Skills:** For Study 1 Social skills were assessed by the Social Skills Rating System (SSRS; Gresham and Elliott 1990). We used the composite Social Skills which includes scales cooperation, assertion, responsibility & self-control and Problem Behavior Composite which includes subscales of externalizing, internalizing and hyperactivity.
- **Life Satisfaction:** Children's life satisfaction was measured by Student Life Satisfaction Scale (SLSS: Huebner et al. 2004), a 7 item, six point Likert scale, with one item reverse scored. Items are summed to create a total score with a range 7–49. The SLSS has demonstrated good internal consistency and test-retest reliability and correlates highly with other subjective well-being measures (Huebner et al. 2004). Adult life satisfaction was measured by the Satisfaction With Life Scale (SWLS; Diener et al. 1985), a 5-item, seven point Likert scale with a range of 5–35. It is one of the most widely used of well-being with excellent psychometric properties (Pavot and Diener 1993)
- **Well-being:** Positive Psychotherapy (PPTI; Seligman et al. 2006): PPTI is a 21-item measure with scoring range 0–63. It assesses positive emotions, engagement, relationships, meaning and accomplishment. PPTI was validated designed to be an outcome measure of PPT (Seligman et al. 2006). A recent study with 908 adults individuals found that PPTI has good internal consistency, test-retest reliability, factor analysis and correlations with good convergent validity (Guney 2011). There is also an 18-item children's version (Rashid and Anjum 2008).
- **Values in Action – Inventory of Strengths: (VIA-IS):**
  - **Youth Version (**VIA Youth Survey; Park and Peterson 2006) is a 198-item self-report inventory of strengths that measures the 24 VIA strengths on a Likert Scale ranging from 1 ("Not like me at all") to 5 ("Very much like me"). The VIA-Youth scales have demonstrated good internal consistency (with alpha's ranging from 0.72 to 0.91).
  - **Adult Version:** Values in Action Inventory of Strengths (VIA-IS); Peterson and Seligman 2004). VIA–IS measures 24 core strengths (See Table 10.2) through 240 items. Satisfactory psychometrics of VIA–IS has been developed (Peterson and Seligman 2004).

10.2.3 Pilot Results

The two groups differed significantly on PPTI, but not on SLSS (Table 10.3), with the intervention group demonstrating a significant increase, with a large effect size ($d = 0.90$). This is consistent with the results of the individualized PPT pilot

Table 10.2 VIA classification of character strengths

Wisdom and knowledge – strengths which involve acquiring and using knowledge.
- **Creativity** [Ingenuity; Originality]: Thinking of novel and productive ways to do things.
- **Curiosity** [Interest; Novelty-seeking; Openness to Experience]: Taking an interest in all of ongoing experience.
- **Judgment** [Critical Thinking]: Thinking things through and examining them from all sides.
- **Love of learning**: Mastering new skills, topics, and bodies of knowledge.
- **Perspective** [Wisdom]: Being able to provide wise counsel to others; taking the "big picture" view.

Courage – emotional strengths which involve exercise of will to accomplish goals in the face of opposition, external or internal.
- **Bravery** [Valor]: Not shrinking from threat, challenge, or pain.
- **Perseverance** [Persistence; Industry; Diligence]: Finishing what one starts, completing a course of action in spite of obstacles.
- **Honesty [**Authenticity and Integrity]: Speaking the truth and presenting oneself in a genuine way.
- **Zest** [Vitality]: Approaching life with excitement and energy; not doing things half-way or halfheartedly, living life as an adventure, feeling alive and activated.

Humanity – interpersonal strengths that involve tending and befriending others.
- **Love** [Capacity to Give/Receive Love]: Valuing close relations with others, in particular those in which sharing and caring are reciprocated; being close to people.
- **Kindness** [Compassion; Altruism; Generosity; Care]: Doing favors and good deeds for others; helping them; taking care of them.
- **Social intelligence**: Being aware of the motives and feelings of self and others; knowing what to do to fit into different social situations; knowing what makes other people tick.

Justice – strengths that underlie healthy community life.
- **Teamwork [**Citizenship; Social Responsibility; Loyalty]: Working well as member of a group or team; being loyal to the group; doing one's share.
- **Fairness [**Equity]: Treating all people the same according to notions of fairness and justice; not letting personal feelings bias decisions about others; giving everyone a fair chance.
- **Leadership**: Encouraging a group of which one is a member to get things done and at the same time maintain good relations within the group; organizing group activities and seeing that they happen.

Temperance – strengths that protect against excess and vices.
- **Forgiveness** [Mercy]: Forgiving those who have done wrong; accepting the shortcomings of others; giving people a second chance; not being vengeful.
- **Humility** [Modesty]: Letting one's accomplishments speak for themselves; not seeking the spotlight; not regarding oneself as more special than one is.
- **Prudence:** Being careful about one's choices; not taking undue risks; not saying or doing things that might later be regretted.
- **Self-Regulation** [Self-Control]: Regulating what one feels and does; being disciplined; controlling one's appetites and emotions.

Transcendence – strengths that forge connections to the larger universe and provide meaning.
- **Appreciation of beauty and excellence** [Awe; Wonder; Elevation]: Noticing and appreciating beauty, excellence, and/or skilled performance in all domains of life, from nature to arts to mathematics to science.
- **Gratitude**: Being aware of and thankful for the good things; taking time to express thanks.
- **Hope [**Optimism; Future-Mindedness]: Expecting the best in the future and working to achieve it; believing that a good future is something that can be brought about.
- **Humor** [Playfulness]: Liking to laugh and tease; bringing smiles to other people, seeing the light side; making (not necessarily telling) jokes.
- **Spirituality** [Sense of Purpose; Faith; Meaning; Religiousness]: Knowing where one fits within the larger scheme; having coherent beliefs about the higher purpose and meaning of life that shape conduct and provide comfort.

Peterson and Seligman (2004)

Table 10.3 Total, means, standard deviations, significance levels and effect sizes on outcome measures for group positive psychotherapy (PPT) and control group with middle school students

	PPT (n = 11)	Control (n = 11)	Effect size	
	M/total *(SD)*	M/total *(SD)*	*F*	*d*
Depressive symptoms				
CDI-II (Higher is more depressed)				
Pre	8.91 *(7.62)*	8.45 *(6.92)*		
Post	6.22 *(6.72)*	8.73 *(9.85)*	n.s	
Well-being				
SSLS (Higher is more satisfaction)				
Pre	4.17 *(0.91)*	4.15 *(0.89)*		
Post	4.34 *(0.89)*	4.29 *(0.67)*	n.s	
PPTI (Higher is more well-being)				
Pre	20.27 *(6.93)*	21.18 *(5.67)*		
Post	27.09 *(3.65)*	23.28 *(5.02)*	4.42*	0.45
Social skills functioning				
SSRS (Higher is better functioning)				
Parents (n = 8)				
Pre	53.07 *(6.09)*	55.12 *(4.97)*		
Post	61.57 *(6.16)*	57.44 *(6.34)*	13.32**	1.88
Teachers (n = 9)				
Pre	46.55 *(7.40)*	43.51 *(5.30)*		
Post	49.89 *(6.13)*	44.37 *(5.77)*	3.4	.08

CDI-II mean score on children depression inventory (CDI), *SLSS* student life satisfaction scale (SLSS)

Positive Psychotherapy Inventory (PPTI)-Children Version, Composite Score, Social Skills Rating System (SSRS)-Overall composite score, Parent & Teacher Version

Post-treatment significant differences adjusted for pre-treatment scores

Due to exploratory nature of the study and small sample size, pairwise correction was not applied

Note. $*p < .05$; $**p < .005$; *df* 1, 19, *d* effect size (Cohen's *d*), *n.s* not statistically significant

(Seligman et al. 2006). About half of the PPT sessions focused on using character strengths to solve problems, to assess the impact, we administered the 18-item Problem Behavior Scale of the SSRS (Table 10.3). These items assess behaviors such as fighting, fidgeting, getting angry, being impulsive or getting distracted. From pre to post, compared to the control group (Table 10.4).

Our second study involved a much longer and more comprehensive implementation of PPT. It ran for 6 months. It was conducted with teachers, in weekly after school sessions of 60 min each at two schools. One group was facilitated by first author and another doctoral level licensed psychologist, who was trained by the first author and provided with detailed, well-scripted manual. Initially a total of 21 participants consented to participate in the study, which was approved by research board of the school board. However, a total of 9 participants from both sites dropped out. Most of them cited inability to complete weekly homework as the primary reason for dropping out. Our final sample with at least 75 % attendance, was 63 % females, 58 % Caucasian, with average age of 34.54 year *(SD 9.69).*

Table 10.4 Using strengths in challenges and in solving problems-Some illustrations

Character strength	Challenge	Strategy
Zest, vitality, enthusiasm: Student is energetic, cheerful, and full of life	Student does not show interest with other students (e.g., does not talk much, share or participate much in group activities, has few friends).	Encourage student to do at least one outdoor activity weekly such as hiking, biking, mountain biking, mountain climbing, brisk walking or jogging.
Persistence, industry, diligence and perseverance: Student finishes most things, even when distracted, and is able to refocus to complete task	Student gives up easily, has difficulty finishing tasks and performs assignments carelessly.	Help student identify factors that diminish their interest in the assignment, and help students monitor their progress to incrementally overcome difficulties.
Self-regulation and self-control: Students gladly follows rules and routines	Student behaves impulsively, without self-control, lacks time-management skills, and is disorganized.	Help student be aware of the time of day when they are most productive. Ask them to remove distractions and utilize this time in tasks requiring mental and physical organization rather than mundane tasks.
Forgiveness and mercy: Student does not hold a grudge and forgives easily those who offend him/her.	Student holds grudges, exaggerates minor offenses of others, and does not accept sincere apologies.	Identify how holding a grudge affects student emotionally. Help student picture themself as offender and remember times when they offended someone and were forgiven.
Hope and optimism: Student hopes and believes that more good things will happen than bad ones.	Student is preoccupied with their failures and shortcomings, and is overly negative.	Coach student to focus on their strengths, and find positive aspects of bad things that have happened to them.
Humor and playfulness: Students is playful, funny, and uses humor to connect with others	Student responds inappropriately to friendly teasing (e.g., jokes, name calling).	Encourage student to engage in light-hearted gestures and playful activities with a good-natured attitude.
Social and emotional intelligence: Student manages themselves well in social situations and has good interpersonal skills.	Student does not socialize appropriately with peers and does not respond appropriately to nonverbal cues from others.	Encourage student to watch others how they make and maintain connections, rather than seeking friends, student can seek experience which bring together like-minded people together
Teamwork and citizenship: Student relates well with teammates or group members and contributes to the success of the group	Student is very competitive, will not let others take turns, and cannot stand to lose in a game.	Help student identify their motivation for completion and help create a motivational climate focused on doing their best, not to achieve external rewards. Coach student to cultivate reciprocity and to promote cooperation.

(continued)

Table 10.4 (continued)

Character strength	Challenge	Strategy
Open-mindedness: Student thinks through and examines all sides before making a decision. Is not reluctant to change mind.	Student is rigid, and inflexible. Does not adjust well to changes such as new settings, teachers, peers and situations.	Ask student to adopt the perspective of the "other side" in an argument in which they are inflexible or have strong opinions.
Gratitude: Student expresses thankfulness for good things through words and actions.	Student takes good things in life and well-intentioned acts of others for granted.	Encourage student to reflect on the positive things that have happened throughout their day before going to bed. Discuss with student some of the things they are most grateful for.
Modesty and humility: Student does not like to be the center of attention and prefers others to shine.	Student lacks modesty, draws attention unnecessarily, and overrates one's qualities and achievements.	Coach student to an accurate, realistic estimate of their abilities and achievements. Have student write statements acknowledging their imperfections and how they make them human.
Perspective/wisdom: Student often is the source of advice for peers and often settles disputes among peers.	Student does not learn from mistakes and often repeats them. Lacks deeper understanding of moral and ethical issues. Is unable to apply knowledge to practical problems.	Help student become open to experience. Encourage students to be adventurous, curious and inquisitive about different things. Encourage students to find the purpose and motivations of their past decisions.
Capacity to love and be loved: Student shows genuine love and affection through actions.	Student withdraws by isolating himself or herself or appearing uninterested. Other student do not accept student.	Help student communicate care in small ways to those who are interested in them and to be honest and transparent with their friends.
Fairness, equity and justice: Student stands up for others when they are treated unfairly, bullied or ridiculed.	Student behaves inappropriately in specific situations and does not demonstrate sensitivity or care towards those who are different.	Encourage student to reflect how she/he would like to be treated, in situations he treats others unfairly.

Table 10.5 Total, means, standard deviations, significance levels and effect sizes on outcome measures for group Positive Psychotherapy (PPT) and control group with teachers

	SBR (n = 12)	Control (n = 10)
	M/total *(SD)*	M/total *(SD)*
Depressive symptoms		
BDI (Higher is more depressed)		
Pre	8.71 *(7.32)*	7.69 *(5.30)*
Post	5.71 *(5.46)*	7.81 *(5.37)*
Follow-up	4.58 *(3.37)*	6.92 *(4.29)*
Life satisfaction		
SWLS (Satisfaction with life scale)		
Pre	22.29 *(6.50)*	25.19 *(4.39)*
Post	25.12 *(7.04)*	26.56 *(3.50)*
Follow-up	25.17 *(7.41)*	24.33 *(3.28)*
Well-being		
PPTI (Higher is more well-being)		
Pre	31.59 *(10.45)*	32.88 *(12.50)*
Post	38.94 *(10.15)*	33.37 *(12.104)*
Follow-up	42.58 *(9.93)*	38.92 *(10.18)*

BDI mean score on Beck's depression inventory, *SWLS* satisfaction with life scale (SWLS) Positive Psychotherapy Inventory (PPTI); Composite Score

We failed to find statistically significant differences between the SBR and control groups in all three outcome measures (Table 10.5). However, we believe this to be a consequence of our small sample size. Indeed, the effects sizes suggests that teachers who undergone SBR were associated with higher scores of well-being, life satisfaction and few depressive symptoms. Though the pilot results are promising, further study into the efficacy of the SBR is necessary.

10.3 Implications

Helping individuals to identify their strengths and teaching them ways to use strengths in problem solving not only makes them efficient problem solvers but also enhances their well-being, which in turn, we hope is likely to raise their resilience. We conclude with implications for future strength-based initiatives, these are:

- To understand risk and protective factors, integrating measures of psychopathology and strengths could be a strategy that yields a holistic and balanced way. Resilience, especially strength-based resilience should not only rely on standardized measures. Structured or semi-structured interviews can also be used to assess. For example, asking questions such as "*Tell me about a challenge you handled adaptively?"* or *"What have you done to overcome a serious difficulty?"*

or *"Tell me about a setback from which you learned a lot about yourself."* These lines of inquiry can be customized to adapt to the cognitive and academic level of children and adolescents. Standardized questionnaires, which assess resilience, can be adapted to an interview format and critical items can be used to initiate discussion. This will also help to conceptualize the cultural context of strengths, which is difficult to capture within standardized measures.

Furthermore, Collateral information from family members, teachers, and peers about the strengths of the child or adolescent can be very useful, as we found in our interventions. It is particularly helpful to assess and identify social and communal buffers for children and adolescents living in neighborhoods ridden with social problems. For example, in addition to inquiring about problems with family members, professionals can also assess attachment, love, and nurturance from the primary support group. Instead of looking for problems related to the social environment, a children or adolescent can be asked to describe humor and playful interactions, connectedness, and empathetic relationships at work.

- The professional should assess whether children and adolescents are able to translate abstract strengths into concrete actions, behaviors, and habits. This assessment is important because in real life challenges rarely come in neat packages with labeled instructions such as, "When feeling down, use zest and vitality." Challenges and hassles often occur amidst a dizzying jumble of emotions, actions and their effects. The role of the strengths-based professional is to gently guide the student to use strengths adaptively – to solve their problems adaptively and to come to know themselves better.
- Some children and adolescents, especially those with behavioral concerns may be reluctant to explore or believe their strengths because they have been conditioned to associate negatives about themselves. In such cases, the professional may first work on building the self-efficacy of children and adolescents by using evidence-based strategies such as cognitive-behavioral programs that can help them to believe that they have the ability to change. Once they focus and spend more time on what they are capable off, they will automatically spend less time in thinking about their shortcomings.
- If adults in lives of children are not aware of strengths of children and adolescents, they would not able to coalesce resources to build strengths and skills which would enable resilience. Therefore, it is critically important that strengths are also build within the family context. As observed by Seligman and Csikszentmihalyi (2000), "promoting competence in children is more than fixing what is wrong with them. It is about identifying and nurturing their strongest qualities, what they own and are best at, and helping them find niches in which they can best live out these strengths" (p. 6). Another way to assess strengths in children and adolescents is to explore how they spend time with their immediate and extended family, including time doing recreation (indoor and outdoor games; art and sports activities), household chores, caregiving to a sibling or grandparent, play with neighborhood peers, and time with volunteering. Having knowledge of these activities offers professional a better leverage to find ways to cope with a challenge or adversity.

- In addition to family, equally important is the role of teacher. If the teacher's focus is primarily remedial, on correcting weakness, he/she will have a mindset that looks for and discovers problems, not resilience. Therefore, we trained both students and teachers in our pilot studies. Teachers serve as role models, if they don't demonstrate acknowledgement and cultivation of strengths, students are unlikely to do so. Working from a strength-based perspective can help teachers to have a huge impact on students, in inspiring them and motivating them because teachers not only teach curriculum but also implicitly teach emotional and psychological well-being and teach ways to respond to a challenge. Furthermore, enhancing strengths of students will help teachers to refine their own.
- Finally, the role of culture in understanding resilience is crucial. In most respects, resilience is not a singular construct. It essentially is a process which entails interplay between individual and environment in complex ways. Professionals need to be sensitive to the cultural context and social ecologies, which may have significant impact on both strengths and strength-based resilience. One should evaluate the influence each element of this complex interplay and intervene with elements that have the greatest positive impact (Ungar 2008). Increasing cultural diversity in most urban centre requires that we intervene at multiple points (e.g., family, school, individual, community) and in through multiple modalities (e.g. counselling, arts, sports, vocations…etc.).

References

Antaramian, S. P., Huebner, E. S., & Valois, R. F. (2008). Adolescent life satisfaction. *Applied Psychology: An International Review, 57*, 112–126. doi:10.1111/j.1464-0597.2008.00357.x.

Beaver, B. R. (2008). A positive approach to children's internalizing problems. *Professional Psychology: Research and Practice, 39*(2), 129–136.

Beck, A. T., & Steer, R. A. (1992). *Beck anxiety inventory manual*. San Antonio: The Psychological Corporation.

Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist, 59*, 20–28.

Bonanno, G. A., Westphal, M., & Mancini, A. D. (2011). Resilience to loss and potential trauma. *Annual Review of Clinical Psychology, 7*, 511–535.

Brackenreed, D. (2010). Resilience and risk. *International Education Studies, 3*(3), 111–121.

Brooks, R., & Goldstein, S. (2004). *The power of resilience: Achieving balance, confidence, and personal strength in your life*. New York: McGraw-Hill.

Brunwasser, S. M., Gillham, J. E., & Kim, E. S. (2009). A meta-analytic review of the Penn Resiliency Program's effect on depressive symptoms. *Journal of Consulting and Clinical Psychology, 77*(6), 1042–1054.

Bundick, M. J. (2011). The benefits of reflecting on and discussing purpose in life in emerging adulthood. *New Directions for Youth Development, 132*, 89–104.

Cacioppo, J. T., Reis, H. T., & Zautra, A. J. (2011). Social resilience: The value of social fitness with an application to the military. *American Psychologist, 66*(1), 43–51.

Cardemil, E. V., Reivich, K. J., Beevers, C. G., Seligman, M. E. P., & James, J. (2007). The prevention of depressive symptoms in low-income, minority children: Two-year follow-up. *Behaviour Research and Therapy, 45*, 313–327.

Chaplin, T. M., Gillham, J. E., Reivich, K., Elkon, A. G. L., Samuels, B., Freres, D. R., et al. (2006). Depression prevention for early adolescent girls: A pilot study of all girls versus co-ed groups. *Journal of Early Adolescence, 26*, 110–126.

Cicchetti, D. (2010). Resilience under conditions of extreme stress: A multilevel perspective. *World Psychiatry, 9*, 145–154.

Derauf, C., LaGasse, L., Smith, L., Newman, E., Shah, R., Arria, A., & Lester, B. (2011). Infant temperament and high-risk environment relate to behavior problems and language in toddlers. *Journal of Developmental and Behavioral Pediatrics, 32*(2), 125–135. doi:10.1097/DBP.0b013e31820839d7

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

Duckworth, A. L., Steen, T. A., & Seligman, M. E. P. (2005). Positive psychology in clinical practice. *Annual Review of Clinical Psychology, 1*, 629–651.

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82*(1), 405–432.

Fowers, B. J., & Davidov, B. J. (2006). The virtue of multiculturalism: Personal transformation character, and openness to the other. *American Psychologist, 61*, 581–594.

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

Fredrickson, B. L., Tugade, M. M., Waugh, C. E., & Larkin, G. (2003). What good are positive emotions in crises? A prospective study of resilience and emotions following the terrorist attacks on the United States on September 11th, 2001. *Journal of Personality and Social Psychology, 84*, 365–376.

Fredrickson, B. L., Cohn, M. A., Coffey, K. A., Pek, J., & Finkel, S. M. (2008). Open hearts build lives: Positive emotions, induced through loving-kindness meditation, build consequential personal resources. *Journal of Personality and Social Psychology, 95*(5), 1045–1062.

Garmezy, N. (1990). A closing note: Reflections on the future. In J. Rolf, A. Masten, D. Cicchetti, K. Nuechterlein, & S. Weintraub (Eds.), *Risk and protective factors in the development of psychopathology* (pp. 527–534). New York: Cambridge University Press.

Gillham, J. E., Reivich, K. J., Freres, D. R., Chaplin, T. M., Shatté, A. J., Samuels, B., Elkon, A. G., Litzinger, S., Lascher, M., Gallop, R., & Seligman, M. E. P. (2007). School-based prevention of depressive symptoms: A randomized controlled study of the effectiveness and specificity of the penn resiliency program. *Journal of Consulting and Clinical Psychology, 75*(1), 9–19. doi:http://dx.doi.org/10.1037/0022-006X.75.1.9.

Gillham, J. E., Reivich, K. J., Jaycox, L. H., & Seligman, M. E. P. (1995). Prevention of depressive symptoms in schoolchildren: Two-year follow-up. *Psychological Science, 6*, 343–351.

Gillham, J., Adams-Deutsch, Z., Werner, J., Reivich, K., Coulter-Heindl, V., Linkins, M., Winder, B., Peterson, C., Park, N., Abenavoli, R., Contero, A., & Seligman, M. (2011). Character strengths predict subjective well-being during adolescence. *The Journal of Positive Psychology, 6*, 31–44.

Govindji, R., & Linley, P. A. (2007). Strengths use, self-concordance and well-being: Implications for strengths coaching and coaching psychologists. *International Coaching Psychology Review, 2*, 143–153.

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

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

Hass, M., & Graydon, K. (2009). Sources of resiliency among successful foster youth. *Children and Youth Services Review, 31*, 457–463.

Huebner, E. S., Suldo, S., Smith, L., & McKnight, C. (2004). Life satisfaction in children and youth: Empirical foundations and implications for school psychologists. *Psychology in the Schools, 41*, 81–94.

Inhelder, B., & Piaget, J. (1958). *The growth of logical thinking from childhood to adolescence*. New York: Basic Books.

Joseph, S., & Wood, A. (2010). Assessment of positive functioning in clinical psychology: Theoretical and practical issues. *Clinical Psychology Review*, *30*(7), 830–838. doi:10.1016/j.cpr.2010.01.002

Kesebir, S., Gündoğar, D., Küçüksubaşı, Y., & Tatlıdil Yaylacı, E. (2013). The relation between affective temperament and resilience in depression: A controlled study. *Journal of Affective Disorders, 148*(2–3), 352–356. doi:10.1016/j.jad.2012.12.023

Keyes, C. L. M. (2006). Mental health in adolescence: Is America's youth flourishing? *The American Journal of Orthopsychiatry, 76*(3), 395–402. doi:10.1037/0002-9432.76.3.395

Kia-Keating, M., Dowdy, E., Morgan, M., & Noam, G. G. (2011). Protecting and promoting: An integrative conceptual model for healthy development of adolescents. *Journal of Adolescent Health, 48*, 220–228.

Kovacs, M. (1981). Rating scales to assess depression in school-aged children. *Acta Paedopsychiatria, 46*, 305–315.

Larsen, J. T., Hemenover, S. H., Norris, C. J., & Cacioppo, J. T. (2003). Turning adversity to advantage: On the virtues of the coactivation of positive and negative emotions. In L. G. Aspinwall & U. M. Staudinger (Eds.), *A psychology of human strengths: Fundamental questions and future directions for a positive psychology* (pp. 211–225). Washington, DC: American Psychological Association.

Liebenberg, L., & Ungar, M. (Eds.). (2009). *Researching resilience*. Toronto: University of Toronto Press.

Lopez, S. J., & Louis, M. C. (2009). The principles of strengths-based education. *Journal of College and Character, 10*, 1–8.

Luthar, S. S., & Cicchetti, D. (2000). The construct of resilience: Implications for interventions and social policies. *Development and Psychopathology, 71*, 543–562.

Lyubomirsky, S., King, L. A., & Diener, E. (2005). The benefits of frequent positive affect: Does happiness lead to success? *Psychological Bulletin, 131*, 803–855.

Maddi, S., Harvey, R. H., Khoshaba, D., & Fazel, M. (2009). Hardiness training facilitates performance in college. *The Journal of Positive Psychology, 4*(6), 566–577.

McWhinnie, C., Abela, J. R. Z., Hilmy, N., & Ferrer, I. (2008). In J. R. Z. Abela & B. L. Hankin (Eds.), *Positive youth development programs: An alternative approach to the prevention of depression in children and adolescents*. New York: Guilford Press.

Maslow, A. H. (1970). *Motivation and personality* (2nd ed.). New York: Harper & Row.

Masten, A. S. (2001). Ordinary magic. *American Psychologist, 56*(3), 227–238.

Nelson, W. M., & Politano, P. M. (1990). Children's depression inventory: Stability over repeated administrations in psychiatric inpatient children. *Journal of Clinical Child Psychology, 19*(3), 254–256.

Nezu, A. M., Nezu, C. M., McClure, K. S., & Zwick, M. L. (2002). Assessment of depression. In I. H. Gotlib & C. L. Hammen (Eds.), *Handbook of depression* (pp. 61–85). New York: Guilford Press.

Ouweneel, E., Le Blanc, M. L., & Schaufeli, W. B. (2011). Flourishing students: A longitudinal study on positive emotions, personal resources, and study engagement. *The Journal of Positive Psychology, 6*(2), 142–153.

Park, N., & Peterson, C. (2006). Moral competence and character strengths among adolescents: The development and validation of the values in action inventory of strengths for youth. *Journal of Adolescence, 29*, 891–909.

Park, N., & Peterson, C. (2008). Positive psychology and character strengths: Application to strengths-based school counseling. *Professional School Counseling, 12*, 85–92.

Pavot, W., & Diener, E. (1993). Review of the satisfaction with life scale. *Psychological Assessment, 5*, 164–172.

Petersen, A. C., Sarigiani, P. A., & Kennedy, R. E. (1991). Adolescent depression: Why more girls? *Journal of Youth and Adolescence, 20*, 247–271.

Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A handbook and classification*. New York/Oxford/Washington, DC: Oxford University Press/American Psychological Association.

Peterson, C., Park, N., Pole, N., D'Andrea, W., & Seligman, M. E. P. (2008). Strengths of character and posttraumatic growth. *Journal of Traumatic Stress, 21*, 214–217.

Proctor, C. L., Linley, P. A., & Maltby, J. (2009). Youth life satisfaction measures: A review. *The Journal of Positive Psychology, 4*, 128–144.

Proctor, C. L., Tsukayama, E., Wood, A. M., Maltby, J., Fox Eades, J. M., & Linley, P. A. (2011). Strengths gym: The impact of a character strengths-based intervention on the life satisfaction and well-being of adolescents. *The Journal of Positive Psychology, 6*, 377–388.

Rashid, T., & Anjum, A. (2008). Positive psychotherapy for children and adolescents. In J. R. Z. Abela & B. L. Hankin (Eds.), *Depression in children and adolescents: Causes, treatment and prevention*. New York: Guilford Press.

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

Richards, M., & Huppert, F. (2011). Do positive children become positive adults: Evidence from a longitudinal birth cohort study. *The Journal of Positive Psychology, 6*, 75–87.

Rogers, C. R. (1951). *Client-centered therapy, its current practice, implications, and theory*. Boston: Houghton Mifflin.

Roth, J., & Brooks-Gunn, J. (2003). Youth development programs: Risk, prevention and policy. *Journal of Adolescent Health, 32*, 170–182.

Rust, T., Diessner, R., & Reade, L. (2009). Strengths only or strengths and relative weaknesses? A preliminary study. *Journal of Psychology, 143*(5), 465–476.

Rutter, M. (1985). Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry, 147*, 598–611.

Rutter, M. (2006). Implications of resilience concepts for scientific understanding. *Annals of the New York Academy of Sciences, 1094*, 1–12.

Rutter, M. (2012). Resilience as a dynamic concept. *Development and Psychopathology, 24*(2), 335–344.

Saylor, C. F., Finch, A. J., Spirito, A., & Bennett, B. (1984). The children's depression inventory: A systematic evaluation of psychometric properties. *Journal of Consulting and Clinical Psychology, 52*(6), 955–967.

Schmid, K. L., Phelps, E., Kiely Mueller, M., Napolitano, C. M., Boyd, M. J., & Lerner, R. M. (2011). The role of adolescents' hopeful futures in predicting positive and negative developmental trajectories: Findings from the 4-H Study of Positive Youth Development. *The Journal of Positive Psychology, 6*(1), 45–56.

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

Seligman, M. E. P. (2008). Positive health. *Applied Psychology: An International Review, 57*, 3–18.

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

Seligman, M. E. P., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*, 5–14.

Seligman, M. E. P., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist, 61*, 774–788.

Ungar, M. (2008). Resilience across cultures. *British Journal of Social Work, 38*(2), 218–235.

Wallace, A. B., & Shapiro, S. L. (2006). Mental balance and well-being: Building bridges between Buddhism and Western psychology. *American Psychologist, 61*, 690–701.

Waters, L. (2012). A review of school-based positive psychology interventions. *The Australian Educational and Developmental Psychologist, 28*(02), 75–90. doi:10.1375/aedp.28.2.75.

Weisz, J. R., McCarty, C. A., & Valeri, S. M. (2006). Effects of psychotherapy for depression in children and adolescents: A meta-analysis. *Psychological Bulletin, 132*(1), 132–149.

Yeager, J. M., Fisher, S. W., & Shearon, D. N. (2011). *Smart strengths: Building character, resilience and relationships in youth*. New York: Kravis Publishing.

Chapter 11
School Programs for the Prevention of Mental Health Problems and the Promotion of Psychological Well-being in Children

Dalila Visani, Elisa Albieri, and Chiara Ruini

11.1 Introduction

Schools could be crucial settings for mental health promotion, since they represents an easy-access environment with a daily and direct contact with young people and their families. Nowadays schools are conceived not only as the ideal setting for developing learning and educational processes, but also for promoting mechanisms of resilience and psychological well-being (Flament et al. 2007; Gillham et al. 2007). As a consequence, in the last 20 years many school-based programs were developed with clear and repeated evidence of positive impact (Jenkins and Barry 2007).

One of the motivations for this focus on mental health in schools is the growing awareness on the rising number of children and young people who experience mental health problems (Patel et al. 2007). As to clinical interventions, the majority of school preventive interventions have been tested mainly on Western middle-class populations (Kumpfer et al. 2002). Also Australia is the scene of important research in this field, and some of its programs are well-established parts of children educational curriculum (see Chap. 9, Noble and McGrath, in this book). These programs are focused on resilience and prevention of youth mental health problems.

Traditionally, preventive interventions could be classified as universal, selected and indicated (Mrazek and Haggerty 1994). The first ones are administered to an entire population, whereas the other two pertain to individuals who are judged to be at risk because of environmental problems (selected interventions) or individual risk factors (indicated interventions). In general, less expensive interventions with a lower potential of negative side effects are implemented universally. As the cost and risk increase, targeted interventions are often administered since they present several advantages: (a) a greater coverage of at-risk children, in comparison with

D. Visani (✉) • E. Albieri • C. Ruini
Department of Psychology, University of Bologna, Bologna, Italy
e-mail: elisa.albieri3@unibo.it

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_11, © Springer Science+Business Media Dordrecht 2014

clinical interventions, and (b) a more efficient allocation of resources, in comparison with universal interventions. Some preventive interventions include both universal and specific components (McMahon and Rhule 2004), in fact the best practice is to include both universal and target approach, which appear to be stronger in combination, although the exact balance has yet to be determined (Weare and Nind 2011).

11.2 The Characteristics of Effective School-Based Programs

Recently, some indications have been suggested with regard to preventive school programs. The most effective programs do not wait for their participants to enter adolescence, instead they start with younger children. However, among preschoolers, the optimal age remains unclear (Merry et al. 2011; Weare and Nind 2011).

Effective programs should take a long term approach, in order to overcome the typical decrease of intervention's effect in the longer term. They may include regular booster sessions with growing students, addressing new specific problems, associated to students' developmental stage (Weare and Nind 2011).

Further, multi-modal programs, involving changes in school ethos and process, teacher and parenting education and liaison between schools, families and community agencies, are more likely to be effective than those restricted to one part of the school (for example, only teachers). School-based programs should be shared by the whole school environment, leadership and policies and mental health focus should be integrated with daily school life and not seen as a separate issue.

Programs work best when tailored to the cultural background of their participants (Flament et al. 2007), but little is known about how risk factors for a disorder may vary according to socio-demographic variables. An important question that needs to be addressed is the extent to which these programs work with different cultural groups, whether there is a need to adapt them or whether culturally-specific interventions would be even more effective. Unfortunately, a paucity of studies aims to answer these questions, but some have noted the generalization of effects across groups (McMahon and Rhule 2004).

11.3 School Based Interventions

Several school-based programs were developed to promote mental health of all who learn and work in school and/or prevent affective disorders in students:

- the "Paths curriculum" (Kam et al. 2003) and "Zyppy's Friends" (Clarke and Barry 2010) for the promotion of coping and social skills;
- the "Gatehouse project" (Patton et al. 2003) and the "Skills, Opportunities, and Recognition" (Hawkins et al. 1999) for increasing the attachment and the sense of belonging to a school in students;

- the "Bounce Back program" (McGrath and Noble 2003) and the "Bright Ideas" (Brandon et al. 1999) for promoting resilience and coping skills;
- The "PENN Prevention Programme", the "PENN Resiliency Programme", and the "PENN Optimism & Life Skills Programme" (Cardemil et al. 2007; Gillham et al. 1995, 2007, 2008, 2012) for promoting optimism and preventing depression;
- the "Coping with Stress Course" (Clarke et al. 1995), "The Stress Inoculation Model" (Hains and Ellmann 1994), "The Resourceful Adolescent Program" (RAP) (Shochet et al. 2001), "Problem Solving for Life" (Spence et al. 2003) and "Psychological Personal Growth Class" (Thompson et al. 2000) for preventing depression;
- the "Stress Inoculation training" (Meichenbaum and Deffenbacher 1988), the "Coping Cat" (Kendall 1994), "Queensland Early Intervention and Prevention of Anxiety Project" (Dadds et al. 1999) and the "FRIENDS Program" (Lowry-Webster et al. 2001, 2003) for preventing anxiety in children and adolescent;
- The "Resolving Conflicts Creatively Program" (De Jong 1994), the "Good Behavior Game" (Harris and Sherman 1973), the "Respect Program" (Ertesvåg and Vaaland 2007), "Save: Anti-bullying programme in Seville" (Ortega and Lera 2000) to prevent and stop bullying, violence, disobedience and conduct problems.

Even though all the interventions listed above vary in their content, their principal common feature is the cognitive-behavioral framework, which aims to encourage children to explore the connection between what they think, what they feel and the way they behave, reflecting on how they respond to stressors or emotional problems. These programs were mainly focused on teaching emotional and social skills and developing competences, such as self awareness, emotional management, resilience, stress reduction, relaxation, and empathy. For example, Zippy's Friends program promotes positive emotional well-being by encouraging all children to deal with everyday difficulties (e.g. abilities to recognize, manage and communicate negative feelings) and to develop a wide range of coping strategies that can also be used later in life (abilities to cope with rejection and loneliness, to solve interpersonal conflicts and to deal with change and loss).

Other interventions specifically address emotional disturbances or behavioural problems (e.g. bullying). For instance, the Coping Cat Program includes the following components: *psychoeducation* for understanding the manner in which abnormal levels of anxiety are learned and maintained; s*omatic management techniques* (e.g., relaxation); c*ognitive restructuring of anxiety-provoking thoughts*; *problem solving skills* to deal with situations that previously generated anxiety and fear; *gradual and systematic exposure* to feared situations.

Therefore, the goal of these protocols is training students to cope better with future adversities and negative emotions, using emotional and social skills taught in class. In other words, their rationale is that students are lacking instruments to manage daily stressful events, and consecutively they are at risk for mental health disorders. The final outcome of these school interventions should be the prevention of mental distress and, at the same time, the promotion of subjective well-being (SWB) and positive emotion.

To our knowledge, none of the above listed protocols focuses specifically on the promotion of psychological well-being (PWB), according to eudaimonic perspective (for a better description of this concept, see Chap. 2).

11.4 The Importance of Psychological Well-being in School Settings

According to the eudaimonic perspective, psychological well-being consist of more than just feeling happy. Thus, it consists of actualizing one's true potentials and making the most of one's talents and capacities. This conceptualization suggests that well-being is not an end state, but a process of fulfilling one's human potential and living as one was inherently intended to live (Ryff 1989; Waterman 1993). The emphasis on the life course dynamics of psychological well-being, allows us to identify possible strengths and vulnerabilities in psychological functioning throughout the life cycle (Fava 2012). A substantial number of studies have empirically dissociated PWB and SWB (Ryan and Deci 2001; Deci and Ryan 2008). Bauer et al. (2008) exploring PWB concluded that people who are able to experience higher levels of eudaimonic well-being, view challenging life experiences, which include significant pain and adversities, as transformational opportunities and display a high level of ego-development. Therefore, improving PWB in young people means helping them to recognize their strengths and vulnerabilities and to achieve the best that is within their true nature (Ryff and Singer 2008). The concept of "well-being balance" (Ruini and Fava 2012) emphasizes the respect of individual differences, which are particularly relevant in developmental age.

Improving psychological well-being within school settings may be a useful strategy to offer the opportunities for self-realization and optimal functioning to every students. Further it may also create a school culture, environment and ethos that highlight diverse human potential and interpersonal connections. Indeed, Ryff and Singer (2008) documented the role of socioeconomic variables on well-being, suggesting that psychological well-being is profoundly influenced by the surrounding contexts of people's lives. Particularly, education was found to positively correlate with PWB (Keyes et al. 2002). As main learning and educative agencies, schools should be a fundamental setting for the promotion of psychological well-being and the realization of personal talents and capacities.

11.4.1 Well-being Therapy School Protocol

A new school program for the promotion of psychological well-being and optimal human functioning according to the eudaimonic perspective (Ryff 1989; Ryan and Deci 2001) has been recently developed: the Well-being Therapy (WBT) – School Protocol (see Box 11.1). The applicability and effectiveness of the protocol (four

Box 11.1 WBT School Protocol

The protocol consists of 6, 2-h sessions, which are held once a week.

Sessions

1. Focus on emotions and improvement of team work in classes: students are trained to identify, recognize and express a wide range of emotions (positive and negative) and they are asked to relate different colors or different animals to different emotions for helping them realize the variety of emotions they can feel (like colors) and how all these emotions can influence their behavior (as for animals). Then students are trained to recognize emotions by face expressions or body gestures, and through role-playing are asked to communicate their emotions to the class in an assertive way.
2. Focus on the relationship between thoughts and emotions, according to the cognitive model: students are trained to self-observation and were asked to report in a diary their daily situations (at school, with friends, with parents) for helping them realize that the way they interpret situations can influence their emotions.
3. Cognitive restructuring according to CBT model, performed through role-playings and games in the class. Students are taught to identify and differentiate between negative thoughts and helpful thoughts, taking as examples their daily activities. They are instructed to recognize their cognitive mistakes and to correct them with alternative, more positive interpretations.
4. Focus on positive relations and self-acceptance: students are asked to recognize some positive characteristics of their schoolmates and then they are asked to pay each other a compliment. Then they were asked to report in their diary the compliments they receive. This allows students to reflect on how it can be difficult to be nice with a schoolmate, but also how it could be gratifying to receive an unexpected compliment.
5. Autonomy (perception of one's skills and abilities) and Purpose in Life (objectives to be reached in the future). Students are asked to write for themselves a personal horoscope concerning their social activities, school, sports and leisure time for the following year, reflecting on realistic goals they could achieve.
6. The last session is based on happiness and emotional well-being: students were asked to communicate and share with school-mates some very positive moments they have experienced during their life. They are instructed to recognize also daily positive moments they can experience and to report them on their diary.

class sessions lasting a couple of hours) were tested for the first time in a population of 111 middle school students and compared with an Attention-Placebo protocol (AP), based on theories and techniques derived from cognitive behavioral therapy (without any emphasis on positive emotions or Ryff's dimensions of psychological well-being). Both school-based interventions resulted in a comparable improvement in symptoms and psychological well-being (Ruini et al. 2006). The differential effects of WBT and CBT approaches have been subsequently explored in another controlled school investigation, involving longer interventions and an adequate follow-up. In this trial (Tomba et al. 2010) 162 students (mean age = 11.44; DS = 0.56) attending junior high schools were randomly assigned to either: (a) a protocol derived from WBT; (b) an anxiety-management (AM) protocol. The results of this investigation showed that WBT was found to produce significant improvements in the autonomy and friendliness dimensions, whereas AM ameliorated anxiety.

Considering the promising results obtained with middle school students (Ruini et al. 2006; Tomba et al. 2010), WBT school intervention has been extended also to high school students, considered a more "at risk population" for mood and anxiety disorders (Clarke et al. 1995). School interventions were performed in a sample of 227 students (mean age = 14.4; DS = 0.673) (Ruini et al. 2009). The classes were randomly assigned to either: (a) a protocol derived from WBT (five classes); or (b) attention-placebo (AP) protocol (four classes), which consisted of relaxation techniques, group discussions on common problems reported by students and conflict resolution. The WBT school intervention was found to be effective in promoting psychological well-being, with particular reference to personal growth, compared to the AP group. Further, it was found to be effective also in decreasing distress, in particular anxiety and somatization. In this study the beneficial effect of WBT school protocol in decreasing anxiety was maintained at the follow-up, whereas in the AP group improvements faded and disappeared. The promotion of positive functioning and building of individual strengths in young populations could yield more enduring effects, than simply addressing depressive or anxious symptoms (Ruini et al. 2009).

Even though these studies present several limitations (the limited number of sessions in each intervention, the sample of self-selected school students, with no particular physical or mental problems; the fact that assessment was based on self-rating scales only), results show that WBT-School intervention was effective in promoting psychological well-being, with particular reference to personal growth, compared to the attention placebo group. Further, it was found to be effective also in decreasing distress, in particular anxiety and somatization. An important criticism to be addressed in future research lies in the fact that WBT school interventions do not fully meet all criteria for effective school programs, such as the involvement of families and school environment, the use of booster sessions, etc. However, the beneficial effect of WBT school protocol in decreasing anxiety was maintained in the 6-month follow-up, demonstrating also its potential preventing role.

11.5 Conclusions

A widespread global interest is how school practices can help children and young people to prevent mental problem and to develop a sense of personal well-being (Weare and Nind 2011). Indeed, in addition to family and health services, school represents a key-setting for mental health promotion. Studies suggest that the most effective school-programmes are multi-modal and the involvement of the entire school environment is required. Considering socio-demographic and cultural variables, some data suggest the generalization of school-programmes effects across groups, but a more accurate and careful evaluation of these important aspects cannot be neglected in future research.

The existing programmes aim to prevent psychological disturbances and to develop coping strategies, emotional and social skills in children. An increasing area of interest concerns the promotion of psychological well-being in developmental settings, that entails helping students to recognize their own strengths, talents and capacities, and considering adversities as transformational opportunities for personal growth. As a result, preventing the "negative" (psychological distress) through targeted school-programs is one purpose, but engendering the "positive", through the promotion of psychological well-being, could be another way to reach the same goal, and may yield important protective factors in the face of future challenges (Ryff and Singer 1996). A new preventive intervention, the WBT-School Program, aims to enhance students' psychological well-being according to a eudaimonic perspective. Even though it is only in its preliminary stages, it has shown promising results both in the short and long term.

References

Bauer, J. J., McAdams, D. P., & Pals, J. L. (2008). Narrative identity and eudaimonic well-being. *Journal of Happiness Studies, 9*, 81–104.

Brandon, C. M., Cunningham, E. G., & Frydenberg, E. (1999). Bright ideas: A school-based program teaching optimistic thinking skills in pre-adolescence. *Australian Journal of Guidance and Counselling, 9*, 153–163.

Cardemil, E. V., Reivich, K. J., Beevers, C. G., Seligman, M. E. P., & James, J. (2007). The prevention of depressive symptoms in low-income, minority children: Two-year follow-up. *Behaviour Research and Therapy, 45*, 313–327.

Clarke, A., & Barry, M. (2010). An evaluation of the Zippy's friends emotional wellbeing programme for primary schools in Ireland. Health Promotion Research Centre, National University of Ireland, Galway. http://aran.library.nuigalway.ie/xmlui/bitstream/handle/10379/2170/04%20-%202010.rep.zippys.friends.main.pdf?sequence=1. Accessed Sept 2012.

Clarke, G. N., Hawkins, W., Murphy, M., Sheeber, L. B., Lewinsohn, P. M., & Seeley, J. R. (1995). Targeted prevention of unipolar depressive disorder in an at-risk sample of high school adolescents: A randomized trial of a group cognitive intervention. *Journal of the American Academy of Child Adolescent Psychiatry, 34*, 312–321.

Dadds, M. R., Holland, D. E., Laurens, K. R., Mullins, M., Barrett, P. M., & Spence, S. H. (1999). Early intervention and prevention of anxiety disorders in children: Results at 2-year follow-up. *Journal of Consulting and Clinical Psychology, 67*, 145–150.

De Jong, W. (1994). School-based violence prevention: From the peaceable school to the peaceable neighborhood. *Forum, 25*, 8–14.

Deci, E. L., & Ryan, R. M. (2008). Hedonia, eudaimonia, and well-being: An introduction. *Journal of Happiness Studies, 9*, 1–11.

Ertesvåg, S. K., & Vaaland, G. S. (2007). Prevention and reduction of behavioural problems in school: An evaluation of the respect program. *Educational Psychology, 27*, 713–736.

Fava, G. A. (2012). The clinical role of psychological well-being. *World Psychiatry, 11*, 102–103.

Flament, M. F., Nguyen, H., Furino, C., Schachter, H., MacLean, C., Wasserman, D., et al. (2007). Evidence-based primary prevention programmes for the promotion of mental health in children and adolescents: A systematic worldwide review. In H. Remschmidt, B. Nurcombe, M. L. Belfer, N. Sartorius, & A. Okasha (Eds.), *The mental health of children and adolescents: An area of global neglect* (pp. 65–135). Chichester: Wiley.

Gillham, J. E., Reivich, K. J., Jaycox, L. I., & Seligman, M. E. P. (1995). Preventing depressive symptoms in school-children: Two year follow-up. *Psychological Science, 6*, 343–351.

Gillham, J. E., Reivich, K. J., Freres, D. R., Chaplin, T. M., Shatté, A. J., Samuels, B., et al. (2007). School-based prevention of depressive symptoms: A randomized controlled study of the effective-ness and specificity of the Penn Resiliency Program. *Journal of Consulting and Clinical Psychology, 75*, 9–19.

Gillham, J. E., Chaplin, T. M., Reivich, K. J., & Hamilton, J. (2008). Preventing depression in early adolescent girls: The Penn Resiliency and Girls in Transition Programs. In C. LeCroy & J. Mann (Eds.), *Handbook of prevention and intervention programs for adolescent girls* (pp. 123–161). Hobokon: Wiley.

Gillham, J. E., Reivich, K. J., Brunwasser, S. M., Freres, D. R., Chajon, N. D., Kash-Macdonald, V. M., et al. (2012). Evaluation of a group cognitive-behavioral depression prevention program for young adolescents: A randomized effectiveness trial. *Journal of Clinical Child & Adolescent Psychology, 41*, 621–639.

Hains, A. A., & Ellmann, S. W. (1994). Stress inoculation training as a preventative intervention for high school youths. *Journal of Cognitive Psychotherapy, 8*, 219–232.

Harris, V. W., & Sherman, J. A. (1973). Use and analysis of the "Good Behavior Game" to reduce disruptive classroom behavior. *Journal of Applied Behavior Analysis, 6*, 405–417.

Hawkins, J. D., Catalano, R. F., Kosterman, R., Abbott, R., & Hill, K. G. (1999). Preventing adolescent health-risk behaviors by strengthening protection during childhood. *Archives of Pediatrics & Adolescent Medicine, 153*, 226–234.

Jenkins, R., & Barry, M. M. (2007). *Implementing mental health promotion*. London: Churchill Livingstone/Elsevier.

Kam, C. M., Greenberg, M. T., & Walls, C. T. (2003). Examining the role of implementation quality in school-based prevention using the PATHS curriculum. Promoting Alternative Thinking Skills Curriculum. *Prevention Science, 4*, 55–63.

Kendall, P. C. (1994). Treatment of anxiety disorders in children: A randomized clinical trial. *Journal of Consulting and Clinical Psychology, 62*, 100–110.

Keyes, C. L., Shmotkin, D., & Ryff, C. D. (2002). Optimizing well-being: The empirical encounter of two traditions. *Journal of Personality and Social Psychology, 82*, 1007–1022.

Kumpfer, K. L., Alvarado, R., Smith, P., & Bellamy, N. (2002). Cultural sensitivity and adaptation in family-based prevention interventions. *Prevention Science, 3*, 241–246.

Lowry-Webster, H. M., Barrett, P. M., & Dadds, M. R. (2001). A universal prevention trial of anxiety and depressive symptomatology in childhood: Preliminary data from an Australian study. *Behavior Change, 18*, 36–50.

Lowry-Webster, H. M., Barrett, P. M., & Lock, S. (2003). A universal prevention trial of anxiety symptomatology during childhood: Results at 1-year follow-up. *Behavior Change, 20*, 25–43.

McGrath, H., & Noble, T. (2003). *BOUNCE BACK! A classroom resiliency program for schools. Book 1: The teacher's handbook*. Sydney: Pearson Education.

McMahon, R. J., & Rhule, D. M. (2004). The prevention of conduct problems. In P. Graham (Ed.), *Cognitive behavior therapy for children and families* (2nd ed., pp. 481–503). Cambridge: Cambridge University Press.

Meichenbaum, D., & Deffenbacher, J. L. (1988). Stress inoculation training. *Counseling Psychologist, 16*, 69–90.

Merry, S. N., Hetrick, S. E., Cox, G. R., Brudevold-Iversen, T., Bir, J. J., & McDowell, H. (2011). Psychological and educational interventions for preventing depression in children and adolescents. *Cochrane Database Systematic Review, 12*, CD003380.

Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Washington, DC: National Academy Press.

Ortega, R., & Lera, M. J. (2000). The Seville anti-bullying in school project. *Aggressive Behaviour, 26*, 113–123.

Patel, V., Flisher, A. J., Hetrick, S., & McGorry, P. (2007). Mental health of young people: A global public-health challenge. *Lancet, 369*, 1302–1313.

Patton, G., Franzcp, M. D., Bond, L., Butler, H., & Glover, S. (2003). Changing schools, changing health? Design and Implementation of the Gatehouse Project. *Journal of Adolescent Health, 33*, 231–239.

Ruini, C., & Fava, G. A. (2012). Role of well-being therapy in achieving a balanced and individualized path to optimal functioning. *Clinical Psychology and Psychotherapy, 19*, 291–304.

Ruini, C., Belaise, C., Brombin, C., Caffo, E., & Fava, G. A. (2006). Well-being therapy in school settings: A pilot study. *Psychotherapy and Psychosomatics, 75*, 331–336.

Ruini, C., Ottolini, F., Tomba, E., Belaise, C., Albieri, E., Visani, D., et al. (2009). School intervention for promoting psychological well-being in adolescence. *Journal of Behavioral Therapy and Experimental Psychiatry, 40*, 522–532.

Ryan, R. M., & Deci, E. L. (2001). On happiness and human potentials: A review of research on hedonic and eudaimonic well-being. *Annual Review of Psychology, 52*, 141–166.

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

Ryff, C. D., & Singer, B. (1996). Psychological well-being: Meaning, measurement and implication for psychotherapy research. *Psychotherapy and Psychosomatics, 65*, 14–23.

Ryff, C. D., & Singer, B. H. (2008). Know thyself and become what you are: A eudaimonic approach to psychological well-being. *Journal of Happiness Studies, 9*, 13–39.

Shochet, I. M., Dadds, M. R., Holland, D., Whitefield, K., Harnett, P. H., & Osgarby, S. M. (2001). The efficacy of a universal school-based program to prevent adolescent depression. *Journal of Clinical Child Psychology, 30*, 303–315.

Spence, S. H., Sheffield, J. K., & Donovan, C. L. (2003). Preventing adolescent depression: An evaluation of the Problem Solving for Life Program. *Journal of Counseling and Clinical Psychology, 71*, 3–13.

Thompson, E., Eggert, L., & Herting, J. (2000). Mediating effects of an indicated prevention program for reducing youth depression and suicide risk behaviors. *Suicide and Life-Threatening Behavior, 30*, 252–271.

Tomba, E., Belaise, C., Ottolini, F., Ruini, C., Bravi, A., Albieri, E., et al. (2010). Differential effects of well-being promoting and anxiety-management strategies in a non-clinical school setting. *Journal of Anxiety Disorders, 24*, 326–333.

Waterman, A. S. (1993). Two conceptions of happiness: Contrasts of personal expressiveness (eudaemonia) and hedonic enjoyment. *Journal of Personality and Social Psychology, 64*, 678–691.

Weare, K., & Nind, M. (2011). Mental health promotion and problem prevention in schools: What does the evidence say? *Health Promotion International*, *26*(S1), Oxford University Press. doi:10.1093/heapro/dar075.

Chapter 12
The Promotion of Hope in Children and Youth

Susana C. Marques and Shane J. Lopez

12.1 The Promotion of Hope in Children and Youth

It is theorized that children are hopeful and that they report higher hope than most adults (Marques and Lopez 2014; Snyder 1994). Although the school years should be among the most hopeful in student's lives, recent research suggests that hope is moderate during late childhood (ages 10–13), declining from late childhood to adolescence (ages 14–17), with only people 65 year and older reporting lower levels than adolescence during the entire lifespan (Marques and Lopez 2014). This finding seems to imply that children and adolescents are ideal targets for programs and interventions aimed at fostering hope. This chapter briefly review details how hope construct is meaningful, measureable, and malleable via intentional change efforts.

12.2 Hope Theory and 20 Years of Research

Hope, the ideas and energy for the future, is one of the most potent predictors of success of our youth. Earlier writers have defined hope as an unidimensional construct involving an overall perception that one's goals can be met (French 1952; Lewin 1935; Menninger 1959; Stotland 1969). In the past decade, the prevailing scholarly view of hope (Snyder 1994) has gone beyond wishful thinking to an understanding of how multi-dimensional intentional thought leads to adaptive action. C. R. Snyder and colleagues (1991) developed a psychological theory and cognitive motivational

S.C. Marques (✉)
Faculty of Psychology and Educational Sciences, Porto University, Portugal
e-mail: smarques@fpce.up.pt

S.J. Lopez
Gallup and The Clifton Strengths School, USA

School of Business, University of Kansas, USA

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_12, © Springer Science+Business Media Dordrecht 2014

model of hope that is based in goal-directed thinking. Hope theory involves a person capacity to (a) clearly conceptualize goals (goals thinking), (b) develop the specific strategies to reach those goals (pathways thinking), and (c) initiate and sustain the motivation for using those strategies (agency thinking). "I'll find a way to get this done!", "I can do this", "I am not going to be stopped" are examples of hope messages. Pathways and agency thinking are stronger in high-hope individuals – as compared to low-hope people – and it is especially evident when the goals are important and when people are confronted with challenges or obstacles.

Over the last 20 years, researchers have gained a clearer understanding of the relationships between hope and important aspects of students' lives. Put simply, research demonstrates that more hopeful students do better in school and life than less hopeful students. Some relevant findings with children and youth demonstrate that hope is positively associated with perceived competence, self-worth, life satisfaction and well-being (e.g., Gilman et al. 2006; Marques et al. 2007), and negatively associated with symptoms of depression (Snyder et al. 1997b). High hope students typically are more optimistic (Snyder et al. 1997b), develop many life goals, and perceive themselves as being capable of solving problems that may arise (Snyder et al. 1997b).

Hope is not significantly related to native intelligence (Snyder et al. 2002) or income (Gallup 2009a), but instead is linked consistently to attendance and credits earned (Gallup 2009b) and academic achievement (Lopez et al. 2014). Specifically, hopeful middle school students have better grades in core subjects (Marques et al. 2011b) and scores on achievement tests (Snyder et al. 1997a). Hopeful high school students (Gallup 2009a; Snyder et al. 1991; Worrell and Hale 2001) and beginning college students (Gallagher and Lopez 2008; Snyder et al. 2002) have higher overall grade point averages. In these studies, the predictive power of hope remained significant even when controlling for intelligence (Snyder et al. 1997a), prior grades (Gallagher and Lopez 2008; Snyder et al. 1991; Snyder et al. 2002), self-esteem (Snyder et al. 2002), and entrance examination scores (Gallagher and Lopez 2008; Snyder et al. 2002).

Higher hope has been correlated positively with social competence (Barnum et al. 1998), pleasure in getting to know others, enjoyment in frequent interpersonal interactions (Snyder et al. 1997b), and interest in the goal pursuits of others (Snyder et al. 1997a). Hope also plays a role in children's health such as adherence to treatment among asthma patients (Berg et al. 2007). On the other hand, hopelessness (i.e. negative expectations about oneself and one's future, Beck et al. 1974) is an important predictor of violence, aggressive behaviour, substance use, sexual behaviour, and accidental injury among adolescents (Bolland 2003).

12.3 Measuring Hope in Children and Youth Across Cultures

Hope can be detected in action by someone who knows a child well. Daily conversations, letters, stories, games, poems, diaries, journal entries are some of the most meaningful ways to determine individuals' hope. Additionally, there are various

self-reported measures of hope that can facilitate hope assessment. We describe the two most widely used scales (which are in the public domain) to measure the trait aspect of hope (i.e., as a relatively stable personality disposition).

The Children's Hope Scale (CHS) developed by Snyder et al. (1997b) is a trait hope measure for children ages 7 through 14 years. The scale is comprised of three agency (e.g., "I am doing just as well as other kids my age") and three pathways items (e.g., "When I have a problem, I can come up with lots of ways to solve it"). The CHS has demonstrated satisfactory psychometric properties when used with physically and psychologically healthy children from public schools, boys diagnosed with attention-deficit/hyperactivity disorder, children with various medical problems, children under treatment for cancer or asthma, child burn victims, adolescents with sickle-cell disease, and early adolescents exposed to violence (Snyder et al. 1997b). Besides the original version from Snyder et al. (1997a), this scale has been translated and validated to Portuguese (Marques et al. 2009) and Spanish languages (McDermott et al. 1997). Hope levels are similar between the Portuguese and the English language versions. Children from both countries ascribed the hopeful content to themselves "a lot of the time" (Marques et al. 2009; Snyder et al. 1997a). Among different ethnic groups, it appears that while not statistically significant, Caucasians tend to report fewer obstacles in their lives than their ethnic minority counterparts. However, minority groups have been shown to produce higher average hope scores than Caucasians (e.g., McDermott et al. 1997; Snyder et al. 1997a).

To measure the trait aspect of hope in adolescents (and adults) ages 15 and older, Snyder et al. (1991) developed the Hope Scale (HS). This scale consists of four items measuring agency (e.g., "I energetically pursue my goals"), four items measuring pathways (e.g., "There are lots of ways around any problem"), and four distracter items. This scale has been used with a wide range of samples and has exhibited acceptable psychometric properties. Besides the original version from Snyder et al. (1991), the HS has been translated and validated into different languages, including Portuguese (Marques and Pais-Ribeiro 2006), Dutch (Carifio and Rhodes 2002), French (Dube et al. 2000), Slovak (Halama 2001), Chinese (Ho 2003), Korean (Yun 2003), and Arabic (Abdel-Khalek and Snyder 2007). Higher hope, as measured by the Hope Scale, seems to relate to similar psychological profiles for the English, Portuguese, Dutch, French, Slovak, Chinese, Korean, and Arabic speaking people.

There are additional ways to measure hope besides observation and the use of the CHS/HS. The Gallup Student Poll (GSP) is an online school-based measure of student hope (and engagement and well-being). The survey and the dates to be administered by interested schools are available at the gallupstudentpoll.com website. The following items were used to measure hope in the GSP:

- I know I will graduate from high school.
- There is an adult in my life who cares about my future.
- I can think of many ways to get good grades.
- I energetically pursue my goals.
- I can find lots of ways around any problem.
- I know I will find a good job after I graduate.

Findings from this latter survey, based on convenience and representative samples, demonstrate that half of American students are hopeful, meaning they have many future ideas and goals and strategies and energy to get the things done. The other half of students do not have the hope they need to succeed (Gallup 2009b). These stuck (33 %) or discouraged (17 %) students may lack the energy to pursue goals and often give up when facing obstacles because they can't find alternative pathways or can't get the support they need to overcome obstacles. Moreover, failure in hopeless students is not used to improve performances in the future (Onwuegbuzie 1998) and may result in frustration, loss of confidence and lowered self-esteem (Snyder 1994).

12.4 Promoting Hope in Children and Youth Across Cultures

Over the last 10 years, researchers have developed programs or interventions aims to enhance hope in children and youth. These programs (e.g., Lopez et al. 2000; Marques et al. 2011a) have demonstrated that hope can be cultivated and despite students with the least hope tend to benefit most from hope interventions (Bouwkamp 2001), research shows that virtually all students raise their hope levels when taking part in school hope programs (Lopez et al. 2000; Marques et al. 2011a).

12.4.1 The Role of Parents and Teachers in Foster Students Hope

Given that hope is malleable and that the hopeless can learn to be hopeful, our youth need a focused effort from people who care about them and their future. Parents are the first important agents to impact children's hope. They model hope by the way they communicate ("hopeful language" in the every day life, such as "when you finish your homework we can go out" instead of "if you can finish your homework we can go out"), set goals, view challenges and cope with problems. In the same manner, teachers play an important role in children's perceptions about their competences to achieve goals and to cope with obstacles that can arise. For example, educators should provide help students develop the capacity to think about the future in a complex way, develop flexible thinking about how to attain future goals, and how to renew motivation when willpower is depleted. Additionally, being a high-hope parent and teacher facilitates children's hopeful thinking, and school psychologists are well positioned to facilitate this hope transmission. See Appendix A for some suggestions to work and refine with teachers and parents to enhance children's hope. For more detailed information about imparting goal setting as well as pathways and agency thinking to students, parents and teachers see McDermott and Snyder (1999, 2000), Snyder et al. (2002) or Lopez et al. (2009).

Besides parents and teachers, there are other significant influences on children's hope, such as peer groups. It is important that parents stay in touch with these influences and be active participants in their children's interests. Hope transmission between peers' interactions should also be a focus of attention in hope development. In this regard, we suggest the inclusion of peers when adults intentionally work on children's hope.

By integrating hope into curriculum or doing separate and regular hope-enhancing group sessions, the school is an ideal place to work in groups and include peers. It is possible to find ways to infuse hopeful thinking into the subject matter that children are studying. For example, history is replete with high-hope people, and students may be oriented to explore their goals, the problems that had to be overcome, and the initiative and energy it took to achieve their objectives. In literature, teachers can benefit from personal narratives and can assign short stories to illustrate the hope process. In mathematics, teachers can infuse hope and at the same time may reduce math anxiety, a problem that frequently inhibit the learning of relevant skills (Snyder 1999). For this purpose, it is important to teach the concepts in small steps and praise the child's comprehension of each step, giving a special emphasis on their efforts besides their achievements. In fact, mathematics may be one of the most strategic subjects where the steps to enhance hope described in Appendix A can produce benefits in learning and in reducing math anxiety. Physical education is also a critical area because the goals and movement toward them are visually perceived.

School professionals may implement group programs to infuse hope in children by including all the class (for some proposals, see the Sect. 12.4.2), and with a collaboration effort, psychologists, teachers, parents and school administrators can build an hope-inducing school atmosphere.

12.4.2 Helping Students Capitalize on Their Strengths and Build Hope

Helping students capitalize on their strengths, may be one of the most successful ways to improve the conditions that promote learning and grow.

The Clifton Strengths Finder, an online measure of personal talent that identifies areas where an individual's greatest potential for building strengths exists, initiates a strengths-based development process in work and academic settings, and findings in the school setting suggest the efficacy of strengths development interventions in fostering students' hope and engagement at school (Lopez and Calderon 2011; Lopez and Louis 2009).

Other efforts to foster hope in children and youth include the "Making Hope Happen Program" (Lopez et al. 2000) designed and implemented with U.S. students and the "Building Hope for the Future – A Program to Foster Strengths in Middle-School Students" (Marques et al. 2011a) designed and implemented with Portuguese students. These programs were designed for a group format delivered over five weekly sessions,

to help students to (1) conceptualize clear goals; (2) produce numerous range of pathways to attainment; (3) summon the mental energy to maintain the goal pursuit; and (4) reframe seemingly insurmountable obstacles as challenges to be overcome.

The "Building Hope for the Future" (BHF) is a social-ecological program that comprises five 1-h sessions with students and direct work with key stakeholders such as parents, teachers and school peers (1 h during the first week of the students' intervention). See Appendix B for the contents of the BHF program.

A first implementation and examination of this program with Portuguese middle-schoolers, their parents, teachers and school peers (Marques et al. 2011a) revealed that students in the intervention group increased hope, life satisfaction and self-worth for at least, 1-year and 6-months after the program. The matched comparison group demonstrated no change in hope, life satisfaction and self-worth from baseline to post- or follow-up assessments. Results suggest that an intervention designed to foster hope in middle schoolers, with the collaboration of key stakeholders (parents, teachers and peers) can produce psychological benefits, by increasing hope, life satisfaction and self-worth. These findings are consistent with previous interventions to enhance goal-directed thinking. For example, the "Making Hope Happen Program" (Lopez et al. 2000) produced increases in hope across different school grade levels. Moreover, BHF strongly support the application of group-based approaches for raising the hopeful thinking of all students (e.g., the curriculum and school environment for students could be arranged and improved in the direction of supporting hopeful thinking). Finally, this intervention has the potential to address issues of efficacy, accessibility (students, teachers, and parents) and sustainability (low cost to deliver in a group-setting and with 5 weeks only).

12.5 Conclusion

In this chapter, we presented the fundamentals of hope theory to our school-based psychology colleagues around the world. A brief literature review details how hope construct is meaningful, measureable, and malleable via intentional change efforts.

It probably is accurate to say that all students, independently of their culture and language, need support from parents, school, community to build their energy and ideas for the future. As such, we hope to encourage researchers, psychologists and school educators to keep hope alive in our schools and in our worldwide students.

Appendix A: Some Suggestions to Work and Refine with Teachers and Parents to Enhance Children's Hope

- Let teachers and parents know that children build hope through learning to trust in the ordered predictability and consistency of children interactions with them.
- Explain the importance of being firm, fair, and consistent in engendering hope among their children.

- Explain the importance of creating an atmosphere of trust, where students are responsible for their actions and supported to establish growth-inducing stretch goals.
- Emphasize that children should be praised and rewarded for both their efforts and achievements.
- Encourage teachers and parents goals that are made concrete, understandable, and are broken down into subgoals.
- Work with them to focus on long-range as opposed to short-term goals.
- Emphasize the importance of preparation and planning.
- Develop an atmosphere where students are focused on expending effort and mastering the information rather than a sole focus on obtaining good outcomes (e.g., high grades or stellar athletic records).
- Encourage an atmosphere through a give and take process between teachers/parents and students.
- Teachers should be encouraged to remain engaged and invested in pursuing their own important interests and life goals outside of the classroom.
- Let them know that being a hopeful adult has many benefits. High-hope people perform better at work (Peterson and Byron 1997), have higher well-being (Gallagher and Lopez 2009), and live longer (Stern et al. 2001).

Appendix B: Content of the BHF

Sessions with Students

Session 1: Learning about Hope

Goals. The primary goal of this session is to improve the students' understanding of hope theory and its relevance to the change process and to achieve positive outcomes.

Content. This session offers the participants an overview of the topic of hope, including its three components (pathways, agency and goals). Additionally, the central role that hope plays in daily communication is addressed by learning, identifying and practicing the vocabulary used in the model.

Example of an exercise. The students are asked to acting out the hope picture.

Session 2: Structuring Hope

Goals. A major goal of this session is students learn to recognize pathways and agency components of hope, and obstacles to a goal attainment. In addition, this session aims to help students build or identify personal goals (salient and attainable) they could work with for the next 4 weeks.

Content. This session encompasses three important elements, the discussion of stories and goal-oriented characters, the brainstorm of goal-oriented ideas from the past life and the identification of present goals they would like to work.

Example of an exercise. Participants are asked to identify goals, obstacles, pathways and agency, first from stories or past situations of their real life, and after from present situations they would like to work with the hope buddy.

Session 3: Creating Positive and Specific Goals

Goals. The goals of this session is to practice the model, refine personal workable goals in order to be more specific, positive and clearer, create multiple pathways and identify agency thoughts for each personal goal.

Content. First, the introduction of new narratives and group activities offers the participants to reinforce and practice the model. This session also draws on the progress of personal goals and collaboration can occur to adjust or modify any disparities in actions or thinking that may hinder the successful achievement of the desired goals.

Example of an exercise. Participants are asked to reorganize goals in a "goal enhancer worksheet" by making it more specific and positive.

Session 4: Practice Makes Perfect

Goals. The goals of this session are to judge, identify and create an "hopeful talk"; to reinforce the hope model; and to review and introduce personal workable goals in a personal hope story.

Content. Hopefulness communication patterns, as well as hopeful communication behavior are presented and supervised role plays to help students better identify and understand hopefulness and hopeful voices is reinforced. The progress of personal goals is continually monitored.

Example of an exercise. Each student is asked to share with the buddy the progress of his/her goal through a "Hope Buddy Journal".

Session 5: Review and Apply for the Future

Goals. The primary goal of this session is to enhance exchange of personal hope stories and to plan future steps.

Content. This session proposes to the students the exchange with the group how they implement the hope theory to their unique life experiences. The process over achievement is emphasized as well as the next steps in the goal process.

Example of an exercise. Participants are encouraged to evaluate the process and discuss next steps with the hope buddy and finally share his/her personally hope story with the rest of the group.

Shared Considerations across the five-sessions

- Each session started with a 10 min segment dedicated to modeling and developing enthusiasm for the program and to reinforcing ideas learned in the previous session.
- The sessions are based on the theoretical and applied work of Snyder and colleagues (e.g., Lopez et al. 2000; Snyder 1994; Snyder et al. 2002; McDermott and Snyder 1999).
- The sessions integrate solution-focused, narrative and cognitive-behavioral techniques.
- The sessions offer psycho-educational, skills training and group process components, and include structured activities, roleplaying, brainstorming, and guided discussion.
- The program is designed to be controlled for adult attention, group cohesion, social support, the discussion of hope components, sharing thoughts and feelings with peers, and engagement in session's activities.

Session with Parents and Teachers

The direct work with parents and teachers is supported by a manual designed to: (1) increase parents and teachers awareness of the principles of hope and enhance their goal-setting behavior; and (2) promote goal-setting behavior in their children/students. This manual has three sections: The first section is dedicated to "Learning about hope" (e.g., hope concept, research on hope, how hope can be cultivated, reflection questions). The second section is the "Instilling Hope" section and participants are first oriented to a "Hope Finding" (e.g., self-evaluation with the Hope Scale from Snyder et al. 1991) and next to a "Hope Bonding" (how to build hopeful relationships). The third section, "Increasing Hope", is dedicated to "Hope Enhancing" (this segment provides basic steps associated with hope enhancement) and "Hope Reminding" (this segment provides strategies and practical exercises to improve their own hope and in their children/students).

References

Abdel-Khalek, A. M., & Snyder, C. R. (2007). Correlates and predictors of an Arabic translation of the Snyder Hope Scale. *The Journal of Positive Psychology, 2*, 228–235.

Barnum, D. D., Snyder, C. R., Rapoff, M. A., Mani, M. M., & Thompson, R. (1998). Hope and social support in the psychological adjustment of pediatric burn survivors and matched controls. *Children's Health Care, 27*, 15–30.

Beck, A. T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The Hopelessness Scale. *Journal of Consulting and Clinical Psychology, 42*, 861–865.

Berg, C. J., Rapoff, M. A., Snyder, C. R., & Belmont, J. M. (2007). The relationship of children's hope to pediatric asthma treatment adherence. *The Journal of Positive Psychology, 2*, 176–184.

Bolland, J. M. (2003). Hopelessness and risk behaviour among adolescents living in high-poverty inner-city neighbourhoods. *Journal of Adolescence, 26*, 145–158.

Bouwkamp, J. (2001). *Making hope happen: A program for inner-city adolescents.* Unpublished master's thesis. University of Kansas, Lawrence.

Carifio, J., & Rhodes, L. (2002). Construct validities and the empirical relationships between optimism, hope, self-efficacy, and locus of control. *Journal of Prevention, Assessment, and Rehabilitation, 19*, 125–136.

Dube, M., Lapierre, S., Bouffard, L., & Labelle, R. (2000). Psychological well-being through the management of personal goals: A group intervention for retirees. *Revue Quebecoise de Psychologie, 21*, 255–280.

French, T. M. (1952). *The integration of behaviour*. Chicago: University of Chicago Press.

Gallagher, M. W., & Lopez, S. J. (2008). *Hope, self-efficacy, and academic success in college students*. Poster presented at the annual convention of the American Psychological Association, Boston.

Gallagher, M. W., & Lopez, S. J. (2009). Positive expectancies and mental health: Identifying the unique contributions of hope and optimism. *The Journal of Positive Psychology, 4*, 548–556.

Gallup. (2009a). *Relationships between hope, income, and teacher-student ratio in March 2009 Gallup Student Poll.* Unpublished data. Omaha, Nebraska.

Gallup. (2009b). *Hope, engagement, and well-being as predictors of attendance, credits earned, and GPA in high school freshmen.* Unpublished data. Omaha, Nebraska.

Gilman, R., Dooley, J., & Florell, D. (2006). Relative levels of hope and their relationship with academic and psychological indicators among adolescents. *Journal of Social and Clinical Psychology, 25*, 166–178.

Halama, P. (2001). The Slovak version of Snyder's Hope Scale. *Ceskoslovenska Psychologie, 45*, 135–142.

Ho, S. M. Y. (2003). *Hope in Hong Kong.* Unpublished manuscript. University of Hong Kong, China.

Lewin, K. (1935). *Dynamic theory of personality*. New York: McGraw-Hill.

Lopez, S. J., & Calderon, V. (2011). The Gallup Student Poll: Measuring and promoting what is right with students. In S. I. Donaldson, M. Csikszentmihalyi, & J. Nakamura (Eds.), *Applied positive psychology: Improving everyday life, schools, work, health, and society* (pp. 117–134). New York: Routledge.

Lopez, S. J., & Louis, M. C. (2009). The principles of strengths-based education. *Journal of College and Character, 10*, 1–8.

Lopez, S. J., Bouwkamp, J., Edwards, L. M., & Terramoto Pedrotti, J. (2000). *Making hope happen* via *brief interventions.* Paper presented at the second Positive Psychology Summit, Washington, DC.

Lopez, S. J., Rose, S., Robinson, C., Marques, S. C., & Pais-Ribeiro, J. L. (2009). Measuring and promoting hope in school children. In R. Gilman, E. S. Huebner, & M. J. Furlong (Eds.), *Handbook of positive psychology in the schools* (pp. 37–51). Mahwah: Lawrence Erlbaum.

Lopez, S. J., Reichard, R. J., Marques, S. C., & Dollwet, M. (2014). Relation of hope to academic outcomes: A meta-analysis. Manuscript submitted for publication.

Marques, S. C., & Lopez, S. J. (2014). Age differences and short-term stability in hope: Results from a Portuguese sample aged 15 to 80. Manuscript submitted for publication.

Marques, S. C., & Pais-Ribeiro, J. L. (2006). *Contribution for the validation of the Snyder Trait Hope Scale.* Paper presented at the 3rd European conference on positive psychology, Braga.

Marques, S. C., Pais-Ribeiro, J. P., & Lopez, S. J. (2007). Validation of a Portuguese version of the Students' Life Satisfaction Scale. *Applied Research in Quality of Life, 2*, 83–94.

Marques, S. C., Pais-Ribeiro, J. L., & Lopez, S. J. (2009). Validation of a Portuguese version of the Children's Hope Scale. *School Psychology International, 30*, 538–551.

Marques, S. C., Lopez, S. J., & Pais-Ribeiro, J. L. (2011a). "Building hope for the future" – A program to foster strengths in middle-school students. *Journal of Happiness Studies, 12*, 139–152.

Marques, S. C., Pais-Ribeiro, J. L., & Lopez, S. J. (2011b). The role of positive psychology constructs in predicting mental health and academic achievement in children and adolescents: A two-year longitudinal study. *Journal of Happiness Studies, 12*, 1049–1062.

Marques, S. C., Lopez, S. J., Fontaine, A. M., Coimbra, S., & Mitchell, J. (2014). Hopeful youths: Benefits of very high hope among adolescents. Manuscript submitted for publication.

McDermott, D., & Snyder, C. R. (1999). *Making hope happen*. Oakland: New Harbinger.

McDermott, D., & Snyder, C. R. (2000). *The great big book of hope: Help your children achieve their dreams*. Oakland: New Harbinger.

McDermott, D., Hastings, S. L., Gariglietti, K. P., Gingerich, K., Callahan, B., & Diamond, K. (1997). *A cross-cultural investigation of hope in children and adolescents.* Resources in Education, CG028078.

Menninger, K. (1959). The academic lecture on hope. *The American Journal of Psychiatry, 109*, 762–769.

Onwuegbuzie, A. J. (1998). Role of hope in predicting anxiety about statistics. *Psychological Reports, 82*, 1315–1320.

Peterson, S. J., & Byron, K. (1997). Exploring the role of hope in job performance: Results from four studies. *Journal of Organizational Behavior, 29*, 785–803.

Snyder, C. R. (1994). *The psychology of hope: You can get there from here*. New York: Free Press.

Snyder, C. R. (1999). Hope, goal blocking, thought, and test related anxieties. *Psychological Reports, 84*, 206–208.

Snyder, C. R., Harris, C., Anderson, J. R., Holleran, S. A., Irving, L. M., Sigmon, S. T., Oshinoubu, L., Gibb, J., Langelle, C., & Harney, P. (1991). The will and the ways: Development and validation of an individual-differences measure of hope. *Journal of Personality and Social Psychology, 60*, 570–585.

Snyder, C. R., Cheavens, J., & Sympson, S. C. (1997a). Hope: An individual motive for social commerce. *Group Dynamics: Theory, Research, and Practice, 1*, 107–118.

Snyder, C. R., Hoza, B., Pelham, W. E., Rapoff, M., Ware, L., Danovsky, M., Highberger, L., Ribinstein, H., & Stahl, K. J. (1997b). The development and validation of the Children's Hope Scale. *Journal of Pediatric Psychology, 22*, 399–421.

Snyder, C. R., McDermott, D., Cook, W., & Rapoff, M. (2002). *Hope for the journey (revised ed.)*. Clinton Corners: Percheron Press.

Stern, S. L., Dhanda, R., & Hazuda, H. P. (2001). Hopelessness predicts mortality in older Mexican and European Americans. *Psychosomatic Medicine, 63*, 344–351.

Stotland, E. (1969). *The psychology of hope*. San Francisco: Jossey-Bass.

Worrell, F. C., & Hale, R. L. (2001). The relationship of hope in the future and perceived school climate to school completion. *School Psychology Quarterly, 16*, 370–388.

Yun, N. M. (2003). *Translating the Hope Scale into Korean.* Unpublished manuscript, Yonsei University, Seoul, Korea.

Chapter 13
Life Satisfaction in Youth

Carmel Proctor and P. Alex Linley

13.1 Introduction

The promotion of well-being among young people is an ongoing concern for mental health professionals and educators (Huebner et al. 2006). Indeed, how to better the lives of children is central to the mission of positive psychology. Although a variety of constructs have been proposed, understanding and fostering life satisfaction is widely agreed as being critical to achieving this goal. Life satisfaction is the cognitive, global appraisal of life as a whole (Shin and Johnson 1978), and one of the most well-established indicators of happiness, well-being, and positive functioning among young people (Suldo et al. 2006). Indeed, empirical research has demonstrated it to be positively related to a broad spectrum of positive personal, psychological, behavioral, social, interpersonal, and intrapersonal outcomes (see Proctor et al. 2009b for a review). Life satisfaction is seen as one element of subjective well-being (SWB; together with positive affect and negative affect), and thereby distinct from, but related to, psychological well-being as defined by Ryff and Keyes (1995). Evidence suggests that, for adults at least, the domains of subjective well-being and psychological well-being are distinct, yet still related (Keyes et al. 2002; Linley et al. 2009). Notwithstanding this, this chapter focuses specifically on the role of life satisfaction in youth, and does not review subjective well-being or psychological well-being more broadly.

C. Proctor (✉)
Positive Psychology Research Centre, PO Box 544, St. Peter Port GY1 6HL, Guernsey
e-mail: carmel@pprc.gg

P.A. Linley
Centre of Applied Positive Psychology, The Venture Centre, University of Warwick
Science Park, Sir William Lyons Road, Coventry CV4 7EZ, UK
e-mail: alex.linley@cappeu.com

G.A. Fava and C. Ruini (eds.), *Increasing Psychological Well-being in Clinical and Educational Settings*, Cross-Cultural Advancements in Positive Psychology 8,
DOI 10.1007/978-94-017-8669-0_13, © Springer Science+Business Media Dordrecht 2014

Recent empirical evidence suggests that youths with extremely high levels of life satisfaction benefit from increased adaptive psychosocial functioning, intrapersonal, interpersonal, and social relationships, academic success, and decreased behavioral problems, over and above those with average levels of life satisfaction (Gilman and Huebner 2006; Proctor et al. 2010; Suldo and Huebner 2006). Increased life satisfaction is also associated with multiple school-related variables, including school satisfaction, teacher support, and perceived academic achievement, competence, and self-efficacy (see Suldo et al. 2006 for a review). Moreover, research suggests that life satisfaction is not simply an epiphenomenon (i.e., a by-product of individual differences in personality and life experiences), but an important determinant of outcomes that are beneficial to individuals, families, and communities (K. Martin et al. 2008). For example, empirical evidence suggests that life satisfaction buffers against the negative effects of stress and the development of psychological disorder (Suldo and Huebner 2004a). That is, adolescents with positive life satisfaction have been demonstrated to be less likely to develop later externalizing behaviors as a result of stressful life events than adolescents with low life satisfaction, suggesting that life satisfaction acts as a moderator for (i.e., buffer against) externalizing behavior (Suldo and Huebner 2004a).

Historically, approaches aimed at promoting well-being among young people have focused on maladaptive outcomes, with positive psychological function being informed from the absence of psychopathological symptoms; psychopathology refers to both internalizing psychological disorders (e.g., depression, anxiety) and externalizing disorders (e.g., conduct disorder, oppositional defiant disorder) (Suldo and Shaffer 2008). However, more recent evidence suggests that high psychopathology can be accompanied by high SWB, just as low psychopathology can be accompanied by low SWB (Greenspoon and Saklofske 2001). For example, an individual may display symptoms of psychopathology and still be highly satisfied with life or not display psychopathological symptoms and yet be very dissatisfied with life. These findings suggest that the absence of psychopathological symptoms is not necessarily an indication of positive mental health and that the study of optimal functioning and well-being is an important endeavor in its own right (Huebner et al. 2006). In the first part of this book the relationships between well-being and distress have been analyzed in adult clinical populations.

With the advent of positive psychology, there has been resurgence of the study of optimal functioning and well-being among young people and increased recognition of the distinction between these two conceptualizations. For example, Suldo and Shaffer (2008) examined the existence and utility of a dual-factor model in early adolescence and found that students with complete mental health (i.e., high SWB, low psychopathology) had better reading skills, school attendance, academic self-perceptions, academic-related goals, social support from parents and peers, self-perceived physical health, and fewer social problems than vulnerable youths (i.e., low psychopathology, low SWB). Among students with clinical levels of psychopathology, students with high SWB (symptomatic but content youth) perceived better social functioning and physical health (Suldo and Shaffer 2008). Overall, results support the existence of a dual-factor model and the importance of high SWB to optimal functioning during adolescence (Suldo and Shaffer 2008).

In their review of 141 empirical studies of youth life satisfaction C. L. Proctor et al. (2009b) concluded that, in general, research indicates that youths who report high levels of life satisfaction have better social and interpersonal relationships, engage in healthier behaviors, exhibit less antisocial and violent behavior, and develop fewer externalizing problems following stressful events than those with low life satisfaction; for a review of the measures of adolescent life satisfaction, the interested reader is directed to C. Proctor et al. (2009a). Expanding on this review, the following sections contain summaries of the current major findings of the youth life satisfaction literature as it pertains to the promotion of well-being in young people.

13.2 Supportive Interpersonal Relationships

13.2.1 Parenting Style

Both being involved in supportive relationships with parents and peers and the perception of adequate social support from significant others is essential to positive mental health throughout development. Although reliance on support can shift from parents to peers as age increases (e.g., Steinberg 1987; Nickerson and Nagle 2004), it is adolescents' perception of parental involvement, relationship with parents, and family functioning that has the greatest impact on level of life satisfaction, over and above stressful life circumstances. For instance, Suldo and Huebner (2004b) found that all three dimensions of the authoritative parenting style: social support-involvement, strictness-supervision, and psychological autonomy granting were positively related to life satisfaction among adolescents, with perceived parental social support having the strongest correlation. Specifically, an interaction effect was found between life satisfaction and parental social support such that the influence of parenting behaviors on adolescent global life satisfaction decreased as age increased (cf., Goldbeck et al. 2007).

Similarly, Milevsky et al. (2007) found authoritative mothering to be related to higher self-esteem and life satisfaction, and lower depression among adolescents, with the advantages of authoritative mothering being more advantageous than permissive mothering on all outcomes. Thus, despite the increasing importance of autonomy among young people, programs aimed at enhancing life satisfaction need to include strong family components (Huebner et al. 2006). Moreover, considering the greater impact of peer relationships in older adolescents, programs aimed at the development of social skills and peer interactions are also crucial (see Waas 2006 for a review).

13.2.2 Family Relationships and Family Structure

Cross-culturally, research among British and Italian adolescents has shown that cohesive family relationships are associated with better psychological well-being (Manzi et al. 2006). Comparatively, studies of adolescents in the East have revealed

relationships between parenting style and adolescent life satisfaction similar to those found in the West. For example, Shek et al. (2006) found that satisfaction with and quality of parent-adolescent communication were more strongly related to adolescent psychological well-being than frequency of parent-adolescent communication; similar results have also been found among Hungarian adolescents where being able to talk to parents about problems was a universal correlate of increased life satisfaction (see B. F. Piko and Hamvai 2010).

Related to these findings, research among Chinese adolescents has demonstrated that perceived parental psychological control is associated with reduced psychological well-being (Shek 2007a) and that parental behavioral control processes and parent–child relationship quality is higher in intact families (Shek and Lee 2007; Shek 2007b). Indeed, research conducted by Kwan (2010) found that Chinese adolescents living with both parents enjoyed higher life satisfaction across six domains (i.e., family, friends, school, self, living place, and overall), and had higher assessed health across four aspects (i.e., overall, physical, mental, and activity-day); comparatively however, self-assessed health and life satisfaction were lower among Chinese adolescents than American. Similarly, Antaramian et al. (2008) found that among American middle school students family structure was significantly related to family satisfaction, with adolescents from single-parent and stepparent families reporting lower satisfaction than adolescents from intact families.

In Germany, however, Winkelmann (2006) demonstrated that it is living circumstance and not parental separation, which is having the greatest negative effect on adolescent well-being among youths from non-intact families (cf., Sharma and Silbereisen 2007). Further, research with adopted children demonstrates the reciprocal nature of family relationships by indicating that the parent's level of relationship satisfaction with their adopted child is positively related to the parent's level of satisfaction and adolescent attachments to parents is related to adolescent life satisfaction and parent level of relationship satisfaction with their adopted child (Erich et al. 2009). These findings highlight the importance of the family as an institution that is central to the facilitation of optimal well-being (Antaramian et al. 2008).

13.2.3 Relationship Quality, Perceived Support, and Values

Additional elements of a supportive parent–child relationship include the facilitation of protective factors, quality of attachment, and the modeling of values. For example, Valois et al. (2009) explored the relationship between developmental assets (building blocks that, when present in children and adolescents, serve to protect them from engagement in health-compromising behaviors and to enhance their opportunity to achieve success in academic and interpersonal contexts) and life satisfaction. These researchers explored seven important developmental assets (i.e., support by parents/other adults; accountability to adults; empowerment; school support; values regarding risk behaviors; quantity of other adult support; empathetic relationships) and life satisfaction among adolescents.

Consistent with findings from previous studies, results revealed life satisfaction to be significantly related to perceived support by parents (e.g., Dew and Huebner 1994; Greenberg et al. 1983; Ma and Huebner 2008). For example, Ma and Huebner (2008) examined the extent to which the quality of parent and peer attachments related to early adolescents' life satisfaction and found parental attachment to be the strongest unique predictor, with peer attachment partially mediating the relationship between parental attachment and life satisfaction among adolescent girls.

Life satisfaction was also related to accountability to parents/other adults and values regarding risk behaviors among African American females, which is consistent with previous studies of risk-taking behavior and life satisfaction (Valois et al. 2001, 2002, 2003, 2004, 2006, 2010; Zullig et al. 2001, 2005).

Similarly, life satisfaction was found to be significantly associated with quality of other adult support, which is consistent with findings from a study by Paxton et al. (2006) demonstrating that in addition to supportive parental relationships, opportunities for adult bonding and meaningful relationships in the neighborhood are associated with increased life satisfaction.

Related to this, research has shown that there is substantial transmission of mental distress and SWB between parents and children, such that parental distress effects the life satisfaction of their child and the child's life satisfaction influences the happiness of their parent (Powdthavee and Vignoles 2008). Finally, life satisfaction was also linked to empathetic relationships such that students who reported an absence of this quality were more likely to report lower levels of life satisfaction.

13.3 Meaningful Instrumental Activities

As noted, perceptions of adequate social support from parents, peers, and others is a key factor in the life satisfaction of adolescents. Notwithstanding this, is the importance promoting involvement in meaningful instrumental activity. The term 'meaningful instrumental activity' denotes individual perceptions of participating in psychologically significant, as well as personally significant, activities that are not limited to the work/school domain, but that may include other skill, goal, or task-based activities as well (Maton 1990).

13.3.1 Flow

For example, researchers such as Csikszentmihalyi (2002) have long underscored the importance of encouraging adolescent participation in activities that facilitate 'flow' – a mental state in which the challenge of an activity matches skill, such that neither anxiety or boredom occur (i.e., the activity is neither too easy nor too difficult). The flow state is an innately positive experience, one which is linked to academic success, diminished delinquency, physical health, and satisfaction with life

(see Nakamura and Csikszentmihalyi 2002). Thus, providing opportunities for students to engage in activities that facilitate flow states allows them to perform optimally in education and sport.

13.3.2 Physical Exercise and Structured Extracurricular Activities

Indeed, life satisfaction has been consistently linked with academic achievement and participation in exercise and structured extracurricular activities (see Gilman et al. 2004; Suldo et al. 2006 for reviews). Similarly, Froh et al. (2010b) found that young people high in engaged living (social integration and absorption; i.e., having a passion to help others and be completely immersed in activity) are more grateful, hopeful, happier, prosocial, and report elevated life satisfaction, positive affect, self-esteem, school experience, and grade point average, as well as, tend to be less depressed, envious, antisocial, and delinquent. Thus, helping adolescents become more passionate about helping others and absorbed in their activities is one way to help lay the foundation for growth and positive experiences, which promotes psychological well-being both now and in the future (Froh et al. 2010b). Moreover, being engaged in life may help cultivate a sense of purpose in life, which is vital considering evidence that many young people lack a realistic plan for succeeding in life, with no commitment beyond disconnected interests, and therefore are in need of serious guidance in an increasingly complicated society (Froh et al. 2010b).

13.3.3 Employment Experience

Purpose in life plays an important positive role in the development of young people (Bronk and Finch 2010). Indeed, having an identified purpose in life is associated with increased life satisfaction during adolescence (Bronk et al. 2009). Moreover, purpose in life is associated with having long-term aims in life, including vocational interests – which involves setting goals and developing skills enabling young people to obtain their desired career.

By providing opportunities for work experience, educators and support staff (e.g., school counselors) are able to link adolescent career development with positive youth development. Indeed, findings reported by Hirschi (2009) demonstrate that by supporting the connection between career adaptability and positive youth development through vocational education and social support, young people experience an increased sense of power and life satisfaction. Related to these findings, O'Brien et al. (1994) found that employed youth have higher adjustment levels (as measured by affect, work values, and personal control), lower depressive affect, higher life satisfaction, greater commitment to values, more internal control, and higher perceived competence than low-quality leisure unemployed youth.

13.4 Healthy Lifestyle

13.4.1 Substance Abuse

Successful transition into adulthood can be greatly hindered by health-risk behavior during adolescence. Unfortunately, a great number of young people do not make it through adolescence unscathed by the effects of substance use and abuse. Indeed, development of substance use disorders during adolescence is associated with deleterious consequences across multiple life domains, including school dropout, delayed entry into the labor force, job instability job dissatisfaction, early marriage and divorce, impaired relationships with family and friends, and early parenthood (see Rohde et al. 2007 for a review).

As demonstrated by Rohde et al. (2007), adolescent substance use disorder (before age 19) is associated with numerous functioning difficulties at age 30, including academic and occupational functioning and lower life satisfaction. Similarly, Valois et al. (2010) found that reduced life satisfaction is associated with cigarette smoking, chewing tobacco, cigar smoking, and alcohol, marijuana, and inhalant use in students as young as 11–14.

Related to these findings are those reported by Sun and Shek (2010) among Chinese adolescents, whereby it was found that adolescents with poor positive development have lower life satisfaction and higher levels of substance abuse, delinquency, and intention to engage in problem behavior. Examination of the longitudinal associations between adolescent tobacco and cannabis use and young adult functioning has further shown that those who initiate tobacco use in adolescence, but desist, continue to be at an elevated risk for poorer physical health, depression, low life satisfaction, and fewer years of education 14–18 years later (Georgiades and Boyle 2007). Similarly, cannabis use continued into adulthood is associated with lower life satisfaction and increased risk of major depressive disorder (Georgiades and Boyle 2007).

Moreover, research has demonstrated that alcohol is the most important predictor variable associated with cigarette smoking, regardless of socioeconomic status, school type, or parental demographic features (Kasapoglu and Ozerkmen 2008). Further, more frequent use of alcohol and cigarettes is associated with increased sexual activity, physical fighting, and stress among adolescents (Harvey 1995).

Overall, research findings suggest that health-risk behaviors initiated in childhood and adolescence are associated with behavioral, psychological, psychosocial, and physical factors that continue for a lifetime. Thus, the long-term risks associated with adolescent health-risk behavior underscore the importance of early prevention and intervention (Georgiades and Boyle 2007). Indeed, promotion of positive youth development is of paramount importance in enabling life satisfaction and mitigating the risk-taking behavior among early adolescents (Sun and Shek 2010).

13.4.2 Eating Behaviours and Obesity

Early prevention and intervention of health-risk behaviors among young people also includes addressing the psychosocial factors associated with the etiology of obesity. Although obesity is influenced by multiple factors, including both biological and genetic conditions, the impact of social, physical, and dietary influences cannot be ignored, especially considering that the psychological issues and habits of young people with excess weight can persist into adulthood (Saloumi and Plourde 2010). For example, Saloumi and Plourde (2010) found that being dissatisfied with the way their body looks, having a strong fear of being too fat, and engaging in potential weight control practices, such as smoking and avoiding food, were associated with reduced life satisfaction among Canadian adolescents.

In contrast, B. F. Piko (2006) found that health behaviors and good diet control practices contributed significantly to life satisfaction, whereas smoking was related to decreased life satisfaction among Hungarian adolescents. Moreover, body image dissatisfaction and poor weight control practices, including poor eating and low physical activity, were found to persist to adulthood. Considering societal changes in energy intake and sedentary lifestyle, promotion of healthy eating and exercise is a timely concern.

13.5 Positive Behavior and Prosocial Peer Interactions

Peer victimization is associated with reduced emotional well-being among adolescents and continues to be a pervasive problem for young people today (Martin and Huebner 2007). As demonstrated by Martin and Huebner (2007), overt (e.g., physical or verbal insults) and relational (e.g., spreading rumors, exclusion) victimization experiences are correlated with reduced life satisfaction and affect among adolescents. Similarly, low life satisfaction is a precursor of relational victimization and reduced prosocial experiences, suggesting bidirectional effects between these variables (Martin et al. 2008).

Research has also revealed, however, that prosocial experiences are associated with increased life satisfaction and positive affect over and above the influence of victimization experiences, suggesting that receipt of positive social acts from peers operates as a protective factor for adolescents' emotional well-being.

Similar findings have been reported by Sun and Shek (2010) in the Chinese context, whereby adolescents were less likely to be involved in problem behavior when they are more satisfied with life, have strong relationships with adults and peers, have a sense of purpose and meaning in life, and have clear standards for prosocial engagement; results support findings indicating a bidirectional relationship between life satisfaction and problem behavior. Therefore, facilitating opportunities for students to engage in positive interactions with other students in different settings is an intervention that will enhance resilience in the face of adversity (Martin and Huebner 2007).

As discussed by M.T. Greenberg et al. (2003), education should teach young people to interact in socially skilled and respectful ways, practice positive, safe, and healthy behaviors, contribute ethically and responsibly to their peer group, family, school, and community, and possess basic competencies, work habits, and values, and in order to achieve this school-based prevention and intervention programming needs to be based on a coordinated social, emotional, and academic learning environment.

13.6 Positive Psychological Interventions and Character Strengths

A promising approach to increase well-being among young people is through positive psychological interventions – that is, intentional activities that aim to cultivate positive feelings, behaviors, or cognitions (Sin and Lyubomirsky 2009). For example, recent research has demonstrated that performing positive psychological exercises, such as counting blessings (i.e., daily gratitude journal-keeping exercise) (Froh et al. 2008) or counting one's own acts of kindness for 1 week (Otake et al. 2006), are associated with increased positive affect and life satisfaction. Indeed, Froh et al. (2008) found that adolescents who listed up to five things that they were grateful for daily for 2 weeks had increased well-being, life satisfaction, and decreased negative affect at follow-up. Further, research has demonstrated that adolescents who report grateful moods indicate greater SWB, optimism, prosocial behavior, gratitude in response to aid, and social support (Froh et al. 2009).

Gratitude has also been found to be a motivator of future benevolent actions on the part of the recipient (Froh et al. 2010a). Specifically, findings reported by Froh et al. (2010a) indicate that gratitude predicts social integrations, prosocial behavior, and life satisfaction among early adolescents, which suggests an 'upward spiral' of gratitude and happiness. Similarly, Geraghty et al. (2010b) have found that cultivating gratitude through daily gratitude diaries is as successful at reducing worry as standard cognitive techniques (cf. Geraghty et al. 2010a). Moreover, M. E. P. Seligman et al. (2005) have demonstrated that writing down three good things that went well each day, and using identified top strengths in a new way each day, for 1 week increases happiness and decreases depressive symptoms for 6 months. For a detailed description of strengths based interventions in young populations, see Chap. 10 of this book.

13.6.1 Curriculum Based Interventions

Exploratory investigations into the teaching of well-being in school through the application of positive psychology interventions and theory has also led to reliable improvements in students' well-being (see Seligman et al. 2009 for a review).

For example, in America the *Positive Psychology Program*, which consisted of approximately 20–25 sessions delivered over 1 year, integrated learning of the 24 VIA (Values-In-Action – Inventory of Strengths; Peterson and Seligman 2004) character strengths through character strengths discussion sessions, in-class activities, real-world homework activities, and follow-up journal reflections (Seligman et al. 2009). Participating students were randomly assigned to Language Arts classes that either contained the positive psychology curriculum (positive psychology condition) or did not contain the positive psychology curriculum (control). The program was demonstrated to increase enjoyment and engagement in school and improve social skills among adolescent students (see M. E. P. Seligman et al. 2009).

A similar example of a program based on the VIA classification from Britain is *Strengths Gym* (Proctor and Fox Eades 2009). This program involves students completing age appropriate strengths-based exercises on each of the 24 VIA strengths through in-class activities, philosophical discussions, stories, and real-world homework activities where students can apply the concepts and skills in their own lives. Students are provided with the opportunity to self-identify with their signature strengths at the beginning of each of the three levels of the program and to re-evaluate them again before moving on to the next level. This program provides teachers with flexible lesson plans enabling them to choose activities that suit the mood and the needs of their class. Students who have participated in Strengths Gym have been demonstrated to have significantly higher life satisfaction compared to adolescents who did not participate in the program (Proctor et al. 2011).

Another similar program from Australia, the *Geelong Grammar School Project*, involved training 100 members of faculty in the principles and skills of positive psychology, such as resilience, strengths, gratitude, and positive communication so that they could incorporate these skills into their teaching. The program has resulted in the creation of stand alone courses in several grades, such as character strengths and positive education, supplemented by whole school practices, such as students in the elementary school starting the day with a focus on ‘what went well’ the day before (Fox Eades 2008). Teachers are developing their own methods of using the principles they have learned. For example, a sports coach may use a character strengths framework to debrief teams following a game.

13.6.2 Character Strengths

Character strengths have also been shown to longitudinally predict SWB during adolescence. For example, Gillham et al. (2011) have demonstrated that transcendent (e.g., hope, gratitude, meaning), temperance (e.g., self-regulation, perseverance), other-directed (e.g., forgiveness, kindness, teamwork), and intellectual (e.g., curiosity, love of learning) strengths significantly predict greater life satisfaction, and that other-directed strengths and temperance at the start of high school predict fewer symptoms of depression by grade 10, even when controlling for the influence of other types of strengths; similarly hope and optimism have been shown

to predict life satisfaction in adolescents with cognitive disabilities (see Shogren et al. 2006). Similarly, hope has been found to be positively related to positive affect, life satisfaction, support from family and friends, and optimism (Edwards et al. 2007).

In contrast, other research has indicated that both working on developing character strengths and relative character weaknesses may assist in increasing life satisfaction (see Rust et al. 2009). Finally, spirituality, positive religious coping, and daily spiritual experiences have also been show to be positively related to positive affect and life satisfaction among young people (Van Dyke et al. 2009). These results suggest that holistic approaches to increasing well-being should consider the use of positive religious coping strategies among youths who are religious and the role of spirituality in early adolescents' psychological well-being (Bjorck et al. 2010; Van Dyke et al. 2009; Baroun 2006).

13.7 Cultural Integration

The acculturation and psychological adaptation of adolescents of immigrant families has important implications for life satisfaction as young people experience changes in identity, attitudes, values, and behaviors as a function of intercultural contact (Ward 2006). For example, Ward (2006) has demonstrated that dual heritage youth absorb cultural influences from two traditions and that, as a result, their values, perceptions and patterns of adaptation fall between those of single heritage youth. Specifically, among New Zealand adolescents, adolescents identified as Maori and Pakeha exhibited pragmatically blended constellation of values, attitudes and self-perceptions that reflected the influence of both cultural groups and did not significantly differ from single ancestry groups in terms of psychological symptoms, life satisfaction, behavioral problems, or school adjustment. Similarly, in Germany Pfafferott and Brown (2006) found that acculturative integration was more strongly associated with favorable intergroup relations and, in the case of minority members, life satisfaction, than the other acculturation orientations; highlighting the personal relevance of acculturation for adolescents from immigrant families.

Perceived family support and family processes also play a crucial role in the well-being of immigrant adolescents. For example, Edwards and Lopez (2006) found that perceived support from family and Mexican orientation were significantly positively associated with life satisfaction among Latino American adolescents. In fact, youths identified their family as the most important contributing factor in their level of life satisfaction, over and above the influence of friends, religion, or money.

In Canada, non-economically motivated immigration by Hong Kong families was associated with markedly higher level of life satisfaction among their adolescent children, along with positive experience making friends with Canadians, positive academic experience, absence of discrimination experience, and presence of both parents in Canada. Moreover, research has also demonstrated that context

influences adolescent perceptions of racial discrimination. For example, Seaton and Yip (2009) found that school diversity appears to be linked to increasing perceptions of individual racism, whereas neighborhood diversity appears to be linked to decreasing perceptions of cultural racism among African American youths and that high levels of collective/institutional discrimination is associated with lower life satisfaction. Moreover, perceptions of discrimination have been demonstrated to be linked to depressive symptoms and low self-esteem and life satisfaction (Seaton et al. 2008, 2010). Similarly, R. Q. Shin et al. (2010) found that neighborhood satisfaction was a significant predictor of both school and overall life satisfaction among adolescents of diverse ethnic backgrounds. Finally, Neto and Barros (2007) found that psychosocial adjustment variables (i.e., psychological symptoms (e.g., absence of depression), mastery, and behavioral problems (i.e., absence of antisocial behavior)) were the best predictors of life satisfaction among Portuguese immigrant families in Switzerland. Indeed, adaptation to a new cultural context is challenging, however research suggests that support from families and communities, cultural integration, and mastery are important in the life satisfaction of adolescent immigrant youths. Thus, providing environments that support cultural integration and opportunities for developing a sense of mastery may improve the life satisfaction and successful acculturation of immigrant youths.

13.8 Conclusion

As we hope to have demonstrated throughout this chapter, life satisfaction is integral to positive and successful functioning in youth. Youths with higher levels of life satisfaction benefit from a range of positive life outcomes, including adaptive psychosocial functioning, better interpersonal and social relationships, fewer behavioral problems, and a host of school-related positive outcomes, including greater academic success, higher school satisfaction, perceived academic achievement, competence, and self-efficacy. Clearly, experiencing high levels of life satisfaction is good for youth and leads to a range of good outcomes for youth.

Further, we have shown the diverse range of variables that can and do impact on life satisfaction in youth, including, for example, supportive interpersonal relationships with family, friends, and school colleagues, participation in meaningful instrumental activities, leading a healthy lifestyle that avoids substance misuse, excess alcohol, and tobacco, and demonstrating positive behavior that reinforces positive, prosocial interactions with peers.

From the perspective of positive psychology, we have also shown how certain positive psychology interventions have been shown to promote and enhance life satisfaction in youth. These include having young people complete gratitude diaries which record the things for which they are grateful, teaching well-being at school, and enabling students to develop character strengths through a series of tailored developmental interventions.

Above all, we have set out to show in this chapter that, first, life satisfaction is fundamentally important for well-being in youth; second, to review and summarize the various factors that influence and enable life satisfaction in youth; and third, to show that life satisfaction can be enhanced through the deployment of positive psychology interventions. It is this final element that we believe holds the greatest promise for the future, and we encourage researchers and practitioners alike to turn their attention to greater understanding of the ways in which we can enhance and promote life satisfaction and well-being in young people. Such a laudable undertaking will ultimately be to the advantage of us all.

References

Antaramian, S. P., Huebner, E. S., & Valios, R. F. (2008). Adolescent life satisfaction. *Applied Psychology: An International Review, 57*, 112–126.

Baroun, K. A. (2006). Relations among religiosity, health, happiness and anxiety for Kuwaiti adolescents. *Psychological Reports, 99*(3), 717–722.

Bjorck, J. P., Braese, R. W., Tadie, J. T., & Gililland, D. D. (2010). The adolescent religious coping scale: Development, validation, and cross-validation. *Journal of Child and Family Studies, 19*, 343–359.

Bronk, K. C., & Finch, H. W. (2010). Adolescent characteristics by type of long-term aim in life. *Applied Developmental Science, 14*(1), 35–44.

Bronk, K. C., Hill, P. L., Lapsley, D. K., Talib, T. L., & Finch, H. (2009). Purpose, hope, and life satisfaction in three age groups. *The Journal of Positive Psychology, 4*(6), 500–510.

Csikszentmihalyi, M. (2002). *Flow: The classic work on how to achieve happiness*. London: Rider.

Dew, T., & Huebner, E. S. (1994). Adolescents' perceived quality of life: An exploratory investigation. *Journal of School Psychology, 33*(2), 185–199.

Edwards, L. M., & Lopez, S. J. (2006). Perceived family support, acculturation, and life satisfaction in Mexican American youth: A mixed-method exploration. *Journal of Counselling Psychology, 53*(3), 279–287.

Edwards, L. M., Ong, A. D., & Lopez, S. J. (2007). Hope measurement in Mexican American youth. *Hispanic Journal of Behavioral Sciences, 29*(2), 225–241.

Erich, S., Kanenberg, H., Case, K., Allen, T., & Bogdanos, T. (2009). An empirical analysis of factors affecting adolescent attachment in adoptive families with homosexual and straight parents. *Children and Youth Services Review, 31*, 398–404.

Fox Eades, J. M. (2008). *Celebrating strengths: Building strengths-based school*. Coventry: CAPP Press.

Froh, J. J., Sefick, W. J., & Emmons, R. A. (2008). Counting blessings in early adolescents: An experimental study of gratitude and subjective well-being. *Journal of School Psychology, 46*(2), 213–233.

Froh, J. J., Yurkewicz, C., & Kashdan, T. B. (2009). Gratitude and subjective well-being in early adolescence: Examining gender differences. *Journal of Adolescence, 32*, 633–650.

Froh, J. J., Bono, G., & Emmons, R. (2010a). Being grateful is beyond good manners: Gratitude and motivation to contribute to society among early adolescents. *Motivation and Emotion, 34*, 144–157.

Froh, J. J., Kashdan, T. B., Yurkewicz, C., Fan, J., Allen, J., & Glowacki, J. (2010b). The benefits of passion and absorption in activities: Engaged living in adolescents and its role in psychological well-being. *The Journal of Positive Psychology, 5*(4), 311–332.

Georgiades, K., & Boyle, M. H. (2007). Adolescent tobacco and cannabis use: Young adult outcomes from the Ontario Child Health Study. *Journal of Child Psychology and Psychiatry, 48*(7), 724–731.

Geraghty, A. W. A., Wood, A. M., & Hyland, M. E. (2010a). Attrition from self-directed interventions: Investigating the relationship between psychological predictors, intervention content and dropout from a body dissatisfaction intervention. *Social Science and Medicine, 71*, 300–337.

Geraghty, A. W. A., Wood, A. M., & Hyland, M. E. (2010b). Dissociating the faces of hope: Agency and pathways predict dropout from unguided self-help therapy in opposite directions. *Journal of Research in Personality, 44*, 155–158.

Gillham, J., Adams-Deutsch, Z., Werner, J., Reivich, K., Coulter-Heindl, V., Linkins, M., et al. (2011). Character strengths predict subjective well-being during adolescence. *The Journal of Positive Psychology, 6*(1), 31–44.

Gilman, R., & Huebner, E. S. (2006). Characteristics of adolescents who report very high life satisfaction. *Journal of Youth and Adolescence, 35*(3), 311–319.

Gilman, R., Meyers, J., & Perez, L. (2004). Structured extracurricular activities among adolescents: Findings and implications for school psychologists. *Psychology in the Schools, 41*(1), 31–41.

Goldbeck, L., Schmitz, T. G., Besier, T., Herschbach, P., & Henrich, G. (2007). Life satisfaction decreases during adolescence. *Quality of Life Research: An International Journal of Life Aspects of Treatment, Care and Rehabilitation, 16*, 969–976.

Greenberg, M. T., Siegel, J. M., & Leitch, C. J. (1983). The nature and importance of attachment relationships to parents and peers during adolescence. *Journal of Youth and Adolescence, 12*(5), 373–386.

Greenberg, M. T., Weissberg, R. P., O'Brien, M. U., Zins, J. E., Fredricks, L., Resnik, H., et al. (2003). Enhancing school-based prevention and youth development through coordinated social, emotional, and academic learning. *American Psychologist, 58*(6–7), 466–474.

Greenspoon, P. J., & Saklofske, D. H. (2001). Toward an integration of subjective well-being and psychopathology. *Social Indicators Research, 54*(1), 81–108.

Harvey, S. (1995). Factors associated with sexual behavior among adolescents: A multivariate analysis. *Adolescence, 30*(118), 253–264.

Hirschi, A. (2009). Career adaptability development in adolescence: Multiple predictors and effect on sense of power and life satisfaction. *Journal of Vocational Behavior, 74*, 145–155.

Huebner, E. S., Suldo, S. M., & Gilman, R. (2006). Life satisfaction. In G. G. Bear & K. M. Minke (Eds.), *Children's needs III: Development, prevention, and intervention* (pp. 357–368). Bethesda: National Association of School Psychologists.

Kasapoglu, A., & Ozerkmen, N. (2008). Predictors of adolescent cigarette smoking behavior: A sociological case study in Ankara, Turkey. *Journal of Child & Adolescent Substance Abuse, 17*(4), 115–132.

Keyes, C. L. M., Shmotkin, D., & Ryff, C. D. (2002). Optimizing well-being: The empirical encounter of two traditions. *Journal of Personality and Social Psychology, 82*, 1007–1022.

Kwan, Y. K. (2010). Life satisfaction and self-assessed health among adolescents in Hong Kong. *Journal of Happiness Studies, 11*, 383–393.

Linley, P. A., Maltby, J., Wood, A. M., Osborne, G., & Hurling, R. (2009). Measuring happiness: The higher order factor structure of subjective and psychological well-being measures. *Personality and Individual Differences, 47*, 878–884.

Ma, C. Q., & Huebner, E. S. (2008). Attachment relationships and adolescents' life satisfaction: Some relationships matter more to girls than boys. *Psychology in the Schools, 45*(2), 177–190.

Manzi, C., Vignoles, V. L., Regalia, C., & Scabini, E. (2006). Cohesion and enmeshment revisited: Differentiation, identity, and well-being in two European cultures. *Journal of Marriage and Family, 68*(3), 673–689.

Martin, K. M., & Huebner, E. S. (2007). Peer victimization and prosocial experiences and emotional well-being of middle school students. *Psychology in the Schools, 44*(2), 199–208.

Martin, K., Huebner, E. S., & Valios, R. F. (2008). Does life satisfaction predict victimization experiences in adolescence? *Psychology in the Schools, 45*(8), 705–714.

Maton, K. I. (1990). Meaningful involvement in instrumental activity and well-being: Studies of older adolescents and at risk urban teen-agers. *American Journal of Community Psychology, 18*(2), 297–320.

Milevsky, A., Schlechter, M., Netter, S., & Keehn, D. (2007). Maternal and paternal parenting styles in adolescents: Associations with self-esteem, depression and life-satisfaction. *Journal of Child and Family Studies, 16*(1), 39–47.

Nakamura, J., & Csikszentmihalyi, M. (2002). The concept of flow. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 89–105). New York: Oxford University Press.

Neto, F., & Barros, J. (2007). Satisfaction with life among adolescents from Portuguese immigrant families in Switzerland. *Swiss Journal of Psychology, 66*(4), 215–223.

Nickerson, A. B., & Nagle, R. (2004). The influence of parent and peer attachments on life satisfaction in middle childhood and early adolescence. *Social Indicators Research, 66*(1–2), 35–60.

O'Brien, G. E., Feather, N. T., & Kabanoff, B. (1994). Quality of activities and the adjustment of unemployed youth. *Australian Journal of Psychology, 46*(1), 29–34.

Otake, K., Shimai, S., Tanaka-Matsumi, J., Otsui, K., & Frederickson, B. L. (2006). Happy people become happier through kindness: A counting kindnesses intervention. *Journal of Happiness Studies, 7*(3), 361–375.

Paxton, R. J., Valios, R. F., Huebner, E. S., & Drane, J. W. (2006). Opportunity for adult bonding/meaningful neighborhood roles and life-satisfaction among USA middle school students. *Social Indicators Research, 79*(2), 291–312.

Peterson, C., & Seligman, M. E. P. (2004). *Character strengths and virtues: A classification and handbook*. Washington, DC: American Psychological Association.

Pfafferott, I., & Brown, R. (2006). Acculturation preferences of majority and minority adolescents in Germany in the context of society and family. *International Journal of Intercultural Relations, 30*(6), 703–717.

Piko, B. F. (2006). Satisfaction with life, psychosocial health and materialism among Hungarian youth. *Journal of Health Psychology, 11*(6), 827–837.

Piko, B. F., & Hamvai, C. (2010). Parent, school and peer-related correlates of adolescents' life satisfaction. *Children and Youth Services Review, 32*, 1479–1482.

Powdthavee, N., & Vignoles, A. (2008). Mental health of parents and life satisfaction of children: A within-family analysis of intergenerational transmission of well-being. *Social Indicators Research, 88*, 397–422.

Proctor, C., & Fox Eades, J. (2009). *Strengths gym: Teacher's manual*. St. Peter Port: Positive Psychology Research Centre.

Proctor, C., Linley, P. A., & Maltby, J. (2009a). Youth life satisfaction measures: A review. *Journal of Positive Psychology, 4*(2), 128–144. doi:http://dx.doi.org/10.1080/17439760802650816.

Proctor, C. L., Linley, P. A., & Maltby, J. (2009b). Youth life satisfaction: A review of the literature. *Journal of Happiness Studies, 10*(5), 583–630. doi:http://dx.doi.org/10.1007/s10902-008-9110-9.

Proctor, C., Linley, P. A., & Maltby, J. (2010). Very happy youths: Benefits of very high life satisfaction among youths. *Social Indicators Research, 98*(3), 519–532. doi:http://dx.doi.org/10.1007/s11205-009-9562-2.

Proctor, C., Tsukayama, E., Wood, A. M., Maltby, J., Fox Eades, J. M., & Linley, P. A. (2011). Strengths Gym: The impact of a character strengths-based intervention on the life satisfaction and well-being of adolescents. *Journal of Positive Psychology, 6*(5), 377–388.

Rohde, P., Lewinsohn, P. M., Seeley, J. R., & Klein, D. N. (2007). Psychosocial functioning of adults who experienced substance use disorders as adolescents. *Psychology of Addictive Behaviors, 21*(2), 155–164.

Rust, T., Diessner, R., & Reade, L. (2009). Strengths only or strengths and relative weaknesses? A preliminary study. *The Journal of Psychology, 143*(5), 465–476.

Ryff, C. D., & Keyes, C. L. (1995). The structure of psychological well-being revisited. *Journal of Personality and Social Psychology, 69*, 719–727.

Saloumi, C., & Plourde, H. (2010). Differences in psychological correlates of excess weight between adolescents and young adults in Canada. *Psychology, Health & Medicine, 15*(3), 314–325.

Seaton, E. K., & Yip, T. (2009). School and neighborhood contexts, perceptions of racial discrimination, and psychological well-being among African American adolescents. *Journal of Youth and Adolescence, 38*, 153–163.

Seaton, E. K., Caldwell, C. H., Sellers, R. M., & Jackson, J. S. (2008). The prevalence of perceived discrimination among African American and Caribbean black youth. *Developmental Psychology, 44*(5), 1288–1297.

Seaton, E. K., Caldwell, C. H., Sellers, R. M., & Jackson, J. S. (2010). An intersectional approach for understanding perceived discrimination and psychological well-being among African American and Caribbean Black Youth. *Developmental Psychology, 46*, 1372–1379.

Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive psychology progress: Empirical validation of interventions. *American Psychologist, 60*(5), 410–421.

Seligman, M. E. P., Ernst, R. M., Gillham, J., Reivich, K., & Linkins, M. (2009). Positive education: Positive psychology and classroom interventions. *Oxford Review of Education, 35*(3), 293–311.

Sharma, D., & Silbereisen, R. K. (2007). Revisiting an era in Germany from the perspective of adolescents in mother-headed single-parent families. *International Journal of Psychology, 42*(1), 46–58.

Shek, D. T. (2007a). A longitudinal study of perceived parental psychological control and psychological well-being in Chinese adolescents in Hong Kong. *Journal of Comparative and Physiological Psychology, 63*(1), 1–22.

Shek, D. T. (2007b). Intact and non-intact families in Hong Kong: Differences in perceived parental control processes, parent–child relational qualities, and adolescent psychological well-being. *Journal of Divorce and Remarriage, 47*(1/2), 157–172.

Shek, D. T., & Lee, T. Y. (2007). Perceived parental control processes, parent–child relational qualities and psychological well-being of Chinese adolescents in intact and non-intact families in Hong Kong. *International Journal of Adolescent Medicine and Health, 19*(2), 167–175.

Shek, D. T., Lee, B. M., & Lee, T. Y. (2006). Frequency, satisfaction and quality dimensions of perceived parent-adolescent communication among Chinese adolescents in Hong Kong. *Journal of Adolescent Medicine and Health, 18*(2), 259–270.

Shin, D., & Johnson, D. M. (1978). Avowed happiness as an overall assessment of the quality of life. *Social Indicators Research, 5*, 475–492.

Shin, R. Q., Morgan, M. L., Buhin, L., Truitt, T. J., & Vera, E. M. (2010). Expanding the discourse on urban youth of color. *Cultural Diversity and Ethnic Minority Psychology, 16*(3), 421–426.

Shogren, K. A., Lopez, S. J., Wehmeyer, M. L., Little, T. D., & Pressgrove, C. (2006). The role of positive psychology constructs in predicting life satisfaction in adolescents with and without cognitive disabilities: An exploratory study. *The Journal of Positive Psychology, 1*(1), 37–52.

Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of Clinical Psychology, 65*(5), 467–487.

Steinberg, L. (1987). Impact of puberty on family relations: Effects of pubertal status and pubertal timing. *Developmental Psychology, 23*(3), 451–460.

Suldo, S. M., & Huebner, E. S. (2004a). Does life satisfaction moderate the effects of stressful events on psychopathological behavior during adolescence? *School Psychology Quarterly, 19*(2), 93–105.

Suldo, S. M., & Huebner, E. S. (2004b). The role of life satisfaction in the relationship between authoritative parenting dimensions and adolescent problem behavior. *Social Indicators Research, 66*(1–2), 165–195.

Suldo, S. M., & Huebner, E. S. (2006). Is extremely high life satisfaction during adolescence advantageous? *Social Indicators Research, 78*(2), 179–203.

Suldo, S. M., & Shaffer, E. J. (2008). Looking beyond psychopathology: The dual-factor model of mental health in youth. *School Psychology Review, 37*(1), 52–68.

Suldo, S. M., Riley, K. N., & Shaffer, E. J. (2006). Academic correlates of children and adolescents' life satisfaction. *School Psychology International, 27*(5), 567–582.

Sun, R. C. F., & Shek, D. T. L. (2010). Life satisfaction, positive youth development, and problem behaviour among Chinese adolescents in Hong Kong. *Social Indicators Research, 95*, 455–474.

Valois, R. F., Zullig, K. J., Huebner, E. S., & Drane, J. W. (2001). Relationship between life satisfaction and violent behaviors among adolescents. *American Journal of Health Behavior, 25*(4), 353–366.

Valois, R. F., Zullig, K. J., Huebner, E. S., Kammermann, S. K., & Drane, J. W. (2002). Association between life satisfaction and sexual risk-taking behaviors among adolescents. *Journal of Child & Family Studies, 11*(4), 427–440.

Valois, R. F., Zullig, K. J., Huebner, E. S., & Drane, J. W. (2003). Dieting behaviors, weight perceptions, and life satisfaction among public high school adolescents. *Eating Disorders: The Journal of Treatment & Prevention, 11*(4), 271–288.

Valois, R. F., Zullig, K. J., Huebner, E. S., & Drane, J. W. (2004). Life satisfaction and suicide among high school adolescents. *Social Indicators Research, 66*(1–2), 81–105.

Valois, R. F., Paxton, R. J., Zullig, K. J., & Huebner, E. S. (2006). Life satisfaction and violent behaviors among middle school students. *Journal of Child and Family Studies, 15*(6), 695–707.

Valois, R. F., Zullig, K. J., Huebner, E. S., & Drane, J. W. (2009). Youth developmental assets and perceived life satisfaction: Is there a relationship? *Applied Research in Quality of Life, 4*, 315–331.

Valois, R. F., Paxton, R. J., Zullig, K. J., & Huebner, E. S. (2010). Substance abuse behaviors and life satisfaction among middle school adolescents. *Adolescent and Family Health, 5*(1), 27–37.

Van Dyke, C. J., Glenwick, D. S., Cecero, J. J., & Kim, S.-K. (2009). The relationship of religious coping and spirituality to adjustment and psychological distress in urban early adolescents. *Mental Health, Religion & Culture, 12*(4), 369–383.

Waas, G. A. (2006). Peer relationships. In G. G. Bear & K. M. Minke (Eds.), *Children's needs III: Development, prevention, and intervention* (pp. 325–340). Bethesda: National Association of School Psychologists.

Ward, C. (2006). Acculturation, identity and adaptation in dual heritage adolescents. *International Journal of Intercultural Relations, 30*(2), 243–259.

Winkelmann, R. (2006). Parental separation and well-being of youths: Evidence from Germany. *Journal of Socio-Economics, 35*(2), 197–208.

Zullig, K. J., Valois, R. F., Huebner, E. S., Oeltmann, J. E., & Drane, J. W. (2001). Relationship between perceived life satisfaction and adolescents' substance abuse. *Journal of Adolescent Health, 29*(4), 279–288.

Zullig, K. J., Valois, R. F., Huebner, E. S., & Drane, J. W. (2005). Associations among family structure, demographics, and adolescent perceived life satisfaction. *Journal of Child & Family Studies, 14*(2), 195–206.