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Positive Psychology in the Clinical Domains

Research and Practice

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I am deeply grateful to many people that contributed in various ways to this book:
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To my patients, whose difficulties, resources, and quest for happiness have been essential in understanding the complex relationships between positive functioning and distress,
To my family, whose unconditional love and support have encouraged and sustained this project

Preface

This book has been conceived as an integration between clinical and positive psychology fields of research and practice. Clinical psychology has a long tradition and several theoretical contributions that have addressed issues such as happiness, resilience, and optimal functioning. However, the medical model that conditioned clinical practice has overshadowed these contributions and given privileged attention to distress and negativity in human existence.

On the other hand, the emerging field of Positive Psychology has devoted attention and resources to the investigation of positivity. However, it has often been criticized for not fully considering the complexities of human experience and the relationships with distress and psychopathology. The purpose of this book is building a useful bridge between positive and clinical psychology.

This book could provide clinical psychologists and mental health practitioners with insights and recent findings derived from the positive psychology research. This would indeed improve clinical practice by integrating the evaluation of patients' strengths and resources, by enlarging therapeutic goals to the restoration and maintenance of well-being, and by using specific positive interventions.

The book is also addressed to positive psychologists and researchers who aim to address their field of investigation to the clinical domains, since it may provide insightful perspectives derived from the historical and theoretical background of clinical psychology. These contributions indeed call for a whole consideration of individuals' characteristics and specificities, and they may provide suggestions for overcoming the "one-size-fits all approach" often criticized inside the positive psychology research.

The book is conceived in two parts. The first one provides an introduction and a theoretical framework for describing concepts such as hedonic and eudaimonic well-being, resilience, character's strengths, positive health and positive functioning, with a special reference to their clinical implications.

The second part provides a review of positive interventions aimed at promoting positivity in clinical practice/psychotherapeutic settings. The variety of positive interventions described in the second part of the book is aimed at providing clinicians with different strategies that could be easily chosen according to patients' needs and

peculiarities. A specific focus on a balanced application of positive interventions with clinical populations strongly characterizes this book. Controversies emerging from current research in positive psychology, in fact, have suggested that the promotion of happiness and well-being sometimes may yield paradoxical results. These considerations and the complex relationship between well-being and distress are discussed along all chapters of this book. They aim at providing useful insight for choosing the most appropriate therapeutic strategy, at the most appropriate timing, according to patients' characteristics and clinical needs.

Bologna, Italy Chiara Ruini

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"No medicine cures what happiness cannot."

Gabriel García Márquez

Abstract The chapter provides the historical, philosophical and theoretical underpinnings shared by positive and clinical psychology. A brief overview of definitions and paradigms of well-being (hedonia versus eudaimonia) is presented, with a cross-cultural perspective (Eastern and Western perspectives). Finally, early contributions to the study of positive functioning within the clinical psychology literature are articulated, with a concluding remark of possible integrations between positive and clinical psychology research and practice.

1.1 Introduction

Historically, the movement of positive psychology was born as a criticism to current research within the field of traditional psychology, that was dominated by a medical model of human functioning (Seligman & Csikszentmihalyi, 2000). In the abstract of a pivotal article, Authors stated:

> "*The exclusive focus on pathology that has dominated so much of our discipline results in a model of the human being lacking the positive features that make life worth living. Hope, wisdom, creativity, future mindedness, courage, spirituality, responsibility, and perseverance are ignored or explained as transformations of more authentic negative impulses*" (p 5)

They proclaimed the mission of a new era of psychology research:

> "*The aim of positive psychology is to begin to catalyze a change in the focus of psychology from preoccupation only with repairing the worst things in life to also building positive qualities.*" (p.5)

Seligman and Csikszentmihalyi (2000) thus, identified specific "positive dimensions" of human functioning (hope, wisdom, courage, spirituality, etc.…) that have been neglected by traditional psychology research and they claimed a change in the

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focus, with the building of such positive dimensions as primary mission for psychologists (Seligman & Csikszentmihalyi, 2000).

Traditional psychology, in fact, after World War II had been mainly focused on relieving and healing people from the sufferings of the war, and had moved into a discipline based upon a medical model of psychological distress and disorders.

However, it was inside the clinical arena that the term "positive psychology" was coined. In fact as early as 1954, *Abram Maslow* wrote a chapter on his book "Motivation and Personality" entitled Toward a Positive Psychology (Maslow, 1954). He advocated that psychology, and particularly the clinical domains of counseling and psychotherapy should pay more attention to the positive sides of human beings and facilitate their maturation and growth. Officially, the birth of the Positive Psychology as an ideological movement is attributed to Martin E.P. Seligman, who served as president of the American Psychological Association (APA) from 1998 to 1999 and made the promotion of positive psychology his key presidential initiative of his term in office (Seligman & Csikszentmihalyi, 2000).

In any case, many of the theoretical roots of positive psychology could be tracked back within the clinical domains. Since its early stages, clinical psychology research emphasized issues such as the concept of individuation (Jung, 1933), the concepts of resilience and meaning (Frankl, 1959), and developed criteria for positive mental health (Jahoda, 1958). Similarly, humanistic psychology suggested concepts such as self-realization and self-actualization as final therapeutic goal (Maslow, 1954; Rogers, 1961). More recently, Keyes (2002) and Huppert and So's (2013) definitions of flourishing mirror the DSM diagnostic criteria for psychiatric disorders (American Psychiatric Association, 2000) by identifying each symptom's opposite. Thus, current definitions of well-being and flourishing derive (by opposite or inverse mechanisms) directly from clinical psychology/psychopathology classification systems. These issues will be deeply discussed in the next sections of this chapter.

More generally, it could be asserted that the roots of positive psychology can be found in the history of the humankind, that constantly inquired on what makes life worth living, with the aim of seeking for a satisfactory life and an optimal human functioning. This theoretical perspective can be found in Athenian as well Eastern philosophy, in religion, in social and clinical sciences, as it will be briefly described in the following sections.

The first scientific investigations within the positive psychology domains stressed out the juxtaposition of two lines of research: the hedonic and eudaimonic perspectives.

1.2 Hedonic and Eudaimonic Well-Being: Basic Concepts

Historically, psychosocial research on well-being has been dominated by two opposite approaches: the hedonic/subjective one, and the eudaimonic/psychological perspective. A seminal review by Ryan and Deci (2001) examined these two concepts.

In the subsequent sections their main characteristics, theoretical contributors and assessment tools will be briefly summarized.

1.2.1 Hedonic Well-Being and Its Assessment

According to the hedonic perspective, well-being consists of subjective happiness, pleasure and pain avoidance. Thus, the concept of well-being is equated with the experience of positive emotions over negative emotions, and with satisfaction in various domains of one's life. The hedonic perspective appears to be particularly in accordance with the core values and ethos of modern western culture, namely liberal modernity, hedonism, and romantic individualism, (Joshanloo, 2013). Thus, in the contemporary Western society, happiness is defined by the absence/presence of pleasure and positive emotions (Kahneman, Diener, & Schwarz, 1999).

Hedonic well-being has also been labeled as "*subjective* well-being" (SWB) in order to stress out the importance of individuals' evaluations of their lives, in two broad domains: the affective (emotions) and the cognitive one (Diener, Suh, Lucas, & Smith, 1999). The term "subjective" is put in juxtaposition to the objective conditions of living, such as material good or health status, even though these can influence ratings of SWB. Accordingly, SBW or hedonic well-being may be described as the presence of positive emotions over negative ones and a global positive evaluation of one's life condition, namely life satisfaction (Diener et al., 1999).

Psychosocial research has traditionally assessed hedonic/subjective well-being by psychometric instruments devoted to measure the affective components and the cognitive one. One of the pioneer researcher in assessing both positive and negative emotions was Bradburn (1969) who created the "*Affect balance scale*" for measuring the positive affect (five items) and the negative affect component (five items). This scale simply asks individuals if, in the past few weeks, they have felt certain emotions. The scale provides a final score by subtraction the "No" score from the "Yes" score to create a positive/negative affect equilibrium. By a theoretical viewpoint, Bradburn considered positive and negative affect as independent, although related dimensions. However, subsequent research disconfirmed this model and pointed out the psychometric limitations of the Affect Balance Scale (Kim & Mueller, 2001).

In order to overcome these limitations Watson, Clark, and Tellegen (1988) created the *Positive and Negative Affect Scale* (PANAS) a 20-item self-report measure of positive (10 items) and negative affect (10 items) where subjects have to answer with a 5 point Likert scale that adds information on the intensity of the emotions reported. The independence of positive and negative affect is recognized by keeping two separate scores for the two dimensions. PANAS displayed good psychometric properties (high test-retest reliability in the long term; high internal consistency for the two subscales) and has been used conjunctly with personality inventories and clinical scales for assessing anxiety and depression, showing significant correlations with traits and affective symptoms (Crawford & Henry, 2004). The PANAS scale is nowadays largely applied in clinical settings, and may provide useful

information on patients' mood, encompassing the positive, as well as the negative components. Similarly, the PANAS has become one of the most used questionnaires for measuring hedonic well-being in the field of positive psychology research. Thus, a first bridge between these two disciplines could be represented by this shared assessment tool.

On the other hand, the cognitive component of hedonic/subjective well-being has been evaluated by a variety of instruments. Historically, one of the first scale is the *Life Satisfaction Index* (Neugarten, Havighurst, & Tobin, 1961) which comprises 20 items for assessing five components: zest (as opposed to apathy), resolution and fortitude, congruence between desired and achieved goals, positive self-concept and mood tone.

More recently, Diener, Emmons, Larsen, and Griffin (1985) developed the *Satisfaction with Life scale* (*SWLS*), a short 5-item instrument designed to measure global cognitive judgments of satisfaction with one's life, by using a 7 point Likert scale. For its good psychometric properties and its easiness to be filled, it has been translated and validated cross –culturally. Some criticism derives from the fact the SWLS provides an index of general positive evaluation of individuals' life, without considering various domains and area of functioning (i.e., work, familiar, income, etc.…). However, SWLS has been one of the first instruments to be applied in clinical populations for assessing their positive features together with their symptoms. These investigations involved patients with severe psychopathology, such as depression and schizophrenia (Fervaha, Agid, Takeuchi, Foussias, & Remington, 2016; Palmer, Martin, Depp, Glorioso, & Jeste, 2014). Also in this case the disciplines of positive psychology and clinical psychology indeed share assessment methods.

In order to overcome to the limitations of the SWLS in terms of domains' specificity, the International Wellbeing Group developed the *Personal Wellbeing Index* (*PWBI*) (The International Well Being Group, 2006) that evaluates individual's satisfaction in eight domains (standard of living, health, relationships, achievements in life, safety, community connectedness and spirituality) using a 10 point Likert scale. The domains resulted to be strongly intercorrelated, and taken together, they still provide a general evaluation of individuals life, that displayed a convergent validity with the SWLS.

Finally, often the term "*happiness*" has been commonly used in regards to SWB. In this case, happiness could be defined as "satisfaction of desires and goals" (therefore related to life satisfaction), or as a "preponderance of positive over negative affect" (therefore related to emotional components of SWB). Thus, by using the term "happiness" researchers have tried to combine and evaluate together these two components. For instance, Sonja Lyubomirsky (Lyubomirsky & Lepper, 1999) one of the pioneer researcher on happiness and life satisfaction, developed the *Subjective Happiness Scale* (SHS): a short scale where two items ask respondents to characterize themselves using both absolute ratings and ratings relative to peers, whereas the other two items offer brief descriptions of happy and unhappy individuals and ask respondents the extent to which each characterization describes them. The SHS has high internal consistency, which has been found to be stable across samples. Test-retest and self-peer correlations have suggested good to excellent reliability.

Box 1.1 Measures for Subjective Well-Being (Hedonic Well-Being)

- Affect Balance Scale (**ABS**; Bradburn, 1969)
- Positive and Negative Affect Scales (**PA.NA.S**; Watson et al., 1988)
- Life Satisfaction Index (**LSI**; Neugarten et al., 1961)
- Satisfaction With Life Scale (**SWLS**; Diener et al., 1985)
- Personal *Well-being* Index (**PWBI**; Cummins, Eckersley, Van Pallant, Van Vugt, & Misajon, 2003)
- Subjective Happiness Scale (**SHS**; Lyubomirsky & Lepper, 1999)

These instruments represent only a limited sample of currently available inventories for assessing positive emotions and life satisfaction. Even though reviewing current assessment tools for measuring SWB and happiness falls beyond the scope of this book, these paragraphs aimed at providing various options and tools to be applied in well-being research, as well as in clinical investigations.

1.2.2 The Influence of Personality Traits, Genes and Life Circumstances on Hedonic Well-Being: The Homeostatic Model

These instruments for assessing subjective well-being, life satisfaction and happiness have being extensively applied in investigations aimed at discovering predictors and sociodemographic factors associated to these positive characteristics. Considering their high stability over time, the major empirical hypotheses that were tested, concerned their association with specific personality traits. Even though the description of positive personality characteristics will be analyzed in Chap. 3 of this book, indeed high levels of *extroversion* were found to be linked to stable indexes of SWB. Conversely, the trait of *neuroticism* was found to be linked to negative affect and lower levels of SWB. Subsequently, other studies documented the roles of other basic personality traits: *agreeableness and conscientiousness* that are related to positive affect and life satisfaction.

The stability of SWB and its link with personality traits lead investigators to hypothesize a genetic component of well-being embedded in DNA. Early contributors in this area of research were Tellegen et al. (1988) that estimated that 40% of the variability in positive emotions and 55% for negative emotions could be predicted by genes. Confirming this prior genetic finding, Lykken and Tellegen (1996) reported stable positivity levels in adults, and they proposed the "*set-point" levels of happiness"*. Thus, this set point could provide a valuable explanation for the stability of SWB over time. Accordingly, people move above or below their baseline level of SWB, depending on the nature of experienced events, and over time they return to their genetically determined SWB set-point (Diener et al., 1999). This theory emerged from a seminal investigation in which paralysis accident victims as well as major lottery winners returned to prior levels of SWB shortly after their major life event, and

did not differ from the average person (Brickman, Coates, & Janoff-Bulman, 1978). This process of adaptation is commonly referred to as the *hedonic treadmill* (Diener, Lucas, & Scollon, 2006) or "*homeostatic control*" (Cummins, 2003). These phenomena have been conceptualized into the "*Happiness Set Point Theory*", also known as the "*Dynamic Equilibrium Theory*", which asserts that happiness levels remain stable over time despite changes in life circumstances, even major events.

Using the Personal Well-being Index in national and international surveys, Cummins, Eckersley, Van Pallant, Van Vugt, and Misajon (2003) confirmed the happiness set point theory and explained that the happiness set point is similar to other human homeostatic systems, whereby the body endeavors to maintain a predetermined level of happiness despite of external factors. While happiness levels may alter temporarily after significant life events, they soon return to a physiologically determined set point for each individual. In fact, the findings from these surveys documented that most people experience a moderately positive level of well-being, with the population average normally held at about 75% of maximum. This homeostatic system is designed to hold this value within a narrow, positive, set-point-range and to prevent SWB from falling below its set-point (Cummins, 2003). This homeostatic process is activated by each individual using different psychological devices. First, the personality traits determine the set-point range for each individual. Secondly, a set of cognitive buffers involving perceived control, self-esteem and optimism, modulates the impact of different life events, such as trauma, stressors, chronic illnesses etc. Other buffers implicated in this process of habituation and adaptation are social support, relationships and income. Most of these processes of habituation and adaptation constitute the first line of defense against the threat of changed extrinsic conditions that may influence the individual levels of SWB. The failure of this homeostatic system of defense may lead to the development of depression and anxiety disorders (Cummins, Li, Wooden, & Stokes, 2014). In fact, Cummins et al. (2014) found elevated anxiety levels in people that presented an homeostatic breakdown and decreased SWB levels outside of normal range.

Further, recent findings in general population documented that certain life transitions have a different impact on individuals, according to various sociodemographic variables. For instance, transition into widowhood is more harmful to men than to women, and divorce is much more harmful to young males (below 35) than to any other age or gender group (Naess, Blekesaune, & Jakobsson, 2015). Longitudinal studies on changes in marital status also documented a more complex picture. For instance, the event of marriage provides, on average, only a small increase in SWB levels, that gradually disappear over few years of marriage. The event of widowhood, on the other hand, seems to determine long-lasting effects on SWB. Widows and widowers, in fact, presented a decline in average satisfaction, which was due to strong initial reactions followed by relatively slow adaptation. These results show that although adaptation does often occur, it can be slow and partial, and there are many people who show no evidence of adaptation (Lucas, Clark, Georgellis, & Diener, 2003).

In medical settings, Silver (1982), used a longitudinal design to follow individuals with spinal-cord injuries from 1 to 8 weeks after the accident that produced their disability. Immediately after the accident negative emotions were stronger than positive, but happiness gradually increased, and by the 8th week, positive emotions

were stronger than negative ones. These longitudinal data offer support for some degree of adaptation, though it is unclear whether respondents ever returned to their preaccident baseline levels of SWB. These findings prompted authors to recommend major revisions to the set point theory to accommodate the evidence of malleability in well-being for some people, especially those with particular personality profiles (Diener et al., 2006; Lucas et al., 2003).

Similarly, Lyubomirsky, Sheldon, and Schkade (Lyubomirsky, Sheldon, & Schkade, 2005) developed a model of well-being that estimates that 50% of the variance in happiness is attributable to genetics and 10% to life circumstances and socio-economic status. However, this model also acknowledges that 40% of one's happiness depends on the extent to which an individual engages in intentional activities aimed at fostering well-being. Such activities can be cognitive (e.g., adopting an optimistic outlook), behavioural (e.g., physical activity), or volitional (e.g., using signature strengths to help others), paving the way for the development of positive interventions aimed at improving individuals' levels of well-being, that will be described in the next chapters of this book.

1.2.3 Eudaimonic Well-Being and Its Assessment

According to the eudaimonic perspective, well-being consists of fulfilling one's potential in a process of self-realization. Under this umbrella some researchers described concepts such as fully functioning person, self-actualization and vitality. Eudaimonic theories also emphasized traits as self-esteem, meaning in life, optimism, enjoyment of activities as personally expressive, and autonomy (Ryan & Deci, 2001; Ryff, 1989; Waterman et al., 2010). Thus, providing a complete and conclusive definition of eudaimonia is not an easy task, since it is a multifaceted concept (Huta & Waterman, 2014).

One of the first contributors who extensively studied eudaimonic well-being is Carol Ryff (1989). She summarized several points of convergence in psychological literature related to positive functioning and she proposed a multidimensional model of eudaimonia. She initially referred to it as *psychological well-being* (*PWB*) in order to differentiate it from the predominant approach on subjective well-being. Her model of psychological well-being encompasses six dimensions: autonomy, environmental mastery, purpose in life, personal growth, self-acceptance and positive interpersonal relationships. Taken together, these dimensions characterize individual's optimal functioning:

- *Autonomy*: This construct refers to independence, self-determination and the ability to resist social pressure to think or act in certain ways. The person who has autonomy possesses an internal locus of control and can evaluate the self by a personal standard.
- *Environmental mastery* consists of taking advantage of environmental opportunities, participating in work and familial activities and possessing a sense of competence in managing everyday activities.

- *Personal growth*: This construct consists of being open to new experiences, being capable of facing challenges and tasks at different periods of life and considering the self as growing and expanding over time (process of self-realization).
- *Positive relations with others*: It consists of possessing warm and trusting relationships with others, being capable of strong empathy, affection and intimacy.
- *Purpose in life*: A person who has a purpose in life has goals, intentions, and a sense of direction which contributes to the feeling that life is meaningful.
- *Self-acceptance*: This construct consists of possessing a positive attitude toward the self, recognizing various parts of oneself, such as one's good and bad qualities, feeling self-confident and accepting one's past life and all its positive and negative experiences.

The operationalization of this model led to the creation of the "*Psychological Well-Being Scales*" (PWBS), which are well validated and reliable (Ryff, 1989). The six-factor structure has been confirmed in the MIDUS (Midlife in the United States) study (Ryff, 2014) and up to date PWB is the most used inventory to evaluate eudaimonic well-being.

The other relevant contribution to the study of eudaimonia comes from Waterman (Waterman, 1990, 1993) who described it as "*personal expressiveness*" This concept indicates the perceived identification and development of one's "true self" by an intense involvement in activities (flow), and enjoyment of them as personally expressive. In Waterman formulation, other components of eudaimonic well-being include a sense of meaning and purpose in life, and a personal effort in the pursuit of excellence. Recently, a group of investigators developed a new questionnaire to assess these issues: the *Questionnaire for Eudaimonic Well-Being* (*QEWB*) (Waterman et al., 2010). It includes 20 items and evaluates dimensions of self-discovery, perceived development of one's best potentials, a sense of purpose and meaning in life, intense involvement in activities, investment of significant effort, and enjoyment of activities as personally expressive. Differently from Ryff's PWB, the QEWB displayed a high internal consistency of its items, and one single common factor. Sociodemographic and personality variables appear to be weakly predictors of QEWB, but more investigations are needed in order to verify its validity as a measure of eudaimonic well-being.

A theoretical approach to eudaimonia comes from the *Self-Determination Theory* (*SDT*) (Ryan & Deci, 2000) that posits that individuals are proactive organisms who actively pursuit opportunities to feel effective, who choose their goals and work for the realization of their talents. This theory strongly emphasizes personal, intrinsic motivation as a natural human tendency toward self-realization. Thus, according to SDT human beings possess a natural tendency toward optimal functioning which is possible if their social environment provides the necessary nutrients for fulfilling three basic human needs: autonomy, competence and relatedness. The first need (autonomy) refers to the possibility of acting through choice and volition; the second basic need refers to the capacity of successfully dealing with the surrounding environment; and the third need concerns interpersonal bonds. Based on this model, Deci and Ryan developed the "General Causality Orientations Scale" (GCOS) as a measure of autonomous motivation (Deci & Ryan, 1985). The measure

consists of the three subscales: autonomy orientation, control orientation and impersonal orientation. Individuals high on autonomy orientation tend to seek interesting and challenging activities, take responsibility for their own behavior and are more self-initiated in relation to activities and choices. Individuals high on controlled orientation depend on rewards or external controls (such as what others might demand) to initiate and regulate their own behavior. Finally, individuals high on impersonal orientation tend to feel ineffective and perceive their behavior as beyond their internal control. They also find it hard to cope with environmental demands or changes (Deci & Ryan, 2000). In subsequent research, Authors (Ryan, Huta, & Deci, 2008) produced a more comprehensive definition of eudaimonia. They integrated the importance of satisfying the needs for autonomy, competence and relatedness (being autonomously motivated), with the dimensions of personal growth, relationships, community contribution, physical health and behaving with a "mindful" attitude. Within the Self-Determination Theory of motivation (Deci & Ryan, 2000), another two measures were developed, namely the Need Satisfaction Scale (Sheldon, Elliot, Kim, & Kasser, 2001) and the Balanced Measure of Psychological Needs (Sheldon & Hilpert, 2012). These scales similarly assess fundamental needs such as autonomy, competence, and relatedness.

Another perspective on eudaimonia was formulated by Martin Seligman, who equated eudaimonic well-being with "*life of meaning*". He differentiated it from the pursuit of pleasure, and measured it with the *Orientation to Happiness Scale* (Peterson, Park, & Seligman, 2005). This scale contains two related scales (i.e., the life of meaning and the life of engagement) and another one measuring hedonic well-being (i.e., the life of pleasure). This latter appears to be weakly associated to the previous two, supporting the empirical distinction between hedonic and eudaimonic well-being. Further, Seligman suggested that eudaimonic well-being might be achieved by living according to one's signature strengths (Park, Pererson, & Seligman, 2004). He later enlarged his model by including interpersonal relationships and accomplishments. Taken together, these dimensions constitute the PERMA model, where the acronym stands for Positive Emotions, Relationships, Meaning and Accomplishments (Seligman, 2011). Recently, some Authors (Schultze-Lutter, Schimmelmann, & Schmidt, 2016) underlined the resemblances of the PERMA model with Ryff's multidimensional model of eudaimonia in describing and determining a complete paradigm of resilience in youth. These authors (Schultze-Lutter et al., 2016) suggested that the two models largely overlap in many conceptual definitions of positive functioning, with the exception of positive emotions (not included in Ryff's model) and of autonomy (not included in the PERMA model). Both models, hence, share a strong emphasis on positive interpersonal relationships, whereas the PERMA dimension of engagement corresponds to Ryff's purpose in life, the dimension of meaning corresponds to Ryff's self-acceptance, and the dimension of accomplishments can be described by combining together Ryff's dimensions of personal growth and environmental mastery (Schultze-Lutter et al., 2016). In this article, the authors demonstrated that the definitions and assessment of resilience often included the various formulations of eudaimonic well-being, and they advocate future agreement on the use of these terms and their specific theoretical frameworks.

Box 1.2 Measures for Eudaimonic Well-Being

- Psychological Well-Being Scale (**PWBS**; Ryff, 1989);
- Orientation to Happiness Scale (OHS Peterson et al., 2005)
- Pemberton Happiness Index (PHI) (Hervás & Vázquez, 2013)
- Eudaimonic and Hedonic Components of Happiness (Delle Fave et al., 2011)

On the European side, Vitterso has operationalized eudaimonia including dimensions such as personal growth, openness to experience, interest, engagement and challenge (Vitterso, 2004). He differentiated eudaimonia from hedonia by suggesting that the former is more associated with processes of personal change, growth and accommodation, whereas the latter is related to stability, homeostasis, savoring and assimilation (Vitterso, 2004; Vitterso & Nilsen, 2002; Vitterso & Soholt, 2011).

Finally, two international groups of investigators recently developed self-report instruments that combines together hedonic and eudaimonic dimensions of well-being, with the aim of providing an integrative assessment. The *Pemberton Happiness Index* (*PHI*) (Hervás & Vázquez, 2013) makes an interesting distinction between remembered well-being and actual experience of well-being in present life. PHI contains eleven items that measure remembered well-being (general, hedonic, eudaimonic, and social well-being) and ten items related to experienced well-being (i.e., positive and negative emotional events that possibly happened the day before); the sum of these items produces a combined well-being index. Initial results from this cross-cultural, international validation study provided support for the good psychometric properties of the PHI (i.e., internal consistency, a single-factor structure, and convergent and incremental validity) and Authors suggest that it could be used as an instrument to monitor changes in well-being in individuals and communities.

The second group of investigators (Delle Fave, Brdar, Freire, Vella-Brodrick, & Wissing, 2011) provided a definition of eudaimonic well-being as being composed of two core components: flow and long-term meaning making. The "Eudaimonic and Hedonic Happiness Investigation" is an instrument consisting of open-end questions addressing objects such as the respondent's definition of happiness and what is perceived as most meaningful in life. The instrument also includes ratings of happiness levels and meaningfulness in different life domains.

1.2.4 The Integration of Hedonic and Eudaimonic Well-Being: Optimal Well-Being

Recently, with the diffusion of positive psychology movement, there have been important tentatives to integrate hedonic and eudaimonic approaches, since they complement each other in defining the overall construct of well-being (Ryan &

Deci, 2001). Some Authors have also suggested that they can compensate each other; thus individuals may have profiles of high eudaimonic well-being and low hedonic well-being, or vice versa. These profiles were found to be associated with sociodemographic variables, such as age, years of education and employment (Keyes, Shmotkin, & Ryff, 2002). Comparing the subjects of a national sample composed of 3032 adult Americans, Keyes et al. (2002) suggested a typological model based on cross characterization of SWB and PWB:

- Optimal well-being (high SWB and high PWB),
- Low well-being (low SWB and low PWB), and
- Off-diagonal type of well-being (high PWB and low SWB / or high SWB and low PWB).

Adults with higher PWB than SWB (one of the two off-diagonal type) were younger, had attained higher level of education, and showed more openness to experience. However, they presented higher levels of neuroticism and consciousness. Adults with higher SWB than PWB (the other off-diagonal type) were midlife or older with less education, and with low levels of openness to experience.

These findings suggest that when SWB and PWB existed at equivalent levels (on-diagonal types) they may complement each other. When SWB and PWB existed at disparate levels (off-diagonal types) they may compensate each other. Finally, the probability of optimal well-being (high SWB and PWB) increased as age, education, extraversion, and conscientiousness increased and as neuroticism decreased. Importantly, only a small proportion of people reported optimal well-being, paving the way for possible psychosocial interventions.

Another important issue raised by cross cultural research suggests that the hedonic and eudaimonic dimension of well-being could be differently combined and expressed according to cultural values (Delle Fave et al., 2011). For instance, eastern populations are more collectivistic and tend to pay more attention to social dimensions of positive functioning, and to moral issues connected with personal happiness as the following section will illustrate.

1.3 Philosophic Contributions to Positive and Clinical Psychology (Seneca, Aristotle, Buddhism and Eastern Philosophy)

1.3.1 Western Theories of Well-Being and Mental Health

Both hedonic and eudaimonic perspectives 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 & Singer, 2008). The former underlined the importance of pleasure, regardless of its cause. According to the hedonic philosophy, happiness

can be defined as the total amount of pleasure experienced in life. According to this line of thought, the truly happy person is blessed with fortune along his/her life. Similarly, epicurean philosophers equated happiness with "pleasure in tranquility", "and pain avoiding" (aponia). Contemporary utilitarian philosophy strictly refers to these Greek approach, by affirming the principle of utility. It states that thanks to individual's attempt to maximize pleasure and self-interest, the good society is developed and maintained.

In overt contrast to this approach, other ancient philosophers as Aristotle, Plato and Socrates stated that happiness is something more noble, and argued that pleasure comes from exercising individual's virtues, in a process of self-realization. In the "*Nichomachean Ethics*", written in 350 B.C., Aristotle asserted that human beings are basically virtuous and aspire to the highest of all goods: "eudaimonia." He used this term to refer to activities of the soul in accordance with virtue. Accordingly, each person receives a call to know and to live in line with his *daimon* (a sort of spirit given to all individuals), thereby progressively actualizing an excellence (from the Greek "arête"). Aristotle's deeper message about virtues was that it involves achieving the best that is within the individual, each according to his/her unique talents and capacities. This achievement leads to happiness. Importantly, Aristotle admonished to seek "that which is intermediate", avoiding excess and extremes. Those of virtuous character thus, engage in deliberate actions chosen to avoid excess or deficiency, whether they are extremes of pleasure or pain, fear or confidence, vanity or humility. In fact, the pursuit of well-being may 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 & 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. This latter refers to the balance between reason, spirit and appetites, whereas Epicure's concept of ataraxia refers to freedom from worries or anxiety through the ability of maintaining balance and serenity in both enjoyable and challenging times (Li, 2008).

1.3.2 Eastern Theories of Well-Being and Mental Health

Concepts of harmony, balance and equilibrium strongly characterize Eastern philosophical definitions of happiness and well-being (Joshanloo, 2013). In these traditions hedonism as a way of pursuing happiness is not favored, since positive emotions and pleasures are considered too temporary and marginal to be the criterion against which happiness is measured (Joshanloo, 2013). Confucianism, Buddhism Taoism, and Hinduism, as major philosophical traditions in Eastern countries such as China, India, Japan, indeed share more similarities with the eudaimonic perspective. For instance, *Confucianism* emphasizes the importance of self-cultivation, self-conquest, and self-discipline, and this may lead to valuing self-abnegation and asceticism. Pleasure and positive emotions are not especially

emphasized in this notion of happiness (Lee, 2004). In Confucianism optimal functioning can be achieved by sticking to virtues, disciplined self-governance, and by maintaining a harmonious attachment with others and the world. Similarly, *Hinduism* emphasizes virtues and righteousness, rather than hedonism, in conceptualizing happiness (Shamasundar, 2008). Cardinal virtues of Hinduism include gratitude, non-violence, compassion, and generosity. Acting in accordance with these virtues is believed to lead to a state of harmony inside and with the outer world (Shamasundar, 2008).

Buddhism advocates a state of happiness which is not dependent on any external or internal pleasurable stimuli (Wallace & Shapiro, 2006). In this doctrine, there is no direct relationship between pleasure and happiness. Pleasure is temporary, and generally it is centered on the self, which can make individuals selfish and sometimes in conflict with the well-being of others. The Buddhist version of well-being is based on mental balance and contentment, which can be cultivated by "reflecting on the transitory, unsatisfying nature of hedonic pleasures and by identifying and developing the inner causes of genuine well-being"(Wallace & Shapiro, 2006) . Importantly, in the Buddhist approach, happiness is not necessarily incompatible with suffering, sadness, and tragedy, confirming that in this approach well-being is not premised on the hedonic balance.

Finally, in *Taoism* happiness and unhappiness complement one another, and are mutually dependent. Taoism embraces the idea that the positive is hidden in the negative and vice versa (yin and yang) and happiness occurs as the by-product of living in accordance with Tao, that is the principle regulating nature, heaven, and the lives of human beings (Littlejohn, 2007).

Considering that such suffering and negative emotions are not regarded as entirely bad in Eastern cultures, and are thought to contribute to spiritual development, hedonism cannot be the basis for defining optimal human functioning in these cultures . Instead, the Eastern conceptualization of happiness is more consistent with the eudaimonic perspective (Joshanloo, 2013). Compared to the Western eudaimonic perspective, embedded in an individualistic model of society, Eastern conceptualization of eudaimonia emphasizes positive qualities such as selflessness, adjustment to the environment, social unity, and transcendence. These issues have important clinical implications, as illustrated in the next section.

1.4 Traditional Contributions to Positivity in Clinical Domains: Humanistic, Clinical Psychology and Psychotherapy

1.4.1 Humanistic and Existential Psychotherapy

Humanistic psychology suggested concepts such as self-realization and self-actualization as final therapeutic goal (Maslow, 1954; Rogers, 1961). The "person centered approach" developed by Rogers explicitly emphasized the positive nature

of human beings and their natural tendency toward personal realization. Accordingly, the emphatic listening and understanding of the client, the unconditional support and positive regard are the core ingredients of humanistic counseling. These are considered the necessary and sufficient conditions to trigger individual's healing and pursuit of happiness. Recently, an important author referring to the positive psychology movement, Prof. Stephen Joseph (2015) suggested the person centered counseling to be the father of all subsequent positive psychotherapies. Even though some important contributors inside positive psychology strongly underlined its independence from the humanistic psychology (Waterman, 2013), indeed they both share the fundamental assumptions about the positivity of human nature and its innate tendency toward self-actualization. This crucial theoretical assumption orientates subsequent research and clinical applications of the two disciplines. As Prof Joseph asserted:

"…person centered psychology with its emphasis on becoming fully functioning is a positive psychology" (Joseph, 2015; p. 37)

Other early contributors emphasized the importance of finding meaning and purpose in life, sometimes in a world that makes no sense (e.g., times of war). For instance, *Vicktor Frankl* developed a clinical approach called *Logotherapy*. In Frankl's conceptualization of resilience and meaning (Frankl, 1959), each person is seen as an authentic and unique being, striving for finding meaning and realization even in the midst of severe life adversities. His clinical approach, derived from psychodynamic tradition, was also labeled as "Existential Analysis" and is focused on assisting individuals in perceiving and removing those factors that hinder them in pursuing meaningful goals in their lives. Logotherapy as an intervention for promoting meaning in life will be further described in Chap. 8 of this book.

1.4.2 Traditional Clinical Psychology and Psychodynamic Perspectives

Many contributions from clinical psychology have addressed the task of defining positive functioning. A major contribution in this field comes from Erickson's formulations of stages of developments, which puts an emphasis on human growth and development (Erikson, 1959). Accordingly, each stage encompasses a specific task to be achieved. The successful achievement leads to positive outcome and growth, conversely, the negative outcome leads to crisis and impasse. Interestingly, Erickson described specific lines of development of positive human functioning across the lifespan, from childhood to old age. In Erickson's theory of human development, thus, the possibility of growth and self-improvement was indeed recognized across the whole life span.

However, other major contributions in defining well-being and positive functioning could date back to traditional clinical psychology and psychodynamic perspectives. Since its early stages, clinical psychology research emphasized issues such as

the concept of *individuation*, formulated by Jung (1933). This concept refers to the process of self realization, which encompasses the discovery and experience of meaning and purpose in life. Jung postulated that this process depends upon the interplay and synthesis of opposites (e.g. conscious and unconscious, personal and collective, psyche and soma, divine and human, life and death). Thus, he strongly emphasized a more holistic approach to human being, that encompasses also spiritual or more noble needs beyond Freudian instincts and emotional conflicts. Jung also suggested that the clinical work (i.e., the psychoanalytic psychotherapy) could be considered itself as an individuation process leading to well-being.

Inside the psychodynamic approach, another important contribution comes from Karen Horney's formulation of the "self". In her book "*Neurosis and Human Growth: The Struggle Toward Self-Realization*", published in 1950, she made a distinction between real and ideal self (Horney, 1991). The former defines who and what we actually are, the latter is the type of person we feel that we should be. Importantly, according to Horney, the real self has the potential for growth, realization of talents, and happiness, whereas the ideal self is used as a model to assist the real self in developing its potential. The healthy person's real self is aimed at reaching self-actualization throughout life by overcoming its deficiencies and neuroses.

Even though Jung and Horney were indeed considered outsiders from the traditional Freudian psychoanalytic approach, they indeed challenged it by emphasizing the positive characteristics of human nature. These positive dimensions, such as transcendence and the process of self-individualization an self idealization, coexist with negative impulses and destructive parts of human beings, in the complexity of human conditions. Accordingly, both positive dimensions and negative impulses should be included in the psychodynamic work with clients, as Jung and Horney underlined in their seminal formulations.

1.4.3 Cognitive Behavioral Therapies and Other Psychotherapeutic Approaches

Other traditional approaches in the clinical psychology domains underlined the importance of considering positive functioning in clinical work. For instance, in 1954, Parloff, Kelman and Frank suggested that the goals of psychotherapy were increased personal comfort and effectiveness (Parloff, Kelman, & Frank, 1954). Further, Ellis and Becker (1982) formulated the classical cognitive behavioral therapy (CBT) approach for treating anxiety disorders, and entitled their book as "*A guide to personal happiness*". Together with principles of rational-emotional therapy, Ellis argued that the most general and far-reaching goal people have is to live a long and happy life. According to Ellis, the attainment of this goal is facilitated when three conditions (or sub-goals) exist: (1) People are achieving to the best of their ability in their chosen field of work, that they find interesting and absorbing; (2) People are involved in satisfying and loving relationships with significant others

(partner, family, friends, social group); and (3) People experience a minimum of needless pain and emotional misery, as well as a maximum of comfort and pleasure. Thus, the basis of current evidence-based psychotherapy (CBT) encompasses a complete formulation of hedonic and eudaimonic well-being.

Similarly, Fordyce (Fordyce, 1977, 1983) developed a program to increase happiness. This program includes activities such as socialising more, focusing on the present, being organised and adopting an optimistic mindset. Participants in the happiness program reported increased happiness compared to control participants. According to Fordyce (1983), the program fostered "the development of new behaviors and attitudes, changes in life-style, new insights and understandings, better copings with bad moods, enhancement of happy moods, and a better awareness of happiness itself" (p. 495). Fordyce's (1977, 1983) work provided some preliminary evidence that happiness could be improved using deliberate strategies.

Along this tradition, CBT adopted a directed, collaborative therapeutic relationship, which encompasses the consideration of patients as experts of their own problems and their full involvement in clinical decision making (Dudley, Kuyken, & Padesky, 2011; Padesky & Mooney, 2012). Hence, CBT indeed calls for an empowered vision of the patients, similar to the one endorsed by humanistic psychology first, and positive psychology afterwards (Joseph, 2015). In such approach, CBT can be considered a pioneer form of positive intervention. Further, CBT already has a 20-year research tradition of clinical interventions where protocols have been modified to integrate specific strategies to promote positivity and well-being, as briefly summarized here below.

Christine Padesky (Padesky, 1994; Padesky & Mooney, 2012) was one of the first within the cognitive therapy tradition to highlight the importance of positive thinking. She realized that patients were often unable to correct their negative thinking as a result of being unable to process positive experiences. Over the therapy patients discovered that these positive experiences would easily be forgotten or explained away. Padesky (1994) suggested that positive corrective experiences were important in challenging negative beliefs, and that current CBT should include a specific work for helping patients in building up a positive self-schema that could assimilate and benefit from these positive experiences. Later formulations of this model (Padesky & Mooney, 2012) included specific strategies to help clients to identify their strengths, in order to reinforce their self-identity, to reduce distress and to pursue significant life goals. Importantly, this approach tends to be incorporated as an element within CBT, rather than as an alternative stand-alone approach. According to Dudley et al. (2011), in fact, the incorporation of a strength and resilience model to clinical practice could greatly improve the case conceptualization process and could individualize therapy, with a long-lasting beneficial effect for patients.

Other contributions from the CBT arena called for the implementation of positive interventions with clinical populations (D'raven Lamber & Pasha-zaidi, 2014; Karwoski, Garratt, & Ilardi, 2006; Schrank, Brownell, Tylee, & Slade, 2014). Karwoski et al. (2006) proposed to integrate standard CBT protocol for depression with strategies derived from positive psychology. Based on the observation that not

all patients fully benefit from standard CBT, they suggested that the inclusion of positive psychology exercises could greatly improve the CBT efficacy for depressed individuals. In fact, both CBT and positive interventions already share conceptual overlaps, such as a focus on the present, on discrete goals, and a collaborative, direct alliance with the patients. Karwoski et al. (2006), thus, highlighted that it seems quite feasible and beneficial to add a specific work on the promotion of patients' well-being. Accordingly, CBT practitioners should assess and capitalize on their clients' strengths during the course of therapy, they should promote optimal experience, and should integrate some mindfulness techniques (see Chap. 8 of this book). Further, together with standard problem solving techniques, CBT therapists should add a training in optimism as well as in wisdom, in order to help their clients to cope with adversities and unsolvable life problems (see Chaps. 5 and 6 of this book). Such an extension of standard CBT would guarantee a better treatment response with durable positive benefits for depressed patients.

These observations are well summarized in the work of Bannink (2014), who proposed a *Positive CBT* approach, aimed at improving CBT cost-effectiveness and at shifting its focus into the improvement of patients and therapists well-being. Also in this case, Positive CBT is focused on client's strengths, on building a positive therapeutic alliance and on setting common therapeutic goals. However, Positive CBT calls for a shift from "problem talk" to "strengths and solutions talk", meaning that no details about the nature and severity of the problem are asked during sessions, rather its possible solutions. Alternatively, symptoms, complaints and problems are first collected and then 'translated' into therapeutic goals (Bannink, 2014). The intervention plans are focused on increasing the use of appropriate skills that clients already possess to realize therapeutic solutions to their problems. The Author, thus, stated that this approach

"*…shifts the focus of therapy from what is wrong with clients to what is right with them, and from what is not working to what is. This transition represents a paradigm shift from problem analysis to goal analysis, from a focus on deficits and weaknesses to one that builds on resources …*" (Bannink, 2014, p. 8)

A similar shift of paradigm, however, has been advocated by "*Third wave psychotherapies*". These approaches expanded their targets from the mere reduction of symptoms to the development of skills aimed at significantly improving the quality and quantity of activity in which the patient finds value and well-being (Kahl, Winter, & Schweiger, 2012). The new therapies , such as Behavioral activation (BA), Acceptance and Commitment Therapy (ACT) and Mindfulness Based Stress Reduction (MBSR) emphasize patients' empowerment and increase in skills and behavioral repertoires that may be used to overcome psychological distress (Hayes, 2004). Importantly, third wave psychotherapies adopted a model of well-being which is deeply rooted in the Eastern perspective, encompassing dimensions such as harmony, transcendence and detachment form materialism. By a technical viewpoint, this is realized by using relaxation techniques derived from Buddhist tradition, namely mindfulness meditation and exercises (see Chap. 8 of this book for a deeper description of these approaches).

In conclusion, as briefly demonstrated in this section, a large number of clinicians and psychotherapists advocated for an integration of positive dimensions of human functioning in their clinical work since many years. Unfortunately, these issues were neglected for a long time, or considered as a byproduct of symptom's reduction, or even a luxury that clinicians cannot afford (Fava, Ruini, & Belaise, 2007). In almost all Western countries, in fact, a negativity bias that drives researchers and clinicians to attend to and to be more affected by the negativity has prevailed (Maddux, 2008; Ryff & Singer, 1996).The concept of recovery in psychiatry, for instance, did not include the restoration or the achievement of patients' well-being and positive functioning (Fava et al., 2007). Thus, when patients did not meet full criteria for DSM disorders, they were judged to be remitted and not requiring further treatment. However, as Ryff and Singer (1996) remarked, the route of recovery lies not exclusively in alleviating the negative, but in engendering the positive. Recently, the new approach labeled as "Positive Psychiatry" (Jeste, 2013) is gradually advocating for an inclusion of patients' personal resources and well-being in the clinical work. Also in this case, the roots of this modern positive psychiatry could be tracked back to previous seminal contributions, as described below.

1.5 Definitions of Well-Being Deriving from Psychiatric Research

Early contributions from clinical psychiatry sought to define mental health in positive terms, rather than to focus on dysfunction. For instance, as early as 1958, Mary Jahoda developed criteria for defining positive mental health (Jahoda, 1958). These criteria encompassed five out of the six dimensions of eudaimonic well-being that were subsequently reformulated by Carol Ryff in her model of positive functioning (see paragraph before). Jahoda (1958) considered the term "mental health" as vague, elusive and ambiguous (p. 3), but a needed concept. In fact she argued that "the absence of mental illness was not a sufficient criterion for mental health" (Jahoda, 1958, p. 15). In her seminal work, Jahoda (1958) described these criteria for positive mental health: regulation of behavior from within (autonomy), environmental mastery, satisfactory interactions with other people (positive interpersonal and social functioning), individual sense of growth and self-actualization, integration and positive attitudes toward his/her own self (self-perception/self-acceptance). This latter dimension describes the awareness of individual strengths and weaknesses, whereas self-perception refers to a positive connotation in one's own judgment, ability and power. The sense of personal growth, development and self-actualization refers to what a person does with his self over a certain period of time and his/her trajectories of positive human development. Moreover, Jahoda added the criterion of integration of the personality, which refers to the balance of psychic forces (flexibility), to a unifying outlook on life, and to resistance to stress. She defined it as the criterion that guides actions and feelings for shaping the future

and includes concepts such as anxiety/ frustration tolerance and resilience when facing life adversities. Another indicator of mental health is represented by the autonomy or independence from social influences, which refers to the conscious discrimination by the individual of accepting or rejecting the environmental factors. Jahoda also articulated the concept of environmental mastery, referring to the efforts to achieve success in some social roles, to the ability to have positive social relationships and to solve problems in an efficient way. In sum, according to Jahoda criteria, mental health basically refers to the adequacy of an individual's functioning in his/her reality. It includes the individual's perception free from need distortion, the ability to successfully deal with stressors and environmental demands and possessing a personal sense of growth. At interpersonal levels, Jahoda underlined the importance of feeling empathy or social sensitivity (p. 49), which refers to the capability of an individual to perceive situations from others' standpoint, anticipating and predicting their behaviors.

Even though some criticisms could be raised to this model (i.e., overgeneralization, Western-culturally orientation, and the absence of practical assessment tools that operationalized these concepts), the work of this Jewish psychologist indeed challenged the dominant medical model of that time. In fact, it paralleled the release of the first version of DSM by the American Psychiatric Association. Thus, Jahoda formulation challenged the development of the DSM by the American Psychiatric Association (APA) for the classification of mental disorders, and it was aimed to provide a positive connotation to the concept of *mental health*. Later on, Maddux (2008) replicated the work of Jahoda by claiming the necessity to overcome the illness ideology, which is deeply rooted in the biomedical model, and is still dominant in modern clinical psychology. The Classification of Strengths (Peterson & Seligman, 2004) that will be described in Chap. 4 of this book, continued these seminal works and served as an antithesis of the DSM, by providing psychologists and therapists a common terminology for defining, diagnosing and promoting the strengths of individuals.

Similarly, in his complete mental health model, Keyes (2002) suggested to parallel the DSM diagnostic criteria for psychiatric disorders (American Psychiatric Association, 2000) to identify each symptom's opposite, and to formulate a diagnosis of *flourishing* (or complete mental health). According to this model, psychopathology and well-being coexist along a continuum, where languishing is a state of emptiness, where no specific criteria for a psychiatric disorder are met; nevertheless no instances of positivity are present. Flourishing, on the opposite end of the spectrum, requires the combined presence of high levels of emotional, psychological and social wellbeing (Keyes, 2002). Social well-being includes social acceptance, social actualization, social contribution, social coherence and social integration. Keyes developed the questionnaire "Mental Health Continuum" (Keyes, 2002) as a measure of these dimensions. In addition to providing a continuous measure of mental health, this instrument can be used to categorize individuals according to specific criteria, ranging from the conditions of pure mental illness, to languishing, to pure mental health or flourishing. To be categorized as flourishing in life, individuals are required to display high levels on indicators of emotional well-being

(positive affect, low negative affect and high life satisfaction) and high levels in six out of 11 subscales of eudaimonic well-being (psychological and social well-being). The model will be further described in Chap. 2 of this book, but it is of crucial importance to underline its connections with traditional classification systems. Hence, in the same way that a diagnosis of depression requires indications of low mood and malfunctioning over a certain period of time, Keyes's model requires the presence of hedonic symptoms and positive functioning for a person to be classified as flourishing.

On the same vein, Huppert and So's theoretical and conceptual definition of flourishing (Huppert & So, 2013) was designed to mirror both DSM (American Psychiatric Association, 2000), and the International Classification of Diseases ICD-10 (World Health Organization, 1993), by requiring the presence of opposite symptoms of Major Depressive Episode (DSM-IV), Depressive Episode (ICD-10), and Generalised Anxiety Disorder (terminology common to both systems) to be classified as a flourishing person. Identifying the opposite symptoms of these mental illnesses gave Huppert and So a list of ten positive features (competence, emotional stability, engagement, meaning, optimism, positive emotion, positive relationships, resilience, self-esteem, and vitality) that were taken as ingredients of flourishing. Huppert and So proposed a categorical diagnosis for flourishing that required a strong endorsement of positive emotions, together with a strong endorsement of eight out of ten positive features (Huppert & So, 2013). Like Keyes, this system intentionally mirrors the DSM's methodology by not requiring the simultaneous presence of all symptoms, but a specified number, for a specific timeframe.

Thus, current definitions of well-being and flourishing derive (by opposite or inverse mechanisms) from clinical psychology / psychopathology classification systems. The formal establishment of a positive psychiatry approach (Jeste, 2013) would indeed determine future developments and applications of these issues into the clinical domain. Considering that positive psychology movement was born as a criticism to traditional psychology, it may appear as a paradox that its core definitions of well-being and positive functioning actually mirror those of psychopathology. Indeed, positive psychologists may look at the positive spectrum, nevertheless positive psychology still relies on a medical model psychology, where distress is described, categorized and conceptualized according to specific criteria. These clinical criteria guide the diagnostic process of psychopathology, and the diagnostic process guide the therapeutic prescription(s). By paralleling this medical model, positive psychology seems to classify individuals according to their levels of well-being, and this process paves the way for implementing positive interventions (described in the second part of this book). Positive psychology, thus, challenged the focus of traditional psychology by introducing the shift to the positive domains, but it never really challenged the theoretical and conceptual model, by embracing its classification systems, research methods, and strategies of interventions. On the other hand, this common theoretical background could serve as an important base for a fruitful integration of the two disciplines, as described in the next paragraph.

1.6 The Integration Between Positive and Clinical Psychology

This chapter was aimed at underlying the common theoretical background, shared by clinical psychology and modern positive psychology approach. Even though conceptualizations and models of positive functioning were indeed available in clinical settings, for a long time these were viewed only as by-products of the symptoms' reduction of or as a luxury that clinical investigators could not afford. The medical model in mental health research, indeed dominated over last century. 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 & Singer, 1996). The growth of positive psychology has therefore served as a wakeup call for clinicians, psychotherapists, and psychiatrists, by underling the limitations of their reductionist approach.

First of all, individuals were labeled and considered mainly for their psychopathologies (Maddux, 2008). As consequence of this pathologization, psychological symptoms and disorders have been studied mainly by their biological, genetic and medical components, rather than applying a holistic approach to the patients. This holistic approach calls for a recognition of important human issues, such as positivity, meaning and eudaimonic well-being, that indeed have been neglected in clinical practice. The medical model is also limited in describing the full reality of human beings and their psychopathology. The medical model, in fact, exacerbates dichotomies between normal and abnormal emotions, behaviors and populations (clinical vs. non clinical). Most importantly, the medical model entails a passive view of human beings, that are regarded as victims of genetic, biological and intrapsychic factors and are considered passive recipients of therapeutic treatments (Joseph, 2015; Maddux, 2008). Finally, as underlined in the previous pages, cultural issues may have an important role in defining well-being dimensions. The medical model in mental health research does not fully take these cultural issues into consideration (Ruini & Fava, 2014). Thus, positive psychology has introduced an alternative, more holistic consideration of human beings, and its positive approach could be applied to address the limitations of the medical model.

Conversely, clinical psychologists and psychiatrists have strongly criticized the positive psychology movement, without fully considering some positive initiatives and possible contributions (Fernández-Ríos & Novo, 2012). Many clinicians, in fact, underlined the over-simplification of current positive psychology theories and accused positive psychologists to neglect negativity, symptoms and problems, and the complexity of human nature (Held & Bohart, 2002). Positive psychology research and interventions have been criticized for adopting a "one size fits all" approach in studying positive experiences and in planning interventions. It means that models describing the features of positive emotions, optimism and character's strengths have been proposed and indiscriminately applied to a large variety of populations from American college students to work-teams and finally to older adults. Indeed, current research in positive psychology has underlined some methodologi-

cal flaws of this simplistic approach. Moreover, some negative and paradoxical effects of promoting some positive dimensions have recently emerged, particularly in clinical populations, as described in the second part of this book. By a cultural viewpoint finally, positive psychology has been labeled as being culturally biased toward a Western/American perspective. Only recently, in fact, research on positive psychology has spread in Asian countries. Thus, positive psychology has been harshly criticized by traditional psychology, that considered it biased in the formulations of research designs, and in implementing interventions.

However, this juxtaposition and mutual criticisms seem to be quite unfruitful to both disciplines. They indeed share the same scientific methodologies for studying human nature (i.e., the use of standardized assessment tools-whether self-reports or observed rated measures). They also share some common theoretical background referring to the medical model implicitly endorsed by traditional psychology research. For instance, both positive and clinical psychology share the mission of improving individual's life, by specific interventions. The former (positive psychology) targeted a larger number of individuals, form normal to clinical populations. Conversely, clinical psychology restricted its line of intervention to the second type of populations. Nevertheless, as underlined along the chapters of this book, only by analyzing psychological symptoms and dysfunction, can positive human functioning be fully understood and conceptualized. Further, understanding and promoting well-being was found to predict psychopathology (Wood & Joseph, 2010). Hence, the benefit of an integrative line of research seem to be twofold: it may help clinicians to conceptualize distress and plan appropriate interventions, and it may guide positive psychologists to better understand positive dimensions and their relationships with distress and negativity.

Thus, an increasing body of literature (that will be reviewed in this book) calls for an integration between positive and clinical psychology. This integration can be considered as a constructive and modern scientific approach, which calls for a number of different strategies and interventions to be selected based on individual specific needs. Wood and Tarrier (2010) referred to this integrated clinical approach as "*Positive Clinical Psychology*" (Wood & Tarrier, 2010). According to this perspective, there is no need to develop

> ".. a new fragment of clinical psychology, but rather a change or reorientation of clinical psychology itself, so that positive and negative functioning are considered equally when predicting, understand and treating distress" (Wood & Tarrier, 2010, p.825)

This book aims to provide further clinical and scientific support to the integration between positive, clinical psychology, psychotherapy and psychiatry (Fava & Ruini, 2003; Jeste, 2013; Rashid, 2009; Wood & Tarrier, 2010).

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Chapter 2
Positive Human Health, Positive Mental Health, Resilience and Their Psychosomatic Underpinnings

Mens Sana in Corpore Sano

Giovenale

Abstract This chapter offers a review of various theoretical and clinical contributions that have described positive health, positive mental health and resilience, starting from the classical psychosomatic perspective. The concepts of hardiness, toughness and sense of coherence are illustrated, underlying their similarities with positive psychology perspective. The role of positive emotions and eudaimonic well-being in influencing physical health is also reviewed. Finally, the concepts of flourishing and positive mental health are presented, with a particular emphasis on their relationships with psychopathology and psychological distress.

2.1 Early Contributors in the Psychosomatic Fields: Commonalities with Positive Psychology Perspective

Early experts in psychosomatic realm, such as Alexander, Kissen (1966, 1967), Engel (1977), and Lipowski (1988) suggested the importance of evaluating the complexity of clinical phenomena. Alexander argued that every illness could be considered "psychosomatic" since emotional reactions inevitably influence somatic processes by activating neuro-affective ways. On the same vein, Kissen (1966, 1967) clarified that the relative weight of psychosocial factors may vary considerably from one individual to another within the same illness, and he underscored the basic conceptual flaw of considering diseases as homogeneous entities. Each patient thus, could have a different emotional reaction(s) to an illness. At the same time, psychosocial variables may have different roles on patients who present the same illness. Alexander, Kissen and Lipowsky, thus, challenged the traditional approach to medical illnesses by introducing the role of psychosocial variables, which was largely neglected at that time in medical settings. They also challenged the medical model by emphasizing the complexities of human conditions and the inter-individual differences.

These innovative perspectives converged into the *biopsychosocial model* of illness and disease that emerged from psychosomatic research. It was developed by

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George Engel, who suggested that health and disease are the result of interacting systems at the cellular, tissue, organismic, interpersonal and environmental levels. In Engel's view (Engel, 1977), the study of the diseases must then include the individual, his body and his surrounding environment as essential components of the total system. In the same vein, Lipowski (1969) underlined the importance of studying the relationships of biological, psychological and social determinants of health and disease. These authors indeed renovated the medical approach and clinical interventions and they opened a fruitful path of research in psychosomatics (Fava & Sonino, 2009). Unfortunately, researchers, clinicians and consultation-liaison psychiatrists embracing this biopsychosocial model seldom included the study of positivity in their work.

Subsequently, in 1948 the World Health Organization (WHO) defined health as a "*state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*" (World Health Organization, 2005). Since then, researchers recognized the need for multiple indicators in assessing health and treatment outcomes (Hunt, McEwen, & McKenna, 1985). Later on, the Ottawa Charter (World Health Organization, 1986) produced "*The central document of health promotion*" which 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 and to lead an active and productive life, that is, a good quality of life (World Health Organization, 1986). This document paved the way to modern research and to clinical developments in psychosomatic medicine, by focusing on health, rather than on disease (Kickbusch, 2006). This direction indeed is in line with current positive psychology perspective, particularly the research on positive human health, as briefly summarized along this chapter.

Some pivotal theorethical insights were provided by Fava and Sonino (2009). In their review of the literature on psychosomatic medicine, Fava and Sonino (2009) summarized these historical contributions and underlined their modern developments. In particular, they suggested that modern psychosomatic approach should investigate the role of chronic stress, traumatic events, early life adversities and personality factors and their interactions with physical health and disease. Importantly, on the same call of the WHO and the Ottawa Charter, Fava and Sonino (2009) argued that personal well-being should be considered an important protective factor, influencing both physical and mental health.

The positive psychology perspective could be indeed similar to this holistic approach, which assigns well-being a key role in individual's life. Thus, issues such as resilience, personal strengths, psychological adaptation and individual empowerment in managing his own health status appear to be common lines of research characterizing modern psychosomatic approach as well as positive psychology (Delle Fave, 2007).

In the following sections of this chapter the main points of convergence between these disciplines will be presented. Taken together, these points of convergence describe main concepts of positive human health, and its related discipline: positive mental health.

2.1.1 The Concepts of Salutogenesis and Sense of Coherence

As early as 1987 Aaron Antonovsky focused 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, and he referred to this phenomenon as "*Salutogenesis*". Antonovsky began his investigations with a group of subjects who stayed healthy, despite the fact that they had had experiences from the concentration camps of the Second World War. He postulated that this happened as the result of the way they were able to fully understand life around them, to manage the situation on their own or with the support of others, and to find meaning in the situation. According to Antonovsky, these people had a certain life orientation, precisely called "sense of coherence", which helped them dealing and coping with external stressors. Antonovsky then introduced the salutogenic concept of "*Sense of Coherence*" (SOC) (1993, 1996). The SOC refers to an enduring personal attitude and evaluates how people view life and, in stressful situations, identify and use their resources to maintain and develop their health. SOC consists of three dimensions: *comprehensibility (cognitive), manageability (instrumental/behavioural), and meaningfulness (motivational)*. Antonovsky emphasized that the sense of coherence concept is a dispositional orientation, rather than a personality trait/type or a coping strategy, which reflects a person's capacity to respond to stressful situations.

Subsequently, Antonovsky developed the Sense of Coherence (SOC) scale, a self-rated questionnaire for assessing the cited construct (1993, 1996). The original version contains 29 items measuring the three salutogenic factors. The SOC scale was translated in many different languages and used in Western, Eastern and African countries, suggesting the questionnaire to be a cross culturally applicable instrument. A large body of research has documented how SOC is strongly related to perceived health, especially mental health, and is an important contributor for health maintenance (Antonovsky, 1996).

2.1.2 Resilience

The concept of resilience was extensively defined and formulated by various authors. One of the most used definitions of resilience states: "*the ability to bounce back effectively in the face of adversities, challenges, traumas and setbacks* (Brooks & Goldstein, 2003; Masten, 2001). 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 experiences (Rutter, 1993).

The initial research on resilience stemmed from the observation that many children were able to achieve a positive developmental outcome despite early adverse experiences (Yates & Masten, 2004), such as poverty and violence. Poverty includes poor nutrition, lower educational achievement, and insufficient medical care,

whereas violence often entails physical, sexual, emotional, psychological and financial abuse (Brackenreed, 2010). Studies of resilient children have underscored the importance of both internal factors (character strengths) and environmental elements (such as family cohesion and warmth) when dealing with these adversities (Kumpfer, 1999; Yates & Masten, 2004). Despite a full review on resilience in developmental settings falls beyond the scope of this chapter, this is still a dominant field of research, which shares commonalities with positive psychology. In particular, the *positive youth development model* (Catalano, Hawkins, Berglund, Pollard, & Arthur, 2002) has been receiving increasing attention in these last decades. It mainly refers to the identification and use of youth assets in order to counterbalance potential risks factors and adversities.

Research now has progressed to include the study of resilience in early, middle, and late adulthood. In their work examining aging adults, Ryff, Love, Essex, and Singer (1998) defined resilience as the capacity to maintain or recover high well-being in the face of life adversity. They underlined that certain dimensions of eudaimonic well-being (such as positive interpersonal relations, purpose in life and personal growth) can be considered key ingredients of resilience in adulthood and older age (Ryff, 2014). This approach was further confirmed by Fava and Tomba (2009) who suggested the promotion of eudaimonic well-being as a mean to sustain resilience in clinical settings (see Chap. 4 of this book).

When describing his model of resilience in adulthood, Bonanno (2004) referred to "potentially traumatic events" for indicating that negative events may become disrupting and trigger psychopathological symptoms only in certain individuals, whereas others may successfully adapt to them, or even find maturation and growth (i.e., see Chap. 6 of this book). When adopting a life span perspective, in fact, adversities and traumatic experiences in people's life are quite common, but the effects of these events are not uniformly negative. Bonanno described different trajectories of resilience versus disruption after loss or traumatic experiences. Resilient individuals may experience transient perturbations in normal functioning (e.g., several weeks of worries or sleep disturbances) but generally they may exhibit a *stable trajectory of healthy functioning* across time, as well as the capacity for generative experiences and positive emotions. Other individuals, by contrast, display a trajectory in which normal functioning temporarily falls into the threshold or sub-threshold forms of psychopathology (e.g., symptoms of depression or posttraumatic stress disorder), and eventually and gradually returns to pre-event. Interestingly, using a longitudinal perspective, Bonanno found that indicators of disruption following a traumatic event could be manifested also after a certain amount of time (several months or even years) (delayed disruption). He argued that this should not be considered necessarily as a pathological defense mechanism, nor a delayed grief reaction, but rather as an indication of healthy adjustment. Most importantly, the work by Bonanno and colleagues supports the idea that human resilience is a quite common phenomenon, in different life stages. Notably, resilience should be considered in the complexity of a clinical and longitudinal approach (Bonanno, 2004). In fact, Bonanno found that the majority of resilient individuals reported emotional distress, low mood and negative intrusive cognitions following the stressors. However, these

experiences were transient, rather than enduring, and did not interfere with the ability to continue to function in other areas of life, including the capacity for positive affect.

On the wake of these findings, nowadays current literature considers resilience not as an entirely fixed personality predisposition, but as a malleable ability that can be acquired by specific interventions, such as the Penn Resiliency program (Freres, Gillham, Reivich, & Shatté, 2002), the Bounce Back program (Noble & McGrath, 2005) (to be performed at school), or the Strength Based Resilience (Rashid et al., 2014), or Well-being Therapy (to be performed in the psychotherapeutic setting) (Ruini, Belaise, Brombin, Caffo, & Fava, 2006; Tomba et al., 2010). The former are designed to foster resilience in children and young populations, whereas the latter are more feasible in clinical or therapeutic settings. These approaches will be further described in the second part of this book.

2.1.3 Hardiness

Later developments of the salutogenic/resilient approach could be recognized in the work of Deborah Kobasa and Salvatore Maddi (Kobasa, 1979; Kobasa, Maddi, & Kahn, 1982) who formulated the model of hardiness in the 80's. Accordingly, hardiness could be defined as "*a pattern of learned attitudes and skills that helps in turning stressful circumstances from potential disasters into growth opportunities that do not only merely maintain, but also enhance performance and health*" (Maddi et al., 2013, p. 1).

Authors defined hardiness as a personality trait comprising three related general dispositions: *commitment, control,* and *challenge*. Taken together, they function as a resistance resource in the encounter with stressful conditions. Challenge refers to the consideration of difficulties as a challenge rather than as a threat, and to the acceptance of the fact that the only thing in life that is constant is change. Commitment refers to an active involvement in family, work, community, social, friends, religious activities, which gives meaning to lives. Control refers to a strong sense of control on everyday life. The balanced combination of these dimensions (the 3Cs) constitutes hardiness. In their pioneer investigations, Kobasa (1979) and Kobasa et al. (1982) found that people with high levels in these 3Cs were productive at workplace and presented a lower risk of developing illness. In this view, illness is considered the result of a coping deficiency. Hardy people in fact resulted to be engaged in *hardy coping, hardy social interaction* and *hardy self-care*. The former refers to correctly identifying a situation as stressful and trying to efficiently solve the actual problems. The opposite negative attitudes are avoiding, or denying the problems. Hardy social interactions involve giving and receiving social support from significant other, in opposition to social isolation, self-victimization and blaming others for the stressful situation. Hardy self-care, finally, refers to engage in healthy life habits, such as moderate physical activity, relaxation, healthy eating. In short, hardy self-care refers to keep the bodily arousal at an optimal level (i.e.,

toughness, see below). The combination of these three characteristics results into the "hardy pattern", which facilitates turning stressors into personal advantage; decreasing the strain, and avoiding the physical or psychological breakdowns associated with chronic or severe stress (Selye, 1976).

Importantly, these skills could be learned and trained. Khoshaba and Maddi (2004) developed a program—HardiTraining—that has been applied to clinical settings and counseling, as well as to school and organizational settings. The results are promising, and HardiTraining could indeed be subsumed under the rubrics of positive psychology interventions.

2.2 Allostatic Load Versus Optimal Allostasis and Optimal Experience

2.2.1 Allostatic Load and Allostatic Overload

The role of acute and chronic stress in influencing human health has been extensively studied in traditional psychosomatic approach. Authors such as Selye (1976), Sterling and Eyer (1981), and McEwen and Stellar (1993), documented the modifications in systems such as the hypothalamic-pituitary-adrenal axis (HPA-axis), the autonomic nervous system (ANS), and the immune system, that do vary in response to challenges/demands from external world. The modifications of such systems occur in order to facilitate the maintenance of homeostasis in human body. This process of actively maintaining homeostasis has been labeled "*allostasis*" (Sterling & Eyer, 1981). In normal situations, the allostatic response is initiated by a stressor, sustained for an appropriate interval and then turned off when the stressor has stopped (McEwen, 2007). However, when the allostasis mechanism occurs too frequently and/or when it is inefficiently carried out, the body pays a price for being forced to suddenly adapt to adverse psychological or physical challenges.

The concept of *allostatic load*, as introduced by McEwen and Stellar (1993), represents the cost of the continual adjustment of the internal milieu required by the organism to adapt to different social, environmental and personal challenges. Allostatic load thus, represents the long-term cumulative view of the process of allostasis and its negative consequences in terms of risks of pathology.

Allostatic load has been evaluated considering several biological markers: systolic and diastolic blood pressure as indices of cardiovascular activity; waist-hip ratio as an index of metabolism and adipose tissue deposition; serum High-Density Lipoprotein (HDL) and total cholesterol as indices of atherosclerotic risk; plasma levels of glycosylated hemoglobin as an indication of glucose metabolism; 12-h urinary cortisol excretion as an indicator of hypothalamic-pituitary-adrenal axis activity; urinary epinephrine and norepinephrine levels as index of sympathetic nervous system activity. These correlates have been used to measure a threshold between tolerable level of stress (a physiological state buffered by the personal and

interpersonal resources of the individual within a time-limited period) and toxic stress (strong, frequent and/or prolonged activation of the body stress response system in the absence of buffering factors/protection). Indeed, the distinction between tolerable and toxic stress is not easy to identify (Shonkoff, Boyce, & McEwen, 2009).

McEwen and Wingfield (2010) defined *allostatic overload* as the transition to this extreme state. Thus, the physiological unbalance in these biomarkers is the consequence of the 'wear and tear' resulting from repeated or chronic challenges, or from the failure of the allostasis management. A growing body of literature on mind-body connection documented the impact of allostatic overload on individuals' health (Offidani & Ruini, 2012) and on the onset of various physical and mental diseases, such as cardiovascular diseases, cognitive functioning decline, and mortality (Ryff, Singer, & Love, 2004).

2.2.2 Toughness and Optimal Allostasis

On the opposite vein, some researchers and clinicians have underlined the biological risks of the opposite scenario, i.e., the lack of a proper stimulus from external world and a poor or insufficient activation of the allostasis. Richard Dienstbier (1989) proposed a physiological model that operates on the premise that "all physiological systems are strengthened through use" and "intermittent stress over time causes some physiological changes that promote effective coping", rather than a damaging response (Dienstbier, 1989, p. 849). Thus, he described an optimal level of physiological arousal (achieved with a proper stimulation) that is related to maintain organs and tissues in good health. He introduced the "*Toughness*" model, which relies on the mechanisms of catecholamine (dopamine, epinephrine and norepinephrine) production and depletion. These are secreted and activated as a result of stress. The changes in the catecholamine functioning activated by this proper stimulation may produce an "*increased central nervous system (CNS) catecholamine capacity, lower peripheral catecholamine base rates, but increased capacity and responsivity with severe or prolonged stressors, an increased tissue-specific sensitivity, and finally, a delay or suppression of pituitary-adrenal-cortical responses*" (Dienstbier, 1989, p. 850, 1991).

These modifications are associated with positive effects in the individual: the ability to tolerate stress successfully, and to cope with it, without developing a mental illness; the ability to maintain positive performance in contexts that an individual would appraise as stressful or challenging, and the presence of greater emotional stability (Dienstbier, 1989, 1991). According to the toughness model, tough individuals will likely seek out challenging situations, which will make them even tougher (Dienstbier, 1989, 1991). This consideration indeed parallels the "Hardiness model" described in the previous section of this chapter. An important distinctive point of the toughness model posits that tough individuals will likely maintain calm in stressful situations and will therefore be more emotionally stable as they are less

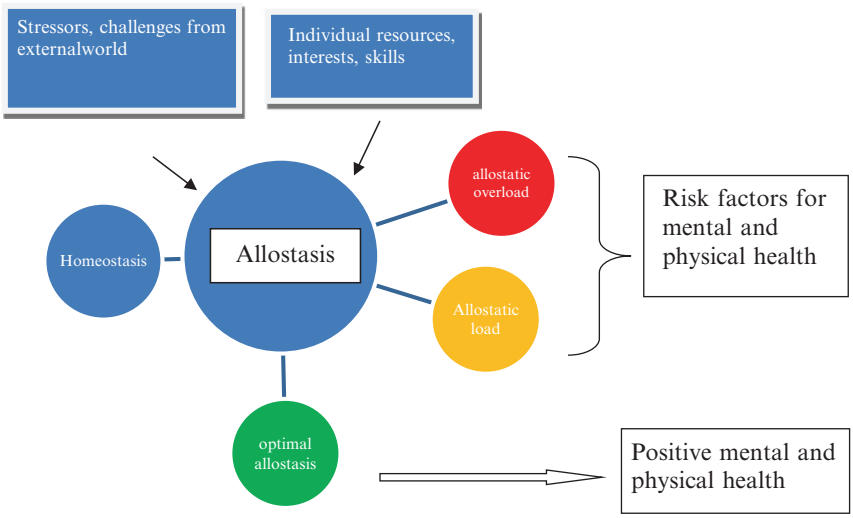

Fig. 2.1 Allostasis outcomes

likely to have "strong negative emotional reactions" in response to stressful situations (Dienstbier, 1991, p. 93). When situations arise that do stress them out, though individuals are able to quickly return to base rates once the stressful event has concluded (Dienstbier, 1991; Dienstbier & Zillig, 2009). In short, according to this model, stressful experiences both early and later in life, coinciding with a sense of control or followed by sufficient recovery, increase the likelihood of a specific pattern of physiological responses to subsequent challenging events. These physiological responses tend to optimize emotional stability and performance.

This process has been identified also as "*Optimal Allostasis*" (Ryff et al., 2004) that encompasses the cumulative long-term pattern of resistance to catecholamine depletion (SNS activity), rapid return of cortisol to normal levels following exposure to stress (normal HPA axis activity) and maintenance within optimal ranges various biological markers (immune, cardiovascular and metabolic parameters). The optimal allostasis model suggests that mental and physical health may be preserved and even enhanced by the complexity of these processes. Thus, the effects of stressors on individuals' physical and mental health largely depend on the combination of individual resources, coping skills and personal interests, ranging from the damaging effects of allostatic load and overload, to the beneficial one of optimal allostasis, as described in Fig. 2.1.

2.2.3 Optimal Experiences or Flow

A similar model of balance between environmental challenges and individual resources is represented by the *Flow model*. Originally described as a hedonic experience, flow is "….*The state in which people are so intensely involved in an activity*

that nothing else seems to matter; the experience itself is so enjoyable that people will do it even at great cost, for the sheer sake of doing it" (Csikszentmihalyi, 1990, p. 4). This positive experience emerges when there is harmony between goals, thoughts, and affect, which enables the full engagement of physical and mental resources of the individual. Importantly, no matter the specific activities that trigger this subjective state of flow, this experience begins only when the challenges required by the performance and the individuals' skills are balanced and above a certain level. When the skills are high and challenges low, a state of boredom more likely will ensue. Conversely, when skills are low and challenges are high (i.e., not balanced) a state of anxiety will be activated. Thus, the flow state is also labeled *optimal experience*, since it entails a pleasurable activation of individuals' talents and capacity in order to deal with balanced challenges associated with selected activities (i.e., sports, learning, work, leisure time, etc.). The end of the flow-inducing activity, in fact, is usually followed by intense feelings of strength, greater positive affect, increased sense of autonomy and competence, and desire to repeat the experience (Csikszentmihalyi, 1996, 2002).

However, even in structured activities, the flow state changes as internal resources and external opportunities change. The dynamic and chaotic nature of the flow state relies on the dynamic interchange between individual resources and contextual opportunities, which must be in constant balance. The need to balance internal resources and external opportunities to achieve and maintain this experience leads the individual to develop his/her skill set, and to search for greater challenges. The flow experience contributes to the development of the individual by guiding behavior toward challenging opportunities that develop personal resources and resilience. Thus, the engagement (flow state) in specific activities is connected both to hedonic (pleasure), and eudaimonic (meaning) well-being (Csikszentmihalyi, 1996, 2002).

Recent investigations on optimal experiences have found peculiar associations with physical and mental health. Bruya (2010) reports that even if "optimal experience" is characterized by high concentration and attention on the activity, by a neurocognitive point of view there is no energy-consuming pattern, as it should be expected. On the contrary, a phenomenon called "*effortless attention*" has been observed. When the challenges presented by the activity are matched by the individual's skills, they are conceived as opportunities rather than obstacles, and the mind gets into a state of exceptionally focused and effortlessly maintained attention. Thus, optimal experience with its own positive effects can promote and enhance cognitive and attentive skills. Further, de Manzano, Theorell, Harmat, and Ullén (2010) asked professional classical pianists to play a musical piece (using piano playing as a flow-inducing behavior) in order to study the relationship between subjective flow reports and psychophysiological measures. A significant relation was found between flow and decreased blood pressure and heart rate variability, together with increased activity of the zygomaticus major muscle (associated with positive emotions) and respiratory depth. Again, a state of optimal experience is correlated with a healthy and balanced biological pattern.

These various approaches to investigate the role of challenges and stressors on mental and physical health has gradually documented that not only they compro-

mise health and are associated with various disorders in a negative spiral of diathesis-stress dynamics. On the contrary, an opposite pattern of relationships may even be triggered, with a "crescendo" of individuals' personal, cognitive, physical and resiliency skills (Fig. 2.1).

A growing number of recent investigations further supported these findings and documented the buffering effect of hedonic and eudaimonic well-being on human's equilibrium of health and disease. Ryff and Singer (1996) have hypothesized that, as well as the presence of distress, negativity and psychosocial diseases could influence the onset and the prognosis of many illnesses, well-being and positive experiences could similarly have an important role.

2.3 The Protective Role of Positive Emotions (Broaden & Build Theory)

Positive affect and subjective well-being are extremely important for health, displaying many correlations with biological indexes (Chida & Steptoe, 2008; Steptoe, Wardle, & Marmot, 2005).

Barbara Fredrickson (1998; Fredrickson and Joiner, (2002) was one of the first researchers who studied and highlighted the importance of positive emotions. She developed the *Broaden and Build Theory of Positive Emotions* (1998, 2002), which affirms that positive emotions play a crucial and adaptive role in human being' evolution comparable to the one of negative emotions. If negative emotions are linked to survival by the activation specific action tendency (i.e., fear-escape; anger-attack, disgust-expel), Fredrickson's theory supports that positive emotions can broad and improve cognitive, social and behavioral skills, showing an equally crucial role in evolutionary system. According to Broaden and Build Theory, positive emotions broaden the thought-action repertoires of individuals. For instance, joy and interest trigger the urge to play and explore, contentment the urge of savoring, love, etc. As with the previous theories on flow, hardiness and optimal allostasis, positive emotions enlarge and improve individuals' physical, social, cognitive and psychological resources over time. Positive emotions, thus, carried adaptive significance for our human ancestors over longer time scales, by building new personal resources and by increasing the odds of experiencing subsequent positive emotions, thus creating an upward spiral toward improved odds for survival, health, and fulfillment. This theory found confirmation in many empirical investigations. Importantly, these investigations documented that positive emotions represent an *antidote* against physiological arousal produced by negative emotions (*undo mechanism*). Therefore, they could be considered important ingredients for resiliency and recovery processes. Tugade and Fredrickson (2004) for example, found that positive emotions may contribute to recovery from cardiovascular diseases: independently form the stressful illness experience and its negative emotions, individuals who experience many positive emotions can heal faster. In particular, the regulation of blood pres-

sure in the aftermath of a negative event is more rapid in those who are happy and satisfied with their lives.

Consistently with these findings, authors posited that positive emotions are active ingredients within trait resilience. Fredrickson and colleagues (Tugade & Fredrickson, 2004) published a seminal investigation where U.S. college students (18 men and 28 women) were tested in early 2001 and again in the weeks following the September 11th terrorist attacks. Mediational analyses showed that positive emotions such as gratitude, interest and joy experienced in the wake of the attacks significantly explained for the relations between (1) precrisis resilience and later development of depressive symptoms, and (2) precrisis resilience and postcrisis growth in psychological resources. Findings suggested that positive emotions are active ingredients for resilience, that might be used as buffers against depression. Further, these positive emotions may fuel thriving and growth, consistent with the Broaden-and-Build Theory.

2.3.1 Neurological and Biological Correlates of Hedonic Well-Being

Modern neuropsychology has documented that the two hemispheres play a different role in the positive and negative affect experience (neural asymmetry), providing further confirmation for the independence of negative and positive states (Davidson, 1992a, 1992b, 1995, 2000). The functional asymmetry at the electroencephalogram (EEG) emerges with a *greater activation of left prefrontal cortex when individuals engage in pleasant and relaxing activities*, and experience positive affect (Tomarken, Davidson, Wheeler, & Doss, 1992). It is associated with higher levels of well-being, positive affect as dispositional trait (Tomarken et al., 1992), greater skills in gaining benefits from compliments, rewards and positive experiences (Tomarken & Keener, 1998; Wheeler, Davidson, & Tomarken, 1993) and in overcoming critical situations (Jackson et al. 2003). On the contrary, anxious and depressive symptoms are more related to *a greater activation of right prefrontal cortex*. Further investigations confirmed that when left prefrontal cortex hypo-activity individuals (versus left prefrontal cortex hyper-activity) are exposed to stressors, they could be at higher risk of developing depressive symptoms (Davidson, 1995, 2000).

By a neurobiological viewpoint, hedonic well-being is associated with the release of *dopamine*, following pleasurable or rewarding experiences. Recent investigations found that high levels of dopamine are associated with improved cognitive performances (memory, creativity and problem solving). These findings may provide a neurobiological underpinning to the Broaden & Build Theory of positive emotions. Further, extroverted personalities have been found to display greater dopaminergic activation. Dopaminergic system, which has much more projections in the left hemisphere and is involved both in goal-directed behaviors and in the experience of positive emotions, may play an important role both in the left

prefrontal cortex activation and in the phenotypic differences in positive emotions (Depue & Collins, 1999).

Similarly, Guillemin, Cohn, and Melnechuk (1985) observed that endorphins, which are involved in cardiovascular and immune system activities, are released during euphoric moments. Pleasant experiences, which produce positive affect play a key role in protecting and strengthening the body system, representing thus protective health factors. In fact, it has been extensively demonstrated that positive emotions and well-being, with the contribution of other factors, can also influence the healing process from various diseases and longevity (Chida & Steptoe, 2008). A review of the literature conducted by Chida and Steptoe in 2008 on 35 studies with healthy subjects and 35 studies with people who had received a diagnosis of HIV/AIDS, showed that positive affect and positive traits (such as optimism and hope) were associated with longer life expectancy, especially among healthy people. Authors observed that well-being was associated with reduced mortality in both groups of populations, independently of the potential effect of negative affect. Both positive affect (e.g., emotional well-being, positive mood, joy, happiness, vigor, energy) and positive trait-like dispositions (e.g., life satisfaction, hopefulness, optimism, sense of humor) resulted related to lower mortality also in healthy population studies (Steptoe, Dockray, & Wardle, 2009; Steptoe, O'Donnell, Badrick, Kumari, & Marmot, 2008).

Some studies displayed how positive affects are negatively correlated to heart rate (Steptoe et al., 2005), systolic pressure and cardiovascular reactivity induced by negative emotional states (Ong & Allaire, 2005). Similarly, Kubzansky and Thruston (2007) used a cohort-longitudinal study design for evaluating possible predictors of a cardiovascular illness onset. They found that those with a greater sense of emotional vitality (a mix of vitality, hedonic well-being and emotional self-control) displayed a significantly lower risk of developing coronary disorders. Authors observed this relation even when they considered the potentially confounding effects of variables as age, gender, ethnicity, marital status, educational level, blood pressure, cholesterol, body mass index (BMI), smoking, alcohol, physical activity, diabetes, hypertension, and psychological diseases.

Hedonic well-being influences also inflammatory processes. In particular, it modulates the number of Natural Killer Cells (NK) and the immune system activity. Individuals who experience many positive emotions were found to be up to three times less likely to develop symptoms of respiratory infections after inoculation with a rhinovirus, and they had lower risk of a cold (Cohen, Alper, Doyle, Treanor, & Turner, 2006; Cohen, Doyle, Turner, Alper, & Skoner, 2003; Feldman et al., 1999). A large number of control factors (including age, gender, education, negative affect, and virus-specific antibody status before challenge, optimism) were not able to explain decreased risk for colds among persons with higher dispositional positive affect and there was no relationship between negative emotional styles and colds. These findings are similar to those of Marsland, Cohen, Rabin, and Manuck (2006). They observed a greater immune function indicated by higher antibody responses following vaccination for hepatitis B, in those who experienced more positive affect regardless of age, gender, health behaviours and negative affect.

Concerning the inflammatory pattern, an inverse association between positive affect and InterLeukin 6 (IL-6), was found by Friedman et al. (2007). Confirming these results, Steptoe et al. (2008) observed an inverse relation between positive affect and IL-6, C-reactive protein (CRP) concentration, and fibrinogen stress responsivity in women. Less happy people displayed greater fibrinogen responses, and coped worse with stressful events (Steptoe et al., 2005).

Similarly, Tsenkova, Love, Singer, and Ryff (2008), through a longitudinal study, displayed how problem focused coping strategies and positive emotions contributed to the decreasing of glycosylated hemoglobin (Hba1c) and to a better glycemic control. On the opposite, when people cannot use active coping strategies and, at the same time, do not experience hedonic well-being, their vulnerability to stressful events increases. Authors concluded that positive emotions can moderate the lack of functional coping strategies, increasing its negative consequences when they are not experienced, and enhancing their positive benefits when they are available.

Similarly, Moskowitz, Epel, and Acree (2008) showed an association between subjective well-being and reduced risk factors for mortality in people with diabetes (type II). Thus, recent scientific evidences showed how positive emotions and hedonic well-being are strongly associated with biology and human health. They can be independent predictors of health conditions per se and promoters of more positive health behaviours (Steptoe et al., 2009).

2.4 The Protective Role of Eudaimonic Well-Being: Positive Human Health

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 positive and healthy habits (i.e., good nutrition, regular physical activity, no smoking, or use of drugs and other risky habits) and by the presence of emotional and psychological well-being (see Fig. 2.2). Ryff and Singer (1998) have suggested that, by an etiological point of view, the presence of stress and negativity as well as the absence of well-being work together to influence human health. The absence of positivity represents a vulnerability factor, whereas the presence of well-being can be considered a protective factor in case of adversities.

2.4.1 Eudaimonic Well-Being and Allostatic Load

Considering the reciprocal and interactive nature of well-being and distress in determining positive human health, Ryff et al. (2006), verified whether psychological well-being would be associated to modifications of the same biological parameters

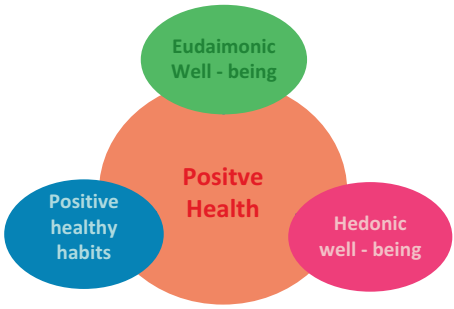

Fig. 2.2 Positive human health

identified for allostatic load (see paragraph before). Ryff et al. (2006) have found all dimensions of psychological well-being, but autonomy, to be associated with lower levels of allostatic load. These relations presented gender differences: women reported lower levels of allostatic load than men. Women with higher levels of autonomy, however, experienced also higher levels of allostatic load. It was argued that autonomy in certain women might activate a physiological stress response.

The association between positive relations and allostatic load has been studied also considering age, gender and socio-economic differences (Seeman, Singer, Ryff, Love, & Levy-Storms, 2002). Younger individuals (between 58 and 59 years), who experienced positive relationships, tended to have lower levels of allostatic load. Among older people (70–79 years), men who described more pleasant relations, reported lower (but non-significantly) levels of allostatic load than those of women. Cumulative positive relations seemed to be a protective factor also against socio-economic disadvantageous life conditions. Poor individuals tended to report higher levels of allostatic load. However, these levels decreased when people were supported by satisfying relations with others (Singer & Ryff, 1999).

In a representative sample of 7189 individuals (age = 25–74 years), Brim, Ryff, and Kessler (2004) investigated the relations between biological correlates of allostatic load and psychological well-being. Higher levels of positive relations with others were negatively linked with weight, waist–hip ratio and glycosylated hemoglobin. These effects were evident for the whole sample. Personal growth was positively correlated to good cholesterol (HDL), and negatively to the total/HDL cholesterol ratio. Purpose in life was positively correlated with HDL cholesterol and negatively with waist–hip ratio. Individuals with higher levels of these two dimensions also reported lower levels of daily salivary cortisol, than those who reported less purposeful engagement and growth (Ryff et al., 2004). Those with higher levels of environmental mastery and self-acceptance had significantly lower levels of glycosylated hemoglobin.

These results have been confirmed by an Italian study (Offidani, Bevilacqua, & Ruini, 2009). Findings showed that when people experienced distress, anxious and depressive symptoms, they presented also higher levels of platelet count (other indicator of cardiovascular risk). This biological index seemed to be negatively correlated to environmental mastery.

Research on social inequalities documented that those with lower levels of educational standing had higher levels of interleukin-6 (IL-6), after adjusting for numerous factors (Morozink, Friedman, Coe, & Ryff, 2010). However, among those with a high-school education or less, higher eudaimonic well-being (multiple dimensions) was associated with lower IL-6, thus revealing a possible protective influence.

In conclusion, there is substantial evidence (Ryff, 2014; Ryff et al., 2004) that psychological well-being is an important contributor to general quality of life and it plays a buffering role in coping with stress. In fact, it is consistently linked to indicators of allostatic load.

2.4.2 Neurological and Biological Correlates of Eudaimonic Well-Being

The neural correlates of eudaimonic well-being have been studied quite extensively. Urry et al. (2004) found that *greater left than right superior frontal activation* was associated with higher levels of hedonic and eudaimonic well-being. Urry and colleagues claimed that hemisphere differences depended on goal-directed approach tendencies, characteristic of *higher left* than right baseline levels of *prefrontal activation*. *Mesolimbic dopaminergic system*, that is involved in goal-oriented behaviors, has many projections in left hemisphere (Depue & Collins, 1999). Thus, it could be responsible for the functional hemisphere asymmetry and for its associations with higher levels of positive affect and eudaimonic well-being.

Using functional magnetic resonance imaging, those who were faster to evaluate negative emotional stimuli showed increased *amygdala activation*, but the effects varied according to the reported levels of eudaimonic well-being (van Reekum et al., 2007). Those with higher levels of well-being were slower to evaluate negative information and they showed *reduced amygdala activation*. Thus, these findings suggest that eudaimonic well-being is associated with a specific pattern of amygdala activation.

Another study documented that higher eudaimonic well-being was linked with sustained activity in *reward circuitry (*e.g.*, ventral striatum)* while viewing positive stimuli, as well as with lower cortisol output (Heller et al., 2013).

Finally, eudaimonic well-being has been linked with *insular cortex volume*, which is involved in higher-order functions. Those with higher levels of personal growth, positive relations with others and purpose in life showed greater right insular cortex great matter volume (Lewis, Kanai, Rees, & Bates, 2014).

By an endocrine point of view, the role of *oxytocin* has been studied as a hormonal underpinning for positive relations. It is released during pleasant social experiences, such as sexual activity, delivery and breastfeeding (Uvnäs-Moberg, 1998). In stressful situations, it is associated with *down regulation* of HPA axis and with low levels of epinephrine. A recent research (Ishak, Kahloon, & Fakhry, 2011)

observed the key role of oxytocin in fostering well-being. It can induce a general sense of well-being characterized by calm, positive social interactions, trust, and decreased fear, as well as with endocrine and physiological changes. It was found that oxytocin release was associated with activation of secondary biochemical actions, which mediated the long-term benefits in terms of blood pressure reduction and calm and affiliated behaviours. Its dysfunction, on the contrary, was found to be associated with morbidity and decreased quality of life (Ishak et al., 2011). Lower levels of oxytocin are observed in neuropsychiatric conditions such as autism, schizophrenia and social phobias. Thus, it could play a key role in neuropsychiatric disorders characterized by persistent fear, repetitive behaviour, reduced trust and avoidance of relations.

A recent Italian study was not primarily focused on oxytocin, but it demonstrated that low levels of environmental mastery and positive relations (PWBS; Ryff, 1989) during pregnancy represented risk factors for developing obstetrical complications and pre-term delivery (Facchinetti, Ottolini, Fazzio, Rigatelli, & Volpe, 2007). Considering that oxytocin has a fundamental role just in inducing delivery, this investigation documented that it could be linked to decreased levels of psychological well-being.

2.4.3 Eudaimonic Well-Being and Health

Numerous studies, as reviewed by Ryff (2014), have linked eudaimonia to physical health outcomes. Some have shown diminished well-being when people are dealing with health problems (e.g., frailty, disability, fibromyalgia, Parkinson's), but others have examined possible protective benefits of higher well-being, measured in terms of having fewer chronic conditions, greater productivity, and lower use of health care. For instance, maintenance of psychological well-being following the onset of breast cancer implied longer survival time (Spiegel, Kraemer, Bloom, & Gottheil, 1989), whereas impaired well-being tended to shorten it (Ramirez et al., 1989). Engaging in better health behaviors (exercise, not smoking) has been shown to predict higher eudaimonic well-being as well as good sleep (Ryff, 2014).

Recent investigations highlighted the peculiar role of "purpose in life", a key existential aspect of eudaimonia. Longitudinal inquiries have shown that those higher in purpose in life had decreased risk for mortality, after adjusting for numerous potential confounds (Boyle, Barnes, Buchman, & Bennett, 2009; Hill & Turiano, 2014). Higher levels of purpose in life also predicted reduced risk for incident Alzheimer's disease and mild cognitive impairment (Boyle, Buchman, Barnes, & Bennett, 2010), even in the presence of organic pathology in the brain (Boyle et al., 2012). Higher levels of purpose in life also predicted reduced risk of stroke and myocardial infarction (Kim, Sun, Park, Kubzansky, & Peterson, 2013; Kim, Sun, Park, & Peterson, 2013) as well as better preventive healthcare practices (Kim, Strecher, & Ryff, 2014). In summary, growing evidence indicates that eudaimonic well-being plays a protective role in the face of disease risk and earlier mortality. Further, benefits have linked it with lower stress hormones and lower inflammatory

markers, including in contexts of adversity or challenges. Together, these investigations underscore the reciprocal relationships between eudaimonic well-being and health.

Recent investigations have also discovered some *genetic underpinnings* that could explain the positive influence of eudaimonic well-being on health. In consecutive investigations Fredrickson et al. (2013, 2015) found that dimensions of eudaimonic well-being are associated with a reduced activation of the conserved transcriptional response to adversity (CTRA) gene expression. This response is characterized by up-regulated expression of pro-inflammatory genes and down-regulated expression of Type I interferon- and antibody-related genes. Thus, CTRA is generally activated by stress and adversities, and this activation produces many of the negative physiological effect described under the umbrella of allostatic load. As reported by Fredrickson et al. (2013, 2015), this mechanism is modulated by eudaimonic well-being. Eudaimonic well-being, either measured with Ryff PWB or Keyes Mental health continuum, showed a significant association with reduced CTRA gene expression. Conversely, hedonic well-being showed no significant predictive effect.

Hence, promoting well-being largely implies promoting a better physical health, less morbidity and delayed mortality, in a spiral of positive feedback. In the following section, the role of eudaimonic well-being and hedonic well-being will be explored in determining mental health.

2.5 The Concept of Positive Mental Health and Flourishing: Their Relationship with Psychological Well-Being and Psychological Distress

As illustrated in Chap. 1 of this book, the movement of positive psychology was born as a criticism to traditional psychology, which largely relied on a medical model of well-being and distress. Chap. 1 described how humanistic psychology provided seminal contributions and theoretical background to positive psychology. For instance, when it comes to psychopathology, the Rogersian person-centered approach provides a peculiar point of view. Accordingly, psychological disorders are viewed as determined by negative interactions between the individual and his/her own living environment, where he/she finds little opportunity for self-actualization (Joseph, 2015). The concept of psychopathology, thus, overlaps with the concept of incongruence in personal development (i.e., not entirely following one's organismic value tendency) (Joseph & Worsley, 2005). The medical model with its biological characterization, its diagnostic and classification systems does not fit with this person centered approach, that indeed put the client and his/her own intrinsic motivation to personal growth as essential determinants of mental health or psychopathology.

Conversely, the medical approach to mental health maintains a naive conceptualization, where psychological well-being and distress may be seen as mutually exclusive (i.e., well-being is lack of distress). According to this model, well-being should result from the removal of distress. Yet, there is evidence both in psychiatric (Rafanelli et al., 2000) and psychosomatic (Rafanelli & Ruini, 2012) research to call such views in question.

2.5.1 Well-Being and Recovery

A substantial residual symptomatology (anxiety, irritability, interpersonal problems) was found to characterize the majority of patients who was judged to be remitted according to psychiatric criteria and no longer in need of active treatment. Further, remitted patients with mood and anxiety disorders presented significant impairments in well-being compared to healthy control individuals (Rafanelli et al., 2000). In this controlled investigation (Rafanelli et al., 2000), 20 remitted patients with mood or anxiety disorders displayed significantly lower levels of well-being according to the Ryff's Scales of Psychological Well-being (PWB) (Ryff, 1989) compared to healthy control individuals matched for socio-demographic variables. Similarly, Fava et al. (2001) administered the PWB to 30 remitted patients with panic disorder and 30 matched controls and found impairments in some specific areas, but not in others. These investigations were pioneering the assessment of well-being in individuals with a previous diagnosis of mood and anxiety disorders. Further, in psychiatric settings, Thunedborg, Black, and Bech (1995) highlighted that quality of life measurement, and not symptomatic ratings, could predict recurrence of depression. Similarly, it was found that treatment of psychiatric symptoms induced improvements of well-being. In these clinical trials, that used composite measures of well-being and symptomatology, the subscales assessing well-being were more sensitive to drug effects than subscales describing symptoms (Rafanelli & Ruini, 2012).

Various clinical observations, thus, pointed out that well-being may play a crucial role in the process of recovery from a mental disorder (Fava, Ruini, & Belaise, 2007). Experiences of hedonic and eudaimonic well-being can thus be considered as a key component of what is required to define recovery from affective disorder and to prevent relapses (Fava, Ruini, & et al., 2007). In their seminal work Fava, Ruini, et al. (2007) suggested to add the restoration of well-being (at least in one of the eudaimonic dimensions described by Ryff) as a criterion for defining recovery from depression. The restoration of well-being is considered by these authors as important as the normalization of biological parameters that resulted modified during the acute phase of depression (i.e., sleep pattern, cortisol levels, etc.).

2.5.2 *Flourishing Mental Health*

Outside the clinical domains, the relationship between psychological well-being and psychological distress/symptomatology has been increasingly studied. One of the main contributions comes from the seminal work of Corey Keyes. In his complete model of mental health, Keyes (2002, 2005) described the condition of *flourishing*, which refers to the presence of high levels of hedonic, eudaimonic, and social well-being. Keyes proposed a continuum model ranging from complete *mental illness* (low levels of well-being and criteria for a mental disorder), to *languishing*, to moderate mental health and *flourishing*. Of particular clinical interest, the condition of "*languishing*" is characterized by impaired levels of these aspects of well-being, albeit without suffering from anxiety, depression, panic disorder, or alcohol dependence. Keyes suggested that a state of languishing could characterize both the prodromal (early symptom stage) and either the residual phase of mental disorders. This approach indeed embraced a staging model of mental illness (Fava, Tomba, & Grandi, 2007) that received crucial attention in previous psychiatric research, and was considered essential in understanding the phenomena of recurrences, relapse, and chronic trends in affective disorders. Even though Keyes clearly adhered to such a medical/psychiatric model, he openly introduced the role of well-being and its implications, when it is lacking. In fact, the condition of languishing could be considered a state of vulnerability that has negative implications in terms of work productivity, use of health care system and physical morbidities similar to those associated with mental disorders. The absence of well-being was also linked with an increased probability of all-cause mortality (Keyes & Simoes, 2012).

Longitudinal investigations showed that cross-time gains in well-being predicted cross-time declines in mental illness, and alternatively that losses in well-being over time predicted increases in mental illness (Keyes, Dhingra, & Simoes, 2010). Such work underscored that *mental health involves a complex balance of positive and negative psychological characteristics*, and importantly, it emphasized that impaired levels of well-being may constitute risk for psychological distress, including relapse and recurrence in psychiatric disorders (Wood & Joseph, 2010). Further, change in positive mental health predicted the prevalence and incidence of major depressive disorders, panic disorders, and generalized anxiety disorders 10 years later (Keyes et al., 2010).

2.5.3 *Mental Health, Positive Emotion Regulation and Psychopathology*

The growth of positive clinical psychology (Wood & Tarrier, 2010) and positive psychiatry (Jeste, 2015) has indeed contributed to provide pivotal data on the complex relationship between psychopathology and well-being. For instance, Kashdan (2007) pioneered this area of research and found that patients with mental disorders such as anxiety, depressive, schizophrenia present attenuated positive emotions and miss opportunities for enriching and meaningful life experiences.

In a recent review, Carl, Soskin, Kerns, and Barlow (2013) proposed a transdiagnostic clinical model that connects common disturbances in positive emotion regulation across emotional disorders such and depression, bipolar and anxiety disorder. This model refers to four specific problems/bias in processing and regulating positive emotions, that could be detected in these disorders. Individuals, in fact, are usually involved in natural processes of emotion regulation, which encompasses *which emotions they have, when they have them and how they experience and express those emotions* (Gross, 1998, p. 227). The first process has to do with *situation selection and modification* (i.e., how people influence their emotional experiences by choosing which situations to enter or to avoid); the second refers to mechanism of *attentional deployment* (i.e., how people direct attention within a situation in order to modify the emotional qualities of the situation); the third refers to *cognitive change* (i.e., the regulation of emotions through the modification of one's appraisals of emotional information). Finally, the forth area pertaining to emotion regulation refers to the *response modulation for positive emotionality* (i.e., how people consider the qualities of an emotion through one's response to the emotion once elicited). The Authors reviewed in details current evidence from the clinical and laboratory research that documented how these four processes are differently affected by emotional disorders when patients have to deal with positive emotions.

Anxiety disorders, for instance, are characterized by control and avoidance of negative stimuli. These constant and excessive efforts deplete personal resources to engage in meaningful life experiences, to derive positive reward from present life (savoring), to pursue goals and to develop social relationships (Kashdan, 2007). This latter aspect appears to be particularly important in terms of well-being impairment. In fact, the fear of social rejection and the associated social withdrawal in patients with social anxiety may lead to a negative spiral of fewer positive emotions and fewer positive reward in interpersonal experiences. (Kashdan, 2007). Agoraphobia was found to entail avoidance of a wide variety of positive situations such as social and leisure activities (Morissette, Bitran, & Barlow, 2010), whereas panic disorder was found to be associated with decreased participation in activities that generate arousal or excitement such as physical exercise and events involving a large number of people (Morissette et al., 2010). By a neurological viewpoint, anxious patients were found to have deficiencies in the brain dopaminergic system, associated with reward sensitivity and approach behaviors (Carl et al., 2013; Kashdan, 2007).

Kashdan, Ferssizidis, Farmer, Adams, and McKnight (2013) also found that these well-being impairments in people with social anxiety influenced a person's ability to receive and provide support for shared positive events; and that these deficits had adverse romantic consequences. In particular, Kashdan et al. (2013) found that socially anxious people viewed themselves, and were viewed by their partners, as unenthusiastic and disinterested following partner disclosures of positive events. This may suggest that they are particularly vulnerable because they fail to recognize, receive, and/or provide positive behaviors to their partner, hampering the possibility to have a flourishing relationship.

Generalized Anxiety Disorder (GAD) on the other hand, is characterized by excessive worry, somatization and pessimism (catastrophic cognitive attitude).

Unfortunately, patients with GAD often display a positive evaluation of their worries and consider the worry rumination as an effective coping style (Wells, 1995). These negative cognitive attitudes and the metacognitive model of GAD (Wells, 1995) underline that patients are over-concerned with future negative expectations and therefore they manifest inability to relax and savor present moments. These negative expectations may lead to disengagement and missing of important opportunities for personal growth and well-being in their life. Further, Carl et al. (2013) suggested that when it comes to positive emotion regulation, anxious patients are characterized by elevated avoidance motivation, by attentional bias toward negative stimuli and away from positive ones, and by a chronic cognitive deficit in positive appraisal. By a motivational point of view, anxious individuals are motivated to identify and prioritize entering situations that increase safety and security, rather than situations supporting attainment of positive goals. The authors argued that approaching positive goals for these patients might entail potential risks of personal failure, social rejection, physical danger, or other negative outcomes. Thus, the problem of anxious individuals may rely on the fact that they disproportionately weigh these risks over the potential benefits of entering positive situations judged to be important for their goals. Therefore, researchers and clinicians are suggested to better understand social anxiety by exploring a wider range of interpersonal contexts and positive constructs, that may facilitate a better understanding and treatment of these disorders, as described in the second part of this book.

However, *depressive disorders* (encompassing depression and dysthymia) determine the most severe impairments in positive functioning (Carl et al., 2013). First of all, they are characterized by anhedonia (the diminished capacity to experience pleasure), and apathy (deficit in motivation and engagement). Patients also lose the capacity of goal setting and pursuing because of their negative expectations for the future. When it comes to positive emotion regulation, depressed patients are mainly characterized by a decreased approach motivation, that it is often associated with a decreased reward sensitivity (Carl et al., 2013). By a cognitive point of view, these patients were found to present attentional bias away from positive information and toward negative one; together with severe deficits in positive appraisal (presence of negative interpretative bias and decreased positive reappraisal) and deficits in the capacity of forecasting future positive emotions and/or their impact. Importantly, these cognitive biases in depressed populations were found to be not entirely automatic, but involving strategic attentional control (Mathews & MacLeod, 2005). In sum, depressed individuals have difficulties in cognitively maintaining or upregulating their positive emotions. The result is a decreased capacity of savoring (Eisner, Johnson, & Carver, 2009) of present ("savoring the moment"), past ("reminiscing"), and future ("anticipating") experiences (Bryant, 2003), with severe impairments in positive functioning.

Finally, *bipolar disorders* (mania and hypomania) have the opposite characterization; thus, they display an excessive and inappropriate positivity (Carl et al., 2013). Patients in fact present an excessive sensitivity to positive events and responses to reward opportunities, together with excessive excitement and enthusiasm. Differently from anxious and depressed patients, bipolar individual do not generally present deficits in situation selection, rather they excessively search for

positive emotions. However, while mania is associated with increased pursuit of positive emotion-related situations, it is also marked by decreased participation in other types of positive situations, such as prosocial interactions. As a matter of fact, the mood elevation is often accompanied by irritable mood and severe difficulties in interpersonal functioning (Fava, Rafanelli, Tomba, Guidi, & Grandi, 2011). Patients with bipolar disorders often neglect or under-estimate the risk associated to possible rewarding external stimuli and situations (i.e., unprotected sexual encounters, excessive shopping etc.), while they over-evaluate their goals and the expected positive impact, as described in Chap. 5 of this boor. By a cognitive point of view, bipolar patients present an automatic interpretive biases of positive information leading to excessive positive appraisal, which has also been labeled as "*positive overgeneralization"*. It can be described as a cognitive style characterized by inappropriate overextension of positive results or feedback (Eisner, Johnson, & Carver, 2008). Finally, in order to keep their positive emotion up-regulated, bipolar patients were found to display a greater use of emotion-focused and self-focused positive rumination strategies compared to healthy controls (Feldman, Joormann, & Johnson, 2008; Gruber, Eidelman, Johnson, Smith, & Harvey, 2011; Raes, Daems, Feldman, Johnson, & Van Gucht, 2010). These strategies were positively associated with frequency of manic and depressive episodes in bipolar I disorder (Gruber et al., 2011).

Empirical evidences have also indicated that bipolar individuals are more sensitive to incentives in the environment (Alloy, Abramson, Urosevic, Bender, & Wagner, 2009) and show greater positive emotions in a variety of contexts, such as during a viewing of positive, negative and neutral film, as demonstrated by Gruber, Harvey, and Johnson (2009). At the same time, individuals with bipolar disorder, have even a greater negative emotion reactivity during period of depression. In fact, it has been illustrated by several clinical investigations (i.e., Malhi et al., 2004) that depressed patients with bipolar disorder have a more subcortical activation in response to negative pictures. Recent research suggested that individuals with bipolar disorder present a difficulty in the *emotion recovery*, which is the natural decline in emotion intensity over time. This difficulty in decreasing emotional response over time may be a possible explanation of the intensified positive emotional states in their everyday lives (Gruber, 2011). Gruber and Purcell (2015), moreover, defined the amplified positive emotions' pattern in bipolar disorder as *"positive emotion persistence (PEP)*". It refers to the persistence of positive mood states across different situations. The author considers this PEP mechanism as a benchmark between clinical populations (bipolar individuals) and non-clinical populations who are just very happy people, but not bipolar. Specifically, the difference between clinical and non-clinical populations refers to the persistent elevation in happiness and positivity even in non-emotional and neutral contexts, in which emotional responses are inappropriate. In a manic episode, in fact, individuals display an excessive euphoria, manifested in the form of excessive laughter and exuberant speech, which can become inappropriate, disturbing or even dangerous when leading bipolar individuals to ignore important life problems. Thus, the need of experiencing and/or maintaining pleasure and positive mood elevated entails an elevated cost for patients with bipolar disorders.

Gruber and Purcell (2015) recently articulated the clinical problems emerging form dealing ineffectively with positive emotions by proposing a model of *positive*

emotion disturbance. It describes six key positive emotion processes linked to problematic reactions to positivity:

1. *size* or magnitude of positive emotion response: an intensely experienced level of happiness may lead to negative outcomes, rather than leading to benefits, as in the case of bipolar patients.
2. *situation* or context in which positive emotions unfold: individuals who experience positive feelings in inappropriate contexts—such as when watching sad films or listening to a distressed partner—were found to be at greater risk for developing mania.
3. *specificity* of which positive emotions are experienced: certain kinds of positive emotions—such as those that are too self-focused, as pride—may at times hinder individuals' ability to adaptively connect and build bonds with others.
4. *self-regulation*: controllability over positive emotions, which entails both increasing positive emotions and decreasing or dampening positive emotions. This mechanism is associated with beneficial mental health outcomes, and it is the mechanism that basically lacks in bipolar patients.
5. *stability* or the degree by which positive emotions dynamically change over time. Greater oscillations in self-reported positive emotions have been associated with worse psychological health, including lower well-being and life satisfaction and greater depression and anxiety.
6. *striving* or the degree to which one exerts effort in pursuing or attaining positive feelings: the pursuit of happiness may sometimes lead to maladaptive outcomes because it may lead to higher disappointment. Recent work has suggested that the pursuit of happiness was often reported by individuals with a history of depression (Ford, Shallcross, Mauss, Floerke, & Gruber, 2014).

The Authors concluded by advocating new lines of research aimed at providing the causes related to the phenomena of positive emotion disturbances, either involving cognitive or neuroscientific research design. Further, Gruber and Purcell (2015) suggested that psychological interventions should be aimed at targeting disturbances in positive emotion, encompassing the promotions of savoring healthy positive emotions, but also interventions that carefully moderate or even decrease overly intense or inappropriate positive emotions, as described below.

2.5.4 The Balance Between Positivity and Negativity

Considering the beneficial effect of positive emotions, Keyes and Fredrikson posited that they constitute active ingredients for flourishing. According to Fredrikson and Losada,

> "*To flourish means to live within an optimal range of human functioning, one that connotes goodness, generativity, growth, and resilience*" (Fredrickson & Losada, 2005, p. 678).

In that paper, they used a mathematical model applied to psycho-social experiments to predict the exact amount of positive emotions that are require to flourish.

Accordingly, they found that flourishing individuals experience a ratio of 2.9:1 positive to negative emotions. They posited that to overcome the toxicity of negative affect and to promote flourishing, experiences of positivity should outnumber experiences of negativity at a ratio of about 3. In the Authors' argument, feeling good drives optimal function by building the enduring personal resources upon which people live a better and more successful life (Fredrickson et al., 2013). Interestingly, Frederickson and Losada predicted also an upper limit of this ratio. They calculated that a ratio of 11.6 to 1 could characterize excessive mood elevation, which may turn positivity into dysfunctional.

Even though these ratios and the mathematical models behind them have been strongly criticized, and they have been found to be empirically inconsistent (Brown, Sokal, & Friedman, 2013), the issue of balancing positive and negative affectivity has an important clinical value, and has been addressed by many other investigators in previous research. For instance, in 1991, Garamoni et al. (1991) suggested that an optimal balance of positive and negative cognitions or affects characterizes healthy functioning, and that deviations from the optimal balance might indicate psychopathology. In their original *states of mind (SOM) model* (Schwartz & Garamoni, 1986), Schwartz and Garamoni proposed that a balance of 62% positive cognition or affect correlated to general psychological adaptation and healthy functioning. They proposed a simple formula for calculating a balanced ratio between positive and negative affectivity: p/[p + N].

Their model relied on Lefebvre's theory of mind. Lefebvre (1990) proposed that humans have an "inner computer" that allows them to precisely regulate the ratio of positive and negative thoughts and feelings in a variety of human contexts. The positive-negative regulatory process can be functionally described using a Boolean algebra (i.e., an algebra of bipolar situations) to calculate a ratio, which, depending on situational demands and the internal responses of the person, represents the outcome probability of the individual making a positive response to the environment, with "1" for positive states of mind, and "0" for negative states of mind.

Schwartz corrected his initial .62 value (Schwartz, 1997), that characterized clinical populations or people under severe stress, and proposed a *balanced states of mind model (BSOM)*, which differentiated diverse set-points corresponding to different psychological states of mind: from coping with severe negativity and low mood (SOM = .50) to coping with stress (SOM = .62), to normal functioning (SOM = .72), optimal functioning (SOM = .81) and deep positive mood (SOM = .87). Importantly, this revised model affirms that this latter value (.87) may be linked to excess of positivity associated with denial, grandiosity, and current manic states. Subsequent research applied this ratio to clinical populations (depressed and anxious patients) as well as to children and general populations (Kendall & Treadwell, 2007; Treadwell & Kendall, 1996). Recently it has been applied to monitor patients' response to cognitive behavioral therapy (CBT) or other treatments (Wong, 2010). Hence, a converging body of research emphasizes the clinical need of considering the complex dynamics between positivity and negativity in analyzing individuals' experience.

Even though the exact mathematical model has yet to be discovered and empirically tested, these robust bodies of research seem to agree in highlighting that positivity and negativity are not linked by a linear relationship. The prevalence of positive states over the negative ones indeed characterizes people, couple and groups of individuals who flourish or present an optimal human functioning (Fredrickson et al., 2013). Conversely, clinical observations found that a prevalence of negative emotions and cognitions characterized depressed, anxious or distressed individuals (Schwartz, 1997). Over the course of the therapy, this prevalence gradually reverse, as recovery from the mental disorder appears (Schwartz, 1997).

Thus, it is strongly recommended that clinicians pay attention both to symptom reduction (negativity) and well-being improvement, and to their reciprocal influence. It has been suggested that if *a phenomenon called* ***negative potentiation*** *(as greater negative emotional sensitivity) has been found to seed and maintain depression, a parallel* ***positive potentiation*** *process appears to seed and maintain the beneficial state of human flourishing* (Catalino & Fredrickson, 2011).

A more controversial issue that needs further investigation concern the toxicity of excessive positivity and the unbalanced relation with appropriate and functional negativity. Clinical as well as positive psychologists have poorly investigated these issues so far. The clinical background and expertise deriving from clinical psychology might be crucial in investigating these important issues and in filling this gap of research, as highlighted in the following chapters of this book.

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Chapter 3
Positive Personality Traits and Positive Human Functioning

"Consider your origin. You were not formed to live like brutes, but to follow virtue and knowledge."

Dante Alighieri, *The Divine Comedy*

Abstract This chapter offers a brief overview of various personality traits and models that were found to be linked with happiness and positive functioning. Among these, Cloninger's psychobiological model and Peterson and Seligman's character's strengths model are described, underlying their specificities, as well as their commonalities. A particular emphasis is given to the importance of evaluating and considering positive personality traits together with personality disorders (and their mutual relationships) in the clinical practice. Individuals may present different combinations of strengths and vulnerabilities, and a balanced expressions of positive traits could be considered a manifestation of positive human functioning.

3.1 Personality Traits and Well-Being

When studying well-being, personality matters. Lucas and Diener (2008) suggested that some lines of research provide the evidence for the conclusion that the most important factor in determining a person's well-being is personality. First of all, studies on objective life circumstances—including factors such as a person's income, education level, age, doctor-rated health, and social relationships—show that the associations with these factors tend to be quite small. Secondly, well-being was found to be moderately heritable (Tellagen et al., 1988). Third, well-being tends to be stable over time (sometimes even when life circumstances change) and finally, correlations with personality traits tend to be much larger than correlations with external circumstances (Lyubomirsky, Sheldon, & Schkade, 2005).

An important study of Costa and McCrae (1980) across a 10-year interval found that a global happiness or well-being factor was related to chronic negative affect and chronic positive affect, which were themselves independent. The same investigation documented that negative affect was associated with neuroticism, whereas positive affect was associated with extraversion. This study paved the way for

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considering extraversion as the core personality trait associated with happiness and well-being. Subsequently McCrae and Costa (1991) explained these findings by using instrumental and temperamental theories. According to the former, *personality has an indirect impact on well-being*, for example through the selection of certain situations over other situations: extraverts may enjoy and participate in social activities, which may in turn affect the amounts of positive affect that they experience. The instrumental perspective suggests that individuals who possess high levels of extraversion or low levels of neuroticism are more likely to position themselves in positive life situations. The temperamental theory suggests a *direct linkage between personality and well-being*, due to genetically inherited differences in affective reactivity, reward or punishment sensitivity and chronic level of affect (McCrae & Costa, 1991). According to the temperament theories, the association between personality and well-being does not flow through life choices, life events, or life experiences, rather this association depends on biological underpinnings. Of particular interest is research that directly connects serotonin to the neuroticism scale of the NEO Personality Inventory (Costa & McCrae, 1992) and another one that connects it to depression and affective disorders (Lasky-Su, Faraone, Glatt, & Tsuang, 2005). These contributions confirmed the biological underpinnings of negative affect, which has a subsequent influence on experiences of happiness and well-being.

The importance of neuroticism was further confirmed by Vittersø and Nilsen (2002) in their article "*The conceptual and relational structure of subjective well-being, neuroticism, and extraversion: Once again, neuroticism is the important predictor of happiness*". They affirmed that neuroticism explained eight times as much of the well-being variance as does extraversion, it contributed heavily to predict negative affect (explaining 56% of the variance), and Authors suggested that extraversion is more fragile and mainly dominates the facets representing positive emotions (it is shown to have a large and unique influence on positive affect, explaining 26% of the variance). Vittersø (2001) questioned the dominance of extraversion as the cardinal well-being trait and he affirmed that *emotional stability* should more properly assume this role. Similarly, studies on *conscientiousness*, have shown weaker relations to well-being in comparison to neuroticism and extraversion, but still this dimension was found to be generally positively related to well-being (DeNeve & Cooper, 1998; Schmutte & Ryff, 1997). McCrae and Costa suggested that this trait affects well-being in an instrumental way: being efficient, competent, and hardworking facilitates the creation of life conditions that promote well-being (McCrae & Costa, 1991).

Research on *agreeableness* is not numerous, but the relation between this trait and well-being was found to be weak for positive interpersonal relations (DeNeve & Cooper, 1998; McCrae & Costa, 1991; Schmutte & Ryff, 1997). Again, McCrae and Costa suggested that agreeableness affects well-being in an instrumental way. Individuals that possess high levels of agreeableness have generally more close relationships, that can contribute to their well-being.

The dimension of *openness to experience* was found to be linked to different aspects of well-being. This trait shows interesting results, because it seems to be related both to positive and negative affect (McCrae & Costa, 1991). McCrae and Costa suggested that open individuals "experience both the good and the bad more intensely" (p. 228).

3.1.1 Eudaimonic Well-Being and Personality Traits

A large body of research documented strong associations between eudaimonic well-being dimensions and personality traits (Ryff, 2014). An early investigation used the big five model of traits and found that openness to experience was linked with personal growth, agreeableness was linked with positive relations with others, and extraversion, conscientiousness and neuroticism were all linked with environmental mastery, purpose in life and self-acceptance (Schmutte & Ryff, 1997). Longitudinal inquiries have addressed links between early personality profiles and midlife well-being, finding that teenage females who were more extraverted had higher well-being in all Psychological Well-Being Scales (PWBS) in midlife (Abbott et al., 2008). Teenage neuroticism, in contrast, predicted lower well-being on all dimensions, with the effects mediated through emotional adjustment. In another recent investigation Authors compared the prediction of well-being from personality in two samples of adolescents and older adults (Butkovic, Brkovic, & Bratko, 2012). They found that emotional stability and extraversion significantly predicted well-being in both samples. However, personality explained more variance in eudaimonic well-being, rather than hedonic well-being. Further, interactions among personality traits were used to predict changes in well-being over the course of community relocation (Bardi & Ryff, 2007). Older women who experienced relocation displayed different combinations of personality and well-being profiles. Those with higher environmental mastery, autonomy and personal growth before the move also showed better emotional reactions after the move, particularly if the transition was difficult. However, the trait openness to experience played a key role in amplifying extraversion and, as a consequence , in further influencing well-being levels. Thus, it seems that eudamonia entails a dynamic relationship with personality in defining individuals' stable attitude toward positive functioning.

3.2 Temperament and Character Model

Robert Cloninger's work on the psychobiological model of personality (Cloninger, 1998) could be considered one of the seminal theory combining personality dimensions, neurobiological functioning and well-being, or positive functioning. He developed his model in the last 20 years, trying to explain the normal and abnormal differences of the two major components of personality: *temperament* and *character*. From this model, Cloninger has also developed the Temperament and Character Inventory (TCI) which is widely used in clinical practice and research (Paris, 2005). This model is able to give a global understanding of human personality at multiple levels of analysis, beginning from the genetics of personality, and the neurobiological basis of behavior, to cognitive and emotional structures. The models describes personality development, behavioral correlates of individual differences, and the interaction between the components of personality and factors related to the vulnerability to psychiatric disorders.

The *temperamental component* is considered the emotional basis of the personality. It contains neurobiological dispositions, the automatic behavioral reactions, and the answers to specific external stimuli. It encompasses four dimensions: *Novelty Seeking* (NS); *Harm Avoidance* (HA), *Reward Dependence* (RD) and *Persistence (P)*. These traits are genetically independent, relatively stable over time during the life course, and universal in different cultures (Cloninger, 2004). Temperament refers to the constitutionally given and largely genetically determined, inborn disposition to particular reactions to environmental stimuli. These reactions pertain to the intensity, rhythm, and thresholds of affective response (Kernberg, 2005). In this model, the single dimensions of temperament are influenced by a complex network of cerebral connections. These interactions and the modifications of the nervous system conduce to the different profiles of behavior. Accordingly, the different temperamental traits are associated with the release and regulation of specific neurotransmitters: high levels of NS are associated with low levels of dopamine; high levels of HA (dimension of behavioral inhibition) are correlated positively with serotonin and gamma-aminobutyric acid (GABA); high levels of Reward Dependence (dimension of behavioral maintenance) are negatively correlated with the central noradrenergic activity (Norepinephrine) and the dimension of Persistence (persevering) is modulated by a reduced noradrenergic activity (Cloninger, 2004).

The *three-dimensional character component*: Cloninger subsequently added the character components to his model, in order to describe learned characteristics and attributes of people. Differing from temperament, the character traits change over time, while the person grows up. The character, in Cloninger's model, includes cognitive processes, encompassing logics, concepts, symbolical interpretation, and memory. The three dimensions of character are: *Self-directedness* (S); *Cooperativeness* (C) and *Self-Trascendence* (ST) (Cloninger, 2004). Self-Directedness is the extent to which a person identifies the self as autonomous; Cooperativeness expresses empathy and identification with others, and Self-Transcendence involves self-awareness of being an integral part of the unity of all things.

According to Cloninger (2004) the definitive character could be seen as a non linear function (or a result) of temperamental traits that existed before, the social-cultural influences, and the unique casual events of every individual. Due to a bidirectional interaction, the temperament influences what individuals perceive, and the character modifies the meaning, so the meaning and the value of every experience depends on both temperament and character.

Temperament and character are thus two crucial aspects of personality. Their different combinations have been explored in clinical populations and they were found to describe the majority of personality disorders (Cloninger, 2006; Paris, 2005). In particular, Cluster B and C personality disorders were found to be associated with the dimensions of Novelty Seeking and Harm Avoidance, respectively. The low scores on the character dimensions of self-directedness and cooperativeness, on the other hand, were found to characterize individuals with diagnosed personality disorder from those without (Jylhä et al., 2013). Other investigators (Kaess et al., 2013) applied the TCI for measuring personality profiles in female adolescents with

borderline personality disorders. They were found to display high scores in novelty Seeking and Harm Avoidance, and low scores on Reward dependence.

However, it's the combination of high scores in the three character's traits that identify individuals who are healthy, happy and fulfilled (Cloninger and Zohar, 2011). Using TCI, Cloninger (2006) distinguished people who were in the top third of self-directedness, cooperativeness, and self-transcendence, from those in the lowest third, or in the middle third on each dimension. About a third of people whose results were low in self-directedness were depressed. If self-directedness or cooperativeness resulted high, but not both, then individuals did not differ much in their mood from those with average character profiles. If both self-directedness and cooperativeness were elevated, then happiness was more frequent than sadness (19% versus 1%). Finally, individuals that were elevated on all the three aspects of character had the highest percentage of happiness. Explained in other words, according to Cloninger, the development of well-being depends on the combination of all the three aspects of character. If any of the three factors fails in development, this leaves the person vulnerable and can lead into a state of depression (Cloninger, 2006).

Thus, Cloninger model may offer important points of convergence for positive and clinical psychology, by providing a complete system of descriptions of both pathological functioning, normal functioning and optimal functioning. Unfortunately, the application of this model is still neglected in well-being and positive psychology research.

Notable exceptions are some work by Ruini et al. (2003) on an Italian sample of 450 subjects in the general population. They reached to the conclusion that the relationship of well-being to distress and personality is complex. They also suggest that it is not true that the presence of well-being can be explained simply by the lack of distress. This study linked eudaimonic well-being with personality profiles as assessed by TCI. Results partially replicates Schmutte and Ryff's (1997) findings within an Italian sample: Personal Growth was positively correlated with Novelty Seeking; Positive Relations showed positive correlations with Reward Dependence, and Harm Avoidance showed negative correlations with all the six Ryff's dimensions. Thus, the TCI could be used to partially mirror individual's profiles in terms of eudaimonic well-being

Importantly, the TCI model proposed by Cloninger displayed many points of convergence also with another model stemming from the positive psychology perspective, namely, the character's strengths model (Peterson and Seligman, 2004). Dimensions as persistence, cooperativeness, transcendence, caution, modesty and self-transcendence are equally described as positive character's dimensions, as illustrated in Fig. 3.1.

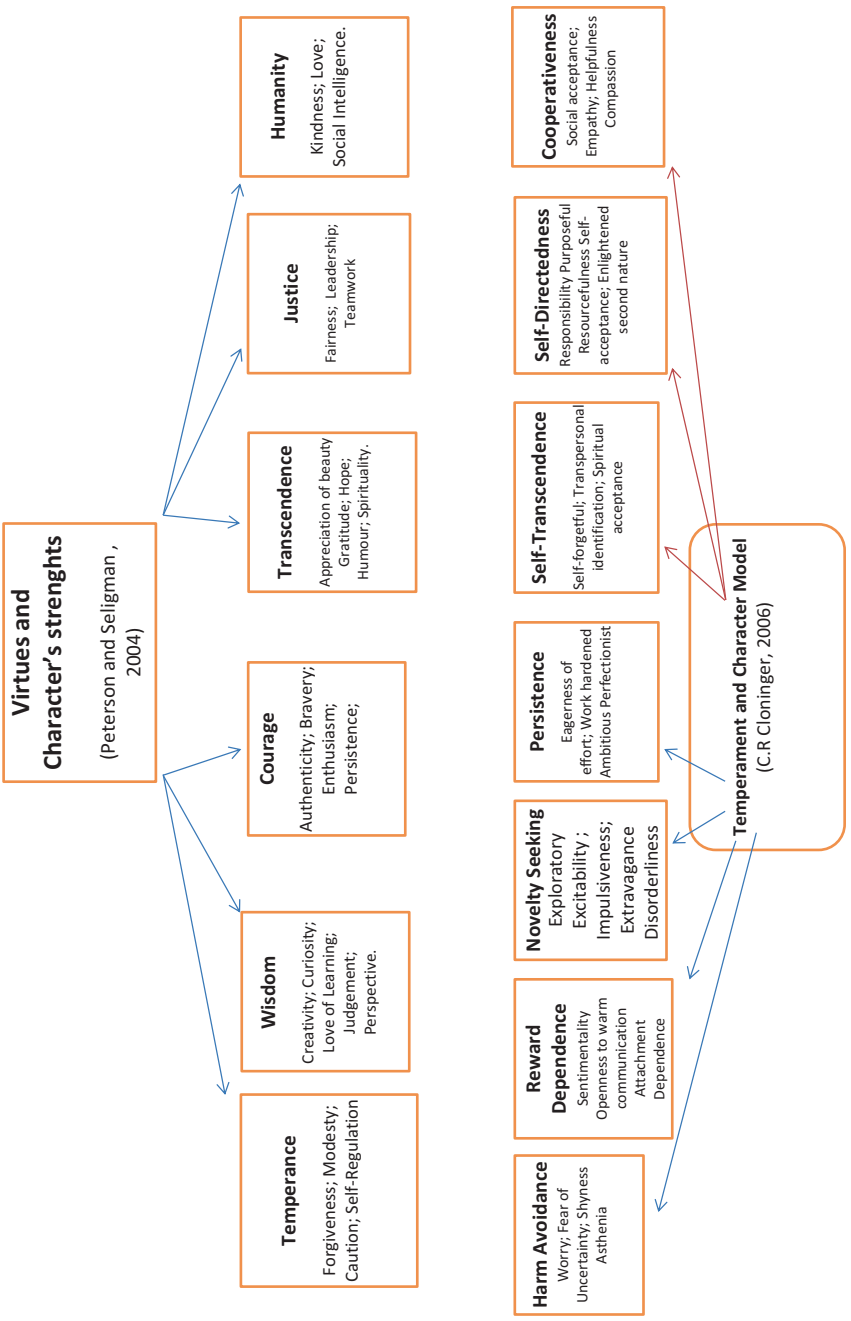

Fig. 3.1 Points of converges between TCI and character's strengths models

3.3 Character's Strengths

In the early 2000s, positive psychology movement criticized the medical model characterizing mental health research and scientists began to advocate the formulation of a classification system for positive aspect of human functioning (Peterson and Seligman, 2004). As the previous versions of the Diagnostic and Statistical Manual for psychiatric disorders (DSM) provided a full description of psychopathological state (Axis I) and dysfunctional personality traits (Axis II), some scientists mirrored this line of research by defining positive attributes of the individual and by developing a classification system. This resulted in the Value In Action (VIA) classification of character strengths and virtues (Peterson & Seligman, 2004), which provides a classification of positive traits in human beings.

The VIA classification of Character Strengths is composed of 24 character strengths that fall under six broad virtue categories: wisdom, courage, humanity, justice, temperance and transcendence. These virtues are morally and universally valued, encompass capacities for helping the individuals and others, and produce positive effects when expressed in real life context. Character's strengths, hence, could be considered as psychological processes or mechanisms that define the virtues. For instance, the virtue of courage may be displayed by the strength of bravery and persistence; wisdom by creativity, perspective and love of learning, transcendence by the strengths of gratitude, hope and spirituality, etc. Some of these strengths indeed parallel the character's components in Cloninger's model of personality (for a full description, see Fig. 3.1).

Similar to Cloninger's perspective, also in Peterson and Seligman formulation each human being has a constellation of positive character traits (character strengths) that makes him or her distinct or unique. The combination of character strengths are ways of thinking, feeling, and behaving that facilitate optimal performance and when used are both energizing and intrinsically motivating. Of particular interest are "signature strengths", or those character strengths most central to an individual's identity (Peterson & Seligman, 2004), which researchers frequently operationalize as a person's top five character strengths (e.g.; Mongrain & Anselmo-Matthews, 2012) as measured with the VIA questionnaire.

3.3.1 The Diagnosis of Positive Personality: The Four Front Approach

Traditionally, psychodiagnosis has focused on symptomatology and dysfunction. Within the framework of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association, 2013) each diagnosis represents a negative syndrome comprising a cluster of symptoms associated with clinically significant impairment or distress. The new edition of DSM has deleted the rigid, axial classification of the previous DSM IV system, and advocated for an higher

consideration of psychosocial and cultural issues related to a manifestation of a specific mental disorder. However, DSM V is still largely focused on negative aspects, at the expense of identifying the strengths of individuals and their environmental resources. Many clinicians still arise criticisms to this DSM classification ad call for a wider focus when diagnosing individuals' functioning. Widening the diagnostic focus, for instance, involves the consideration of the psychological strengths, environmental influences on behavior, and of developmental forces that affect the manifestations of problems as well as strengths.

One useful framework for strengths' assessment and diagnosis was formulated by Wright (1991; Wright & Lopez, 2002). In this *four-front approach*, authors suggested clinicians to gather information about:

I. strengths and assets of the client,
II. deficiencies and undermining characteristics of the client,
III. resources and opportunities in the environment, and
IV. deficiencies and destructive factors in the environment.

Clinicians can use multiple methods, including observation, interviews, and standardized measures, to gather this information and should attempt to include the four-front data in their case conceptualization. This would broaden the current limited approach of the DSM to encompass the evaluation of patients resources and active interplay within his/her environment.

Further, Lopez, Edwards, and Larue (2006) criticized the medical model behind the DSM-IV and suggested to broaden its Axis IV (psychosocial and environmental factors) to consider psychosocial and environmental resources that, alongside the problems, might facilitate the conceptualization of the ways in which the client copes and solves problems in his or her life. They also advised to re-anchor Axis V (the Global Assessment of Functioning- GAF) in order to be able of capturing the absence of functional deficits and the areas of optimal living. Alternatively, they suggested to add a further axis to measure positive functioning: the Global Assessment of Positive Function (GAPF). Accordingly, the GAPF anchors of 1, 50, and 100 would be reflective of severely impaired functioning, good health, and optimal functioning, respectively. Unfortunately, current DSM V dropped the GAF as a severity index of the disorders. Thus, it appears unlikely that clinicians will consider also positive resources and character's strengths with current DSM V classification system. In the near future, it would be recommended that the movement of Positive Psychiatry (Jeste, 2015) would make a contribution in improving this classification system.

On the same vein, Lopez et al. (2006) suggested to add one more axis (Axis VI) to specifically identify and diagnose patients' strengths, alongside with patients' personality disorders/dysfunctional traits. Unfortunately, the controversial classification of personality disorders has not been revised in the current version of DSM (APA, 2013). Again, mental health research has neglected an important opportunity of providing a complete and exhaustive classification of mental health. The growing trend of positive psychology/positive psychiatry might advocate for future revisions that encompasses these suggested integrations (Jeste, Palmer, Rettew, & Boardman, 2015)

3.3.2 *Character's Strengths and Well-Being: A Non-linear Relationship*

The diagnosis and recognition of individual's character's strengths has been documented to be essentially linked to increase in well-being. Seligman, Steen, Park, and Peterson (2005) found that the process of identifying and using one's strengths resulted in increase in happiness and decrease in depressive symptoms after a month. These gains lasted through 6-month follow-up among those individuals who continued to practice it. The actual use of one's strengths, above and beyond learning what one's strengths are, is an essential ingredient of this activity; participants in an "assessment-only" condition (where they learned their strengths but were not asked to use that information in any way) were indistinguishable from those who practiced a placebo activity (Seligman et al., 2005). As a matter of fact, a converging evidence points out that it is worthwhile to identify and promote the development of strengths, and that these benefits are both psychological and motivational. It means that developing strengths feels intrinsically rewarding to people, and so they are more driven to engage in a strengths-development process. For instance, it was found that among youth, the use of signature strengths in novel ways along with personally meaningful goal-setting led to increases in student engagement and hope (Madden, Green, & Grant, 2011). Recently, Sheldon, Jose, Kashdan, and Jarden (2015) have identified ten core characters' strengths (Grit, Gratitude, Curiosity, Savoring, Control Beliefs, Meaning in Life–Presence, Strengths Use, and Engagement, Pleasure, and Meaning-Based Orientations Toward Happiness) and examined their role in goal pursuit and long term boosting well-being. Interestingly enough, they found that only grit was associated to goal attainment at follow up, whereas curiosity and meaning had a major role in influencing well-being. The authors did not intend to dismiss the other positive personality dimensions, but they argued that they probably have a minor effect in the process of goal striving.

In clinical domains, the assessment and use of character's strengths in psychotic patients was found to improve positive affect, by directing attention towards memories associated with strengths and imagining of future positive experiences (Sims, Barker, Price, & Fornells-Ambrojo, 2015). However, no effect on self-esteem and self-efficacy was observed in psychotic patients. A possible hypothesis is that this activity may have triggered negative self-evaluations (i.e. "Lack of Confidence" theme). These negative self-evaluations reflect negative information-processing biases, that are common cognitive characteristics of patients with very low self-esteem (Sims et al., 2015). Similarly, another recent investigation documented that the use of signature strengths is particularly important for individuals with low levels of meaning and aspirations in life (Allan & Duffy, 2013).

Despite these promising findings, researchers have begun to examine the *potential drawbacks* of treating strengths as stable traits. Biswas-Diener Kashdan, and Minhas (2011) warned that an "identify and use" approach, in fact, may encourage individuals to think of strengths as permanent and unchangeable, which may in turn lower the individual's motivation to improve.

Further, Grant and Schwartz (2011) confirmed that all positive traits, states, and experiences have costs that, at high levels, may begin to outweigh their benefits, creating the nonmonotonicity of an inverted U. The authors underlined that even though positive psychology research and interventions have produced fundamental advances in scientific knowledge of positivity, they erroneously assumed that positive traits, experiences, and emotions have monotonic effects on well-being and performance. This theory assumes that "*the more developed any strength is, the better people are*" (Schwartz & Sharpe, 2006, p. 380).

> "*Positive psychologists have recognized that the deficiency of a strength or virtue can harm well-being and performance, but they have paid little attention to understanding when, why, and how the excess of a strength or virtue can harm well-being and performance"* (Grant & Schwartz, 2011, p. 62).

In their pivotal work, they demonstrated that virtues (such as wisdom, optimism, courage, generosity etc.) that positive psychology has linked to higher well-being and performance can, at high levels, undermine the outcomes they are intended to promote. They described a nonmonotonic inverted-U-shaped effect, which could be explained by mechanisms such as conflicts between virtues, and different slopes and thresholds for positivity and negativity.

On the same vein, Parks and Biswas-Diener (2014) argued that strengths research would benefit from the inclusion of nuances. In line with Schwartz and Hill's (2006) call for "practical wisdom," one should aim not only to use one's strengths more often, but to use those strengths well and appropriately. Humor, for example, can be an invaluable tool for building relationships, and for coping with stress; if used inappropriately, however, humor can be insensitive or hurtful. Similarly, the strength "love for learning" may become "inefficient or even dysfunctional" (Bunderson & Sutcliffe, 2003; p. 554) as demonstrated by Bunderson and Sutcliffe's (2003) studies on learning orientations of management teams. They argued that a too high focus on learning can distract attention away from performance results. Thus, an emerging line of investigations warned against an overplay of character' strengths, that turns out to be dysfunctional, as explained in the next paragraph.

3.4 Positive Personality Traits and Personality Disorders

Peterson and Seligman model of character's strengths (2004), assessed by the VIA inventory was fond to display specific correlations with adaptive personality traits, such as conscientiousness and openness to experience, as well as negative correlations with neuroticism. However, when it comes to link character's strengths to DSM personality disorders, the research is still limited.

Cloninger model, on the other hand, has extensively correlated temperament and character dimensions with specific personality disorders (Paris, 2005; Svrakic, Whitehead, Przybeck, & Cloninger, 1993). With the later formulation of his model, involving the three character dimensions, Cloninger documented that deficits in

these dimensions may be find across DSM clusters of personality disorders (Cloninger, Zohar, Hirschmann, & Dahan, 2012; Svrakic et al., 2002). Further, the temperol dimension of Persistence has also an important role in relation to psychopathology. While at balanced levels it may foster happiness and well-being, at excessive levels it characterizes individuals with anxiety disorders and obsessive compulsive personality traits (Cloninger et al., 2012).

Other authors that attempted to link personality disorders to personal strengths were Oldham and Morris (1995). They provided particular support for the dimensional approach with their unique conceptualization of personality disorders. These two authors contended that each of the 14 personality disorders listed in the DSM can be viewed as lying on its own continuum of adaptation. Less acute presentations of these personality types lie at one end of these continua, with the actual manifestations of the personality disorders at the other end. Oldham and Morris posited that an individual may move along this continuum, depending on the environmental and endogenous stressors in his or her life at any one point in time. In this conceptualization, an individual may exhibit behaviors more indicative of the actual disorder at times of high stress, whereas clinical presentation may resemble a less intense version of the disorder in times of less stress. For instance, individuals with narcissistic personality disorder may find that certain aspects of this disorder allow him or her to be autonomous and self-confident and therefore able to function at a superior level. It is only when these characteristics become extreme that they are no longer beneficial to the client. The Oldham and Morris (1995) conceptualization leaves room for individuals to be diagnosed according to the degree of dysfunction or maladaptation as well as to the degree of positive use of personal resources.

Similarly, Evans (1993) described a model of psychological assessment that moved from a deficit-oriented perspective to one that emphasizes a client's assets and strengths. Accordingly, the essential step is to evaluate interactions between characteristics of the social environment and the set of individual behavioral repertoires. This perspective allows to identify parallelism between normal and abnormal functioning (psychopathology). Each personality characteristic, thus, could be regarded as a severe form of deviance, as a neutral state, or a desirable attribute. Courage, for instance, could negatively characterize individuals who commit crimes, violent behaviors or even suicide (Pury, Starkey, Kulik, Skjerning, & Sullivan, 2015); it could be view as a virtue (Peterson & Seligman, 2004) or it could be considered a desirable outcome for individuals with anxiety disorders and avoidant personality traits (Kashdan, 2002, 2007). This approach confirms that personality characteristics are neither positive or negative "a priori". Rather, it is the external context that indicates their appropriateness and valence.

A recent but unfinished model that connects personality disorders and personality strengths was conceptualized by Chris Peterson and described by Martin Seligman (2015). Peterson used his character strengths model to complement the DSM-V. Interestingly, Peterson argued that the "real madness" (i.e. psychopathology) could be derived by unbalanced levels in one or more of the 24 character' strengths. In fact, various definitions of psychopathology may be represented by the *opposite, absence or excess* of one of the 24 character's strengths (Seligman, 2015).

For instance, the strength of persistence, that falls into the virtue of courage, could become pathological by its excess and transformed into obsessiveness; or by its absence, that is laziness. It's opposite (helplessness) represents a relevant clinical sign of dysfunctionality as clearly documented by many clinical studies. Similarly, impulsivity could be considered the opposite of self-regulation (virtue of temperance), that could be nuanced into self-indulgence (its absence) or inhibition (its excess). On the same vein, courage has been found to be impaired in individuals with anxiety disorders (Kashdan, 2002, 2007), but it turns out to be bad in certain social context, by facilitating acts of violence and suicide (Pury, Starkey, Kulik, Skjerning, & Sullivan, 2015). Courage, impulsivity, self-indulgence and inhibition are common issues that clinicians often face in working with their patients.

Rashid (2015) continued this clinical approach by translating each DSM symptom of personality disorder in terms of character's strengths dysregulation. For instance, antisocial personality disorder could be conceptualized as a lack of citizenship, empathy, kindness, and honesty, as well as an excess of courage, passion and vitality. Histrionic Personality disorder, on the other hand, could be described as a lack of persistence, of authenticity and modesty, as well as an excess of enthusiasm, friendliness and spontaneity.

However, in the clinical domain Peterson, Seligman and Rashid emphasized the importance of recognizing and promoting patients' strengths, rather than focusing on the negative. This novel approach represents indeed an important area of innovations in classifying personality traits (either positive or dysfunctional) that each clinician should seriously take into consideration (Rashid, 2015; Seligman, 2015).

3.5 Positive Functioning Manifested as Balanced Expression of Positive Traits

Taken together, these contributions suggest that although positive psychology overtly decided to focus the research field to positive dimensions (Seligman & Csikszentmihalyi, 2000), it clashed with the complexities of the human condition, which inevitably encompasses the negativity. Wood and Tarrier (2010) emphasize that characteristics (such as gratitude and autonomy) that are generally regarded as positive, 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. On the same vein, Kashdan and Rottenberg (2010) suggested that optimal human functioning is linked to the dimension of *psychological flexibility*, which permits to define, use and moderate positive characteristics according to the specific context. They therefore suggested to avoid a "priori" definition of what is positive and what is negative.

Accordingly, there is a growing need of integrating previous knowledge on "negativity" derived from clinical psychology into positive psychology research, particularly when it comes to plan and perform psychosocial interventions (Ruini &

Fava, 2013; Wood & Tarrier, 2010). This insight has important implications for positive and clinical psychology. Indeed, in clinical domains of research, psychologists have increasingly discovered that at high levels, positive affects begin to turn negative. This phenomenon has been described as the "ubiquitous U" (i.e., X increases Y to a point, and then it decreases Y). Common examples include the Yerkes-Dodson law (Yerkes & Dodson, 1908) and classic theories of optimal arousal (Eysenck, 1967; Smith, 1983).

For this reason, traditional clinical psychology has a crucial role in providing integration to positive psychology research. The important insight that comes from studying and dealing with psychopathology, could thus be used in determining the "right" amount of positivity for a certain individual, considering his/her global situation and needs. Without this clinical framework, the risk is to lead individuals at having too high levels of certain positive dimensions (e.g. self-confidence), with unrealistic expectations that may become dysfunctional and/or stressful to individuals (Ruini & Fava, 2013). Thus, this optimal-balanced well-being could be different from patient to patient, according to many factors, such as other personality traits, social roles and cultural and social contexts. It implies a multiple pathway approach, the idea that there is no single right way to be well and that people have different combinations of strengths and vulnerabilities (Ruini & Fava, 2013). As a result, positive interventions should be more articulated than simply increasing positivity, but should take into consideration individual's specific needs and complexities, as described in the second part of this book.

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Part II
The Promotion of Positivity in Clinical Practice

Chapter 4
Positive Interventions and Their Effectiveness with Clinical Populations

Different men seek after happiness in different ways and by different means,
And so make for themselves different modes of life and different forms of government

Aristotle

Abstract This chapter is aimed at emphasizing the importance of promoting positive functioning in clinical settings. Common technical strategies shared by positive and clinical interventions are discussed. In order to provide clinicians with a toolkit of positive psychology strategies, the main positive psychotherapeutic strategies aimed at promoting positive functioning, that have been developed and tested in clinical trials are described: Well-being Therapy, Quality of Life therapy, Positive Psychotherapy and Strengths based Counseling. Finally, the chapter provides an overview on the beneficial effects of positive interventions, as well as on their possible paradoxical effects. Clinical implications are then discussed, with a special recommendation of integrating psychotherapy research design when testing and implementing positive interventions.

4.1 Clinical Interventions and Positive Interventions: Possible Integrations

As described in the first part of this book, the growing of positive psychology research has documented the beneficial effects of positive emotions, well-being and character's strength. The question emerges of whether they can be fostered through specific interventions and techniques. As a matter of fact, the second era of positive psychology research has witnessed the development of positive interventions aimed at promoting positive characteristics of human functioning. Positive emotions, subjective well-being (Diener, Suh, Lucas, & Smith, 1999), human strengths (Peterson & Seligman, 2004) and other positive personality characteristics such as compassion, hope, and altruism (Seligman, Steen, Park, & Peterson, 2005) could be considered as specific ingredients in these "positive interventions" (Rashid, 2009).

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The primary targets of these interventions were normal populations, encompassing children, college students, employees and workers and, more recently, aging populations (Huppert, 2004). However, these interventions were soon tested in clinical populations as well, particularly in depressed patients (Rashid, 2009; Sin, Della Porta, & Lyubomirsky, 2011). Also in this case, thus, the artificial boundaries between clinical and positive psychology have been trespassed, and, interestingly enough, positive interventions have been found to be particularly effective when applied to such clinical populations (Bolier et al., 2013). Moreover, new lines of research are concerned with the applications of positive interventions also in severe psychiatric disorders (Krentzman, 2012; Sims, Barker, Price & Fornells-Ambrojo, 2015), showing promising results.

These interventions encompass various techniques, that indeed are derived from, and overlap with traditional psychology and clinical psychology in particular, as described in the next pages.

4.1.1 Common Therapeutic Techniques and Possible Integrations

By a technical view point, the majority of positive interventions promote positive emotions, gratitude, resilience and positive functioning using traditional strategies that are applied in clinical psychology and cognitive behavioral therapy—CBT (Walker & Lampropoulos, 2014). For instance, the use of a journal where positive emotions, positive events and blessings are recorded by participants is similar to the one used in CBT to monitor anxiety or depressive symptoms, of course with an opposite focus. However, *self-observation* (Emmelkamp, 1974) is a common therapeutic ingredient in both positive interventions and traditional CBT.

Similarly, *homework assignments and behavioral prescriptions* (i.e., acts of kindness exercise) are used in both approaches. Also in this case, the focus is very different: in positive interventions homework assignments are aimed at increasing the amount of positive emotions and well-being experienced by participants; whereas in CBT they are often associated with negative emotions (i.e., anxiety in case of exposure to feared stimuli), but are necessary to help patients to tolerate, habituate and finally overcome psychological distress (Walker & Lampropoulos, 2014). Particularly, the *scheduling of pleasant activity* is an integral part of traditional CBT as well as of many positive interventions. This therapeutic ingredient has been found to be particularly effective for depressed patients, since it contrasts anhedonia and low mood (MacLeod & Luzon, 2014; Ruini & Fava, 2013). These therapeutic gains can now be interpreted and promoted by clinicians in the light of positive psychology research: the documented beneficial role of positive emotions (Fredrickson, 2001) as well as the engagement in intrinsically motivated activities (i.e., flow) (Seligman & Csikszentmihalyi, 2000).

Finally, another common ingredient used in positive interventions as well as in CBT is *cognitive restructuring*. In order to promote optimism, Seligman (2006) suggested to identify negative, pessimistic thoughts and to correct them by changing the individual's explanatory style (see Chap. 5). Similarly, Aaron Beck, the father of modern CBT, discovered that depression was caused by a set of specific cognitive distortions (cognitive triad of depression) and developed specific techniques to address and correct them (Beck, Rush, Shaw, & Emery, 1979). Thus, cognitive techniques used to promote happiness and optimism seem to mirror those traditionally and successfully used to treat anxiety and depression (Beck et al., 1979).

Further, a recent comparison of CBT versus positive psychology (PP) self-help homework assignments in the treatment of mildly depressed college students found that they had similar positive effects, but PP exercises also yielded significant improvements on well-being and positive affect (Walker & Lampropoulos, 2014). Walker and Lampropoulos (2014) randomly assigned college students with mild to moderate depressive symptoms to three interventions with homework assignments and to a control group. One intervention was based on positive psychology and the two others were based on cognitive behavioral therapy (one with and one without an interpersonal element). The control group did not receive any kind of homework assignments, instead participants were asked to continue with "life as usual". All of the three experimental conditions showed a significant decrease in depressive symptoms and distress scores relative to the control condition, but only participants in the positive psychology homework condition experienced an increase in behavioral activation. Authors found no differences in terms of eudaimonic well-being improvements for neither groups when compared to controls. However, compared to controls, both the positive-psychology based intervention and the interpersonal CBT-based intervention enhanced positive affect, compared to the control group. Thus, the added value of using a positive psychology intervention was supported only for hedonic dimensions (Walker & Lampropoulos, 2014). Future research should verify if such benefits and similar effects are still valid when more severe forms of depression will be included, or which specific ingredient(s) in positive psychology and CBT intervention is (are) the most powerful in terms of final outcome.

On the same vein, Karowski, Garrat and Ilardi (2006) proposed to integrate standard CBT protocol for depression with strategies derived from positive psychology. As briefly mentioned in Chapter 1 of this book, according to these authors, both CBT and positive interventions already share conceptual overlaps, such as a focus on the present, on discrete goals, and a collaborative, direct alliance with the patients. For instance, *exposure* to feared situations may serve to address the strengths of courage and bravery, which indeed are necessary to patients to fulfill the exposure homework (Rashid, 2015). Anxious patients, in fact, have been found to be particularly low on these strengths and would benefit from some training

(Kashdan, 2007). Such training could be represented by the exposure homework itself. Similarly, a focus on the importance of *positive interpersonal relationships* could be particularly beneficial for patients with social anxiety in order to better motivate them to engage in social interactions and (more importantly) to derive some positive feedback from such interactions (Kashdan, 2002, 2007). While traditional CBT emphasized the need to overcome social phobia through exposure to social situations, the integration of such positive psychology research would clarify to patients the necessity and utility of engaging in social interactions in order to address their deficits in well-being and positive interpersonal functioning (see Chap. 2 for a more detailed discussion on these issues).

As suggested by Padesky and Bannink (Bannink, 2014; Padesky & Mooney, 2012), the clinical approach could be the same, but the focus is shifted from symptoms to clients' strengths and resources. Accordingly, CBT practitioners should assess, their clients' strengths should promote the experience of well-being, and, together with standard problem solving techniques, they should add a training in optimism as well as in wisdom, in order to help their clients to cope with adversities and unsolvable life problems (see Chap. 6 for a more detailed description of wisdom and other positive coping strategies). Such an extension of standard CBT would guarantee a better treatment response with durable positive benefits for patients, as described in the following pages.

In order to provide clinicians with a toolkit of positive psychology strategies, the main positive psychotherapeutic strategies will be presented in the next sections. Well-being Therapy, Quality of Life therapy, Positive Psychotherapy and Strengths based counseling/coaching.

4.2 Well-Being Therapy

Fava and Ruini (2003) pioneered the inclusion of positivity in CBT protocol and developed an integrated psychotherapy aimed at promoting eudaimonic well-being: Well-being therapy (WBT). It is a structured, sequential approach, where CBT techniques are followed by strategies addressed to the improvement of well-being dimensions, according to Ryff's model of eudaimonic well-being (Ryff, 2014). It was originally developed as a strategy for the residual phase of affective disorders and targeted the promotion of well-being, which was still impaired in clinical populations after standard pharmacological or psychotherapeutic treatments. Almost a decade ago, in fact, an emerging body of research was documenting the clinical need of addressing residuals symptoms in mood and anxiety disorders, which predicted future relapses and recurrences (Fava et al., 2004). A parallel body of research documented the protective role of eudaimonic/psychological well-being for mental health (Ryff & Singer, 1996). The novelty and the uniqueness of WBT, thus, relied on the combination of these two lines of research (Fava & Ruini, 2003). It was based on the assumption that impairments in well-being may represent a vulnerability

Table 4.1 Well-being therapy protocol (adult)

Sessions	Therapeutic goal(s)	Activities
Initial sessions (1–2)	Identification of episodes of well-being, self-observation	Patients are asked to report in a structured diary their episodes of well-being (0–100)
Intermediate sessions (3–5)	Identification of well-being related automatic thoughts, identification of negative attitudes toward well-being, scheduling of pleasant activities.	Patient are encouraged to engage in pleasant, rewarding activities. They are asked to identify thoughts and beliefs leading to premature interruption of well-being, or to a distorted interpretation of happiness and well-being.
Final sessions (6–8)	Positive Cognitive Restructuring, promotion of flourishing	Ryff's six dimensions of psychological well-being are progressively introduced to patients. Patients are not encouraged pursing the highest possible levels in psychological well-being, in all dimensions, but to obtain a balanced, individualized, positive functioning.

factor for adversities and relapses (Ryff & Singer, 1996; Wood & Joseph, 2010). Well-being therapy is a short-term psychotherapeutic strategy, that extends over three main phases, which are usually articulated into eight sessions. The development of sessions is described in Table 4.1.

WBT has been tested in several controlled investigations (Fava, Ruini, Rafanelli, & Grandi, 2002; Fava et al., 2004, 2005) and was found to be effective in mood and anxiety disorders. Importantly, the combination of CBT and WBT techniques was found to be associated with a long lasting recovery form recurrent depression, up to a 6-year follow-up. In this investigation patients with recurrent major depression, who had been successfully treated by pharmacotherapy, were randomly assigned to either WBT or clinical management (CM) and followed up for 6 years. During this period no antidepressant drugs were used unless a relapse ensued. This happened in eight (40%) of the 20 patients in the WBT group, compared to 18 (90%) in the CM group. The WBT group had a total of 12 depressive episodes during the follow-up, compared to 34 of the CM group. Importantly, in the WBT group patients tended to relapse after 4 year from treatment, whereas patients in the CM conditions relapsed after 2 years. Even though it is not possible to distill the single contribution of well-being promotion from the sequential treatment package (CBT followed by WBT), indeed it is possible to observe its highly significant effect in decreasing and delaying the number of relapses into depression compared to CM (Fava et al., 2004).

Further, WBT was found to be particularly effective in treating anxiety disorders (Fava et al., 2005; Ruini & Fava, 2009) with long-lasting effects. Twenty patients with generalized anxiety disorders (GAD) were randomly assigned to eight sessions of cognitive behavioral therapy (CBT) or the sequential administration of four sessions of CBT followed by other four sessions of well-being therapy (WBT). In both groups, self-acceptance and environmental mastery were impaired before treatment and greatly improved after treatment, together with anxiety symptoms. Further, the CBT-WBT approach displayed significant advantages over CBT only, and these

improvements were maintained at 1 year follow-up. Ruini and Fava (2009) provided subsequent clinical evidence for the efficacy of WBT in treating anxious patients. They described a case of a woman with generalized anxiety disorder, perfectionism and obsessive compulsive personality traits, who was treated with a sequential combination of CBT and WBT. CBT was particularly effective in providing cognitive restructuring to worries and catastrophic thinking style, whereas WBT was particularly valuable in addressing perfectionism by promoting self-acceptance. These gains were maintained in the long term and provided protection to the patients when she faced major life changes (work relocation, death of her father in law) (Ruini & Fava, 2009).

WBT was also found to be particularly efficacious in the treatment of complex cases, such as depressed patients not responding to drug treatment, (Fava et al., 2002) as well as patients with comorbid psychiatric disorders or other psychosocial stressors (Ruini, Albieri, & Vescovelli, 2015; Ruini & Fava, 2009). Ruini et al. (2015) described the case of a woman with a severe depressive episode following a marital crisis who was treated by WBT over 1 year. She had no relapses up to 2 year after treatment, even when she faced another marital crisis that led to divorce. The clinical story of this patient illustrates how improved levels of eudaimonic well-being buffered against relapse, which is usually triggered by psychosocial stressor. The sequential administration of CBT and WBT protocol, in fact, made patients more able to address their symptomatology, as well as to actively engage in pursuing well-being. This could be achieved using specific behavioural homework assignments of pleasurable activities, but also using cognitive restructuring aimed at reaching a more balanced positive functioning in well-being dimensions. The clinical protocol of WBT, thus, could vary from person to person, according to his/her own specific needs, personality traits, social roles and cultural factors (Ruini & Fava, 2012; Ryff, 2014). For example, a patient with an initial diagnosis of social phobia, and with low levels of extraversion, could improve his/her interpersonal relationships, as well as his/her autonomy levels (i.e., the capacity to voice out his/her opinions), but it is clinically unrealistic (and probably detrimental) to expect that this patient could transform into an extraverted person. Unlike standard cognitive therapy, which is based on specific assumptions (e.g., the cognitive triad in depression), WBT develops on the basis of findings from self-observations in the patient's diary. WBT is driven by a theory based model of positive functioning (Ryff, 1989, 2014) which is progressively described and implemented in patients according to their clinical characteristics.

Later refinements of the protocol of WBT called for a more balanced interaction between the various dimensions of eudaimonia. In fact, it has been observed that patients may report distress and psychological suffering due to an excess or imbalanced functioning in one or more area of functioning (Ruini & Fava, 2012). These dimensions can compensate each other (some being more interpersonally oriented, some more personal/cognitive) and the aim of WBT should be the promotion of an optimal-balanced functioning between these dimensions, in order to promote a state of euthymia (Fava & Bech, 2016). This means that sometimes, patients should be

encouraged to decrease their level of positive functioning in certain domains of psychological well-being that can become inappropriate in certain situations.

For instance, an *excess of autonomy* could determine conflicts in interpersonal functioning. In fact, 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 level of autonomy can become detrimental for social/interpersonal functioning. Some patients treated with WBT complained they were not able to get along with other people, or to work in team or to maintain intimate relationships, because they were constantly fighting for their opinions and independence. Conversely, an excess of pro-social behavior could become detrimental as well. An individual with a strong pro-social attitude can sacrifice his or her needs and well-being for those of others, and this becomes stressful and sometimes disappointing in the long time. This individual can also become over-concerned and overwhelmed by others' problems and distress and be at risk for burnout syndrome. Finally, a generalized tendency to forgive others and be grateful towards benefactors could mask low self-esteem and low sense of personal worth (Ruini & Fava, 2012). These controversies in interpersonal functioning will be further explored in Chap. 7 of this book. The protocol of WBT, thus, has developed following a converging line of research that merge positivity with negativity and follows the comprehensive approach of positive clinical psychology (Wood & Tarrier, 2010).

Recent and promising development of WBT relies in its applications with younger populations, as described below.

4.2.1 Well-Being Therapy in Children

A modified form of WBT has been developed and applied at first in school settings (*Well-Being Therapy-School Program*, (Ruini, Belaise, Brombin, Caffo, & Fava, 2006). It was tested in several controlled studies both with middle and high school students (Ruini et al., 2009; Tomba et al., 2010). Results showed the effectiveness of the WBT-School protocol (six sessions) in improving psychological well-being, (personal growth particularly), compared to the attention placebo group. Further, it was found to be effective also in decreasing multiple indicators of distress (anxiety and somatization), and the results were maintained at follow-up (Ruini et al., 2009; Tomba et al. 2010). These outcomes suggest that promoting positive functioning and building individual strengths in developmental settings could be more beneficial in the long term than simply addressing depressive or anxious symptoms.

Considering these promising outcomes, Albieri, Visani, Offidani, Ottolini, and Ruini (2009) applied a modified WBT protocol (Child-WBT, CWBT) in a group of clinically distressed children, reporting emotional and behavioural disorders. The protocol encompassed a sequential administration of CBT sessions, followed by sessions focused on well-being restorations (particularly autonomy, self-acceptance, positive relations with others) (Albieri et al., 2009). Preliminary clinical cases evaluation

Table 4.2 Well-being therapy (children protocol)

Sessions	Therapeutic goal(s)	Activities
Initial sessions (1–2)	Psychoeducation, parent training	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
Intermediate sessions (3–5)	Self-observation and cognitive restructuring	Child is asked to report his/her daily situations in a diary for helping him/her realize that the way he/she interprets situations can influence his/her emotions. If needed, cognitive restructuring may be implemented
Final sessions (6–8)	Well-being promotion	Ryff's six dimensions of psychological well-being are progressively introduced to the children, with particular emphasis to autonomy, self-acceptance, positive relations and purpose in life. Behavioral and narrative strategies are used to address these dimensions.

showed encouraging results and children significantly improved after eight sessions of CWBT (Albieri et al., 2009) (see Table 4.2). Future, controlled investigations are needed to confirm the efficacy of this protocol, that may have important implications, both as a preventive and treatment option to promote positive youth development.

4.3 Quality of Life Therapy

Another comprehensive, evidence based positive intervention that derives directly from clinical psychology is Frisch's Quality of Life Therapy, recently evolved into Quality of Life Therapy and Coaching (QOLTC) (Frisch, 2006, 2013). It is based on the clinical observations that depression and other forms of psychological distress derive from a sense of dissatisfaction in various life domains. Thus, differently from Fava and Ruini' WBT (Fava & Ruini, 2003), which relies on promoting eudaimonic well being, QOLT is focused on promoting hedonic well-being and life satisfaction in various significant life domains. These areas have been labeled as "Sweet 16" and include: health, self esteem, goals, money, work, play, creativity, helping, love, friends, children, relatives, home, neighborhood, and community.

In QOLTC clients are taught specific strategies and skills aimed at helping them to identify and fulfill their most valued needs and goals in these sixteen areas of life. The protocol usually starts by administering the Quality of Life Inventory (Frisch, 2013) to clients, in order to map possible area of dissatisfaction. Then, it offers both specific, tailored treatment strategies for each area, as well as general strategies to improve individual's well-being and satisfaction, conceived as the sum of satisfaction in various areas deemed to be important for the individual. This latter therapeutic

Table 4.3 Quality of life therapy (Frisch, 2006, 2013)

C	Circumstances, or characteristics of an area, or objective living conditions	Problem solve to improve situation
A	Attitudes or interpretations concerning one area	Find out what is really happening and what it means for you and your future.
S	Standards or fulfillment in one area	Set realistic goals and experiment with raising and lowering standards.
I	Importance given to an area	Re-evaluate priorities in life and emphasize what is most important and controllable.
O	Overall satisfaction	Increase satisfaction in any areas you care about for an overall boost to happiness

Modified from Frisch (2013)

technique relies on the CASIO acronym (see Table 4.3), that represents the "5 Path to Happiness". QOLTC, in fact, is aimed at helping clients to change the objective circumstances (C) of an area, or their personal attitudes (A), or their standards (S) of fulfillment and importance (I) given to that area, or the overall satisfaction (O) in other area not previously considered by clients (Frisch, 2006). The "O" element of CASIO, in fact, refers to the assumption that overall satisfaction may be increased by boosting satisfaction in any valued area of life, even areas " Other" than those of immediate concern. Further, this Five Paths is also used as a guide for problem solving in Quality of Life Therapy and Coaching.

The manual for QOLTC which is the book entitled Quality of Life Therapy (Frisch, 2006), provides step-by-step instruction and case illustrations for assessing well-being, planning and tailoring intervention for various situations, from serious psychopathology to retirement, work difficulties, interpersonal frictions, etc. These latter interventions may be conceived as forms of coaching. In fact, this approach has been applied in several businesses and non-profit organizations in order to make their employees more satisfied and productive in their work.

In the clinical domains, QOLTC has been used in marital therapy, group therapy, drug and alcohol abuse counseling, and with caregivers of people with DSM mental disorders. It has also been integrated with treatments for depression, bipolar disorders, and anxiety disorders, among other DSM disorders. Further in general medical conditions, QOLTC and the QOLI have been used in cases of heart disease, kidney disease, diabetes, chronic pain, obesity, cancer, traumatic brain injury, and organ transplantation. In each case QOLTC has been applied to both patients and their caregivers and families. In the same vein, it has been used in the contexts of occupational therapy, physical therapy, bariatric surgery, and cardiac rehabilitation (Frisch, 2013). In conclusion, QOLTC may be easily implemented in several clinical contexts, with a specific textbook and toolkit ready to be delivered to clients and to their caregivers.

4.4 Positive Psychotherapy

Positive Psychotherapy (PPT) represents positive psychology's therapeutic effort to broaden the scope of psychotherapy from the alleviation of suffering to systematically enhancing happiness through the building of positive emotions, strengths, and meaning in clients' lives. PPT is based primarily on Seligman's idea that the notion of "happiness" can be decomposed into five scientifically measurable and manageable components: (1) Positive emotion, (2) Engagement, (3) Relationships, (4) Meaning and (5) Accomplishment, with the first letters of each component forming the acronym PERMA (Seligman, 2011). PPT was initially validated with clients experiencing moderate to severe symptoms of depression in individual and group settings (Seligman, Rashid, & Parks, 2006). PPT can be a standalone treatment, or its protocol can be adapted to meet specific needs, or its exercises can be incorporated in other treatment approaches.

The ideal individual PPT's protocol is composed of 14 sessions wherein each exercise is designed to enhance one or more of the PERMA dimensions, as described in Table 4.4. Recent developments of this approach include a specific, integrative approach which merges symptoms with strengths, resources with risks, weaknesses with values, and hopes with regrets in order to understand inherent complexities of human experiences in a balanced way (Rashid, 2015). PPT can be divided into three phases. The first phase focuses on exploring a balanced narrative of the client and exploration of her/his signature strengths from multiple perspectives. The middle phase focuses on cultivating positive emotions and adaptively dealing with negative memories. The final phase include exercises on fostering positive relationships, meaning and purpose.

In the first session patients are encouraged to introduce themselves through a real-life story that described the best in their lives, or a story of overcoming a significant challenge or adversity in their life. They are then invited to subjectively identify their strengths, by selecting from the pool of 24 signature strengths model

Table 4.4 Positive psychotherapy (Rashid, 2015)

Sessions	Therapeutic goal(s)	Activities
Initial sessions (1–3)	Identification and exploration of client's character's strengths	Positive Introduction, individualized strength profile, strengths and vulnerabilities
Intermediate sessions (4–9)	Promotion of positive emotions, management of negative emotions (balance)	Three good thing exercise Good memories and bad memories journal ; writing forgiveness and gratitude letters One door close, one door opened exercise (optimism and hope)
Final sessions (10–14)	Positive relationships, meaning and purpose in life	Positive Communication, Family Strengths Tree; Positive legacy and gift of time exercise; future goals planning and life meaning

Adapted from Rashid, 2015

(see Chap. 3 of this book). Importantly, and differently from the Strength based coaching and counselling, in Positive Psychotherapy therapists invite clients to conceptualize their presenting problems as lack or excess of strengths, as suggested by the latest formulation of Chris Peterson (Seligman, 2015). For instance, indecision could be conceptualized as a lack of determination; feeling inadequate as lack of self-efficacy; and difficulty making decisions as an excess of prudence. Furthermore, therapists also address the problematic consequences of overusing certain strengths (i.e., forgiveness and love, which lead to taking individuals as granted) or under using certain strengths (i.e., self-regulation may turn into self-indulgence). This recent refinements of PPT protocol are indeed in line with those proposed by Ruini and Fava (2012) for WBT.

PPT has been tested and validated in various studies, at international levels. In clinical domains it has been tested for the treatment of depression, anxiety, psychosis, borderline personality disorder, and to support smoking cessation (Rashid, 2015). Most trials have offered PPT as a group intervention, and treated community samples (outpatients in hospital settings, community mental health clinics, college students with depressive disorders). Some studies reported by Rashid (2015) have compared PPT with two other treatments, Dialectical Behavior Therapy (DBT) and Cognitive Behavior Therapy (CBT). In these investigations PPT yielded similar benefits, even though DBT was found to have a higher impact on emotion regulation and distress tolerance. Despite being promising, these are pilot investigations that need to be replicated and confirmed by controlled trials, involving longer follow-ups and larger clinical samples.

4.5 Strengths Based Interventions

The general paradigm characterizing strengths interventions is the same: an individual measure his/her strengths with the Value In Action test (VIA-IS, Peterson & Seligman, 2004) in order to identify his/her strengths. After receiving a hierarchic feedback on them (with the Top Five endorsed as "signature strengths"), the client is advised to change his/her behavior in order to use his/her strengths more often, or in novel ways. In practice, this is done to the extent of experiencing specific adaptive behaviors and allowing people to deploy their strengths in order to feel more fulfilled and satisfied (see paragraph on character's strengths and well-being in Chap. 3). This approach has been applied to clinical populations as well as in work psychology, educational settings, demonstrating positive effects (Gander 2013). There is no specific manualized protocol to be used in these different settings. However, some specific exercises have been created to tackle each of the 24 character's strengths (Rashid, 2009).

On the other hand, some Authors (Young, Kashdan, & Macatee, 2015) recently suggested to adopt a more balanced approach to *strength based interventions*, as an alternative to the typically used "signature strengths" model endorsed by positive psychologists (Mongrain & Anselmo-Matthews, 2012; Seligman et al., 2005). Even

though the identification and use of one's top strengths was found to be associated with increase in well-being and life satisfaction, together with decrease in depressive symptoms (Seligman et al., 2005), some researchers and clinicians belonging to the positive psychology movement started to argue if addressing less developed positive characteristics (weaknesses) may yield similar or even better effects. For instance, Biswas-Diener Kashdan, and Minhas (2011) underlined the importance of helping clients in increasing less-developed strengths, alongside the novel use and development of signature strengths. In fact, they suggested that a signature strength could be appropriately used, underused, but also overused, or used across life situations even when it is inappropriate. This could underline a certain rigidity in deploying one's positive personality trait, that indeed may become detrimental to the individual.

Few investigations have then compared the typical signature strength exercise (use your top strengths in a novel way) versus addressing and developing lesser strengths/weaknesses. Haidt (2002) found that participants preferred working with their signature strengths, whereas Rust, Diessner, and Reade (2009) found no significant differences on life satisfaction when comparing students receiving a signature strength intervention versus students receiving a strength and weakness intervention. More recently and with a more sophisticated design, Proyer, Gander, Wellenzohn, and Ruch (2015) aimed at testing whether both types of interventions (signature strengths-SS vs lesser strengths-LS) would increase happiness and decrease depression compared to a controlled condition, and whether participants would prefer one or the other intervention. They found that both strength conditions had similar effects on depression and happiness, and were similarly enjoyed by participants. However, those participants that reported generally higher levels of strengths benefitted more from working on LS rather than SS, and those with comparatively lower levels of strengths tended to benefit more from working on SS, similarly to participants whose strength's profile differed from the average one derived from a national sample. Hence, authors suggested that the general level of strengths possession may play crucial role in this positive exercise allocation.

Starting by the observation that strengths are interdependent and context-depended, Young et al. (2015) argued that a more balanced strength model would contribute both to well-being and to psychological flexibility. They analyzed how traditional top signature strength approach vs a balanced approach (i.e., average score in the 24 character's strengths) predicted well-being (in terms of competence, relatedness and autonomy) and found that the strength balance one accounted for unique variance in the model. Strength balance instrument predicted life satisfaction, relatedness, and competence, but had no significant effect on autonomy. Authors therefore suggested a dynamic approach to strength-based interventions where the growth of less-developed strengths occurs alongside the novel use and development of signature strengths, in order to have a greater assortment of strengths that indeed increase individual's flexibility and adaptation to environmental demands. Thus, these Authors suggest clinicians and coaches to adopt a wider perspective on the promotion of character's strengths, that encompasses both the identification and use of one's signature strengths and the promotion and use of less

developed individual strengths for their clients. This balanced approach would indeed allows therapists to address a wider spectrum of human behaviors (Young et al., 2015).

4.6 The Effects of Positive Interventions

4.6.1 Beneficial Effects and Mechanisms of Action

Under the broad umbrella of "positive interventions, researcher have included the aforementioned psychotherapeutic protocols, as well as single activity and exercises to promote one specific positive emotion or character's strength (Bolier et al., 2013; Sin & Lyubomirsky, 2009). These positive interventions have been addressed to clinical as well as non clinical populations and, taken together, an increasing line of research documented their benefits and effectiveness (Bolier et al., 2013). For instance, interventions to increase *gratitude* are as effective in reducing body dissatisfaction and worry as commonly used cognitive behavioral techniques (Geraghty, Wood, & Hyland, 2010; Wood, Joseph, & Maltby, 2008). *Act of kindness* or spending money on others (that is prosocial behaviors) and/or making choices that provide a sense of freedom and autonomy (Ryan & Deci, 2000) can boost happiness (Dunn, 2012; Lyubomirsky & Layous, 2013). In the clinical settings interventions to increase positive characteristics prospectively predicted depression (Wood & Joseph, 2010) and were found to reduce the residual effects of affective disorders (Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998; Ruini & Fava, 2012).

Overall, positive psychology interventions have proven to be efficacious for both enhancing psychological well-being and reducing depressive symptoms (Bolier et al., 2013; Sin & Lyubomirsky, 2009). Interventions that yielded major benefits were longer, delivered on individual setting and to clinical populations. Another recent meta-analysis (Weiss, Westerhof, & Bohlmeijer, 2016) confirmed that positive interventions delivered in clinical and non-clinical populations yielded modifications in eudaimonic well-being dimensions (measured with Ryff's scale or with the Mental health continuum—see Chap. 1 of this book). Even though the effect sizes range from small to moderate, the heterogeneity between population is high, and the methodological quality of the trials sometimes is poor, dimensions usually considered stable over time are amenable to improvements by specific behavioral and psychological interventions as documented by this recent meta-analysis.

Lyubomirsky and Layous (2013) suggested that the increase in well-being due to a positive activity is moderated by a variety of interdependent features, such as the features of the activity itself (e.g. its dosage, frequency, variety and duration of the performance); the features of the person (i.e. general demographics, personality characteristics, and baseline levels of well-being and motivation); and finally the "fit" between the activity and the person (i.e. the extent to which the intervention

matches an individual's preferences and characteristics). These observations have been further confirmed by Proyer, Wellenzohn, Gander, and Ruch (2015) who found that the "*person x intervention fit*" predicted happiness and depression over a 3.5 year follow up. In particular, continued practice, effort (conducting the intervention as instructed), preference (liking and perceived benefit), and early reactivity in happiness predict long term changes in happiness, whereas continued practice and early reactivity in depression predicted long-term changes in depression. These results are particularly important since they suggest that positive interventions could contribute to individual well-being and depression also in the long term, pending some conditions. In fact,

"the way people *think* about positive psychology interventions, the way they *work* with them, and the way they *react* to them play a role in predicting well-being at a later point in time" (Proyer, Wellenzohn et al., 2015, p. 121).

Authors suggested that

"*If a person does not show improvements in well-being or depressive symptoms at an early stage when doing an exercise, it could be more efficient, also in the long run, to continue with a different exercise. Also, if a person shows a preference for certain types of exercise, similar exercises could be assigned*" (p.123).

In fact, the long term beneficial effects of the positive interventions might be attributable to the prevention of the hedonic adaptation effect (participants continue to enjoy their positive activity), which constitutes one of the problematic effects encountered by positive psychology interventions, as described in the next paragraph.

4.6.2 Controversial and Paradoxical Effects

In line with the homeostatic model of well-being (see Chap. 1) some form of saturation point that impedes a further gain in hedonic well-being has been largely documented for specific positive interventions (e.g. Gander, Proyer, Ruch, & Wyss, 2013; Lyubomirsky, Sheldon, & Schkade, 2005). For instance, Seligman et al. (2005) found that the exercise "gratitude visit" (i.e., a person is asked to write a gratitude letter and personally deliver it to the recipient) significantly improved happiness, but these improvements faded away in a 3 month period, probably because it was perceived as powerful the first time, and became stale or awkward afterwards.

Further, recent meta-analysis concluded that positive interventions are generally beneficial, but the *effect sizes were small* for depressive symptoms and psychological well-being (Bolier et al., 2013). Unfortunately, this meta-analyses has also highlighted that the quality of the methodology and the *heterogeneity* in samples are important weaknesses of research concerning these positive interventions, that should be addressed in the future.

Another recent review (Hone, Jarden, & Schofield, 2015) the pointed out the *high attrition rates* of these positive interventions, higher than those usually reported

for other psychosocial interventions. Even though the Authors advocated that future investigations would provide valid explanations to this phenomenon, some preliminary hypotheses could be driven from existing literature in positive psychology, but also in clinical psychology.

First of all, Lyubomirsky et al. (2005) discovered that some of these positive interventions yielded unexpected and sometimes *paradoxical results*. They found that individuals who counted their blessings once a week achieved increases in well-being over 6 weeks, but those who counted their blessings three times a week did not. They suggested that the "counting blessing exercise" could have a negative impact on individuals well-being because it may cultivate feelings of indebtedness and promoting guilt (Lyubomirsky et al., 2005). They also suggested that for certain individuals it could be difficult to recall events and experiences for which one is grateful. Individuals may use the cognitive difficulty of the exercise as a signal of the rarity of positive experiences in their lives and evaluate their lives less favorably as a result. Similarly, Gander et al. (2013) investigated 1- and 2-weeks long versions of the "Three Good Thing" exercise (consisting of listing three positive events that happened in the day) and found that there was no effect of the exercise on depressive symptoms, whereas happiness increased only in the group with the shorter period of the exercise. The authors hypothesized that asking people to do the exercise for 2 weeks could be counterproductive as it could be felt too forced, and thus evokes negative affect in participants.

Furthermore, Sin et al. (2011) reported that writing gratitude letters *reduced immediate well-being* for individuals with mild or moderate depressive symptoms.

These findings suggest that to enhance psychological well-being, the optimal frequency and duration of certain exercises (those concerning gratitude in particular) should be better monitored and identified, considering the individual's characteristics, such as personality traits, age, sociodemographic and cultural variables. Thus, even though the growing and variety of these positive interventions are indeed additional tools to be used with clinical and non clinical populations, future advances are needed in order to address the problems that emerged from current literature.

An appropriate and original alternative may be provided by the person-centered approach deeply rooted in positive therapy, as described by Joseph (2015). In order to overcome these paradoxical effects of positive exercises, Joseph suggested that clinicians should adopt the Rogersian approach that affirms that "clients are their own best experts", and thus, they should be left free choice when it comes to activity selection and frequency/intensity of the exercise. Rather than referring to a set of pre-determined list of activities aimed at promoting well-being, and fitting them to the clients' need, Joseph suggested that therapists

"…follow the client's lead and co-creates something unique for that person" (Joseph, 2015, p.73).

This approach would allow more creativity, flexibility both to the clients and to therapists, in line with a positive psychology perspective.

4.6.2.1 Possible Explanatory Mechanisms and Emotion Regulation Strategies

Quoidbach and colleagues (Quoidbach & Gross, 2015) provided a well detailed review of the literature where they linked the effectiveness and possible weaknesses of positive interventions/psychotherapies, to the emotion regulation strategies. They referred to a *model of emotion regulation* that encompasses the following mechanisms: (a) situation selection/modification, (b) attention deployment, (c) cognitive change and d) individual response modulation, that are differently targeted by the positive interventions. Positive interventions are in fact characterized by the overt aim of up-regulating positive emotions, in view of increasing individuals' well-being and down-regulating their negative emotions (following the broaden and built theory of positive emotions, as described in Chap. 2). Accordingly, in order to maximize positive emotions, people not only need to make accurate predictions about which situations are more likely to bring them positive emotions (situation selection/modification), but they also need to act on these predictions "during an event" to actually enter these situations (situation selection and modification during an activity). Cognitive changes are considered necessary in order to have an accurate positive perception of the event, whereas response modulation refers to the expression of positive emotions both physically and verbally during the positive situation. In order to up-regulate positive emotions these various strategies can be applied before, during, and after a positive event by appropriate and structured interventions. For instance, specific rituals may help individuals to optimize the savouring of their positive situations. Cognitive change implies reappraisal of positive emotions by increasing the perceived value of positive situations, and by promoting people's explanatory flexibility about their causes, as well as the role they play in those situations. Finally, the expressions of positive emotions indeed booster them. These are considered the core mechanisms of happiness promotion, and the review by Quoidbach and Gross (2015) described how the majority of existing positive interventions, such as WBT, QOLTC, and PPT target one or several specific components of the emotion regulation process. For instance, attention deployment (i.e., savouring); cognitive change (i.e., optimism, WBT) and response modulations (i.e., expressing gratitude) are emerged as core ingredients of the three positive interventions described in this chapter.

However, this review (Quoidbach & Gross, 2015) documented a well-established short-time effectiveness of the majority of positive interventions in all emotion regulation strategies but situation selection before the event, which remains largely unaddressed. It means that positive interventions have provided individuals with tools and strategies to help them engage in positive, prosocial, or intrinsically valued activities, but there is still scarce evidence suggesting that accurate forecast of positive events may actually increase happiness. Regarding longer-term indicators of treatment effectiveness (i.e., increases in positive emotions) strategies such as situation selection during an event and attentional deployment before, during, and after an event have received strong empirical support and are at the center of many positive interventions (Quoidbach & Gross, 2015).

This review can be considered important for the clinical domains, since it may provide a possible explanation to the controversial findings and paradoxical effects of positive interventions that emerged in recent literature, as discussed in the previous pages. Further this review may provide practitioners with a clear guideline to identify their clients' specific strengths, needs, and weaknesses in terms of emotion regulation, and to help them select the best strategies to increase their happiness. For instance, recent research has shown that schizophrenic patients with anhedonic symptoms present a specific deficit in the ability to derive positive emotions from anticipation (i.e., before positive events). On the other hand, their ability to derive pleasure during positive events remains largely intact (Edwards, Cella, Tarrier, & Wykes, 2015; Horan, Kring, & Blanchard, 2006). This clinical observation lead to a development of a specific cognitive-sensory intervention aimed at improving anticipatory pleasure in schizophrenic patients (Favrod, Giuliani, Ernst, & Bonsack, 2010). Even though it was a pilot study, the findings are promising and pave a new way to address a common and vexing problem (anhedonia) observed in psychiatric settings (Jeste, Palmer, Rettew, & Boardman, 2015).

In contrast, depressed individuals seem to maintain a relatively intact ability to derive positive emotions from anticipation before positive events, but present a reduced capacity to experience positive emotions during these events (Fletcher et al., 2015; Shankman, Sarapas, & Klein, 2011).

Thus, according to the patients' deficits in one or more of the emotion regulation strategies, a certain positive activity/positive homework assignment may yield more clinical benefits for well-being, compared to another one, which provides only marginal effect in the patients' clinical status.

4.6.3 Ambivalence, Fear, and Defense Mechanisms Related to Positivity

It is a common clinical observation that certain individuals with (or without) a diagnosed form of psychological distress may manifest a non-linear relationship with well-being and positivity. As described in the previous sections of this book, psychopathology and personality disorders may results form an excess or distorted manifestation of positive characteristics (Rashid, 2015; Seligman, 2015). On the same vein, deriving from their clinical experiences, Ruini and Fava (2013) described the polarities of eudaimonic well-being dimensions. In their article they provided evidence that not only deficits in Ryff's dimensions of well-being are associated with psychological distress and psychopathology, but also excessive or distorted levels in the same dimensions.

Clinical psychology practice and research, thus, has documented that certain individuals - those with psychological distress or dysfunctional personality traits- may develop ambivalent attitudes toward well-being. For instance, 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. Recently, some authors have described the concept of *aversion to happiness* (Joshanloo & Weijers, 2014), that may be linked to cultural, philosophical and existential issues, but also to difficulties in dealing

with intense emotions. Gilbert and colleagues (Gilbert et al., 2012) also found that *fear of happiness* is frequently observed in clinical settings and is significantly correlated to depression. According to these authors, (Gilbert et al., 2012) happiness can be "frightening" because patients often think that something bad will happen, following instances of well-being. Ben-Shahar (2002, p. 79) also suggested that people might be averse to happiness because they fear the devastating loss of newly attained happiness more than they value the actual attainment of it.

Further, clinical psychology research has also documented the activation of specific *defense mechanisms* (such as a repressive coping style, illusory cognitive bias or even denial) when individuals self-evaluate their levels of well-being, happiness and optimism (Shedler, Mayman, & Manis, 1993; Taylor, Kemeny, Reed, Bower, & Gruenewald, 2000). These defense mechanisms are particularly activated in patients with symptoms of depression, anxiety and neurotic or narcissistic traits (Myers & Brewin, 1996). It was documented that individuals who habitually use defensive strategies (repressors and deniers) and who have biases to see themselves and their world in a positive light may be categorized as mentally healthy, but they are presenting some positive illusions (see Chap. 5 for further discussion).

In conclusions, recent advances in the positive interventions literature found that the sole promotion of positive dimensions (i.e., gratitude exercises) may sometimes backfire and lead to unexpected and paradoxical effects in terms of positive emotions and well-being. As a result, positive interventions should be more complex than simply increasing well-being, but should interact with a number of issues, related to the frequency and dosage of sessions, to the external environment as well as to personality predispositions. These phenomena has lead researchers and clinicians to better formulate and plan positive ingredients for their interventions, especially among clinical populations.

4.7 Clinical Psychology as Source of Expertise for Positive Psychology: The Use of Psychotherapeutic Research Design

Clinical psychology and psychotherapy has a long tradition of research that documented controversies and drawbacks encountered when planning treatments and interventions (Schimmel, 2010). For instance, specific therapeutic ingredients have been isolated from general, aspecific factors connected with treatment effectiveness and adherence (Wampold, Minami, Tierney, Baskin, & Bhati, 2005; Spielman et al., 2007). According to Wampold (2015) psychotherapy works through various mechanisms, related to the patient-therapist relationship, to the patient's expectations and to the specific techniques addressed to specific symptoms. The first mechanism (*therapeutic alliance*) is particularly important in determining initial benefits and engagement in the process. Interestingly enough, it has been found that it was the therapist contribution which was important, not the client one: more effective

therapists were able to form a strong alliance across a range of patients (Baldwin, Wampold, & Imel, 2007). The second mechanism refers to the promotion of *patients' sense of mastery, self efficacy* and *response expectancy*. This mechanism indeed shares similarities with positive psychology interventions that are overtly addressed at improving these positive dimensions during the course of interventions. Up to date, there are only few data on therapeutic alliance and on the therapist's role within the wide range of positive interventions.

Concerning specific therapeutic ingredients, they can vary from one therapeutic approach to another, but also inside a certain psychotherapeutic approach, according to the problems presented by patients. Also in this case, Wampold (2015) documented that more competent therapists display a greater *adherence to the protocol and to its ingredients*, and this translates into better treatment outcomes. However, it is also true that rigid adherence to a protocol can attenuate the alliance and increase resistance to the treatment and that therapist' s flexibility in adherence is related to better outcomes (Goldberg et al., 2016). This clinical mechanism could be extended to positive interventions, that are usually composed of several sessions and activities, delivered in specific sequential order. Up to date, no research within positive psychology examined the therapist's adherence to the positive protocols, and its beneficial effect in terms of intervention effectiveness. Hopefully, this gap would be filled in future research.

Concerning patients' resistances, they also have found to display a strong influence in the final outcome of traditional psychotherapies. First of all, they may interfere with treatment outcome (Beutler, Moleiro, & Talebi, 2002; Ruini & Ottolini, 2014). Resistance was also found to act as a moderating variable in determining the effectiveness of different levels of therapist directiveness. Some clinical evidence suggested that patients who enter treatment with high levels of resistance will benefit most from nondirective interventions, whereas those who enter treatment with low levels of resistance benefit most from therapist directed interventions.

This body of previous research in clinical psychology, thus, underlined the complexity of the "client x therapist" interaction. The same pattern of complexity may be present in planning and implementing positive interventions. In these case, expectations could be particularly high (i.e., patients who extremely value their happiness) or particularly low (i.e., patients who are hopeless, or think they do not deserve to be happy). Participants may eventually equate positive interventions with Pollyanna teaching (Vazquez, 2013) and thus, they may enter the protocol with very low expectations or even skepticism. Furthermore, the concept of *prioritizing positivity*, recently described by Catalino, Algoe, and Fredrickson (2014) may play a relevant role in entering, participating and influencing positive interventions. This concept describes the extent to which individuals organize their lives and select daily activities in order to maximize their experience of happiness. These individuals reported higher levels of subjective well-being, and the authors explained that this was due to the higher likelihood of experiencing more positive emotions in daily life. A recent longitudinal study confirmed the significant correlations between prioritizing positivity, positive emotions and life satisfaction (Alfonso, Datu, & King, 2016). The Authors suggested that prioritizing positivity could be considered

an effective strategy to pursue happiness, more effective than other alternative strategies (such as putting too much emphasis on one's personal happiness, or constantly monitoring one's happiness). However, this longitudinal research also found that baseline positive emotions predicted subsequent prioritizing positivity, and authors explained this finding in the light of the upward spiral of positivity postulated by the broad and build theory of positive emotions (Alfonso et al., 2016).

Up to date no research in positive psychology is available that included these mechanisms in predicting interventions effectiveness. Neither is the one concerning variables related to the therapists/coaches, their expertise, their training, their supervision in promoting well-being. The person x fit model described in the previous pages of this chapter could provide explanations to the paradoxical effect encountered with some positive activities, but research on therapists/clients' expectations and characteristics could shed new light into these phenomena as well.

Moreover, a body of literature on *side effects* of traditional psychotherapies has also been documented in psychotherapy research (Schimmel, 2010). Lilenfeld (2007) reviewed existing literature on negative effect of psychotherapies and suggest that almost 10% of patients would not benefit from the intervention, rather, they may actually feel worse. This has been found to be particularly the case for substance abuse treatments and treatments for adolescents conduct disorders. These negative effects could be measured in terms of negative effect sizes in meta-analyses, or in patients' clinical deterioration. Deterioration includes symptom worsening, the appearance of new symptoms, heightened concern regarding extant symptoms, excessive dependency on therapists, reluctance to seek future treatment, and possible harmful effects to patients' family members and friends (i.e allegation of abuse, separation, divorce). The Authors identified a list of potentially harmful treatments. Among these, two are notably interesting: the first one is stress debriefing to prevent PTSD, that paradoxically triggered more PTSD symptoms than no treatment. The second one is grief counseling following bereavement, which was found to trigger patients' deterioration in 38% of cases. Lilenfeld (2007) argued that these treatment could interfere with the natural trajectory of adaptation and resilience (see Chap. 6 of this book for further discussion of these issues). Thus, it seems that iatrogenic effects of treatments may be related to the complex relationship between negativity and personal resources, and this observation could be particularly important for the implementation of positive interventions, that are often addressed to resilience, growth or positive coping strategies.

Further, another related phenomenon, shared by traditional psychotherapies and positive interventions is related to *attrition rates*. Clients usually drop-out from either especially successful or unsuccessful treatments (Lilenfeld, 2007). Some clients who drop out of therapy, in fact, have improved quickly and no longer perceive a need for therapy, whereas others have deteriorated and are dissatisfied with treatment. Since high attrition rates appears to be quite frequent in positive interventions (Hone et al., 2015) it should be important to distill which conditions determined such phenomenon (rapid improvements in positive emotions, or dissatisfaction with the protocol).

Psychotherapy research provides also a description of various *long-term trajectories of chance* following a psychological treatment. For instance, Owen et al. (2015) classified patients in three classes according to their initial clinical status and their pattern of change following a certain psychological treatment. Class 1 includes the great majority of patients in this naturalistic investigation and is characterized by moderate initial psychological functioning, with improvements evidenced early in treatment, followed by a plateau of functioning until a certain number of sessions (usually around ten) when another notable improvement in functioning was demonstrated. Given the trajectory pattern, Authors referred to this group as "Early and Late Change." Class 2 represents the minority of patients with worse initial psychological functioning, that reported a deterioration in functioning in the early phase of treatment, followed by rapid improvement in functioning around session five and lasting until session nine when the trajectory flattened. For this group Authors referred to them as "Worse before Better". Finally, Class 3 groups those clients (around 20% of the total sample) who tended to stay in therapy longer compared to the other two classes. Clients in this class had levels of initial psychological functioning similar to those in class 1, but displayed slow and steady progress over the course of therapy in a more linear manner. Accordingly, Authors referred to this group as "Slow and Steady Change." The Authors concluded that the majority of patients included in this large naturalistic design, were typified by improvements occurring within the first five sessions, followed by a stability of change and a later additional period of improvement, that was experienced only from those who remained longer in therapy. Patients in class 3 improved more gradually, but without a plateau effect, and Authors suggest that their change could be "dose dependent". Finally, patients in class 2 had a more severe initial psychological distress and, paradoxically, deteriorated in the first sessions of treatment. However, if they remained in therapy, they equally benefitted from the intervention. The authors argued that these clients are struggling with life crises and throughout the therapy process are generally able to cope and improve their psychological functioning. This recent investigation adds important information to clinicians and therapists by providing different trajectories of change for diverse clients' clinical status, suggesting flexibility in evaluating the dose-response patterns and the clinical parameters for improvement, particularly in the long-term.

Future research in positive psychology should indeed mirror this typology of research, in order to *identify the "right dose" of sessions* required to promote well-being and the long term trajectory of response provided by participants, according to their initial set points of positive affect and initial dimensions of eudaimonic well-being. Again, clinical psychology research could provide pivotal research paradigms and methodologies to address these issues. The Personalized Advantage Index (PAI) (Derubeis et al., 2014) is a research design, that allows to predict patients' differential responses to treatments according to baseline variables (i.e., age, marital status, symptoms, personality traits, medications). It resulted to be effective in identifying the optimal treatment modality for a certain patient, depending on his/her clinical and sociodemographic characteristics. Importantly, PAI may also provide a general prediction concerning the percentage of patients that would

derive some beneficial outcome from any treatment modality. Recently, it was used to evaluate the most appropriate psychotherapy (CBT vs interpersonal psychotherapy) for depressed patients (Huibers, Cohen, Lemmens, & Arntz, 2015). The authors concluded that PAI provides a great opportunity for the development of a treatment selection approach that can be used in regular mental health care, advancing the goals of personalized medicine. It could be expected that such methodology may find place in positive psychology research as well, by comparing and selecting the interventions that more likely will yield beneficial effects in terms of well-being, based on participants' baseline characteristics.

Future research should also distill *the single role of specific activity/exercise* to promote positivity. Psychotherapy research performed this type of investigation using a *dismantling design* (Wampold, 2015), where single components of a therapeutic protocol were removed one by one, in order to verify their actual beneficial role. For instance, as early as 1970s, psychotherapy research documented that relaxation and other self-reassuring techniques had a detrimental effect when combined to exposure in the treatment of agoraphobia (Barlow, 2010). Thus, exposure alone was more effective in treating anxious patients. In this case, indeed "less is more". As briefly described in this chapter, positive psychotherapies tend to be composed by multiple ingredients and various activities, and these packages are more or less uniformly implemented with a large variety of populations, from college students to depressed individuals and, lately also to psychotic patients. A rigorous research aimed at identifying the most powerful therapeutic ingredient(s) for targeting specific outcome(s) is indeed needed to provide possible solutions to the controversies emerged in positive interventions. As the case for agoraphobic patients and relaxation, the implementation of gratitude interventions (i.e, gratitude journaling) together with other activities for eliciting positive emotions may not be fully appropriate to address low mood and depression.

Considering and referring to prior clinical experience in psychotherapy designs and tests of efficacy could tremendously advance positive interventions' planning and implementation, with greater success. Thus, positive psychology would benefit from the integration of clinical psychology research, that could provide crucial input in:

(a) Balancing positive and negative dimensions and personal attitudes;
(b) Selecting effective therapeutic techniques, ingredients and their right dosage according to the targeted populations (Ahn & Wampold, 2001; Hansen, Lambert, & Forman, 2002; Kuyken, Dalgleish, & Holden, 2007);
(c) Identifying paradoxical mechanisms triggered by positive psychological interventions and
(d) Identifying different trajectories of client's outcome, with appropriate follow-up.

These recommendations may open a new and fruitful line of integrative research between clinical and positive psychology, with mutual beneficial outcomes for both disciplines.

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Chapter 5
Hope, Optimism, Goals and Passion: Their Clinical Implications

"If a man knows not to which port he sails, no wind is favorable."

Seneca

Abstract In this chapter the concepts of hope, optimism and goal setting are explored and analyzed in their important roles in the clinical domains. Hope has been considered a common therapeutic ingredient in psychotherapy research. Similarly, the optimistic thinking style has been traditionally promoted by cognitive psychotherapies. However, some controversies emerged when addressing the issues of false hope syndrome, or naïve optimism, which emerge in clinical domains. The related phenomena of obsessive passion and conditional goal setting are discussed, with final recommendations for clinicians, positive psychologists and future psychotherapy research.

5.1 The Concepts of Hope and Optimism

In the last decades, the concepts of hope and optimism characterized research within the positive psychology domain. Both these concepts are conceived as positive orientations toward the future, with direct relationships with goals and purpose in life (Gallagher & Lopez, 2009; Ruini & Fava, 2013; Seligman, 2006).

According to *hope theory*, this concept entails three intercorrelated components: (1) clear conceptualization of goals; (2) *pathways thinking*, that is the capacity of developing the specific strategies to reach those goals; and (3) *agency thinking*, thus the motivation for using those strategies. These three components interplay in goal planning and pursing, regardless the type of goal (trivial or meaningful for the individual, long versus brief term, attainable versus unrealistic) (Snyder, 2000)

On the other hand, *optimism* has been defined as positive "generalized outcome expectancies" (Scheier & Carver, 1985, p. 219), or as a stable personality trait that reflects the extent to which one believes that his or her own future will be prosperous and favorable (Gallagher & Lopez, 2009). It was thus distinguished that the optimistic person believes "that somehow—either through luck, the actions of oth-

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ers, or one's own actions—his or her future will be successful and fulfilling"(Carver & Scheier, 2014; Scheier & Carver, 1985). Conversely "the hopeful person, believes specifically in his or her own capability for securing a successful and fulfilling future" (Alarcon, Bowling, & Khazon, 2013, p. 822). Further, by a methodological point of view, hope and optimism have been studied and measured with different tools: the *Life Orientation Test* (LOT; Scheier & Carver, 1985) and the *Hope Scale* (HS; (Snyder, 2000) as mainly used self-report questionnaires.

A recent meta analysis on these two important concepts highlighted that both are intercorrelated, and related to several indexes of psychological and physical well-being (Alarcon et al., 2013). Optimism, for instance, was strongly related to life satisfaction, self-esteem, self-efficacy, happiness, general psychological well-being, general physical health. It was negatively related to anxiety and depression. Similarly, hope was related to happiness, depression and stress (negative correlations with these two dimensions). Thus, this important meta-analysis confirms the beneficial effects of hope and optimism. Authors suggest that these beneficial effects may be explicable in terms of protective resources (such as resilience, effective coping strategies, social support) that hopeful and optimistic individuals activate in daily life, as well as in stressful situations (Alarcon et al., 2013; Gallagher & Lopez, 2009).

This recent meta-analysis disconfirms the pivotal work of Cohen et al. (1999), that demonstrated that dispositional optimism was associated with better physical health (in terms of immune response) among people facing more acute stressors, whereas it was associated with worse immune responding among people facing more chronic stressors. Further, in case of chronic illnesses and pain, it was recently found that optimism was a unique predictor of quality of life, and contributed to better functioning by minimizing pain-related fear and catastrophizing in children and adolescents attending a chronic pain clinic and in their parents (Cousins, Cohen, & Venable, 2014). Conversely, Isaacowitz and Seligman (2002) found that optimism was associated with increased depression over a 6 month time in a sample of older participants. Thus, even though the debate on the positive nature of optimism and hope is still controversial (McNulty & Fincham, 2012; Shah, 2012) recent findings in the medical settings seems to highlight that their promotion could be worthwhile, as described below.

5.2 Hope in Psychotherapy

In clinical domain hope and optimism received attention since many years. As early as 1968 Jerome Frank, for instance, conceptualized hope as a process that is common to all psychotherapy approaches (Frank, 1968). Frank and Frank (1993) in fact, asserted that psychotherapeutic interventions in clinical setting combine specific techniques (such as cognitive restructuring, or the use of a specific drug or treatment modality) and *non specific ingredients*, such as providing attention to patients, facilitating their disclosure, providing interpretation and a frame of explanation to their

symptoms, and providing a specific clinical setting, with rules, rituals and procedures, that are therapeutic *di per se*. It has been suggested that such common non-specific factors may trigger a phenomenon similar to the placebo effect, where expectancies and beliefs of the therapist and the patient that the treatment being administered is effective, influence the therapeutic process as well as its final outcome (Ahn & Wampold, 2001; Frank & Frank, 1993; Wampold, 2015) (see Chap. 4 of this book for a further discussion on therapeutic ingredients in positive interventions). Roberts, Kewman, Mercier, and Hovell (1993) also documented that dimensions such as optimism, strong conviction, and persuasive abilities of the therapist concerning anticipated positive responses to a treatment should be considered important aspects of healing. In their seminal review of the literature, Roberts et al. (1993) advocated that when it comes to psychosocial treatments, the power of non-specific effects may account for as much as two thirds of successful treatment outcomes when both the clinician and the patient believe in the efficacy of a treatment (Roberts et al., 1993). As Frank and Frank (1993) suggested, the clinician applies his/her healing skills in order to activate individuals' inner resources and motivation to change. This phenomenon has been describe also as "*remoralization*" (Howard, Krause, Saunders, & Kopta, 1997), as opposed to the state of demoralization (Connor & Walton, 2011), which is commonly observed in individuals with affective disorders. Remoralization is characterized by enhanced subjective well-being, a sense of relief from distress and a renewed hope that the clinical problem can and will improve. Some Authors have recently developed an useful scale to directly measure this construct, the *Remoralization Scale* (Vissers, Keijsers, Van Der Veld, De Jong Cor, & Hutschemaekers, 2010).

Snyder and colleagues (2000) have suggested that the components of hope (i.e., agency and pathways) might help to explain the role of common and specific treatment factors in psychotherapy. They advocated that the initial improvements of patients (i.e., remoralization) may be explicable as an increase in the agency component of hope, that is, the motivation to change and the efforts put in making improvements in one's life. Accordingly, Authors stated that increases in agency, as opposed to increases in pathways thinking, will be related to positive changes in the first stages of therapy. The first stages of the psychotherapeutic process have been labeled also as "honeymoon phase", where both patients and therapists develop a positive working alliance focused on common goals: resolution of symptoms, as well as increase in well-being. (Fava, Tomba, & Grandi, 2007; Howard, Lueger, Maling, & Martinovich, 1993)

Different Authors in the clinical domain of psychotherapy (Cheavens, Feldman, Woodward, & Snyder, 2006; Larsen & Stege, 2010) suggested that the ingredients of hope (agency and pathway) may also have a crucial function in subsequent phases of the therapeutic process, and clinicians should be more aware of their role in promoting hope. For instance, in the acute stage the client may experience increased agency by observing the therapist as a model of hopeful thinking. The therapist could act as an "in vivo" example of how to set a realistic therapeutic plan into action and how to devote, energy, enthusiasm and commitment to it. In this way, the client's dedication to the therapeutic process is challenged and often promoted.

Further, traditional psychotherapeutic approaches, such as cognitive behavioral therapy (CBT), often use specific therapeutic ingredients, such as monitoring and challenging dysfunctional automatic thoughts and these techniques may foster hope in clients as well. For instance, statements such as "I can't do this" denote a sense of stagnation, which should be substituted by a more positive, goal oriented thought. According to Cheavens et al. (2006), much of the standard cognitive work that often is done in therapy increases hope and goal pursuit. This latter issue is often addressed by using a graded approach. It means that cognitive therapists usually work with a client to develop an incremental and graded hierarchy of goals. Accordingly, this process of creating subgoals, or hierarchies of goals, is likely to increase hopeful thinking in the client, along the course of the therapy.

Finally, in the concluding sessions, clients' hope may be fostered during the standard activities, that usually involve reviewing the therapeutic gains and planning strategies to maintain those gains also after treatment cessation, as well as planning strategies for relapse prevention. In the first case (reviewing gains) agency could be increased and positive emotions and memories could be triggered (Cheavens et al., 2006). In this way the client will probably remain motivated to maintain gains and continue setting goals in order to make additional gains after therapy discontinuation. Relapse prevention techniques usually imply instilling problem solving and helping clients to find alternatives, and these activities may increase pathway thinking. Importantly, as the Authors noted (Cheavens et al., 2006), these hopeful aspects of the termination phase are rarely explicitly acknowledged by therapists or conveyed to clients, missing important opportunities to integrate positive psychology into traditional clinical work. Moreover, traditional psychotherapy is usually focused on removing or reducing hopelessness as opposed to actively building hopeful thoughts (Cheavens et al., 2006; Larsen & Stege, 2010). For this reason a specific intervention dedicate to hope promotion has been developed, as described in the subsequent pages.

5.2.1 Hope Therapy

Starting from the observation that the majority of people has the cognitive and motivational skills needed to enhance their positive expectations for the future, Snyder (2000) developed specific strategies to be applied in the context of supportive helping relationships, such as counseling and psychotherapy. According to this model, four essential steps are involved:

I. *Hope finding*: clients and therapist work together in identifying new methods of detecting hope (initial stage of psychotherapy)
II. *Hope bonding*: instilling hope through the working alliance (form hopeful therapist to low-hope clients) as well as identifying high hope persons in the client's social context

III. *Hope enhancing*: the specific technical methods, composed by different substeps: Conceptualization of reasonable goals; development of various pathways to goal attainment; maintenance of motivation and energy to goal pursuit (agency); Reframing insurmountable obstacles as challenges to be overcome
IV. *Hope reminding*: a set of different strategies used at the end of the protocol, with the aim of promoting a daily and effective use of hopeful thoughts in clients. They include review of hope narratives, correct identification of goal thoughts and barrier thoughts, reviewing personal hope statements, and planning booster sessions with the therapist

A complete description of the protocol is available elsewhere (Lopez et al., 2004). Its efficacy has been largely demonstrated in various settings, from adult psychotherapy, to children and adolescents school interventions, to college students to support their academic achievements, to patients with cancer and other chronic illnesses (Cousins et al., 2014; Gallagher & Lopez, 2009; Geraghty, Wood, & Hyland, 2010; Marques, Lopez, & Pais-Ribeiro, 2011; Schrank, Stanghellini, & Slade, 2008).

Even though some critical issues recently appeared when promoting hope (i.e., cultural factors, personality predisposition and psychopathology, as described below), hope therapy is still the recognized legacy to Jerome Frank observation that hope is an essential ingredient in all psychological interventions (Frank, 1968; Schrank et al., 2008)

5.3 Optimism and Cognitive Therapy

In current research optimism has been defined according to two main perspectives: dispositional optimism (Scheier & Carver, 1985) and optimistic explanatory style (Seligman, 2006). Dispositional optimism has been described as the general tendency to expect good rather than bad outcomes, even in time of adversity (Scheier & Carver, 1985). Optimists have a set of positive beliefs which are relatively stable over the years and in different contexts. Scheier and Carver (1985), developed the Life Orientation Test (LOT) in order to assess optimism as a bipolar dimension, defining optimists by high scores and pessimists by low scores. Authors found that optimists differed from pessimists on the tendency to use more problem-focused strategies, which could remove or reduce the cause of the stress. Pessimists, on the other hand were found to be inclined to use emotion-focused coping, to be oriented to reduce or eliminate emotional distress and they tended to disengage from the goal's achievement (Scheier, Weintraub, & Carver, 1986).

The second perspective (optimism as an explanatory style) derives directly from the clinical psychology tradition. Aaron Beck, the father of modern CBT, based his own clinical work on the assumption that many psychopathological conditions are associated with negative expectations about the future, encompassing depression, suicidal ideation, and completed suicides. Beck's defined hopelessness as a "system

of cognitive schemas whose common denomination is negative expectations about the future" (Beck, Rush, Shaw, & Emery, 1979, p. 864). In particular, he suggested that depression was caused by a set of specific cognitive distortions that led patients to formulate negative views of themselves, of their world and their future (cognitive triad of depression). He subsequently developed specific techniques to address and correct these cognitive bias (Beck et al., 1979). Disputing pessimistic thoughts in cognitive therapy, in fact, means identifying cognitive errors such as generalization, personification and all-or-nothing-thinking, with the final goal of restoring a positive view of the self, the world, and the future. Similarly, Seligman (2006) suggested to identify negative, pessimistic thoughts and to correct them by changing the individual's explanatory style, which is considered as an habitual manner of explaining the causes of events. It is composed of three central dimensions: permanence (temporary vs. long standing), pervasiveness (global vs. specific) and personalization (internal vs. external causes of the event). According to Seligman model of "*Learned Optimism*" (Seligman, 2006) some individuals (particularly those with depression, anxiety and other forms of psychopathology) need to be helped in moving form a pessimistic explanatory style to an optimistic one. The former consist of making attributions that are external, unstable, and specific for good events, and internal, stable, and global for bad events. Conversely, the *optimistic explanatory style* consists of making attributions that are internal, stable, and global for good events, and external, unstable, and specific for negative events (Seligman, 2006). Thus, cognitive techniques proposed by positive psychology research to promote happiness and optimism share those traditionally and successfully used to treat anxiety and depression (i.e., cognitive restructuring) (Beck et al., 1979). Also in this case some commonalities between the two disciplines are emerging.

The benefits of an optimistic explanatory style have been documented, such as good physical health and longevity, decreased depressive symptoms and faster recovery from depression (Boehm & Kubzansky, 2012; Carver, Scheier, & Segerstrom, 2010; Gallagher & Lopez, 2009). Moreover, a scientific study showed a positive association between optimistic explanatory style and reduced suicide ideation, while pessimistic college students tended to develop more suicidal thoughts and behaviours when facing negative life events (Hirsch, Wolford, LaLonde, Brunk, & Morris, 2007).

Beside the adult clinical setting, this model of optimism promotion has been applied to the preventing setting, by administering a group intervention to school children and adolescents at risk for depression. The Penn Resiliency program was developed and tested in a number of controlled investigation (Gillham et al., 2007). A recent review of its application described the beneficial effects of this cognitive training for preventing and treating depression as well as for promoting resilience in youth (Brunwasser, Gillham, & Kim, 2009).

5.3.1 The Nuances of Optimism in Clinical Settings: Defensive Pessimism and Naïve Optimism, and False Hope

Norem and Chang (2002) analyzed optimistic versus pessimistic explanatory styles and highlighted that one cannot simply conclude that "optimism is good" and "pessimism is bad", because "optimism" and "pessimism" cover several different concepts. For instance, these authors distinguished between: *defensive pessimism* (Norem, 2008; Norem & Cantor, 1986) versus *dispositional pessimism* (Scheier & Carver, 1985), and *naïve* and *unrealistic optimism* (Epstein & Meier, 1989) versus *dispositional optimism* (Scheier & Carver, 1985). The former (*dispositional pessimism)* can have debilitating motivational effects, by making individuals believe that nothing they can do will have positive outcomes. Scheier and Carver (1985) suggested that dispositional pessimism is intrinsically linked with giving up syndrome and demoralization, often observed in clinical practice. On the other hand, the concept of *defensive pessimism* describes the tendency of setting unrealistic low expectations and devoting energy to mentally reflecting on all the possible negative outcomes that can be imagined for a given situation (Norem, 2008). It was recently found that it may help anxious individuals to cope with their anxiety so that it does not interfere with their performance (Norem, 2008). In particular, defensive pessimists were found to have better outcomes in their performance when they were allowed to keep their expectations low and to reflect on several negative possibilities before the performance. If this process was disrupted by positive thinking or positive expectations, anxious individuals felt more anxious, with the risk of worsening their performance.

Conversely, *strategic optimism* is described as a *strategy whereby individuals set optimistic expectations for their own performance and actively avoid extensive reflection* (Norem & Chang, 2002). When facing performance situations, strategic optimists were found to set high expectations, felt calm and avoided to extensively reflect on the situation itself. This aspect of self-confidence, which is typical of the strategic optimism could sometimes be considered as a cost of optimism, because optimists could miss important details when the situation is particularly complex, and their performance could be derailed. Norem and Chang (2002) concluded that both defensive pessimists and strategic optimists get successful performances through opposite strategies, which could turn as adaptive/maladaptive for both of them, as described in Fig. 5.1.

On the opposite side, *naïve or unrealistic optimism* describes a universal human tendency to believe that good outcomes are more likely and bad outcomes are less likely to happen to oneself than they are to other people (Sharot, Korn, & Dolan, 2011; Shepperd, Klein, Waters, & Weinstein, 2013). This statement highlights the general individuals' belief of having less chances to experience negative events than the average, which implies an error in judgment concerning future expectations. This optimistic bias may depend on various factors, such as age, socio-economic conditions and health status (Shepperd, Waters, Weinstein, & Klein, 2015; Weinstein & Klein, 1996) and several investigations have tried to identify the mechanisms

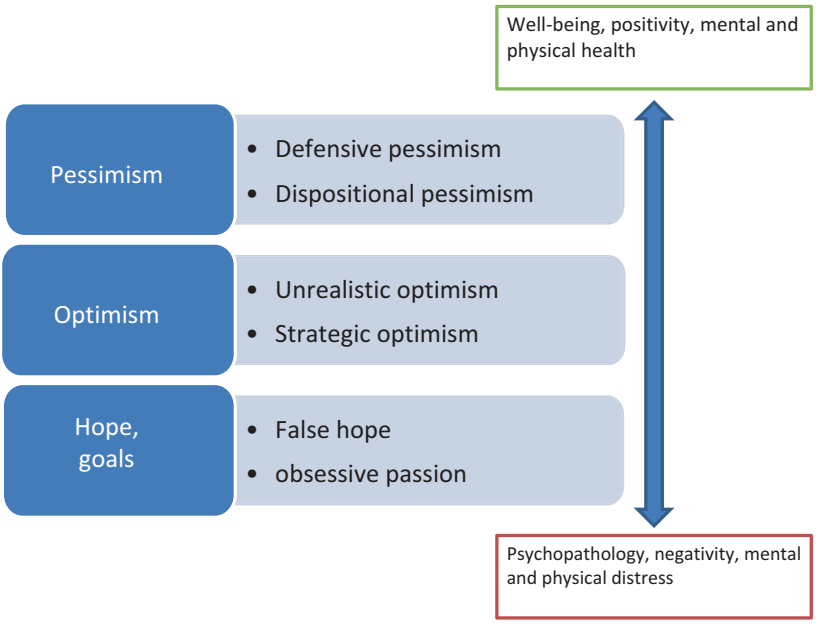

Fig. 5.1 Pessimis, optimism and hope: their nuances and their consequences

responsible for this phenomenon. The basic assumption of the unrealistic optimism consists in the individual's tendency to believe in being *invulnerable to adversity*. This phenomenon could be linked to various psychological mechanisms and defense systems. For instance, Kirscht, Haefner, Kegeles, and Rosenstock (1966) explained the unrealistic optimism as caused by a defensive refusal of accepting one's own vulnerability, since it would produce an unbearable feeling of anxiety. A work of Weinstein (1982) suggested the *early appearance phenomenon* as a predictor of optimistic distortions. Specifically, it concerns the idea that if a problem, such as a chronic illness, did not manifested during a certain age, usually in childhood, the individual is inclined to believe it will not happen in the future. Consequently, it originates the perception that the personal risk of developing a disease is lower than the average (Weinstein, 1989). More recent findings about the possible causes of the unrealistic optimism come from the investigations of Shepperd et al. (Shepperd, Carroll, Grace, & Terry, 2002; Shepperd et al., 2013). Exploring the processes underlying biased thinking, these researchers argued that unrealistic optimism may be motivated by the desire for self-enhancement. Positive expectations about the future or the belief that negative events will happen only to others, make people more satisfied and comforted, increasing their feeling of being in a better condition than other individuals. Since unrealistic optimism's construct presumes a social comparison, it can be described also as *comparative optimism* (Shepperd et al., 2002), because it implies a comparison between risk judgments made for the self and the risk judgments made for the average (Shepperd et al., 2002). Unlike

dispositional optimism which refers to the general expectation of positive outcomes (Scheier & Carver, 1985), comparative optimism concerns the specific belief to expect a threatening event will occur to others, not to oneself.

Even though criticisms on the statistical and methodological procedures used to study the phenomenon of unrealistic optimism emerged (Harris & Hahn, 2011), other recent research in neuroscience shed also new lights into its neural correlates such as an *up-regulation of brain dopaminergic systems* (Shah, 2012). These new findings have a crucial clinical impact, since unrealistic optimism may be the cause of several problems and mistakes in personal, social and economical decision making. Further, it was found that it may prevent individuals from striving and struggling to reach their goals (Shepperd et al., 2015). Conversely, dispositional optimism may motivate people to effectively engage in action in prevision of positive outcomes, by compensating potential problems resulting from avoidance or distortion of negative feedback (Alarcon et al., 2013; Gallagher & Lopez, 2009).

Some authors have proposed the similar concept of *False Hope*, considered as the tendency to generate hope based around personal fantasies, that can affect one's life or habit despite a track record of failure. *False hope syndrome* refers to cases in which individuals repeatedly try and fail to achieve a goal because they have unrealistic expectations about their likelihood of success (Polivy & Herman, 2000; Snyder, Rand, King, Feldman, & Woodward, 2002). Often this phenomenon is linked to overconfidence which engenders inflated expectations of success and eventually the misery of defeat (Polivy & Herman, 2002). This model has been particularly used to describe processes of self-change (i.e., being on a diet, smoking/drug cessation etc.) and their realization or failure. Polivy and Herman (2002) have suggested four specific sources of failure: amount, speed, ease, and effects on other aspects of one's life. Each of them is associated with an unrealistic expectation about self-change. The first one (amount) concerns individuals' exaggerated expectations about their self-changes: they believe they can change more than it is actually feasible, refusing more realistic and achievable goals. Speed refers to the optimistic bias in individuals' anticipated speed in achieving their goals. Specifically, they believe to change more quickly than is possible (e.g., to lose weight more quickly and with much less effort than it is actually possible). Ease describes people's belief that their goals are more feasible and easier to obtain than they actually are. Ease's evaluation is often determined and maintained by an overestimation of people's abilities in many domains, such as in losing weight or in quitting smoking, which are often inaccurate (Weinstein, Marcus, & Moser, 2005).Regarding the effects on one's life, people often consider that a change or pursuing a goal will ameliorate their lives more than it actually does. For example, people believe that following a diet will involve not only a physical change in terms of a weight loss, but also a change of other life's aspects, such as a job promotion or finding a romantic partner (Polivy & Herman, 2002).

The false hope syndrome is documented as a serious mental health problem, because of the frustration and depression that follow such condition, and the general negative effect on physical health. The phenomenon of false hope syndrome, in fact, could be particularly deleterious in chronic illnesses (Hart, Vella, & Mohr, 2008)

and critical life stages, such as adolescence (Greenaway, Frye, & Cruwys, 2015). Adolescents usually have the tendency of setting unrealistic goals for themselves because of their characteristic nature of having a false impression of their self image and capabilities, as well as because of their adventurous nature. Excessive or unrealistic levels of hope in young individuals was recently documented as associated with their level of depression in educative settings (Greenaway et al., 2015). False hope syndrome was documented in many health conditions and was found to influence treatment adherence and a beneficial working alliance with therapists (Alarcon et al., 2013; Bohart, 2002; Cohen et al., 1999; Greenaway et al., 2015; Hart et al., 2008; Held & Bohart, 2002). Moreover, Gibson and Sanbonmatsu (2004), reported three studies showing that optimists are less likely to disengage from gambling—even after experiencing gambling losses. This phenomenon could be indeed explained in light of the false hope syndrome, or the similar concept of *naïve/ unrealistic optimism*.

In conclusion, Norem and Chang (2002) claimed that both optimism and pessimism (or positive and negative thinking styles) have potential benefits and costs, which are highly sensitive to the context, and have to be clearly kept in mind in research designs, interpretations of results, clinical interventions and teaching, as illustrated tin Fig. 5.1. According to these authors, defensive pessimists perform better when they can maintain low expectations and reflect on negative possibilities before a task, while their performance is impaired (and they feel more anxious) when disrupted by positive thinking (Norem & Cantor, 1986). This was confirmed in a longitudinal study (Norem, 2008) where anxious people who used defensive pessimism performed better than anxious people who did not use it. Similarly but opposite to defensive pessimists, strategic optimists are susceptible to derailment of their positive approach when reflecting about possible (positive) outcomes, as this thought may impair their performance due to an excess of self-confidence.

On the same vein, and following his clinical experience as therapist, Bohart (2002) confirmed that some forms of pessimism can be adaptive, since complaining might have positive consequences. Bohart (2002) also suggested that false hope/ unrealistic optimism is not necessarily bad in clinical setting because it may represent a form of clients' "ecological wisdom" in solving their problems, or a defense mechanism aimed at protecting self-esteem. It should therefore be understood and respected, as long as it serves to provide clients with a task-focused orientation towards problems. He also highlighted the relevance of a client's cultural context in order to assess if a certain behavior can be dysfunctional or not. Pessimism, for instance, is not as dysfunctional in Asian culture as it is in American culture (Bohart, 2002). When it comes to plan specific cognitive restructuring interventions in clinical practice, thus, it could be important to carefully evaluate the type of psychological disorder(s) as well as the personality characteristics of clients, in order to reinforce their most effective and adaptive explanatory styles, avoiding priori classification of optimism as always beneficial versus pessimism as deleterious.

5.4 Goals, Passion and Psychopathology

In clinical settings it was found that often patients display impairments in eudaimonic well-being, particularly when referring to meaningful goals and in developing a sense of personal growth (Fava & Ruini, 2003; Ruini & Fava, 2013). Ruini and Fava (2013) described the polarities of eudaimonic well-being dimensions. In their article they provided evidence that not only deficits in Ryff's dimensions of well-being are associated with psychological distress and psychopathology, but also excessive levels in the same dimensions. For instance, they stated that depressed patients often lack a sense of purpose in life, and 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). As described in the previous pages of this chapter, therapy itself offers a sense of direction and hence a short-term goal. However, this does not persist when acute symptoms abate and/or premorbid functioning is suboptimal. In fact patients may perceive a lack of sense of direction and may devalue their function in life, prolonging an internal state of demoralization (Frank, 1968; Larsen & Stege, 2010; Snyder et al., 2000). In this case interventions that promote goal achievement and purpose in life, such as hope therapy and well-being therapy (see Chap. 4 of this book) might be extremely beneficial.

On the other hand, it was well documented in traditional clinical psychology research that specific defense mechanisms (such denial, repression and illusory cognitive bias) may lead people to display levels of personal growth and of future orientations that are excessive. Such individuals tend to forget or not to give enough emphasis to past experiences because they are exclusively future-oriented. Negative or traumatic experiences could particularly be under-estimated, as a sort of extreme defense mechanism (denial), i.e., "I just need to get over this situation and go on with my life" (Norem & Chang, 2002; Schrank et al., 2008). 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.

Similarly, many other conditions worthy of clinical attention may arise from inappropriately 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 eventually to reach excellence. The goal, thus, could turn into a passion that accompany one's life. Cultivation this passion, then, could have a cost in terms of allostatic load and stress (see Chap. 2 of this book). In fact, while this passion may ensure dedication toward the activity and, eventually, a better performance, it may also be associated with distress, depending on the type of affect involved. Vallerand (2012) proposed a Dualistic Model of Passion, where he defined *passion* as a strong inclination toward an activity that individuals like, that they find important, in which

they invest time and energy, and which comes to be internalized in one's identity. Such a passion becomes a central feature of one's identity and serves to define the person. In this case the author proposed the concept of *obsessive passion*. Such an internalization originates from intra and/or interpersonal pressure, either because certain contingencies are attached to the activity (such as feelings of social acceptance or self-esteem), or because the sense of excitement derived from activity engagement becomes uncontrollable. Individuals with an obsessive passion come to develop ego-invested self-structures and, eventually, display a rigid persistence toward the activity thereby leading to less than optimal functioning (Vallerand, 2012). Such persistence is rigid because it not only occurs in the absence of positive emotions and sometimes of positive feedback, 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, 2008).

The individual engagement for a certain goal could thus become a form of psychological inflexibility (Kashdan & Rottenberg, 2010) which is more connected with psychopathology, than well-being. Some individuals, in fact, remains attached to their goals even when they seem unattainable. This phenomenon has been called "*painful engagement"* (MacLeod & Conway, 2007). The painful engagement was studied in a sample of depressed patients, and received explanation through the mechanism of "*Conditional goal setting*" (Hadley & MacLeod, 2010). Accordingly, patients presented a dysfunctional attributional cognitive style toward their goals: they believed that they would be happy and fulfilled only if those particular goals were achieved. Conditional goal setting theory is based on a hierarchical model of goals with the most concrete goals at the bottom (i.e., cooking a meal) and the most abstract goals at the top, as those involving a sense of the idealised self and, often also the concept of happiness. This attributional style was found to be related to hopelessness, rather than depression or anxiety. It means that hopeless people cannot disengage from their goals because they believe that their future well-being (happiness, self-worth, fulfillment) is dependent on those goals being achieved, and often they perceived the unlikelihood of this conditions. Further, this process confirms the idea that hope can become paralyzing and hampers facing and accepting negativity and failures (Held & Bohart, 2002), particularly when hope triggers a false hope syndrome, as previously described.

5.5 Implications for Depression and Mood Disorders

Hope and optimism reflect the generalized expectancies for desirable future outcomes (Carver et al., 2010). They can have positive effects but also some drawbacks, particularly in the realm of mental health. In relation to depression, a prospective, observational study found that in a cohort of community Finnish sample followed up to 4 years, 4% of them developed depression. The likelihood of initiating psychotherapy for depression was lower for those reporting higher initial levels of dispositional optimism. Dispositional pessimism, on the other hand, did

not significantly predicted initiating psychotherapy (Karlsson et al., 2011). Thus, according to this research, optimism seems to be an obstacle for proper help-seeking behavior.

Similarly, other Authors investigated the presence of future positive life expectancies in depressed patients (Busseri & Peck, 2014). Contrary to common sense, the belief that life gets better over time was found to be as common in individuals with major depressive disorder as in controls. Apparently, this finding contradicts Beck cognitive triad of depressions, that would imply depressed individuals anticipating a dark or darker future. Busseri and Peck (2014) indeed documented that their depressed patients imagined an improved future life (in terms of life satisfaction) compared to past and present life. However, they also found that such beliefs predict heightened (rather than less) risk of future depression up to 10 year later. They explained this paradoxical phenomenon either by arguing that depressed individuals perceive this brighter future as an obligation, or a comparison standard against which they fail; or by a form of wishful thinking that even impairs their clinical status. Whatever the explanations, the implications for psychotherapy are relevant, particularly when involving CBT as well as other goal-focused interventions.

On the same vein, the phenomenon of obsessive passion and painful engagement have been found to be implicated in developing hopelessness and parasuicidal behaviors (MacLeod, 2012; Vincent, Boddana, & MacLeod, 2004). As explained before, the mechanism of painful engagement makes individuals unable to change perspective, to set new goals, and makes them believe that they would be happy and fulfilled only if those particular goals were achieved. At the same time, those individuals clearly perceive the unlikelihood of their goal pursuit. Consequently, suicide attempts are considered possible solutions to exit from such painful situations (Vincent et al., 2004). As a result, some clinicians suggested to help depressed patients to set achievable, self-concordant, daily goals and to plan well towards them. A specific group intervention called *Goal Setting and Planning–GAP* (Coote & Macleod, 2012; MacLeod, 2012) is focused on developing positive goals to improve well-being through solving problems, rather than on reducing depressive symptoms or distress. GAP entails five sessions, where patients are taught how to set achievable goals, how to overcome possible obstacles and how to maintain their progress. Interestingly, it was found to improve well-being and life satisfaction of participants, but also their depressive symptoms.

Other mood disorders have been found to be particularly associated with a distorted sensitivity toward happiness and future expectancies. For instance, individuals with *bipolar disorder* who are in remission as well as those at risk for developing the disorder have been found to experience greater positive emotions relative to healthy controls in response to both current and anticipated pleasant stimuli (Gruber, 2011). Similarly, psychiatrist and psychotherapists are well aware of clinical problems related to unrealistic goals, sense of grandiosity and associated risks taking in bipolar patients. These phenomena are explicable with the underestimation of danger, in view of expected rewards and future positive emotions.

These clinical findings have been recently confirmed by (Ford, Mauss, & Gruber, 2015) who found that people who extremely value happiness (i.e., consider happiness as one core goal for their current and future life) tend to be at general risk for mood disturbances, both depressive and manic. Supporting their clinical observation, these authors found that the extreme valuing of happiness was associated with an increased risk for developing Bipolar Disorder (BD), increased likelihood of past diagnosis of BD, and worse prospective illness course in BD, even when controlling for patients' current mood symptoms (Ford, Shallcross, Mauss, Floerke, & Gruber, 2014). Taken together with previous evidence, these findings suggest that the extreme valuing of happiness, as well as the positive emotions that people strive to feel, may play a critical role in influencing psychological health (Gruber, Mauss, & Tamir, 2011).

Similarly, it was found that extreme (i.e., excessively pessimistic or optimistic) attributional styles were predictors for the onset of hypomanic, manic or mixed episodes among bipolar adults receiving psychosocial treatment for depression (Stange, Sylvia, da Silva Magalhães, Frank, et al. 2013; Stange, Sylvia, da Silva Magalhães, Miklowitz, et al. 2013). Also in this trial, patients presenting extreme (both positively- and negatively-valenced) attributions were predicted as having a higher likelihood of (and shorter time until) transition from depression to a (hypo) manic or mixed episode. They were retrospectively associated with more lifetime episodes of (hypo)mania and depression. Authors therefore concludes that the evaluation of extreme attributions may help clinicians to identify patients who are at risk for experiencing a more severe course of bipolar illness, and who may benefit from treatments that introduce greater cognitive flexibility, rather than simply address pessimism.

5.6 Conclusions and Therapeutic Recommendations

This chapter analyzed the important role of hope, optimism and goal setting during the course of psychological interventions and in influencing mental health. A brief review on the link between these issues and various form of psychological disorders was provided. Form such review a fist observation is that psychological disorders are both related to the impairments and to the excessive levels of hope, optimism and future expectations. Thus, a certain clinical caution should be recommended when addressing these issues in patients with mood and anxiety disorders. When dealing with affective and mood disorders, in fact, it seems that clinicians should carefully evaluate patients' cognitive styles, their meaningful goals, as well as their internal defense mechanisms, before proposing any of the positive interventions described so far. As McNully and Fincham (2012) suggested, positive emotions and positive characteristics have been found to have beneficial effects in normal or optimal conditions. When such conditions are sub-optimal, as it is often the case with clinical populations, the promotion of positivity can backfire and become more harmful than helpful. Norem and Chang (Norem, 2008; Norem & Chang, 2002)

underlined the positive effect of defensive pessimism on the performance of anxious patients. Other authors described the negative effect of excessive optimism in individual with (or at risk of) bipolar disorders (Ford et al., 2015; Stange, Sylvia, da Silva Magalhães, Frank, et al. 2013; Stange, Sylvia, da Silva Magalhães, Miklowitz, et al. 2013).

Future investigations are needed to shed new lights on these controversial mechanisms. In the meantime, clinicians should keep in mind that it is important to promote hope in early stage of interventions, in order to improve treatment adherence and developing a positive working alliance with clients (Frank, 1968; Lopez et al., 2004). When it comes to address pessimism, however, clinician should use more caution because it could serve to certain anxious patients, or, at balanced levels, it could facilitate entering psychotherapy, and finally it could influence mood switches in bipolar patients.

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Chapter 6
Life Adversities, Traumatic Events and Positive Reactions

"Only in the darkness can you see the stars."

Martin Luther King Jr.

Abstract This chapter addresses the issue of not simply adapting positively to life adversities, but the description of various processes that lead to self-development and self-maturation, as results of a struggle with such life adversities. In particular, the concepts of post-traumatic growth (PTG) wisdom, forgiveness and self-forgiveness are reviewed, by emphasizing their clinical relevance and by describing specific psychotherapeutic strategies aimed at their promotion. Finally, possible controversial issues concerning the implementation of such interventions are discussed. Clinical recommendations are then suggested.

6.1 Stressors and Life Adversities, and Their Impact on Well-Being

Traumatic experiences in people's life are quite common, but the effects of these events are not uniformly negative: the process of adaptation to stressful life events, in fact, can be different from person to person, leading to distress and psychopathology (such as post-traumatic stress disorder (PTSD), mood and anxiety disorders, adjustment disorders) but also to positive changes. Negative events may become disrupting and trigger psychopathological symptoms only in certain individuals, or under specific circumstances, whereas other individuals may successfully adapt to them, or even find maturation and growth (Bonanno, 2004). Various authors have labeled such positive reactions as *post-traumatic growth, benefit finding, stress related growth, or adversarial growth*, among others. Some authors underlined the emotional component, others the cognitive one or the transcendent/spiritual component. In Chap. 2 other similar concepts, such as resilience, hardiness and sense of coherence have been reviewed. In this chapter the focus will be addressed to the description of a process of self-development and self-maturation that results out of a struggle with such life adversities, which is more than simply adapting positively to them. Linley and Joseph (2004) suggested that stressful events may trigger a

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process of psychological maturation of the individuals, where new priorities, meaningful life goals and more empathic relationships are pursued by traumatized individuals. Such dimensions seem to parallel those of eudaimonic well-being, rather than hedonic well-being (Joseph & Linley, 2008). According to this perspective, trauma may serve as a turning point out of which individuals reframe their life meaning, goals and expectations.

This process of growth appears to be related to the shattering of individual's basic assumptions in life, which occurs in the aftermath of a traumatic event (Cann, Calhoun, Tedeschi, & Solomon, 2010; Linley & Joseph, 2004). Tedeschi and Calhoun (2004) suggested that the "seismic nature" of the event, characterized by uncontrollability, irreversibility and threatening qualities may play an important role in influencing growth following adversities. Some Authors (Linley & Joseph, 2004) on the other hand, suggested that threats of impending mortality and the awareness of mortality more likely lead to positive changes and growth and to a new sense of meaning (see Chap. 8 for further discussion on meaning making).

6.1.1 Mortality Salience, Distress and Well-Being

The theory of terror management (Greenberg, Solomon, & Pyszczynski, 1997) provided a frame of reference for describing these phenomena. It postulates that *mortality salience*, (which involves conscious thoughts about death) affects the personal attitudes and behaviors that protect against death anxiety, with the moderating effect of self-esteem. The theory posits that mortality salience and self-esteem (as a buffer of anxiety) are tied to an heightened accessibility of death-related thoughts and existential values, such as those related to transcendence, spirituality and immortality. Hence, the sense of vulnerability and finites that are normally neglected or denied, when activated by trauma may lead to improved well-being and personal growth.

Mortality salience is an important mechanism implicated in the model of "*Hostile World Scenario*" (HWS) as proposed by Shmotkin (2005). HWS refers to a set of beliefs or images of actual or potential self-perceived threats to one's life or, to one's integrity:

> "…. This image of adversity functions as a system of appraisal that scans for any potentiality of a negative condition, whether dangerous or distressing, or for an even worse condition when a negative one already prevails." (Shmotkin, 2005, p. 295)

Thus, HWS entails a specific (negative) existential concern. In its mild manifestation, it could be considered a form of vigilance and prudence regarding negative eventualities, and in this case it has an adaptative function. Conversely, in its extreme manifestation, it generates a general sense of survivorship or of imminent calamity. According to the Author, subjective well-being (SWB), in its cognitive and emotional components (see Chap. 1 of this book) may regulate the disturbing beliefs entailed in the HWS. In fact, SWB is described as a "favorable psychological environment", or as a positive state of mind that allows an individual to maintain ongo-

ing tasks without being mentally disrupted. SWB, thus, has a role in adjusting individuals' evaluations of their life and world. This positive mechanism may be associated to further processes of coping, meaning making and existential growth. According to the model of hostile world scenario (that is often activated in the aftermath of a traumatic event) baseline SWB serves as a protective factor and may elicit further eudaimonic well-being.

Even though these issues have not developed or applied in medical settings, they are particularly important when the traumatic event concerns an *illness*, such as cancer. In fact, life-threatening illnesses, with the continuous check-ups and medical treatments required, may be conceived as potentially traumatic events or stressors that could elicit psychological symptoms and stressor-related disorders, such as anxiety, fear of death, adjustment disorders or even a post-traumatic stress disorder (PTSD) (Barskova & Oesterreich, 2009; Ruini & Vescovelli, 2013; Ruini, Vescovelli, & Albieri, 2013). On the other hand, when facing these life-threatening conditions, patients' personal cognitive efforts may elicit also positive changes as benefits, psychological growth and maturation (Barskova & Oesterreich, 2009; Cordova, Cunningham, Carlson, & Andrykowski, 2001). The majority of investigations in this area suggests that the experience of growth or benefits—with the contribution of other bio-psycho-social factors—can facilitate patients' adaptation to the illness (Barskova & Oesterreich, 2009).

The common theoretical background of these concepts underlines that people may experience distress and positivity as coexisting in the aftermath of traumatic events. Such coexistence has been largely studied, with inconsistent findings. For instance, Linley and Joseph (2004) reported mixed results with PTSD symptoms negatively associated with positive life changes following sexual assault, but positively related to stress-related growth in survivors of the Oklahoma bombing. Results seemed to be quite inconsistent also across studies on medical trauma. Some of them did not find any relations between PTG and distress, anxiety and quality of life (Helgeson, Reynolds, & Tomich, 2006), whereas others pointed out that higher levels of PTG were associated with lower levels of distress (Barskova & Oesterreich, 2009; Shakespeare-Finch & Lurie-Beck, 2014), of depression and more positive well-being (Helgeson et al., 2006).

6.1.2 The Curvilinear Model

Recently, some researchers suggested that the relationship between traumatic symptoms and personal growth is best explained as a *curvilinear relationship* where distress is required to start the growth process, but high levels of distress prevent the growth process from occurring (Kleim & Ehlers, 2009; Lechner, Carver, Antoni, Weaver, & Phillips, 2006). Helgeson et al. (2006) conducted a meta-analysis examining the relation of growth to psychological health. Results supported the curvilinear model for describing the association between growth and distress. Results described how the theoretical curve moved from low levels of distress and low growth, through a group of traumatized individuals with some growth and mostly

distress, to those with high levels of growth and lower distress. Kleim and Ehlers (2009) confirmed the curvilinear association between growth and distress in a population of physical assault survivors: individuals with high or low growth levels reported fewer symptoms than those with an intermediate growth level. Therefore, some people may not consider the traumatic event as a crisis or may be resilient, reporting low symptomatology and little personal growth.

This non-linear mechanism could be due to the fact that there is no full consensus on the definition of traumatic event. Epidemiological data suggest that some events generally not considered outside the range of "normal" human experience, could still evoke the full range of PTSD reactions. For example, PTSD symptoms were experienced by individuals following events such as childbirth (Olde, Kleber, van der Hart, & Pop, 2006; Sawyer & Ayers, 2009); marital problems and divorce (Dattilio, 2004); economic problems and work-related stress (Scott & Stradling, 1994). Some of these events could be considered challenging, but not exactly "traumatic". Cameron, Palm, and Follette (2010) argued that it is the individual's cognitive and behavioural response to the event, rather than the event itself, that entails a significant risk factor for psychological distress. Consequently, for the same reasons, certain important events may activate specific cognitive processes, eliciting the reconstruction of the meaning of the event, that has the quality to transform person's pre-trauma functioning and to trigger personal growth (Tedeschi & Calhoun, 2004). Adverse events perceived as central to one's identity are more likely to activate a search for meaning and thus, to elicit growth and personal maturation (Boals, Steward, & Schuettler, 2010). In conclusions, independently from their "traumatic nature" certain life adversities can cause psychological distress and impair dimensions of hedonic well-being and life satisfaction in the short run. However, in the long-run, they could serve as a trigger point out of which individuals activate a process of inner maturation and growth, that leads to several changes, as described in the next paragraph.

6.2 Different Definitions: Benefit Finding, Stress Related Growth and Post-traumatic Growth

Many conceptualizations refer to growth in the aftermath of trauma. However, Tedeschi and Calhoun (1996) originally proposed the term "post-traumatic growth" (PTG), suggesting that people may trigger a cognitive process of rumination as a personal tentative to accommodate to a new reality in the aftermath of traumatic events. This struggle seems to generate a cognitive recognition of improvements in individuals' personal strengths and spirituality, in their relationships with others, and in the appreciation of their own life, considering the stressful experience as an opportunity to engage in new possibilities. Taken together, these five characteristics constitute the original concept of PTG. This model has been recently found to be the dominant one among studies (Jayawickreme & Blackie, 2014).

Other authors have referred to these positive changes with similar labels, each of which having its own characteristics. For instance "*Benefit finding*" (BF) refers to the benefits obtained from the adverse experience (Collins, Taylor, & Skokan, 1990; Tennen & Affleck, 2002), which similarly consists of an improvement in personal relationships, changes in life priorities and a better appreciation for life (Harding, Sanipour, & Moss, 2014). However, the difference between PTG and BF seems to be the time of appearance. BF is more prone to emerge just in the close aftermath of an adversity, while PTG tends to appear after a certain amount of time since trauma (Harding et al., 2014; Mols, Vingerhoets, Coebergh, & van de Poll-Franse, 2009; Tedeschi & Calhoun, 1998). This seems to be due to the fact that PTG develops as a result of the rumination and restructuring of the self/world relationship which occur in the weeks, months, and even years following trauma (Tedeschi & Calhoun, 1998). Therefore, PTG seems to require a modification of deeper cognitive representations, involving changed 'rules for living' and 'core schema'. Thus, BF may be more superficial and transient in nature. In fact, Sears, Stanton, and Danoff-Burg (2003) added the concept of "*positive reappraisal"* and differentiated it from *BF* and *PTG*: BF concerns the benefits perceived from the adversity itself, which, if used as a coping strategy, represents a *positive reappraisal* of the adverse experience. The sum of these two phenomena—*BF* and *positive reappraisal*—may result in a later *PTG*.

Other labels have been proposed to describe changes in interpersonal relationships, in the view of oneself, and in the philosophy of one's life (Joseph et al., 2012): *adversial growth, stress-related growth and positive posttrauma life changes* (Joseph et al., 2012; Kaler, Erbes, Tedeschi, Arbisi, & Polusny, 2011; Linley & Joseph, 2004). This latter (Joseph et al., 2012) emphasized the role of eudaimonic/Psychological Well-Being, that could be considered a substantial ingredient of PTG, since it implies high "levels of autonomy, environmental mastery, relationships with others, openness to personal growth, purpose in life and self-acceptance" (Joseph et al., 2012, p. 819). Joseph (2015) also equated the characteristics of PTG to those pertaining to the "fully functioning person" according to Rogers. In fact, Carl Rogers posited that individuals are intrinsically motivated toward growth and fully functioning individuals are those accepting their strengths and weaknesses, those who are compassionate toward others, and consider life as a process of change and are able to find meaning and purpose in their existence. Thus, these characteristics parallel the core features of PTG, and are similar to dimensions of eudaimonic well-being, more than subjective (hedonic well-being).

Finally, *thriving* has also been used to describe a positive reaction when facing a traumatic event, but Carver (1998) posited that psychological thriving results from a continued growth and gains in one or more important psychosocial areas, like personal relationships, self-confidence, and important life skills. The Author also explained that thriving does not always appear out of stressful situations, as the case of PTG. Ickovics and Park (1998) stated that *thriving* is something more than PTG, being the result of growth and of an increased well-being (WB). A list of questionnaires and instruments currently used to measure these issues is provided in Table 6.1.

Far from being exhaustive, this paragraph aimed at briefly illustrating the different conceptualizations and characteristics of positive individual reactions to life adversities. They share common characteristics, such as changes in life philosophy and meaning in life (cognitive component), changes in interpersonal relationships, with more openness and empathy, and changes in spirituality and/or increased capacity for forgiveness and wisdom. These latter two dimensions will be described in the next section of the chapter.

6.3 Forgiveness and Wisdom

6.3.1 Wisdom

Wisdom could be defined as the highest form of expertise in coping with difficult or unsolvable life-problems. It is a psychological competency, which helps people to master everyday life and to tolerate or cope with negative life events or particularly difficult life-situations.

According to Sternberg (1990), there are three major scientific approaches to define wisdom: philosophical, implicit, and explicit theories. The first one defines wisdom as a special form of knowledge. The second one refers to common-sense-concepts usually reported by ordinary persons (i.e., intelligence, problem solving, empathy, intuition, etc.). The third perspective refers to scientific and academic definitions of wisdom. For instance, Erikson (1950), in his life-span theories of human development, considers wisdom has a capacity that appears in later life, and is associated with meaningfulness and acceptance of life finiteness.

Kramer (2000), on the other hand, defines wisdom as a special expertise in relation to life situations, consisting of multiple responses and a sense of cognitive, emotional, and behavioral maturity. Accordingly, the wise person displays high openness for new experiences, dialectic thinking, empathy, and reduced despair or unhappiness in negative situations of life. Dialectical thinking, particularly, refers to the ability to view problems from multiple perspectives and to reconcile seemingly contradictory information (Manzo, 1992). This capacity plays a crucial role also in Sternberg's theory of wisdom (1998) that defined it as a balance of cognitive, emotional, and cognitive functions of a person, as well as a balance between the individual and the environment. Thus, wisdom refers to a form of practical intelligence, which allows to adapt to the environment and also to change it.

It has been shown that people who are not successful in coping with negative life events lack wisdom capacities (Linden, 2008). These capacities can be summarized as follows: (a) change of perspective, (b) empathy, (c) perception and acceptance of emotions (including the "unacceptable" ones), and (d) emotional serenity (to keep a clear mind and not be overwhelmed by one's own emotions), (e) factual and procedural knowledge (what can be done and what cannot), (f) contextualism and value relativism (to put the negative events in a broader context of meaning and life development), (g) uncertainty acceptance (to let the person acts without knowing the

outcome for granted), (h) long-term perspective, (i) distance from oneself, and (j) reduction of level of aspiration (to accept that life is not always following one's wishes and goals). Thus, it seems that wisdom-related knowledge involves problem-solving strategies. As such, they are needed in order to cope with several life adversities. This model has been formulated by a group of German investigators and is known as the "Berlin Paridigm of Wisdom" (Linden, 2008).

6.3.2 Forgiveness

Forgiveness is another essential psychosocial dimension, activated when individuals face stressors, particularly of interpersonal nature, such as injuries and transgressions. For many researchers and clinicians, forgiveness is a controversial term, with positive and negative connotations. Usually, the victim of a transgression experiences an immediate negative affective state characterized by fear and/or anger, resentment and often by the desire of retaliation. According to McCullough and Hoyt (2002), in fact, the two typical reactions following a transgression are avoidance and revenge, that could be easily measured by a specific questionnaire: the *Transgression—Related Interpersonal Motivations Inventory* (TRIM, see Table 6.1) (McCullough et al., 1998).

A large body of applied research seems to agree that forgiveness is a positive method of coping with a hurt or an offense that primarily benefits the victim through a reorientation of emotions, thoughts and/or actions toward the offender. It's important to specify that forgiveness is not necessarily reconciliation, and certainly it is not tolerating, condoning or excusing hurtful behaviour (Wade & Worthington, 2005). Forgiveness can be defined as: (a) response (prosocial change in a victims thoughts, emotions and behaviour toward a transgressor), (b) a personal disposition (propensity to forgive others across interpersonal circumstances) and; (c) a characteristic of social unities (as an attribute of social structure, e.g. marriage).

Forgiveness includes decisional, emotional, and behavioral components. Decisional forgiveness is a cognitive intention to eliminate negative behaviors and to increase positive behaviors toward the transgressor. Emotional forgiveness is the replacement of negative unforgiving emotions with positive other-oriented emotions (Worthington, Witvliet, Pietrini, & Miller, 2007). However, one may sincerely decide to forgive and continue in those benevolent behavioral intentions, without experiencing full emotional forgiveness (Hook, Worthington, & Utsey, 2009). As a matter of fact, forgiveness involves change, and is best viewed as a *process of transformation that occurs over time* (McCullough, Fincham, & Tsang, 2003; McCullough & Root, 2005). In fact, it could be extremely difficult because it involves working through-emotional pain, not avoiding it.

6.3.2.1 The Beneficial Effects of Forgiveness

Forgiveness was found to display important benefits in terms of physical health. In fact, anger and hostility, which are often triggered by transgressions, have been found to be risk factors for cardiovascular diseases (Friedberg, Suchday, & Shelov, 2007). Forgiveness, on the other hand, seems to be an antidote against such toxic reactions. This protective role of forgiveness was recently studied by controlling the modulation of blood pressure, the sympathovagal balance and the aortic hemodynamics. Results confirmed that anger was associated with a more cardiotoxic autonomic and hemodynamic profile, whereas forgiveness was associated with a more cardioprotective profile (May, Sanchez-Gonzalez, Hawkins, Batchelor, & Fincham, 2014). Further, it seems that forgiveness was found to predict longevity (Toussaint, Owen, & Cheadle, 2012).

Other lines of research supported the beneficial effects of forgiveness. For instance, forgiveness can facilitate the repair of supportive close relationships and such relationships are known to protect against negative health outcomes. For example, marital conflict is associated with poorer health (Burman & Margolin, 1992) and with specific illnesses such as cancer, cardiac disease, and chronic pain (Schmaling, Sher, & Kim Halford, 1997). Hostile behaviors during conflict relate to alterations in immunological (Kiecolt-Glaser et al., 1997), endocrine (Kiecolt-Glaser et al., 1997), and cardiovascular (Ewart, Taylor, Kraemer, & Agras, 1991) functioning. It has been suggested that forgiveness may be associated with well-being and health because it helps people to maintain stable and supportive relationships (McCullough, 2000).

Thus, forgiveness has been quite extensively studied in interpersonal settings, particularly in the family and couple settings, documenting again its beneficial effect (Fincham, 2009). For instance, married couples reported that the capacity to seek and grant forgiveness is one of the most important factors contributing to marital longevity and marital satisfaction (Fenell, 1993). Conversely, lower levels of forgiveness predicted psychological aggression and protracted conflict in marriage (Fincham & Beach, 2002; Fincham, Beach, & Davila, 2003).

On the same vein, Fincham, Beach, and Davila (2007) showed that wives' forgiveness was positively associated with improvements in husbands' self-reported communication 12 months later. Also, there is emerging evidence that marital quality predicts forgiveness (Paleari, Regalia, & Fincham, 2003), as well as data that trait forgiveness predicts later marital satisfaction (Vaughan, 2001). Thus, it appears that the association between forgiveness and relationship quality may be bidirectional.

Further, Fincham and Kashdan (2004) found that retaliation and avoidance (i.e., negative dimensions of forgiveness) among husbands and a lack of benevolence (i.e., positive dimension of forgiveness) among wives were linked to ineffective conflict resolution. Although the causal direction of these associations is unclear, Fincham and Kashdan (2004) suggested that unresolved transgressions may spill-over into future conflicts and, in turn, impede their resolution, thereby putting the couple at risk for developing the negative cycle of interaction that characterizes distressed marriages. This explanation would provide a mechanism that links forgiveness and relationship satisfaction.

Finally, rumination often occurs also after interpersonal transgressions. Using short-term longitudinal methods McCullough et al. (2003) confirmed that forgiveness is a process of psychological change, and they found that rumination was inversely related to forgiveness in the long run. Thus, the more forgiving a victim is, the less ruminative he/she will be.

6.3.2.2 Controversial Effects of Forgiveness

A few studies suggest that forgiveness may not always be so beneficial in interpersonal settings (Gordon, Burton, & Porter, 2004; McNulty, 2010, 2011). Gordon et al. (2004), for example, sampled women at a domestic violence shelter and documented that more forgiving women reported being more likely to return to their abusive partners. McNulty (2008) used a sample of 72 newlywed couples that reported their marital satisfaction up to four times over the course of 2 years. Although forgiveness was positively associated with marital satisfaction initially, the association between spouses' forgiveness and changes in their marital satisfaction depended on the frequency with which their partners directed hostile behaviors (e.g., sarcasm, insulting, swearing) toward them. Even though forgiveness helped to maintain marital satisfaction among spouses married to partners who rarely engaged in hostile behaviors, forgiveness was associated with steeper declines in satisfaction among spouses married to partners who more frequently engaged in hostile behaviors. Moreover, McNulty (2010) recently found that less forgiving spouses experienced declines in the frequency with which their partners perpetrated psychological and physical aggression over the first 5 years of marriage, whereas more forgiving spouses actually experienced stable or growing levels of psychological and physical aggression over those years.

Other controversial effects of forgiveness may be subscribed under the rubric of the *dormat effect*. Luchies, Finkel, McNulty, and Kumashiro (2010) documented that forgiving a perpetrator who has not signaled that the victim will be safe and valued may erode one's self-respect and self-concept. Thus, according to these authors, whether forgiveness leads to positive or negative consequences depends on the perpetrator's behavior and attitude. On the same vein, Hall and Fincham (2008) showed that offenders who felt to be forgiven by their victims became more self-forgiving, that is more compassionate and benevolent toward themselves. This result suggests that forgiveness may have positive effects on transgressors as well. Contrary to this line of reasoning, however, Kelln and Ellard (1999) found some support for the idea that forgiveness may exacerbate rather than ameliorate perpetrators' distress, by increasing their sense of guilt and indebtedness, especially when forgiveness is perceived as an unsolicited gift. Hence, the victim's and the perpetrator's responses following a transgression should not be considered as conflict resolution strategies in isolation; they should be considered in tandem.

In conclusions, McNulty and Fincham (2012) argue that forgiveness is a process that can be either beneficial or harmful, depending on characteristics of the relationship in which it occurs (for instance equity and reciprocity), and on individual's characteristics (agreeableness, self-regulation, remorse).

6.3.3 Self-Forgiveness

A less studied issue is *self-forgiveness*. Enright and The Human Development Study Group's (1996) described self-forgiveness as the facing of one's wrong doing while abandoning negative thoughts, feelings, and behaviors directed at the self, and replacing them with compassion, generosity, and love. Enright and colleagues argued that self-forgiveness is synonymous with self-reconciliation and that its outcome is associated with an increase in self-esteem. Self-forgiveness does not excuse behaviour nor should it be mistaken for guiltlessness or narcissism. Indeed, Authors specified that self-forgiveness involves accepting one's responsibility and pain in the process of feelings of remorse. In their study, Wohl, DeShea, and Wahkinney (2008) defined self-forgiveness as a positive attitudinal shift in the feelings, actions, and beliefs about the self, following a self-perceived transgression or wrongdoing. Halling (1994) defined self-forgiveness as the acceptance of those parts of oneself that have previously been thought of as unacceptable due to self-directed inappropriate thoughts or actions. Thus, Halling suggested a parallelism between self-forgiveness and self-acceptance, a key dimension of eudaimonic well-being (see Chap. 1). Likewise, Burton-Nelson (2000) stated that self-forgiveness is the act of generosity and kindness toward the self, following self-perceived inappropriate actions.

Wohl et al. (2008) argued that a failure to forgive the self reflects an intrapersonal disciplinary style, whereas a failure to forgive others reflects an interpersonal disciplinary style. The first one is considered a representative characteristic of patients with anorexia nervosa, obsessive-compulsive disorders and obsessive-compulsive personality disorders. In their study, Authors documented a strong correlation between self-forgiveness and mental health. This correlation, however, is twofold. On one hand, people who are severely depressed because of a single harmful event perpetrated by the self might be inhibited from forgiving themselves. In these cases, Wohl et al. (2008) suggested that the process of self-forgiveness may be the catalyst for personal growth. Those who come to forgive themselves for their mistakes and transgressions may convey more meaning to their future actions and behaviors (i.e., a commitment to behave better in a subsequent romantic relationship might be associated with self-forgiveness following the unwanted end to a romantic relationship).

On the other hand, self-forgiveness for a specific event might lead to a continuation of wrongful behaviors within that situational context. Specifically, extremely high levels of self-forgiveness might result in an unwillingness to alter behavioral patterns. That is, too much self-forgiveness may undermine motivation to initiate behavioral change (Tangney, Boone, & Dearing, 2005; Wohl & Thompson, 2006). In such instances, forgiving the self would be a rather selfish act and may be highly related to narcissism (Wohl et al., 2008).

According to reviewed studies, it is very important for clinicians to know about forgiveness and its positive and negative implications, both when it comes to intrapersonal or interpersonal settings. These issues have implications when translated into interventions aimed at helping individuals overcoming stressful life circumstances as described in the following section of this chapter.

6.4 Psychotherapeutic Steps to Promote PTG, Forgiveness and Wisdom

Interpretations of events and attributions are important processes in influencing individuals' reactions: they are a core feature in explaining how a person reacts to demands or burdens (Peters, Constans, & Mathews, 2011). An important approach in such interpretations and attributions is to give sense to what happened. This could be promoted by a series of different interventions, as summarized in Table 6.1 and described below.

Table 6.1 Positive reactions following traumatic events: assessment and treatment options

Concept	Instruments	Positive treatment
Post-traumatic growth/tress related growth	*Post-traumatic growth inventory* (Tedeschi & Calhoun, 1996)	Positive psychotherapy
	Ryff' Psychological Well-being Scale modified (Joseph et al., 2012)	WBT (Belaise et al., 2005)
		Interventions addressing PTG (Joseph, 2015)
Wisdom	*Three-Dimensional Wisdom Scale* (3D-WS) (Ardelt, 2003) emotional and reflective components	Wisdom psychotherapy (Linden, Baumann, Lieberei, Lorenz, & Rotter, 2011)
	Reflective Judgement Interview (RJI) (Kitchener & Brenner, 1990): wisdom related problem solving using dilemma situations	
Forgiveness	*Enright Forgiveness Inventory*—(Subkoviak et al., 1995): six subscales that assess the extent to which the victim experiences positive and negative effects, cognitions and behaviors/ behavioral intentions regarding a transgressor (60 items adult version; 30 item children version)	Forgiveness Therapy (group and couple settings) (Enright & Fitzgibbons, 2000)
	Transgression—Related Interpersonal Motivations Inventory (TRIM) (McCullough et al., 1998); 12 items assessing avoidance and revenge motive toward an offender	REACH program (Worthington, 2001)
		Treatment for marital infidelity (DiBlasio, 2000)
Self forgiveness	*Forgiveness of Self* (FOS) scale, Mauger, Perry, Freeman, and Grove (1992) 15 item scale	Compassion focused therapy (Gilbert, 2010)
	State Self-Forgiveness Scales (SSFS) Wohl et al. (2008) respondents' feelings, actions, and beliefs about themselves in relation to a specific wrongdoing	

6.4.1 Facilitating Post-traumatic Growth

Regardless of the type of traumatic events, a growing number of recent findings advocated that similar personal transformations can occur, following a similar process (Tedeschi & Calhoun, 2004). PTG after traumatic events is determined by the interaction between personal resources as well as the environmental ones (Woodward & Joseph, 2003). According to Helgeson et al. (2006), growth does not necessarily reflect the absence of mental health symptoms, however PTG is significantly related to positive well-being measures (Helgeson et al., 2006), and this relationship suggests that perceptions of positive changes may be an indicator of positive mental health in trauma survivors. Thus, PTG may be an important outcome for interventions with individuals exposed to trauma (Prati & Pietrantoni, 2009).

However, other clinicians recommend caution with individuals who have experienced a potentially traumatic event. First, they may not need help. Most of them (50–60%) spontaneously reports positive life changes after an adverse event (Helgeson et al., 2006; Linley & Joseph, 2004), suggesting that this may be a natural process that does not necessarily require clinical intervention. This approach follows the person-centered theory, that posits that human beings have an inner intrinsic motivation toward self-actualization. Accordingly, growth is considered a natural endpoint of trauma resolution, when the social environment provides the facilitative conditions, such as supportive and empathic relationships (Joseph, 2015). PTG indeed shares similar characteristics of psychological/eudaimonic well-being and its presence may *di per se* buffer against trauma and its negative consequences, such as PTSD, depression and other forms of psychological distress (Ryff, 2014a).

Joseph et al. (2012) suggested that in the aftermath of crisis, psychological WB is implicated in the process of assimilation/accommodation to the new trauma-related information. Recovery from trauma, in fact, may be explained as deriving from assimilation of traumatic memory into one's cognitive schema, or as deriving from a revision of existing schema in order to accommodate new and disconfirming information. According to the person centered approach, the process of *growth is embedded in the accommodation mechanism, rather than assimilation* (Joseph, 2015). The latter, in fact, implies that trauma survivors would try to maintain their sense of self and their assumptions about the world exactly as before the negative event. This could be manifested, for instance, in survivors' self-blaming for the event itself: in order to maintain a belief in a just world, where everyone gets what he/she deserves, the survivor may blame himself/herself for what happened, with high distress and emotional costs. Indeed, assimilation may be conceived as a rigid defense mechanism, that leaves individuals more vulnerable when facing future adversities. Conversely, the process of accommodation requires the rebuilding of the assumptions and core schema, following the new reality of the trauma (i.e., negative events occur randomly and are often unfair). Accommodation may have a negative direction (hopelessness, helplessness and depression), but if the traumatized person is able to follow his/her the self-actualizing tendency, accommodation may turn into

positive and the person can reappraise the meaning of the event and its existential implications. Accordingly, the rebuilding of the shattered assumptive world may trigger the individual's PTG (Joseph & Hefferon, 2013)

This process may happen naturally (Joseph, Linley, & Harris, 2004), or may require a specific professional help in order to activate a positive re-experience and confrontation with the meaning of the trauma in one's life. Following a person-centered approach, Joseph (2015) suggested that therapist should act as a facilitator of the clients' organismic valuing process, through the authentic, empathic and unconditional listening of their clients' trauma narratives. Traumatized individuals should be helped in hearing and following their inner voice of wisdom, that will activate a positive accommodation in the aftermath of a trauma. Joseph (2015) also indicated specific therapeutic steps, that may facilitate PTG. For instance, clinicians should stress out the importance of social support, and make specific suggestions to clients in order to help them obtaining an effective supportive system in their living environments. Further, clinicians may plan some exposure activities, or some relaxation techniques, in order to address client's negative or fearful emotions, distress and anxiety symptoms. The characteristics of PTSD symptoms may also be described to clients, in order to normalize their immediate reactions following a trauma. Finally, therapists may also promote new, or diverse coping skills, in order to counterbalance the sense of helplessness and to facilitate the cognitive accommodation. Importantly, Joseph (2015) suggested that the therapeutic process should follow the clients' inner motivation for self-actualization and should not be driven by therapist's values or beliefs. In line with the person centered approach, PTG may be promoted by the empathic assistance of a facilitator (the clinician) that removes the potential obstacles in the clients' organismic valuing process.

On the same vein, Tedeschi and Kilmer (2005) developed a clinical guide to promote PTG, suggesting to integrate this new approach with different psychotherapeutic orientations. Its goal would be to compensate for traditional clinical approaches more focused on the negativity, with greater integration of positive elements of growth and personal development (Tedeschi & Kilmer, 2005). Also in this case, Tedeschi and Kilmer (2005) emphasized the importance of the empathic listening of client's narratives about trauma, which is essential to promote the cognitive process of the event. Similar to the clinical approach described by Joseph (2015), Tedeschi and Kilmer (2005) underlined that the therapist should act as "expert companion" throughout the process of trauma elaboration, and should adopt an attitude of "listening without necessarily trying to solve". For instance, benign positive illusions (such as unrealistic optimism, as descried in Chap. 5 of this book) may serve to help survivors feeling safe and calm after the trauma, and should not be addressed by cognitive restructuring, or other therapeutic techniques. Thus, PTG may be clinically facilitated simply by providing a supportive and protected environment, where survivors may gradually face the negative outcomes of the trauma, and then they may be able to develop a new existential reality. This protocol may be suitable for integration with other well-established therapeutic strategies, such as CBT, counseling or positive psychotherapy.

An example of this integration could be also represented by the Well-being Therapy (WBT; Ruini & Fava, 2012), specifically aimed at promoting eudaimonic well-being according to Ryff's model (Ryff, 2014a, 2014b), which resulted to be promising in treating patients with PTSD (Belaise, Fava, & Marks, 2005) (see Chap. 4 for a full description of WBT). Even though Belaise et al. (2005) did not directly aimed at promoting PTG, they did not address the trauma with standard CBT techniques, or debriefing strategies. Rather, they aimed at improving patients' levels of eudaimonic well-being in the aftermath of a traumatic event, and this process yielded improvements in their levels of anxiety and depression. It was indeed a pilot clinical trial, but findings confirmed the observation that eudaimonic well-being is intrinsically related to positive reactions following adversities.

6.4.2 Facilitating Wisdom

Starting by the observation that feelings like helplessness, powerlessness, anger, and aggressivity are caused by failing to understand why something negative has happened (Tausch, 2004), Linden and colleagues (Linden, 2008; Linden, Rotter, Baumann, & Lieberei, 2006; Linden et al., 2011) developed the Wisdom Psychotherapy to treat the *Post-Traumatic Embitterment Disorder (PTED)*. These authors conceptualized it as a special form of Adjustment Disorder with its own etiology and psychopathological characteristics. PTED arises from a trigger event that is not anxiety-provoking or life-threatening, but is a relatively normal, negative life event (i.e., conflict at workplace, unemployment, death of relative, marital infidelity etc.), which is perceived by the victim as unfair, immoral and unacceptable. A common characteristic of the negative events experienced by patients with PTED is a violation of basic beliefs and values and the psychopathological reaction in PTED (avoidance, rumination, depression and high level of anger) can be explained in terms of a disconfirmation of basic beliefs and values caused by the negative event. The main psychological reaction is a prolonged feeling of embitterment, injustice and helplessness. Its treatment is rooted on cognitive-behavioral models and includes specific sequential strategies to enhance wisdom-related competences.

In Wisdom psychotherapy there is an initial part concerned with problem solving, reframing, change of dysfunctional cognitions, and exposure (Linden & Hautzinger, 2011), followed by specific techniques aimed at teaching and learning wisdom. One of those is the *method of unsolvable life problems*, where vignettes are used to describe severe, unsolvable problems in life, which can happen to everybody, like divorce, death, loss of job, infidelity, etc. Usually, three main characters are involved: (1) The victim, (2) The offender, (3) A third person that has become part of the situation without being intentionally involved. Patients do not get direct help in coping with their personal present problem, rather they exercise their skills through role playing with these characters. Then the patient is asked to imagine how experts for the *management of difficult problems in life* (e.g. manager, priest, elderly

person with much life experience, psychologist, lawyer, etc.) would approach the situation.

By this method patients are taught core wisdom elements like: (a) "factual knowledge and procedural knowledge"; (b) "change of perspective", "empathy" and "emotional serenity" which help to keep a clear mind and not be overwhelmed by one's own emotions; (c) "contextualism", "value relativism" and "long-term perspective" which put the negative event in a broader context of meaning and life development; (d) "uncertainty acceptance" which allows to act without knowing for sure the outcome, and to accept that life is not always following one's wishes and goals. Further, the use of metaphors, aphorisms and proverbs to contextualize problems may also be used.

A recent randomized trial (Linden et al., 2011) has provided evidence of its effectiveness in promoting recovery from PTED and in promoting resilience. Future trials are however needed to generalize these promising results to other traumatic conditions.

6.4.3 Facilitating Forgiveness and Self-Forgiveness

Forgiveness interventions have been discussed in a variety of modalities, including individual, couples, and group. Wade and Worthington (2005) wrote an article that reviews the contents of published interventions designed to promote forgiveness. The review revealed a consensus among applied researchers regarding several broad ingredients to promote forgiveness: (a) defining forgiveness, (b) helping patients remember the hurt, (c) building empathy for the perpetrator, (d) helping patients acknowledge their own past offenses, and (e) encouraging commitment to forgive the offender. A brief description of the main interventions currently available to promote forgiveness is provided below.

Enright group. Enright and his colleagues reported the first empirical investigation of an intervention designed specifically to promote forgiveness: *Forgiveness Therapy* (Hebl & Enright, 1993). They based their intervention strategies on an extensive 20-stepmodel (Enright & Fitzgibbons, 2000) of forgiveness that incorporates cognitive, affective, and behavioral elements (Enright & The Human Development Study Group, 1991). This model describes many possible steps that an injured person might go through before forgiving. The first part of the model (Steps 1–7) describes the importance of identifying psychological defenses, confronting and releasing anger, and realizing the additional psychological pain that the offense has caused (such as shame, unjust suffering, and mental anguish from replaying the event over in one's mind). The victim may experience a "change of heart" toward the offender and may make a commitment to work toward forgiveness (Steps 8 and 9; Hebl & Enright, 1993). Together with the willingness to consider forgiveness as an option for dealing with the offense (Step 10), victims could be helped to see offenders in their life context and to develop compassion and empathy for them on the basis of mitigating situations that may have contributed to the

offense (Steps 10–13). In addition, the individual who was harmed may need to accept or absorb the pain of the offense, which implies sacrificing the psychological benefit that comes through seeking revenge (Step 14). To achieve this, the individual may need to recall times when she or he was the offender and caused other people's pain (Step 15). Doing so helps the victim experiencing changes in affect toward an offender (increasing positive feelings and decreasing the negative ones) and it helps the victim in finding meaning; (Step 16). Finally, the victim could be able to release the burden of unforgiveness (Step 17); gaining the awareness that one is not alone in the experience of being hurt (Step 18). The last steps consist of realizing that the injury may produce a new purpose for one's life (Steps 19 and 20).

A second set of interventions can be grouped together under the theoretical orientation developed by McCullough and Worthington (McCullough & Worthington, 1995; McCullough, Worthington, & Rachal, 1997) and refined into the Pyramid Model to **REACH Forgiveness** (Worthington, 2001). The REACH model delineates five steps to develop forgiveness for a specific harm or offense: participants recall (R) the hurt or offense. Recalling the offense is conducted in a supportive, nonjudgmental environment, with encouragement to remember the hurt (and the associated thoughts, feelings, and behaviors) as fully as possible. The next step of this model encourages participants to build empathy (E) for the offender. Empathy is developed through different exercises and discussions that assist the participant in seeing the situational factors that led to the hurt. Empathy continues through the next step, giving an altruistic (A) gift of forgiveness (see Chap. 7 of this book for a further discussion on altruism). Before the idea of giving a gift of forgiveness is presented, participants remember times when they received forgiveness for hurts that they caused to other people. Participants are encouraged to remember what it felt like to be forgiven. In the fourth step, participants publicly commit (C) to the forgiveness they have experienced for the offender. Committing to forgive is linked to holding (H) on to forgiveness or maintaining the gains achieved.

These two interventions have been widely used in community settings, together with other preventive and educational campaigns on forgiveness (Fincham & Kashdan, 2004).

Among the marital settings, **Forgiveness Therapy** (FT) has been applied to abused women and yielded important results. FT, in fact, assists the emotionally abused woman to examine the injustice of the abuse, to consider forgiveness as an option, to make the decision to forgive, to do the hard work of forgiving (to grieve the pain from the injustice, to reframe the wrongdoer, to relinquish resentment, and to develop goodwill). Also in this case the last steps of this protocol consist of finding meaning in the unjust suffering, and in discovering psychological release and new purpose.

Seagull and Seagull (1991) described an obstacle to recovery for emotionally abused women labeled *accusatory suffering*, which entails maintaining resentment and the victim status. The assumption in accusatory suffering is that healing the wounds of the abuse will somehow let the perpetrator off the hook. At a deeper level, accusatory suffering may be seen as a defense against the fear that the woman is somehow responsible for her own victimization, a fear that is often inculcated by

the victimizer (Sackett & Saunders, 1999). Seagull and Seagull (1991) argued that although accusatory suffering (resentment and victim status) may function as a temporary strategy to help the woman adapt to the extreme experience of spousal emotional abuse, it seriously hinders substantial post-relationship, post-crisis recovery. By contrast, FT supports the patient in appropriately expressing anger about the abusive relationship and grieving the pain from the abuse. Furthermore, it specifically targets the debilitating resentment toward the former abusive partner and explicitly targets this pattern of accusatory suffering.

Within the marital therapy, DiBlasio (2000) presented a decision-based definition of forgiveness that paved the way for an immediate intervention in *marital therapy for infidelity*. A step-by-step strategy was developed. It is aimed at making a forgiveness decision in the beginning of marital treatment possible. Decision-based forgiveness is defined as the cognitive letting go of resentment, bitterness, and need for vengeance. Consequently, couple can choose to forgive or not to forgive. This approach may be part of a standard cognitive-behavioral approach. Patients reported a significant reduction in negative emotions after deciding to forgive. The actual forgiveness session in this protocol is usually lengthy (2 or 3 h) and includes 13 steps. The steps are organized into three sections: defining and preparing (Steps 1–3), where the therapist explains that forgiveness is an opportunity to create goodwill between spouses and a sense of peace within oneself. Subsequently, the therapy concentrates on seeking and granting forgiveness (Steps 4–12), where each partner has an opportunity to seek forgiveness, and the one who was offended may grant or withhold forgiveness. After the offence has been formally stated (step 4), the offender provides explanations and then questions are raised and answers given about the offense (step 6). In Step 7 the offended person gives emotional reactions followed by the offender who provides empathy for the hurt he or she caused (step 8) and develops a plan to stop/prevent behavior (step 9). In Step 10 the victim identifies with the offender's hurt, and an emphasis is placed on choice and commitment in letting go. Finally (Step 12) a formal request for forgiveness is made, and a ceremonial act (Step 13) as symbolic expression that the offense has been formally forgiven is planned and performed. Di Blasio approach has been found to be particularly effective in repairing marital infidelity and in giving partners a second chance for marital satisfaction.

When it comes to self-forgiveness, a critical therapeutic ingredient is *self-compassion*, which consists of three main domains: (a) being kind and understanding toward oneself rather than being self-critical, (b) seeing one's fallibility as part of the larger human condition and experience, rather than as isolating, and (c) holding one's painful thoughts and feelings in mindful awareness rather than avoiding them or over identifying with them (Neff, 2003). Patients with anorexia nervosa, obsessive-compulsive disorders and obsessive-compulsive personality disorders have severe difficulties in developing self-forgiveness. If clinicians promote self-compassion, then self-forgiveness could have good chance of being developed.

A specific psychotherapy aimed at increasing self-compassion has been recently proposed. ***Compassion focused therapy*** (CFT) is a multimodal therapy that builds on a range of cognitive-behavioural (CBT) and other therapies and interventions.

Hence, it focuses on attention, reasoning and rumination, behaviour, emotions, motives and imagery. CFT is based on an evolutionary-neuroscience approach. It was developed with and for people who have chronic and complex mental-health problems linked to shame and self-criticism, and who often come from difficult (e.g., neglectful or abusive) backgrounds (Gilbert, 2010). According to Gilbert (2010) people have "threat mind" if their threat-protection system is active. This will influence their feelings and motives, what they attend to, what they think about and how they think about it, their behavior, their images and fantasies. In contrast, a compassionate mind can organize their minds in different ways: compassionate attention, compassionate thinking, compassionate behaviors, compassionate feelings, compassionate motives and compassionate imagery and fantasies, that are quite different from threat-focused ones. The goal is helping patients to move from threat mind to compassion mind using different strategies such as: cognitive restructuring, role playing, compassion focused imagery, mindfulness, behavioral experiments, exposure, graded tasks, enactment of different selves, learning emotional tolerance, learning to understand and to cope with emotional complexities and conflicts, making commitments for effort and practice, illuminating safety strategies, and mentalizing forgiveness (Gilbert, 2010).

Preliminary findings suggest that this CFT has positive effects on patients with eating disorders, panic attacks, obsessive compulsive disorder, body dysmorphic disorder and depression (Gilbert & Irons, 2004). Pauley and McPherson's investigation (2010) explored the meaning and experiences of compassion and self-compassion for individuals with depression and anxiety. Participants reported that they thought having compassion for themselves yielded meaning in their experiences and was useful in helping with their depression or anxiety. Compassion Focused Therapy for Eating Disorders (CFT-E) has been developed as a transdiagnostic approach to eating disorders, specifically to address affect regulation difficulties, shame, self-directed hostility, and pride in eating disordered behaviors (Goss & Allan, 2010). These results are indeed promising, considering the pervasiveness of eating disorders. They all need to be further confirmed in future studies.

6.5 Conclusions and Therapeutic Recommendations

The integration of positive psychology in the psychotherapeutic room (see Chaps. 1 and 4 of this book) has raised wide variation in the response of clinical researchers and practitioners, ranging from enthusiastic acceptance, wary openness, and vigorous opposition. These issues appear to be particularly crucial when it comes to the promotion of post-traumatic growth, forgiveness and wisdom, as a "positive treatment" for trauma and interpersonal injuries (Coyne & Tennen, 2010). In fact, explicitly addressing these issues in therapy may be therapeutic in its own right because it permits open discussion, provides information about the patient and the offense, and can lead to healing.

On the other hand, therapists must exercise caution when addressing forgiveness, PTG and wisdom explicitly with their patients. Because these issues are normally addressed in religious convictions, or in ethic and cultural norms (particularly in Western cultures dominated by Christianity), broaching the topic in therapy might invoke *feelings of moral responsibility* in some patients, or the sense of being pressured or judged by their therapists. Patients who are struggling with the emotional and relational aftermath of serious offenses, in fact, might perceive a moral failure (i.e., "I should forgive and I am not able to; therefore there is something wrong with me"). In worse case situations, not only might the therapeutic relationship be damaged, but the patient might be further victimized as well (Murphy, 2002). Thus, when deciding whether to explicitly address forgiveness, or PTG, or wisdom, therapists should be particularly sensitive to patients cultural or religious framework, as well as to their clinical status. At the same time, practitioners should always be aware of their own moral and ethic concerns, and may require specific supervision if these are in conflict with those of their patients.

The issue of a *proper timing* during the course of the therapy should also be considered. PTG, forgiveness and wisdom, as described in the previous pages, are difficult emotional/cognitive and motivation processes that require time to appear in traumatized individuals. Thus, they should not be explicitly addressed at initial phases of treatment, when patients are still overwhelmed by distress and symptoms, to leave room for positive reactions to be triggered or even to be accepted. Conversely, if a sense of growth and the motivation to forgive appear quite early in the course of treatment, clinicians should be warned on their illusory nature. In fact, they may serve as defense mechanisms (denial) and hamper any real process of healing from the traumatic event (see Chaps. 2 and 5 for a more detailed description of possible defense mechanisms associated with positivity).

Coyne and Tennen (2010) also questioned whether post traumatic growth is even something that can be defined and promoted, given that people can't really quantify their own growth and even if they could, they couldn't really identify how much to attribute to their experience with trauma. Authors suggested that interventions based on these assumptions are being developed on scant science. Indeed Tedeschi and Calhoun (2004) warn on some points: for many trauma survivors PTG and distress often coexist. Thus, it is important to focus on these positive issues not at the expenses of the empathy for the pain and the suffering of trauma survivors: PTG is neither universal nor inevitable, and clinicians should not give it for granted. Neither should they expect trauma survivors to experience these positive reactions for considering them recovered. Similarly, some authors suggest that PTG, forgiveness and wisdom may be end goals that patients reach late in therapy, or on their own after therapy, or not at all (Wade, Johnson, & Meyer, 2008).

In any case, in clinical settings these issues should be explored considering patients' benefits in terms of emotional, relational and psychological well-being, rather than from societal (or therapist's) point of views.

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Chapter 7
Love, Empathy and Altruism, and Their Clinical Implications

"Being deeply loved by someone gives you strength,
while loving someone deeply gives you courage."

Lao Tzu

Abstract The focus of this chapter is on positive interpersonal relationships, from couple to parenting, to therapeutic alliance and finally to altruism. The final message is that from significant dual relationships (such as marriage and parenting) to larger social interactions, it seems that human beings are capable of bonding together and helping each other. More interestingly, these capacities are deeply embedded in our brain, where specific circuits make us able to feel empathy and sympathy for other human beings. Psychotherapy and healing settings could be considered ideal places to observe and promote these phenomena. The majority of clinical problems are in fact concerned with impairments in social functioning. Psychologists, social workers, and practitioners could help their clients to develop empathy, compassion, and altruism. This would improve their patients' social functioning and, in turn, this may trigger a process of maturation and growth, connected to resilience and to a better recovery from their disorders. Importantly, these benefits could be extended to therapists and clinicians as well, throughout the process of vicarious resilience and vicarious growth.

7.1 Well-Being in Couples and Families

From a historical point of view, psychological research focused on the dark and negative side of human behaviors, investigating problems, symptoms, negative affectivity and neglecting resources and positivity (Ryff, 2014). This approach concerned also close and intimate relationships.

Indeed, when studying close and intimate relationships, many studies have examined how couples respond to each other's misfortune, problems, or bad relational behaviors, but little is known about how partners respond to each other's positive events, and how they share these positive events (Gable & Haidt 2005).

The importance of positive relationships is nowadays well established (Ryff, 1989, 2014). Ryff's psychological well-being model postulates that the presence of

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positive relations with others may play a key role in promoting both psychological and physical health (Ryff, 2014). Many Positive Psychology researchers demonstrated that the most significant ingredients for living a completely satisfying and even healthier life, are positive intimate relationships, and positive emotions (Greenberg & Goldman, 2008; Reis & Aron, 2008). The exploration of how positive relations and relational variables (satisfaction, intimacy, sexual desire, etc.) may correlate to each other and how they influence and may be influenced by hedonic and eudaimonic well-being represents an important new area of research. These issues may help clinicians to develop specific tools for promoting happier and healthier couples and family.

Married people seemed to be happier than those who are not married (Lucas & Clark, 2006) but Stutzer and Freya (2006) found large differences in the benefits from marriage between different kind of couples. For instance, research showed a positive association between marital status and subjective well-being, but a recent longitudinal study pointed out how happiness may drop after a childbirth. Satisfaction appeared to be higher before couples have a child and when their children leave home, because they are at lower risk of being involved in conflicts on child management (Schulz, Cowan, & Cowan, 2006).

Considering personality, Shiota and Levenson (2007) found that greater overall personality similarity (especially on conscientiousness and extraversion among midlife and older sample) predicted more positive marital satisfaction trajectories. A meta-analysis that included 19 samples with a total of 3848 participants (Malouff, Thorsteinsson, Schutte, Bhullar, & Rooke, 2010) showed that low levels of neuroticism, together with high levels of agreeableness, conscientiousness, and extraversion correlated significantly with relationship satisfaction.

Happier couples were found to display peculiar belief systems and interactive patterns (Carr, 2002; Gottman, Levenson, & Carstensen, 1993; Harvey & Wenzel, 2001) that were characterized by a positive combination of respect, acceptance, dispositional attributions for positive behaviors (McNulty, James, O'Mara, & Karney, 2008), and more positive than negative interactions (5 positive interactions out of 1 negative ones). They also tended to focus argument on specific issues, to rapidly repair breaches, to manage different male and female conversational styles (problem focused versus emotion focused, respectively), and to address needs for intimacy, power and forgiveness (Maio, Thomas, Fincham, & Carnelley, 2008). These characteristics of positive couple functioning, derived from recent research in positive psychology may have a crucial importance in complementing standard intervention for repairing couple maladjustment, as described in the next sections of the chapter.

7.1.1 Love Styles and Positive Relationships

Historically, many love theories and psychometric scales have been developed and tested. They were based on different psychological approach (e.g., psychodynamic, cognitive, systemic, etc.) and each of them focused on different aspects (Berscheid,

1994; Clark & Mills, 1979; Kelley & Braiker, 1979; Rubin, 1970). Some of the most well established ones may represent the epistemological basis upon which positive psychologists have recently based and developed innovative strategies to promote personal and couples optimal functioning and well-being (Lee, 1977; Sternberg, 1997).

A pivotal central model of love and couple positive functioning is the one formulated by Stemberg. Sternberg's *Triangular Theory of Love* (Sternberg, 1986, 1997) conceived love as the result of the combinations of three components: intimacy, passion, decision/commitment. They interact and can form a number of different types of loving experiences. Although all of them are crucial aspects within a relationship, their importance can change in different relations and in different moments and life stages. For instance, romantic love may result from the combination of intimacy and passion, whereas the combination of intimacy and commitment describes a companionate form of love. Importantly, a relationship characterized by one component only is considered somewhat unsatisfactory and problematic. Conversely, the balanced expression of all the three components represent an ideal love relationship. This theory provided a comprehensive basis for understanding many aspects of couple love.

Lee's theory of love appeared to be one of the most accredited (Lee, 1977). He described love in terms of personal "*love styles*": Eros, Ludus, Storge, Pragma, Mania, and Agape. Each of these styles is characterized by different ingredients (respectively passion, fun, friendship and similar interests, practical support and common goals, desire to hold one's partner and to be unconditionally loved, altruistic and selfless love).

Another important scientific approach to love was the one proposed by Susan and Clyde Hendrick (1986, 1989). Based on Lee's theory, they developed and validated the *Love Attitude Scale*, a 42 item self-report scale, which investigated the six main love styles (Eros, Ludus, Storge, Pragma, Mania, Agape). Gender differences in these love styles were documented. Accordingly, men appeared higher in Ludus, and women in Storge, Pragma and Mania; Eros correlated to couples satisfaction and this relation was not influenced by age, gender or sex (Hendrick & Hendrick, 1986). Hendrick and Hendrick (2002) found that love was more important than sex in couples, but its lack was predictive of lower relational involvement. In a subsequent research, Hendrick and Hendrick (2002) observed a negative association between neuroticism and relationship satisfaction, that for females was completely mediated by possessive, dependent love (Mania and Agape Styles). Extraversion and agreeableness, which correlated positively to Eros, positively associated with relational satisfaction and intimacy, especially for males. Conscientiousness positively related to Eros, Storge, Pragma and intimacy for males and negatively to Ludus.

Sprecher and Hendrick (2004) found positive correlations between individuals who were higher in self-disclosure and higher levels of self-esteem, relational-esteem (confidence with and intimate partner) and responsiveness. Self-disclosure was also positively associated with relational satisfaction, love, and commitment. With a longitudinal study, they found that a higher perception of partners' self-disclosure associated with lower risk of later breakups.

Thus, self-disclosure appeared to promote positive affects and to serve as a maintenance strategy. Mitchell et al. (2008) confirmed the importance of self-disclosure and empathy for intimate feelings, but the way through which they influence intimacy differed according to gender. In particular, men's disclosure and empathy predicted their personal feelings of intimacy, whereas women's intimacy was predicted by their partner's disclosure and empathic responding.

These findings may provide clinician with a useful map to investigate love styles and communication pattern in distressed couples during marital therapy.

7.1.2 Hedonic Well-Being and Marital Satisfaction

Based on Fredrickson's Broaden and Build Model of Positive Emotions (Fredrickson, 1998; Fredrickson & Joiner, 2002), which suggested how positive emotions could create coping resources and life satisfaction by building resilience, Gable found that experiencing and sharing positive events with others was associated with increased daily positive emotions, well-being and health, above and beyond the impact of the positive events itself and other daily events (Gable, Reis, Impett, & Asher, 2004; Ryff, 2014). Gable and colleagues focused on active and constructive responses to intimate friends and partners' positive events and good fortune, and called this process as *capitalization* (Gable et al., 2004). This constructive capitalization was associated with more commitment, relational satisfaction, love and less break-ups compared to what happened when partners used to discuss about negative events (Gable, Strachman, & Gonzaga, 2006). Since sharing positive events is generally more pleasant and people prefer speaking about them, partners are supposed to better memorize them and, as a matter of fact, their impact on their well-being is stronger. An enthusiastic reaction to a positive event may enhance gratitude, trust, feel of connection and encourage sharing more amusing and relaxing activities (Gable et al., 2004). Men have been found to expect these kinds of responses regardless of the importance of the events, whereas women only for meaningful events. In Gable's studies, capitalization resulted to be the unique variable that was able to distinguish couple that remained together from those that separated.

Similarly, Gottman et al. (1993) documented that the expression of positive affects during a conflict, as humor and glow, was the only variable that was able to predict both couple stability and satisfaction 6 years after marriage. According to Driver and Gottman (2004) the way through which couples respond to their daily and ordinary moments may cumulatively contribute to marital satisfaction, creating a foundation upon which the major, more memorable events unfold. This study was in line with Fredrickson's model of positive emotions (Fredrickson & Joiner, 2002) that suggested how positive affect may be cultivated over time, thanks to a series of enjoyable events. Thus, Driver and Gottman (2004) suggested adapting marital interventions for improving daily life. Indeed, couples build intimacy through hundreds of very ordinary moments in which they try to make emotional connections and to improve their intimacy, satisfaction, and happiness.

Gottman, Coan, Swanson, and Carrere (1998), Gottman and Levenson (1999) investigated the possible predictors of divorce also. One of the most important is represented by coping strategies used in dealing with problems. In particular, through a 14-years longitudinal research, these authors created a two factor model, which can predict the marriage's length. The more critical periods for divorce resulted after 7 years and after 14 years when sons are supposed to be adolescents and the relational satisfaction between partners may collapse (Gottman & Levenson, 2002). Gottman identified two main dysfunctional affective strategies that couples adopt to cope with conflicts: an emotionally disengaged strategy that is devoid of positive affect (either during conflict or when discussing the events of the day) and an attack-defend modality during arguments. Both of them resulted to be associated with marital dissolution: the latter earlier in time, the former later in time. Belas (2008) confirmed that the most common causes of divorce depend on an increased distance and a reduced friendship between partners.

According to Gottman and Levenson (1999), elderly couples showed more positive affects and more ability to gain joy and pleasure from a larger number of arguments. This greater positivity appeared to be associated with less somatic symptoms, with lower irritability, and better health profiles (Levenson, Carstensen, & Gottman, 1994; Ryff, 2014).

7.1.3 Positive Parenting

In the framework of Positive Psychology, recent interventions based on the promotion of positive emotions and positive communication styles appeared to be efficacious at promoting positive parenting roles and consequently, both parents' and children's well-being. A robust body of investigation in fact, has evidenced that the most important factors associated with children, youth and adults' happiness are some specific dimensions such as love, hope, and optimism experienced in their families (Park, Peterson, & Seligman, 2005; Snyder & Lopez, 2007). Thus, treatments aimed at fostering these issues resulted to be protective for both children and parents' well-being and to promote personal and interpersonal resources (Bodenmann, Cina, Ledermann, & Sanders, 2008; Gottman & Levenson, 2002; Schulz et al., 2006). These interventions are mainly based on psychoeducation and focused on teaching parents the importance of cultivating well-being and positivity inside the family. These aims are addressed by using constructive communication style, by sharing and capitalizing on positive events and by successfully negotiating conflicts and roles' functioning. They were found to be helpful in vulnerable period for the couple, such as during the perinatal phase, since they protected parents from the possible decrease of marital satisfaction, and reduced their psychopathological symptoms (Bodenmann et al., 2008; Gottman & Levenson, 2002; Schulz et al., 2006).

Interventions focused on positive parenting and on promoting parental warmth appeared to be effective also for buffering children from the detrimental effects of

harsh physical discipline, which appeared to be associated with later behavioral problems (Stolk et al., 2008).

Furthermore, positive parenting interventions were able to help adolescents to strengthen their identity maturation and psychological growth (Sanders, Kirby, Tellegen, & Day, 2014).

In sum, positive psychology may provide a contribution through the stimulation of resources and competencies of partners and parents, which could potentially limit negative consequences of stressful events, such as miscarriage, abortion, separation, divorce, relocation, economical crisis, diseases, disabilities and premature death, among others.

7.2 Positive Psychology and Positive Couple Therapy

Many well-established and validated couple therapy approaches, such as Cognitive Behavioral Therapy (Epstein, Baucom, & Rankin, 1993a; Fincham, Bradbury, & Beach, 1990; Gottman et al., 1993; Margolin & Weiss, 1978), Emotion Focused Therapy (Gottman et al., 1998; Johnson, 2007), Problem Centered Systems Therapy of the Family (Bishop, Epstein, & Levin, 1978) have been found to effective in treating couple and family distress, mainly by focusing on solving problems and reducing symptoms.

An important exception from this medical model based on distress and dysfunction was represented by the *McMaster Model of Family Functioning* (MMFF; Epstein, Baldwin, & Bishop, 1983). Indeed, it was developed in clinical settings, with a twofold aim of assessing and enhancing positive dimensions and strengths of family functioning, together with reducing family dysfunctional patterns (Epstein et al., 1983). Clinicians should first identify the family functioning in the most important domains (Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, and Behavioral Control) and then help family members to negotiate changes and improve these skills (Miller, Ryan, Keitner, Bishop, & Epstein, 2000). Thus, this model was developed and applied in psychiatric settings (mainly with depressed patients and their families), but it included the evaluation and promotion of healthy family function as an ingredient for recovery.

The dimensions of MMFF could be compared and integrated with many of those of eudaimonic well-being (see Chap. 1 of this book). Problem solving and communication skills, the number and characteristics of playing specific roles, affective communications and responsiveness, affective involvement, and behavioural control appear to mirror the interpersonal counterpart of the eudaimonic well-being dimensions of environmental mastery, positive interpersonal relationships, autonomy, and purpose in life as illustrated in Table 7.1. For the promotion of an optimal family functioning and individuals' well-being, both these models and both their dimensions should be considered as roadmaps and should be integrated in family therapeutic protocols (see Table 7.1).

Table 7.1 Positive family models

	McMaster model of family functioning	Eudaimonic well-being model
Theoretical approach	Systemic and cognitive-behavioural	Eudaimonia, positive relations
Dimension of family functioning	Problem solving	Environmental mastery
	Behaviour control	
	Communication	Positive relationships with others
	Affective responsiveness	
	Affective involvement	Purpose in life
	Roles	Autonomy
Therapy	Problem-centered systems therapy of the family	CBT + well-being therapy

Similarly, Positive Psychology may provide strategies to strengthen couple and family resilience. Indeed, at an individual level positive interventions may help individuals in recognizing and expressing their personal resources such as self-esteem, environmental mastery, self-acceptance, hope, optimism and many other traits, whereas at a relational level they may be useful for promoting emotional comprehension and expression, sympathetic, communication skills and reciprocal support (Gable & Haidt, 2005; Gottman et al., 1998).

In this framework, de Fátima Perloiro, Neto, and Marujo (2009) aimed at enhancing optimal couple's functioning using positive psychology concepts and strategies. They developed a therapeutic protocol model characterized by specific ways of questioning and specific time dimensions (past, present, future). Questions are based on three concepts:

(a) Questions that introduce positive information (e.g. "What is your biggest strength as a couple?");
(b) Questions that induce the search for solutions (e.g. "What does your wife has to do in order to make you happy?");
(c) Questions that follow appreciative inquiry characteristics—being positive, provocative, applicable, collaborative and motivated to identify the best qualities of the couple (e.g. "Tell me about a moment when you both felt you were an exceptional couple").

A specific focus on time dimensions is also included: the past, the present, and the future of the relationship. Authors created a group of questions devoted to different time periods of the relationship, to explore and improve partners' affiliation:

(a) considering past, the work could be centered on gratitude to help couple to feel connected and thankful for their shared experiences ("Think about the moments when you were dating: What are you proud of saying/doing at those moments?"; "How these years as a couple made you grow as a person, even when experiencing more troubled times?");

(b) considering present, therapists could enhance couple's savoring of positive moments and maintaining an optimistic view of their current shared experiences (following Seligman's explanatory style research, as described in Chap. 5 of this book);
(c) when working on future, therapists could develop hope for the future of the relationship (following Snyder's model of hope, with its related concepts of agency and pathways, as described in Chap. 5 of this book).

The model appeared to be clinically helpful for couples in promoting a more positive communicative style focused on optimism and hope, but any controlled trial is available, up to date.

Similarly, Balancho and Marujo (2006) developed a positive preventive program in order to promote family's well-being and happiness in Portugal. The program used teleconferences and internet-chats with experts in order to get in touch with each family from different countries and reduce problems in participation. This project provided families with scheduled exercises aimed at developing individual, relational and parental skills linked with happiness, optimism, hope, and creativity, as much as at creating more pleasurable, positive, and efficacious emotional climates and communicational patterns within the family. Also children were involved and provided with weekly happiness focused assignments. The preliminary results confirmed the feasibility of this virtual training and these new technologies as a frame for creative and innovative psychological interventions to collectively create and increase happiness, positive emotions, and well-being directly in the family context.

Based on previous systemic approach and positive psychology research, Conoley and Conoley (2009) proposed a model of *Positive Family Therapy*. This approach aimed at involving each family member in the construction of a new family context in which everyone can recognize and accept a responsibility for himself/herself and for his/her family's success. The family unit, whatever it is, may progressively create and transmit a "shared culture" that shapes and changes single individuals. This shared knowledge, which is made of shared culture, talents, enjoyed activities, is the family's strength, that may play a crucial role in promoting family's growth. During the sessions, family members are asked to contribute and remind that they may always make a difference in the family's development, recognizing, and applying their strengths. Families' goals are common: they should provide nurturing environments, communicate and preserve values and virtues, and help each family member to reach an optimal level of personal attainment. When family members behave according to these common goals, improvements begin to appear. Statements with positive thoughts, positive behaviors, or expression of positive feelings are accentuated through restatement, deeper questioning, or thanks to the involvement of other family's members. Negative thoughts, feelings, or behaviors are noted but not celebrated and rewarded, and, finally they are actively avoided. During sessions partners are encouraged to plan and pursue goal-oriented actions. Each person should have a role in the goal-oriented actions, have some benefits and have to monitor the process and the outcome. According to this protocol, the change is promoted by

building new goals, using new skills and positive feelings. Harm, blame, and useless discussions are in general minimized by actively interrupting and structuring the process (Conoley & Conoley, 2009). The outcome of a successful Positive Family Therapy should be the feeling of happiness of every member of the family (Conoley & Conoley, 2009).

More recently, Worthington et al. (2015) compared two positive interventions for early married couples: one was focused on positive communication and effective problem solving (HOPE), another one on forgiveness and reconciliation with empathy (FREE). The former HOPE (= Handling Our Problems Effectively) integrated behavioral techniques with problem-focused family therapy and solution-focused therapy and was delivered for a total of 9 h. In this protocol married couple were first assessed in their standard communication styles and problem resolution skills. Then, with a preventive purpose, they were explained that it is better to learn strong communication and conflict resolution skills early in the marriage. This would maintain the marriage satisfaction higher and would prevent serious and long lasting discussions later in time. At the end of the protocol, couple received a clinical report with assessment data and recommendations for improving their marriage (Worthington et al., 2015). The second protocol (FREE), combined forgiveness and reconciliation with the dimension of empathy (see next paragraph of this chapter). Participants were explained that forgiveness is a vital ingredient for happy marriages and they were taught to forgive using the five steps to the REACH Forgiveness (described in Chap. 6 of this book). Each Partner practiced using a past event, and then applied the method to the transgressions in their current marriage. Also in this case the protocol had a duration of 9 h. Both FREE and HOPE programs produced lasting positive changes in communication styles, and in empathy. They also moderately reduced cortisol reactivity, as indicator of stress within the marriage. Thus, as described in Chap. 6 of this book, when individuals are trained to forgive their partners through their empathic understanding, they trigger benefits both at interpersonal (couple) and at subjective levels.

Other important findings concerning empathy are described in the following sections.

7.3 Empathy in the Psychotherapy Room (Vicarious PTG, and Clinicians' Well-Being)

7.3.1 Empathy

As described in the previous lines, human relationships are often built on the capacity to understand and match another person's emotions. This is one of the definitions given to "*empathy*". It has been defined also "as accurately perceiving the internal frame of reference of another" (Gold & Rogers, 1995, p. 79), and includes affective and cognitive components (Zahn-Waxler & Radke-Yarrow, 1990). The former

refers to the concept of empathic emotions also known as *emotional contagion* (i.e., perception of other's welfare and internal state and/or feeling as another person feels). The cognitive component of empathy refers to the accurately imagining or intuiting how another person would feel in a specific situation (intellectual empathy) (Batson, Ahmad, & Lishner, 2002). Both components are considered essential ingredients in intimate relationships, as well as in developing therapeutic alliance in clinical settings.

As a matter of fact, empathy was found to be strongly associated to attachment, and this was recently confirmed by findings in the neuroscience. They documented specific *brain circuits* activated during social interactions. These circuits include the mirror neurons as well as the anterior insula, dorsal anterior cingulate cortex, the anterior midcingulate cortex, supplementary motor area, amygdala, brainstem preoptic area of the thalamus, and periaqueductal gray matter (Coutinho, Silva, & Decety, 2014), suggesting that empathy and the capacity of building significant social interactions are widely embedded in human brains. Further, it emerged that empathic people may manifest an increased level of autonomic arousal that tends to mirror the other person's internal state (synchrony in autonomic response), that could be considered a physiological component of empathy.

Coutinho et al. (2014) suggested that these biological correlates of empathy may entail important implications in the psychotherapy room. First of all, the majority of psychological disorders are characterized by impairments or distortions in social functioning and empathic capacities (i.e., depression, social phobia, paranoia, autism, antisocial and narcissistic personality disorders). Thus, in order to address these clinical phenomena, the therapeutic relationship should correct these impairments through the empathic process. In the clinical settings it may change the therapist and the clients' mind set, via activation of the mentioned brain circuits and related physiological arousal (Coutinho et al., 2014).

Apart from these recent discoveries, as early as 1954, Rogers and Dymond (1954) considered empathy to be one of the several "necessary and sufficient conditions" of psychotherapeutic change and defined it as: "*to sense the client's private world as if it were your own, but without ever losing the 'as if' quality*". Together with therapist's congruence and unconditional positive regard for the client, empathy is considered a core ingredient of the person-centered approach. Empathy, in fact, is central in the therapeutic work since it allows the understanding of the client's frame of reference, and consequently, his/her behavior. According to Rogers and Dymond (1954) all psychotherapies could be considered effective if the necessary and sufficient conditions are met. More recently, Joseph (2015) articulated this concept and suggested that psychotherapists' training should devote more attention to their personal attitude, to their ability to listen and understand empathically other people, rather than focusing on specific techniques for addressing symptoms. According to this perspective, essential to the good outcome of interventions, are the therapist's qualities in terms of empathy and congruence, rather that his/her own technical education (Joseph, 2015, p. 61). Similarly, the three core conditions of the person centered approach (congruence, unconditional positive regard of the client and empathy) have been considered essential characteristic of the virtuous therapist,

according to a neo-Aristotelian concept of virtue (Robbins, 2015). In fact, when empathy is associated with the other core conditions, a positive setting for interpersonal healing could be created.

Even outside the person-centered approach, a converging line of research in the psychotherapy domains confirmed empathy as one of key ingredients of treatment efficacy (Wampold & Imel, 2015). In fact, more empathic therapists were found to develop a stronger alliance with their patients, and resulted to be more effective in triggering improvements in their clients, compared to less empathic therapists (Moyers & Miller, 2013; Watson, Steckley, & McMullen, 2014). Empathic counselors were also perceived as more competent by their patients (MacFarlane, Anderson, & McClintock, 2015).

Coutinho et al. (2014) recently reviewed the concept of empathy in the counseling domains, and considered it a "dynamic process by which one infers the affective state of another person and experience a similar state in ourselves, while at the same time keeping a distinction between the self and the other". They described *empathic bottom-up components*, linked to the emotional contagion between therapist and patient's distress, but also *top-down components*, related to the process of therapist's mentalization and the ability to self-regulate his/her own emotions. Considering the biological correlates of empathy described before, Coutinho et al. (2014) also underlined the physiological and cognitive costs that clinicians pay as a result of being empathic, and suggested several strategies to deal with these costs (for instance, a proper clinical supervision, the use of mindful techniques to down regulate therapist's stress autonomic response, devoting time and attention to clinician's well-being etc.).

However, recent research deriving from positive psychology domain, suggested a shift of perspective in investigating empathy in therapeutic settings. First of all, Conoley et al. (2015) described a positive form of empathy (**Positive empathy**) and suggested that it may be even more powerful in determining patients' positive outcomes. While traditional empathy focuses on negative or difficult emotions shared by therapists and clients, positive empathy focuses on the message of desire hidden within a client's communication, and is hypothesized to facilitate the client's experience of positive emotions, the identification of significant goals and the identification of personal strengths. The Authors compared the effect of traditional versus positive empathy and found out that both were associated with the same amount of empathic understanding, but the latter triggered more positive emotions and stimulated more statements of approach goals and strengths in clients. Even if these findings are preliminary, they introduce a new therapeutic ingredient, worth of further inquiries.

However, it could be hypothesized that the process of positive empathy could be directly related to other positive dynamics associated to health care professions , such as those described in the next paragraphs. They all deal with the benefits of sharing meaningful relationships. Thus, traditional empathy is an essential component of helping relationships, but it could expose practitioners to negative feelings, mental and physical exhaustion. Conversely, a new perspective, deriving from positive psychology, has opened new trajectories that connect empathy to positive

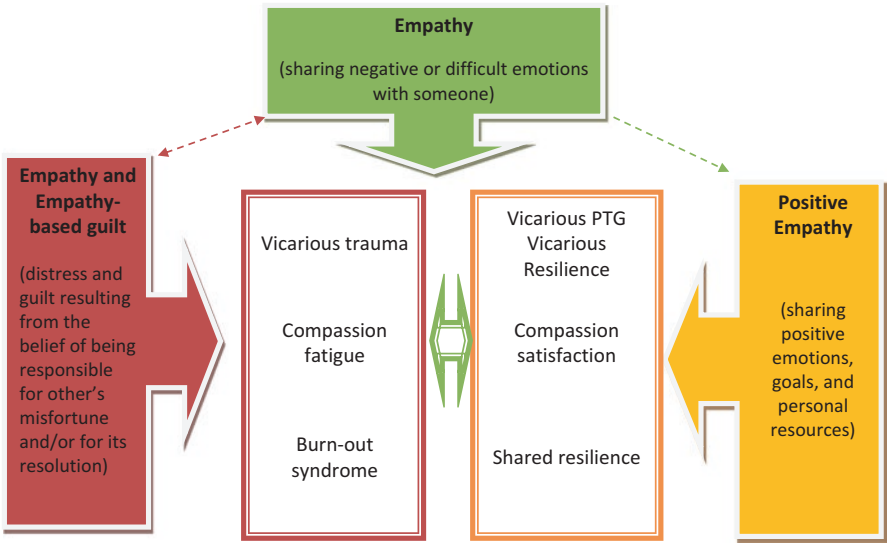

Fig. 7.1 Empathy, its nuances and its consequences (positive and potentially negative)

outcomes in the therapists as well, such as vicarious growth, resilience and compassion satisfaction. The process is described in Fig. 7.1 and in the subsequent paragraphs.

7.3.2 Vicarious PTG and Vicarious Resilience

A second shift introduced by positive psychology research in the therapist's empathy literature concerns the concepts of *vicarious post-traumatic growth (V-PTG), vicarious resilience and compassion satisfaction*. They can be conceptualized as processes of psychological growth and maturation derived from an indirect exposure to traumatic events and narratives.

Vicarious PTG was originally manifested in individuals employed in helping professions, such as those working in the mental health field (Herman, 1995). It can be viewed as a juxtaposition to the conditions of burnout (Maslach & Goldberg, 1999), compassion fatigue (Figley, 2002), and vicarious trauma (Pearlman & Saakvitne, 1995) often reported in health care professions. Herman (1995) reported that clinicians indirectly exposed to trauma narratives developed a better understanding of themselves and others, more compassion, new relationships and more appreciation of life. Similarly, Arnold, Calhoun, Tedeschi, and Cann (2005) found that, as a result of their work with trauma survivors, clinicians presented gains in sensitivity, compassion, insight, tolerance, empathy, and interpersonal relationships. Other qualitative investigations described in the following pages documented how the empathic skills of clinicians working with traumatized individuals lead

therapists to experience psychological distress, ruminations, and intrusions, but, thanks to their metacognitive abilities (Coutinho et al., 2014), they finally developed growth and maturation in the same area reported by traumatized patients (see Chap. 6 of this book).

However, Cohen and Collens (2012) criticized the lack of theoretical models explaining how the phenomenon of vicarious PTG occurs. In attempts to provide such explanation, Hyatt-Burkhart (2014) interviewed 12 mental health individuals working with traumatized children and adolescents. They all reported some level of personal growth as a result of being exposed to the post-traumatic growth of children. In particular, participants became more open-minded, more tolerant, and more flexible (change in self-perception), they tended to make comparison between their own lives and those of the children and their families (change in life philosophy), resulting in an higher appreciation for their life. However, the authors reported that these benefits were reported by mental health workers only when directly asked by the interviewer, suggesting a negative bias still dominant in the clinical work.

Similarly, another qualitative study (Silveira & Boyer, 2015) investigated counselors who work with child and youth victims of interpersonal trauma and indicated that they experienced an increased sense of hope and optimism, and were inspired by the strengths of their young clients for developing their own resilience. Authors described the phenomenon of *vicarious resilience* and its role in the counseling setting. This term was coined by Hernandez, Gangsei, and Engstrom (2007), to describe resilience occurring in therapists as a common and natural phenomenon resulting from their work with trauma survivors. It is a term that refers to positive meaning making, growth, and transformation in the therapist's experience, which results from exposure to clients' resilience in the course of therapeutic processes. Vicarious resilience can be manifested by a variety of behaviors such as (1) reflecting on human beings' capacity to heal, (2) reaffirming the value of therapy, (3) regaining hope, (4) reassessing the dimensions of one's own problems, (5) understanding and valuing spiritual dimensions of healing, (6) discovering the power of community healing, and (7) making the professional and lay public aware of the impact and multiple dimensions of violence (Hernandez et al., 2007).

Another similar phenomenon has been labeled as *compassion satisfaction*, a term coined by Figley (2002), to illustrate pleasure, or professional satisfaction that results from helping others as opposed to compassion fatigue. According to Figley and Stamm (1996), compassion satisfaction is affected by internal motivational factors (i.e., self-efficacy) as well as by external factors (i.e., environmental working demands) and by direct feedback from supervisors and colleagues. Recently, it was documented that compassion satisfaction in trauma counselors was related to the experience of positive emotions (in line with the broaden and build theory of positive emotions, see Chap. 1 of this book) and was partially mediated by positive reframing (Samios, Abel, & Rodzik, 2013). Accordingly, compassion satisfaction might play a protective role for therapists' well-being by strengthening their sense of worthiness. Further, it may paradoxically contribute to preserve optimism and a profound belief in the good of humanity, as opposed to cynicism and despair commonly reported in burn out syndrome.

These positive dimensions have been observed also in other clinical context, such as oncological settings. A qualitative study (Vishnevsky, Quinlan, Kilmer, Cann, & Danhauer, 2015) examined whether oncology nurses experienced personal growth and wisdom as a result of caring for patients. All 30 nurses that were interviewed cited at least one example of growth and wisdom (see Chap. 6 of this book). The former included appreciation of life, new perspective on life, relating to others, spiritual/religious growth, and personal strength. The latter varied from benevolence to altruistic attitudes toward patients and the community. The Authors concluded that nurses developed personal growth, wisdom, and benevolence as a result of the emotional connections formed with patients and the subsequent struggle to cope with their loss.

Finally, some Authors (Nuttman-Shwartz, 2014) recently proposed a new concept, that includes a variety of positive effects deriving from exposure to traumatic events in helping professions: "*shared resilience in a traumatic reality*" (SRTR). It refers to the perception of shared traumatic situations and the ability of trauma workers to cope, to show resilience, and to grow as a result of the mutual relationship with their clients. The Authors reviewed many concepts referring to the positive effects of working with trauma survivors on therapists, and underlined the importance of empathic mutual aid relationships, which are basic components for promoting resilience in a shared traumatic reality. Among others, they describe the concepts of altruism and cooperation, as described below.

7.4 Altruism and Altruism Born of Suffering

7.4.1 Altruism: Lights and Shadows

Altruism can be considered a positive personality trait (Petersen & Seligman, 2004), associated with positive functioning and positive emotions. According to the positive psychology perspective, prosocial behaviors are considered indicators of good interpersonal functioning and contributors to social integration and social well-being (Keyes, 1998), as well as external manifestations of character's strengths and virtues (Peterson & Seligman 2004).

However, the debate on the real "positive nature of altruism" has a long tradition in psychological and social sciences. Even though such debate falls outside the scope of this chapter, it is worth mentioning that some theories consider altruism as a form of self-benefitting, or benefitting one group at the expenses of another (parochial altruism) (Lucas & Wagner, 2005). Thus, such theories question the real positive motivations under the altruistic behaviors.

In the medical settings as well, altruism and altruistic behaviors, such as organ, tissues and blood donation, are considered with caution, or even with skepticism. Blood donation, for instance, has been categorized as an act of benevolence, rather, than "pure" altruism (Ferguson, Farrell, & Lawrence, 2008), since blood donors

may receive several benefits in terms of health monitoring and personal self-efficacy as direct feedback from the act of donation. Similarly, living donors are carefully screened for mental health problems before the medical team gives its consent to accept their organs. While this caution is absolutely necessary in order to protect prospective donors and recipients, this attitude indeed represents a negative bias characterizing the consideration of human nature in medical settings.

Also in mental health settings altruism has received a negative connotation, and was labeled as *pathological altruism*. It could be observed in many forms of psychopathology, such as depression, obsessive compulsive disorders and PTSD (Oakley, Knafo, Madhavan, & Wilson, 2012; Widiger & Presnall, 2012). Pathological altruism derives from the empathic-based guilt mechanism, which drives human beings at acting altruistically when witnessing distress in others. In fact, in some cases empathy-based guilt may become excessive, with unrealistic perspectives: individuals may erroneously believe they caused the distress, and/or that they will be able to relieve it (Tone & Tully, 2014). Altruism then becomes pathological because based on these false beliefs, individuals may engage in pathological acts of altruism, failing to help, or even harming the person in distress as well as themselves (Oakley et al., 2012). This mechanism is triggered by a rigid, overdriven moral system, that produces an unrealistic judgment of the self, considered responsible for the suffering of others. An extreme example of this pathological altruism, observed in psychiatric settings is the depressed patient that thinks that by committing suicide he/she could substantially improve the lives of those around him/her.

Another example comes from clinical experience with PTSD patients and trauma survivors, that overtly inhibit their own healthy goal-seeking, or their path toward resilience because they are overwhelmed by survivor guilt. However, some other survivors with well-developed skills in affect regulation are able to experience survivor guilt without it resulting in a compulsion to act altruistically. They are able to process their empathic response to someone else's suffering in a conscious way, and are therefore able to successfully regulate the intensity and cognitive assessment of the feeling/behavior. The nuances of altruism, from beneficial effects to these negative forms of altruism are described in Fig. 7.2.

Individuals with some personality characteristics, such as extroversion and narcissism are considered less at risk of developing empathy-based guilt and pathological altruism. However, other authors have found other relationships between altruism and personality disorders (Widiger & Presnall, 2012). For instance, even though the trait of altruism is generally conceived as positive, when it becomes rigid, maladaptive and inflexible, it could turn into self-sacrificing selflessness, with severe debilitating consequences, such as victimization and abuse. This is often the case of depend—personality disorder patients, characterized by self-sacrifice and pathological altruism. Apart from DSM classification, Costa and McCrae (1985, p. 87) had suggested that "agreeableness can also assume a pathological form, in which it is usually seen as dependency" (p. 12).

Although the nuances of personality and well-being are described in Chap. 3 of this book, according to the majority of personality theories, altruism is a personality attribute characterized by doing good actions such as giving and benefiting others

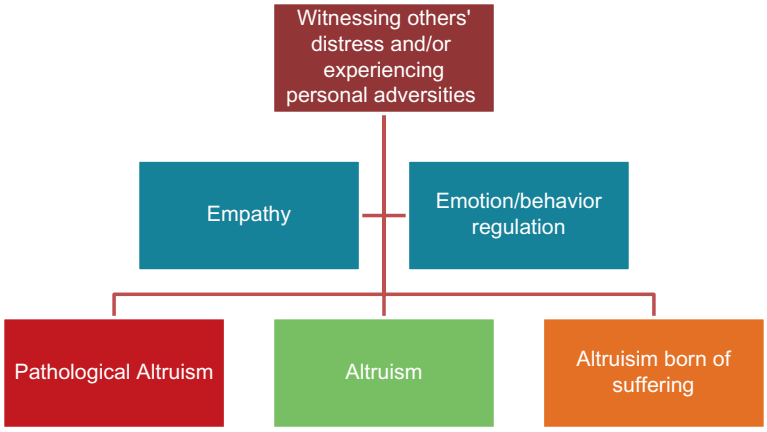

Fig. 7.2 Altruism, its nuances and consequences

without the expectation of personal gain (Ashton, Paunonen, Helmes, & Jackson, 1998; Midlarsky & Kahana, 1994). Accordingly, it can be defined in terms of its underlying motivations or in terms of its behavioral characteristics (Baumann, Cialdini, & Kendrick, 1981; Mikulincer, Shaver, Gillath, & Nitzberg, 2005; Rushton, 1980). Rushton (1980) considered altruism as a positive attribute of personality, and emphasized the behavioral component, whereas "empathy" and "moral judgment" were considered its main motivations. Although Rushton' model of altruism raised some criticism, particularly in its genetic underpinnings (Rushton, 1989), altruism has been linked to interpersonal attitudes and emotions, such as empathy (Batson, Bolen, Cross, & Neuringer-Benefiel, 1986; Batson & Shaw, 1991; Caprara et al., 2012; Graziano, Bruce, Sheese, & Tobin, 2007; Tobin, Graziano, Vanman, & Tassinary, 2000).

Also, individual differences in traits, values, and beliefs are supposed to be important correlates of altruistic and prosocial behaviors (Alessandri, Caprara, Eisenberg, & Steca, 2009; Caprara, Alessandri, Di Giunta, Panerai, & Eisenberg, 2010; Caprara et al., 2012; Graziano et al., 2007; Tobin et al., 2000). Some authors have studied the Five-Factor Model of the personality structure in relation to kin altruism (acting in order to benefit a genetic relative's chance of survival or reproduction at some cost to one own chances) and to reciprocal altruism (acting in such a way that someone else is benefited at some expense to oneself) (Ashton et al., 1998). While traits such as empathy and attachment mainly facilitate kin altruism, traits such as forgiveness and non-retaliation mainly favor reciprocal altruism, confirming the independence of the two types of altruism and their different personality correlates.

Another key dimension in the modulation of altruism is *oxytocin*, a neuropeptide produced in the hypothalamus and released during significant social interactions, such as breast-feeding, sexual intercourse, and cuddle. In an interesting experiment, it was found that oxytocin promoted both in-group trust and cooperation, and

defensive (but not offensive) aggression toward competing out-groups (De Dreu, Greer, Van Kleef, Shalvi, & Handgraaf, 2011) (see Chap. 2 for further details on biological underpinning of well-being).

7.4.2 Altruism Born of Suffering

Recently, Vollhardt et al. (Vollhardt & Staub, 2011; Vollhardt, 2009) proposed a model that indeed link altruism, empathy, forgiveness and a sense of personal maturation and growth. Authors observed that individuals who survived traumatic events, or experienced some forms of physical or psychological sufferance, manifested more prosocial behaviors and were found to be highly altruistic. Authors coined the term "*altruism born of suffering*" and suggested that it could constitute a pathway to develop post-traumatic growth and resilience. The authors put empathy and the experience of suffering as key dimensions linked to subsequent altruistic behaviors. The stressful event activates a more empathic understanding of other people distress and the need to prevent any future form of similar suffering. Thus, traumatized individuals develop a feeling of personal responsibility for other's welfare and consequently they engage in more prosocial behaviors. This, in turn, gives traumatized individuals a stronger sense of self (self-efficacy) and a more positive view of the world, which could be transformed in a process of maturation and perceived personal growth. Importantly, Vollhardt (2009) underlines that, in order to be fostered, altruism born of suffering needs traumatized individuals to be healed by therapy (individual counseling or group therapy). Through the therapeutic process trauma patients could reduce their feeling of vulnerability, identify themselves with their helpers, rather than with the aggressors, and could maintain a positive view of human beings. Thus, once their basic needs are addressed and healed by therapists and other clinical workers, suffering individuals may manifest their need for transcendence, (i.e., the need to go beyond themselves), which could be fulfilled by altruistic behaviors. This creates a virtual circle of positive interpersonal relationships, where love, compassion, empathy, and forgiveness are manifested.

Similarly, an important study found that a psychological training on *compassion* (based on mindfulness techniques) triggered specific modifications in the brain in those regions implicated in social cognition and emotion regulation (i.e., the inferior parietal cortex and dorsolateral prefrontal cortex), and triggered subsequent increase in pro-social behaviors by individuals who underwent such training (Weng et al., 2013). These results suggest that compassion can be cultivated with specific training and that greater altruistic behaviors may emerge from increased engagement of neural systems implicated in understanding the suffering of other people (see Chap. 6 for a more detailed description of Compassion Therapy).

Finally, confirming the hypothesis of altruism born of suffering, other authors have suggested that the underlying facilitating mechanism is a *redemptive narrative*, wherein the tragedy experienced is framed as leading to the prosocial behavior in question, and this mechanism sustains this prosocial shift. Constructing such a

narrative infuses the resulting behavioral pattern with a sense of meaning and purpose (Dunlop, Walker, & Wiens, 2015). These issues will be better described in the following chapter (see Chap. 8 of this book).

7.5 Conclusions and Therapeutic Recommendations

If the focus of Chap. 6 were forgiveness, wisdom, and PTG, resulting from dealing with negative events and interpersonal transgressions, the focus of current chapter was entirely on positive interpersonal relationships, from couple to parenting, to therapeutic alliance and finally to altruism. The final message is that from significant dual relationships (such as marriage and parenting) to larger social interactions, it seems that human beings are capable of bonding together and helping each other. More interestingly, these capacities are deeply embedded in our brain, where specific circuits make us able to feel empathy and sympathy for other human beings. These interpersonal bonds are a direct source of well-being, satisfaction, and support. Further, the literature examined here suggests that the direct or indirect sharing of suffering leads individual to be even more concerned for other people's welfare, and, in turns, this triggers a process of personal maturation and growth.

These observations provide confirmation to the positive view of human beings, entailed by positive psychology perspective. However, they also have important clinical implications. First of all, psychotherapy and healing settings could be considered ideal places to observe and promote these phenomena. The majority of clinical problems are in fact concerned with impairments in social functioning. Psychologists, social workers, and practitioners could directly help their clients to develop empathy, compassion, and altruism, or to modulate these dimensions when they become detrimental to the individuals, as described in Fig. 7.2. Traditional clinical interventions, in fact, address issues such as sense of guilt, remorse, rumination and perception of victimhood. The integration of positive nuances of empathy, altruism and positive communication styles (as described in this chapter) may guide clients toward a more substantial understanding of these issues and their importance in human relationships. This clinical ingredient may improve clients' social functioning and, in turn, this may trigger a process of maturation and growth, connected to resilience and a better recovery from their disorders.

Finally, psychologists, social workers and counselors may derive direct source of maturation, wisdom, and well-being by listening to and accompanying their clients in their process of healing. Thus, if burn out syndrome and personal exhaustion are sometimes the price to pay in helping professions, maturation, growth, and shared resilience are indeed the most rewarding awards.

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Chapter 8
Gratitude, Spirituality and Meaning: Their Clinical Implications

"The function of prayer is not to influence God,
but rather to change the nature of the one who prays."

Søren Kierkegaard

Abstract This chapter reports the most recent findings of scientific literature concerning gratitude, spirituality, and meaning and their possible applications in clinical settings. Although these dimensions were found to be protective for individuals' physical and mental health, they sometimes showed controversial and paradoxical effects. Finally, this chapter briefly describes some of the most recent psychotherapeutic interventions that are based on the above-mentioned transcendental aspects of human functioning and are focused on the importance of the mind-body connections. Among them, Mindfulness Based Cognitive Therapy, Mindfulness Based Stress Reduction, Acceptance and Commitment Therapy, Meaning-Making Intervention, Naikan Therapy and narrative strategies based on positive psychology research are illustrated.

8.1 Theories and Research on Gratitude, Spirituality and Meaning

8.1.1 Gratitude in Clinical Practice

Gratitude derives from the Latin *Gratia* that refers to kindness, generousness, the beauty of giving and receiving. In current psychological literature, it has been considered:

(a) As a psychological state: it is a pleasant state related also to contentment, happiness, pride, hope, a sense of wonder, thankfulness, and appreciation for life. It can be expressed toward others, as well as toward impersonal (nature) or nonhuman sources (God, animals).
(b) As a personality disposition to notice, appreciate and respond with grateful emotions and thankfulness to other people's acts of benevolence and kindness (McCullough, Emmons, & Tsang, 2002). Within this perspective, when assessed

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in combination with the Big Five personality traits, it resulted to be correlated to extraversion/positive affectivity, neuroticism/negative affectivity, and agreeableness. It was also found to display negative correlations with narcissism (Wood, Joseph, & Maltby, 2009).

In clinical psychology, one of the pioneer contributors to the study of gratitude was Maslow, who believed that the ability to express and experience gratitude was essential for psychological health. He considered gratitude as a central part of individual's self-actualization (Maslow, 1950).

Positive psychology research devoted much attention to the investigation of gratitude. First of all it was shown that people who are more consciously grateful lead lives that are more fulfilling, meaningful, and productive (Park, Peterson, & Seligman, 2004). In a study on September 11 terrorist attack Fredrickson, Tugade, Waugh, and Larkin (2003) found that gratitude, considered as a positive emotion, (Fredrickson, 1998) together with interest and love, was the most reported positive emotion by traumatized people. It was positively related to resilience and growth and negatively related to depressive symptoms (Fredrickson et al., 2003).

As a dispositional trait, gratitude may represent a common ingredient of resilience and post-traumatic growth (PTG). Kashdan, Uswatte, and Julian (2006), comparing Veterans combats with and without Post-traumatic stress disorder (PTSD), found that those with PTSD exhibited significantly lower dispositional gratitude. In the PTSD group only, gratitude was associated with higher levels of hedonic and eudaimonic well-being over and above effects attributable to PTSD severity and negative and positive affect. These findings were further confirmed in a sample from the general population, where gratitude predicted psychological well-being, displaying small associations with autonomy, and medium to large associations with environmental mastery, personal growth, positive relationships, purpose in life, and self-acceptance (Sergeant & Mongrain, 2011; Wood et al., 2009).

Gratitude was also found to be directly linked to physical well-being. For instance, Ruini and Vescovelli (2013) found that breast cancer survivors with higher levels of gratitude manifested less psychological distress and somatisation and more PTG compared to survivors with impaired levels of gratitude. Importantly, in this research gratitude was not linked to eudaimonic well-being dimensions, probably because of the peculiarities of the selected population, as opposed to findings concerning general populations or college students (Park et al., 2004; Wood et al., 2009).

In the large majority of investigations, in fact, it emerged that perceiving and being thankful for the positivity in the self and in the world could promote eudaimonic well-being and a sense of a more meaningful life and could strengthen transcendental aspects, such as religiosity and spirituality (Emmons & Crumpler, 2000).

8.1.2 *Spirituality, Transcendence and Meaning in Clinical Practice*

Spirituality, on the other hand, can be conceptualized as "*the search for the sacred*", encompassing not only God's power, but also other manifestations of the Divine and His qualities in ordinary life. They can be perceived through individual subjective experiences including intuitions and fantasies (Pargament, Mahoney, & Exline, 2013). Some authors described spirituality under the virtue category of *Transcendence*, a strength that provides a broad sense of connection to something higher in meaning and purpose than ourselves (Peterson & Seligman, 2004) (see Chap. 3 for a detailed description of Character's Strengths). Spirituality may be an important existential resource, an identity component, which concerns a concrete way of being in the world and implies the ability to accept and negotiate with the unsolvable mystery in life (Gall, Malette, & Guirguis-Younger, 2011).

In the past few decades the interest for spirituality that in this chapter will be considered interchangeably with the term religion (Spirituality/Religion-S/R), arose consistently thanks to the common recognition of their influence on mental and physical health. S/R can positively influence human health through multileveled pathways. These pathways pertain to three main areas:

- *psychological domain*: the use of adaptive coping strategies, better emotional regulation, reappraisal of life events, promotion of meaning processes and purpose of life, internal locus of control;
- *social domain*: the development of socially oriented human virtues, a higher exchange of information about health, the promotion of healthy behaviors, the empowerment of social connectedness and support;
- *biological domain*: the impact on functional interactions among hypothalamus-pituitary-adrenal axis, central nervous system, endocrine system, autonomic nervous system and immune system (Aldwin, Park, Jeon, & Nath, 2014; Baetz & Toews, 2009; Koenig, 2012; Seybold, 2007).

According to a growing body of literature, in fact, spirituality might be a personal resource to be used to cope with several *medical diseases*. Spiritual beliefs resulted to improve hospitalized and chronic patients' coping skills and management of their suffering, to reduce disease severity and to protect patients from negative affectivity (Anema, Johnson, Zeller, Fogg, & Zetterlund, 2009; Ballew, Hannum, Gaines, Marx, & Parrish, 2012; Delgado, 2007; Glover-Graf, Marini, Baker, & Buck, 2007; Hollywell & Walker, 2009; Jafari, Farajzadegan, Loghmani, Majlesi, & Jafari, 2014; Koenig, George, & Titus, 2004; Lucchetti, Almeida, & Granero, 2010; Lynch, Hernandez-Tejada, Strom, & Egede, 2012; McCauley, Tarpley, Haaz, & Bartlett, 2008; Peirano & Franz, 2012; Pizutti, Taborda, & Tourinho, 2012; Rashiq & Dick, 2009; Rippentrop, Altmaier, Chen, Found, & Keffala, 2005).

In neurological diseases, spirituality was found to promote quality of life and adaptive coping strategies among patients living with epilepsy (Giovagnoli,

Meneses, & Da Silva, 2006; Tedrus, Fonseca, Magri, & Mendes, 2013). Among traumatic brain injured patients, well-being, distress and functional outcomes were predicted by the spiritual connection with a Higher Power (Waldron-Perrine et al., 2011). Spiritual faith and practices worked as individual strengths in facing the progressive decline of Alzheimer's disease and were found to decrease the risk of negative affectivity among post-polio syndrome patients (Beuscher & Grando, 2009; Pierini & Stuifbergen, 2010). Spirituality was associated with life satisfaction in case of spinal cord injury, representing a resilience and meaning factor with beneficial effects for rehabilitation in the long-term (Babamohamadi, Negarandeh, & Dehghan-Nayeri, 2011; Brillhart, 2005; Chlan, Zebracki, & Vogel, 2011; Peter, Müller, Cieza, & Geyh, 2012; White, Driver, & Warren, 2010).

In cardiovascular patients, spiritual well-being seemed to reduce cardiovascular risk markers and mortality. It mitigated pain and increased quality of life of patients with chronic heart failure, allowing the adaptation to coronary disease and promoting medical adherence of hypertensive patients (Chida, Steptoe, & Powell, 2009; Dekker, Peden, Lennie, Schooler, & Moser, 2009; Griffin et al., 2007; Holt-Lunstad, Steffen, Sandberg, & Jensen, 2011; Kretchy, Owusu-Daaku, & Danquah, 2014; Naghi, Philip, Phan, Cleenewerck, & Schwarz, 2012; Strada, Homel, Tennstedt, Billings, & Portenoy, 2013; Westlake, Dyo, Vollman, & Heywood, 2008).

Overall, S/R was found to improve individuals' quality of life with some dimensions whose relevance change according to cases: a positive influence on mental health and self-efficacy, meaning of life, inner peace, spiritual connections and strength, coping with death and dying, hope, forgiveness, love, compassion and optimism (Konopack & McAuley, 2012; O'Connell & Skevington, 2005). Ivtzan, Chan, Gardner, and Prashar (2013) assumed that S/R have the power to improve personal well-being throughout the mediation of self-actualization, personal growth initiatives and meaning in life (see next paragraphs of this chapter).

Concerning *mental health*, many studies were focused on the beneficial effects of spirituality on depressive mood disorders. Sorajjakool, Aja, Chilson, Ramírez-Johnson, and Earll (2008) in fact, noticed that sometimes depression could create a disconnection from God, from others and self. In such context, spirituality may help to solve this disruption, letting individuals attributing a meaning to their condition. These authors posited that the acceptance and awareness of the personal illness might promote depression recovery and retrieval of connection to concrete and transcendent reality. Similarly, Bennett and Shepherd (2013) found that higher levels of spirituality and social support determined lower levels of depression and a narrowed range of mental health problems. However, the influence of spirituality on depression was above and beyond the meditative effect of social support because spirituality accounted directly for a proportion of variance in depressive symptoms.

Archibald, Sydnor, Daniels, and Bronner (2013) found that spirituality was significantly correlated to depressive symptoms throughout the mediation of sense of control. Spirituality correlated positively with sense of control, which, in turn, had negative effects on the relationship between stressful life situations and depressive symptomatology. Similarly, Kim, Hayward, and Reed (2014) stressed how higher levels of self-transcendence and a spiritual perspective managed to reduce depression

in Korean elders through the mediation of purpose in life. Subjective spirituality was directly linked with purpose in life and it indirectly reduced depressive symptoms, thanks to the idea of a meaning behind existence and the presence of something to live for.

Finally, Alexander, Haugland, Ashenden, Knight, and Brown (2009) asked some psychiatric patients to write five strategies used to control their suicidal thoughts. Spirituality was indicated among the principle strategies to solve desperation. These authors observed that psychiatric patients often recurred to spiritual beliefs and practices more than to formal religious church affiliation. Such beliefs and practices gave them the idea of personal meaning and connection, contrasting the sensation of helplessness. Helplessness, in contrast, is considered a frequent characteristic in clinical populations and a risk factor for suicide. Spirituality, thus, may support recovering from a mental disorder by transforming anger and disempowerment, linked with suicidal pulses, into self-agency.

Providing a full review of studies on spirituality and on its role in mental and physical diseases falls outside the scope of this chapter. However, these paragraphs were aimed at illustrating how spirituality and gratitude (two active components of transcendence in human functioning) could be used in clinical practice with the aim of facilitating patients' recovery from their disorders and in finding meaning in their experiences.

8.2 Interventions

8.2.1 Interventions to Improve Gratitude

Among positive psychology interventions, those concerning the promotion of gratitude are the most developed and investigated. They concern the "counting blessing exercise", or "the Three good things", where individuals are asked to report and remember positive things/beneficial acts experienced during a certain period of time. Other interventions are more concerned with the expression of gratitude (writing letters, or pay a visit to a benefactor) as opposed to other techniques, which uses meditation and contemplation as a way for fostering appreciation of life and people.

Thus, the gratitude interventions so far available can be grouped into three categories: (a) daily listing of things for which to be grateful, (b) grateful contemplation, and (c) behavioral expressions of gratitude (Joseph & Wood, 2010; Lee Duckworth, Steen, & Seligman, 2005; Seligman, Rashid, & Parks, 2006; Toepfer, Cichy, & Peters, 2012). These gratitude interventions have been effective for decreasing depression and anxiety, and for increasing positive affect, optimism and physical functioning in adults (Emmons & McCullough, 2003; Wood, Froh, & Geraghty, 2010; Wood, Joseph, & Maltby, 2008; Wood, Maltby, Gillett, Linley, & Joseph,

2008). However, they also displayed paradoxical effects on well-being, as described in Chap. 4 of this book.

Strategies for increasing gratitude could be also part of other validated psychotherapeutic strategies, such as the Positive Psychotherapy (Rashid, 2015), the Well-being Therapy (WBT) (Fava & Ruini, 2003), the Meaning Making Intervention (Henry et al., 2010) (see next paragraph), and a specific cognitive-behavioral package (Miller, 1995). This latter psychoeducational program includes four sequential steps: (1) Identify non-grateful thoughts; (2) Formulate gratitude-supporting thoughts; (3) Substitute non-grateful thoughts; (4) Translate the inner feeling into action. This program could be easily integrated into standard cognitive-behavioral therapies.

However, one of the most integrative approach to promote gratitude was developed in Japan and has been labeled as **Naikan therapy**. Naikan therapy is a structured method of self-reflection developed by Yoshimoto Ishin in the 1950s (Reynolds, 1982). The practice is based on three questions posed to the client: (1) what have you received from person X? (2) What have you given to person X? (3) What troubles and inconveniences have you caused to person X?

The clinical intervention starts by focusing on the above three questions, which are expanded to include a number of significant persons in the client's social environment (parents, siblings, teacher, spouse, employer). Most clients soon realize of having received a great deal, returned little, and caused troubles to the person on whom they are reflecting. Initial difficulties in concentrating and feeling bitterness toward others tend to naturally and gradually be replaced by feelings of regret, guilt, and sorry over how one has treated significant others. This awareness prompts gratitude from within the individual which underwent Naikan treatment.

The emphasis of Naikan therapy is not necessarily on providing symptom relief, but on promoting character development and maturation. Since its development, it has been used for mental health counseling and treatment for addictions. With regard to effectiveness, Yamamoto (1972) reported decreased self-evaluation and increased evaluation of others in post-Naikan patients. Ishida (1969) reported over 90% effectiveness in treating neurotic and psychosomatic patients with Naikan alone or in conjunction with other therapies. Thus, as with Mindfulness and other meditative practices, this promising approach should be integrated in standard Western psychotherapies or clinical interventions.

8.2.2 Mindfulness and Acceptance and Commitment Therapy

In line with the importance of personal values and strengths such as gratitude and spirituality, the *third wave psychotherapy* movement (Hayes, 2004; Kahl, Winter, & Schweiger, 2012) which developed as early as in the '80, called for a holistic consideration of patients. Indeed it aimed at addressing also individuals' values, spiritual needs and motivation. Inside this framework, various clinical interventions were developed and implemented.

Clinical interventions such as *Acceptance and Commitment Therapy* (ACT), *Mindfulness based Cognitive Therapy* (MBCT), *Dialectical therapy* (Kahl et al., 2012) overtly emphasized the limited, reductionist cognitive behavioral (CBT) approach and proposed to add therapeutic ingredients such as meditation, meaning and acceptance techniques, in order to achieve a more complete and lasting recovery from mental disorders. They all include a sense of transcendence, which is used as therapeutic ingredient to help patients to achieve a detached perspective on their problems and to reach a higher sense of self. Accordingly, *Transcendence* is mainly promoted through mindfulness meditation.

Mindfulness refers to an aware attention, intentional and with no-judgment toward individuals' current experience (Kabat-Zinn & Santorelli, 1999). Its daily practice appeared to induce a sense of profound inner calmness and a non-reactivity attitude of the mind, allowing individuals to face, and even embrace, all critical and stressful aspects of daily life, regardless of circumstances. By emphasizing being, rather than doing, mindfulness meditation resulted to provide individuals with helpful strategies to deal with their psychological symptoms and distress. It was suggested that mindful individuals promote the development of a compassionate approach toward their own experiences, that help them to avoid making premature decisions, and to be opened to new possibilities, transformation, and healing processes. Mindfulness training can improve working memory capacity, and enhance the ability of participants to talk about past crises remaining focused on specific topic, rather than becoming overwhelmed by them (Williams, 2010). A robust body of evidence provides support to the efficacy of mindfulness for a variety of physical as well as mental problems, from chronic illnesses, cardiovascular diseases, and psychiatric conditions, such as mood disorders, borderline personality disorders, obsessive-compulsive disorders (OCD), etc.

The first introduction of mindful meditation in the psychotherapeutic treatment was proposed by Teasdale et al. (2000), who found that it could address the controversial problem of recurrences and relapses in major depressive disorder. Authors developed and integrated mindfulness into the CBT protocol (**Mindfulness Based Cognitive Therapy—*MBCT***) for addressing depression and other affective disorders. In a series of RCTs, they found that helping patients to accept their negative, intrusive thoughts and observing them with a non-judgmental attitude was more effective in preventing recurrences and relapses than the standard cognitive restructuring. Importantly, this effect was larger for those patients with a longer depression history, and judged to be more vulnerable to future relapses. These findings may be explained by the fact that MBCT and mindfulness techniques are aimed at changing patients' relationships to their thoughts, rather than at changing their contents. Thus, Mindfulness may promote meta-cognitive skills, together with the awareness of the transient nature of thoughts, emotions and other (un)pleasant states (Segal, Williams, & Teasdale, 2002).

Subsequently, mindful meditation has been applied to the prevention of suicidal ideation in borderline patients and has become a central ingredient of the *Dialectical Behavioral Therapy* (***DBT***) (Linehan, 1993). According to its developer, mindfulness can promote borderline patients' wise mind (see Chap. 6) and help them to

down regulate their excessive emotional reactions, connected with symptom maintenance. Basically, the core features of all mindfulness meditation and practices are to develop an accepting, compassionate, loving attitude toward one's own inner world. These positive connotations of mindfulness may explain its strong correlations with well-being and quality of life (Kabat-Zinn, 2003).

In medical settings, mindfulness was applied using the protocol ***Mindfulness Based Stress Reduction*** (***MBSR***), developed by Kabat Zinn in the 1980s (Kabat-Zinn, 1982). Since then, a robust body of evidence has documented its efficacy in improving patient's adaptation to the illness. It was particularly applied in cancer, cardiovascular diseases and chronic illnesses. For instance, a recent meta-analysis (Hofmann, Sawyer, Witt, & Oh, 2010) based on 39 investigations with a total of 1140 participants with mood and anxiety disorders, oncological disorders and other medical conditions treated with MBSR revealed a high effect size (0.97) in improving psychological distress in those populations. Thus, authors concluded that MBT may represent a good treatment option to be used in mental and physical disorders, particularly when anxious symptoms are the core features. Further, Grossman, Niemann, Schmidt, and Walach (2004) conducted a structured meta-analysis where they compared the efficacy of MBSR in promoting physical and mental health versus waiting list or controlled conditions**.** Authors included investigations that provided post-treatment and follow up data. They found that a total of ten controlled studies, involving 771 individuals, (out of which 388 had been treated with MBSR) that yielded a moderate effect size (Cohen's = 0.54) when considering indicators of disability, quality of life, depressive and anxious symptoms. Variables related to physical health were reported for 203 individuals (out of which 122 had been treated with MBSR), with an effect-size of 0.53 concerning pain, medical symptoms, and compromised physical functioning. Authors concluded that even though the effect sizes are moderate, mindfulness can be used to alleviate distress in a large variety of chronic mental and physical conditions, by improving patients' coping resources and general well-being (Cramer, Lauche, Haller, Langhorst, & Dobos, 2016; Godfrey, Gallo, & Afari, 2015; Gu, Strauss, Bond, & Cavanagh, 2015; Marikar Bawa et al., 2015).

8.2.2.1 Neuronal Correlates of Mindfulness

Kang et al. (2013) examined the differences in the brain structures and functioning between expert, long term meditators and controls (inexpert meditators). They found that the former presented substantial modifications in those cerebral areas that are involved in emotion regulations, attentive functioning and regulation of the autonomous nervous system. Similarly, a recent review suggested that a large body of literature documented that mindfulness meditation promotes a better and more flexible emotion regulation, a sense of control and detachment from negative emotions, by dowregulating the amygdala activation and increasing frontal cortex cerebral area (Chiesa, Brambilla & Serretti, 2010).

To further corroborate the efficacy of mindfulness interventions, Davidson et al. (2003) compared an 8-week program of mindfulness meditation with a waiting list. They found significant increases in left-sided anterior activation (a pattern previously associated with positive affect) in the meditators, compared with the non-meditators of the waiting list condition. These two groups were also vaccinated with influenza vaccine after the 8-week period. Authors found also significant increases in immune functioning among subjects in the meditation group, compared with those in the wait-list control group. Furthermore, they observed that the magnitude of increase in brain left-sided activation predicted the magnitude of immune response, suggesting that even a short program in mindfulness meditation may produce a protective effect on brain and immune function.

It has been therefore argued that mindfulness, as part of other behavioral interventions, may elicit more specific biological changes than any pharmacologic intervention (Davidson, 2015; Kaliman et al., 2014, & Rosenkranz et al., 2013). Moreover, pharmacotherapy is more likely to produce various side effects. Thus, many authors have been suggesting that a fruitful alternative to pharmacological interventions could be represented by the integration of ancient transcendental and spiritual traditions that involved mind-body interventions (i.e., various forms of meditation) (Davidson, 2015). These "neurally inspired" behavioral interventions may produce specific important alterations both in behaviorally relevant neural circuits and in systemic biological processes, which could be associated with psychologically and physically healthier profiles (Davidson, 2015).

In sum, Mindfulness techniques have the double benefits of triggering mental relaxation, connected with symptom improvements and personal well-being. Mindfulness, meditation and relaxation strategies are directly linked to the promotion of savoring and pleasantness, (D'raven & Pasha-Zaidi, 2014; Kahl et al., 2012; Karwoski, Garratt, & Ilardi, 2006). Further, meditation can promote gratitude, forgiveness, savoring and other dimensions of positive functioning, which constitute inner qualities of mindfulness (Shapiro, Schwartz, & Santerre, 2002). Thus, Mindfulness could be fully enlisted among pioneer positive interventions performed in clinical settings, with beneficial effects directly embedded in the brain and in the body.

8.2.2.2 Acceptance and Commitment Therapy

The integration of meditation is also a consistent part of acceptance-based approaches. They posit that individuals should not try and change their experiences, but rather accept their experiences without judgment. Under this umbrella and within the third way psychotherapies, Stephen Hayes and colleagues developed **Acceptance and Commitment Therapy** (***ACT)*** referring to the *Relational Frame Theory* (RFT; Hayes, Barnes-Holmes, & Roche, 2001), that links human language, cognitions, emotions and behavior functioning. Accordingly, linguistic processes (thoughts, images, subjective evaluations) are a form of individual, inner narration that could become troublesome when it is characterized by negativity and rigidity.

ACT aims at helping patients to defuse from their inner negative self-dialogue and at promoting psychological flexibility. Furthermore, ACT aims at modifying the linguistic set that defines both problems and their potential solutions. Unlike CBT that aims to change dysfunctional thoughts, ACT focuses on modifying contexts which trigger problematic behavioral repertoires (Hayes, 2004).

This mental and behavioral attitude promotes emotional openness and helps to balance desires and needs, connecting them with the more spiritual part of a person (Kashdan & Rottenberg, 2010).

The acronym ACT has a particular meaning: **A**ccept what cannot be changed, **C**hoose one's values, and **T**ake action toward the pursuit of these values. ACT entails the use of paradox, metaphors, stories, exercises, behavioral tasks, and experiential processes.

Harris (2007) explains that ACT follows six core principles:

- Defusion: this technique aims at breaking the mechanism of cognitive fusion, which is the phenomenon experienced by a person who is completely involved in a determinate thought, situation or emotion. Defusion allows the subject to change the way he/she is interacting thanks to exercises of self-detachment;
- Expansion and Acceptance: it is opening up to unpleasant emotions rather than repressing them and trying to reject them. This change of attitude usually leads to less suffering and a more functional resolution of problems;
- Contact with the Present Moment: awareness of the here and now experience and full engagement in present activities. This attitude results more adaptive than fighting with the past problems or worrying about future expectations;
- Values clarification: contacting with the deepest part of oneself and finding what is really meaningful, being aware of the direction of life and experiencing satisfaction when goals are achieved;
- Committed Action: once values and goals are set, the person can take action and plan how he/she can reach what is meaningful to him/her;
- Self as Context: ACT perceives the self as containing a transcendent and spiritual part;

According to ACT approach, expressive writing about values results to be useful in order to clarify personal values and life goals. This aspect is shared with the phenomenological-existentialist perspective. ACT therapists use a particular technique for working on values, that is the exercise called Writing your Epitaph: the client is encouraged to think and write what he would like people would say in his memory. This exercise aims to clarify personal values and help to commit to them; it allows to identify the direction that clients want to give to their life and to verify if they really are travelling towards that path or have to modify the direction in some measure (Hayes & Wilson, 1994).

Also in this therapy, mindfulness is applied to help clients to become more aware of their internal processes, with a detached, non-judgmental attitude, so that also the most negative thoughts and images do not influence behaviors, choices and meaningful life activities (Hayes, Levin, Plumb-Vilardaga, Villatte, & Pistorello, 2013). ACT has been developed and tested to be applied individually, in group format, in

couples, to address both mental and physical conditions. Evidence for its efficacy has been reported for mood and anxiety disorders, OCD, work-related stress, chronic pain, eating disorder, PTSD, psychosis and substance abuse (Kahl et al., 2012; Pull, 2009).

Although it is hard to categorize, ACT can be considered a positive intervention because the focus is on acceptance and promotion of skills. It concerns the focus on meaningful life goals and values that provide patients with a sense of direction and active engagement in their choices. For this reason, the phenomenological-existential approach embedded in Acceptance and Commitment therapy may act as a bridge that links the traditional clinical approach to the promotion of well-being. In fact, ACT and other positive interventions pertaining to positive psychology perspective have an important conceptual commonality: self-determination theory (Ryan & Deci, 2000). ACT and positive interventions aim to help clients to pursue their goals in a way that is authentic and self-driven; the techniques may differ, but the goals are the same. However, an important distinction in ACT is the focus given to clients' personal values, such as family, friendships, spirituality etc., that are expressly addressed by clinicians to help their clients to develop specific therapeutic goals to be reached.

Thus, in ACT there is specific room to be devoted for meaning making processes. These meaningful values are integral part of ACT. It can be considered indeed a pioneer approach within positive interventions, which integrated psychopathology and suffering in the meaning perspective.

8.2.3 Meaning-Making Interventions and Existential Therapies

The issue of meaning has received increasing attention in many areas of psychology, from clinical psychology, psycho-oncology, humanistic psychology and positive psychology. The main emphasis was given to the subjective experience of meaning (i.e., having experienced meaning, or a meaningful life) (Hicks & King, 2009). As mentioned in the first part of this book (see Chaps. 1 and 2), early pioneers in the domain of meaning and its existential importance were Viktor Frankl, and Aaron Antonovsky. Both had personally experienced the post World War II and emphasized the important role of meaning in order to overcome the long-term consequences of traumatic experiences deriving from the war (i.e., surviving concentration camps). As described in Chap. 2 of this book, Antonovsky developed a model of *Salutogenesis* (1979), where coherence and life meaning are considered essential ingredients that characterize healthy individuals and could help them to maintain their mental and physical health when facing stress. Thus, meaning is intrinsically connected to cope with traumatic events.

8.2.3.1 Logotherapy

Viktor Frankl (1959) developed a specific psychotherapeutic technique, *logotherapy*, aimed at discussing with clients their source of meaning in life. Modern applications of this approach are subsumed under the rubric of *existential psychotherapies*. Logotherapy finds application in the method of *meaning-centered counseling* and therapy. The notion of Logotherapy comes from the Greek term logos that means word; thus, logotherapy is an entirely word-based treatment, and words can be expressed both orally or in written way. Logotherapy assumes that life has always a meaning, even in the most crucial and negative circumstances. Accordingly, people strive to find a personal meaning in their existence (assumption of will to meaning) and the meaning in life can be discovered by three categorical values: *creative value* (doing creative act or creating a work), *experiential value* (undergoing experiences and featuring emotional involvement) and *attitudinal value* (using an attitude to raise above an unchangeable fate) (Frankl, 1969). Another axiom refers to the will of meaning that is the basic attempt of humans to find and fulfill a concrete meaning in personal existence (Frankl, 2010).

Frankl also theorized the "tragic triad" of human existence, referring to pain, death and guilt; later on he introduced also fate as the forth human limitation. The way individuals respond to these limitations makes a difference and determines the different modalities of coping style. In this perspective, writing a journal can be considered a place where people find a meaning to life-threatening events. Logotherapy, in fact, emphasizes the importance of words in creating a meaning and writing techniques are particularly appropriated to this task. When people have to confront with their human limitations, creative writing may be used in order to make meaning to these existential challenges. Writing yields the opportunity to create a reflective space that allows to develop a stance towards the difficult situation. The phenomenological approach of Logotherapy provides also emphasis to the concepts of *self-distancing and self-transcendence* (Frankl, 2004). Self distancing or self detachment refers to the ability to detach from situations or from oneself; and writing is a powerful tool by which self distancing can be practiced. Self-transcendence is the process where the person can find a way of positioning herself and analyzing events from an external point of view. Also in this case, the activity of writing facilitates self-transcendence and it supports the active role of the client in dealing with distress and adversities.

8.2.3.2 Meaning Making

The search for meaning is part of the individual's coping process (Fife, 1994; Folkman & Moskowitz, 2007). Taylor (1983) suggested that people coping with severe negative events may find meaning by considering positive implications, or benefits, of the events for their life, thus minimizing or mitigating the negative implications. Accordingly, meaning-making is a way of changing individuals' view of life in order to integrate what happened and to give the event an existential value in the persons' life framework (Taylor, 1983).

Also Park (2010), who summarized a meaning-making model from previous meaning-focused theories, explained that when stressful live events challenge one's life, meaning-making efforts begin to take place to restore one's meaning in life. Therefore, meaning seems to refer to the process of understanding how the event fits in ones' life. The Author suggested that the discrepancy between the appraised situational meaning linked to trauma and individual's global meaning creates distress, which, in turn, drives meaning making efforts.

Davis, Nolen-Hoeksema, and Larson (1998) suggested that the meaning-making process seeks to understand the stressful event, and they differentiated it form benefit finding (BF) and post-traumatic growth (see Chap. 6 of this book), since BF refers to find positive implications in the event. However, meaning and growth were found to be linked, since the identification of instances related to growth may help to restore a sense that life is coherent and meaningful and that the world is predictable and fair (Park, 2010).

The underling mechanism that connects meaning to growth, wisdom and finally to transcendence refers to the concept of *mortality awareness*, which was largely examined under the terror management theory (Park, 2010). This model postulates that when people are confronted with the concept of death and the thought of their own death, they activate specific defense mechanisms, but they also become more focused on intrinsic needs and goals and they actively fuel their desire to find meaning (Cozzolino, 2006). This model was recently adapted to health settings—medical traumatic events (Terror Management Health Model—Goldenberg & Arndt, 2008) and was found to be associated with modifications in life styles, increase in healthy habits and modifications in relationships with the own body. For these reasons, specific therapeutic protocols involving meaning making (Henry et al., 2010) were developed and validated with oncological patients and in palliative care settings. This Meaning-Making intervention is a brief existential intervention consisting of one to four individual sessions that focuses on finding situational, global, and existential meaning, following a diagnosis of a life-threathening illness. It entails a flexible approach, where therapists facilitate patients' self-exploration during the course of the illness. In this brief protocol patients and therapist discuss life priorities that give meaning to one's life, while considering illness-related limitations (Henry et al., 2010).

However, it should be noted that, as for growth, forgiveness and other existential positive domains, also meaning making is not entirely positive. In fact, the search for meaning was associated with poor psychological well-being and more distress (Steger, Frazier, Oishi, & Kaler, 2006), whereas the presence of meaning (the feeling that one's life is meaningful) was indeed associated with higher psychological well-being and better mental health (Steger, Oishi, & Kashdan, 2009).

8.2.3.3 Autobiography and Meaning

An interesting contribution (Mc Lean & Morrison-Cohen, 2013; McLean, 2008) posits that the gap between search for meaning and the actual presence of meaning in life could be filled using *narrative techniques*. McAdams (2001) developed the

concept of *narrative self-identity* for describing a collection of personal stories about past experiences that people use to define who they are and to find meaning in their existences. These past events and their consequences in fact, provide information for self-understanding and sense of future direction. According to McAdams *autobiographies* are integrated and internalized in the personality (McAdams, 2008). Identity is thus considered an internalized story that is composed by many narrative elements such as setting, plot, character and theme. In fact, people lives are developed in time and space, include a protagonist and many characters and are shaped by various themes. Mc Adams postulated that people implicitly start creating their narrative identities in adolescence and young adulthood, and this process goes on during adulthood. Working on the creation of narrative identities allows to reconstruct the past, to become aware of present and to have a future perspective (McAdams, 2008). The act of writing an autobiography allows, thus, the identification of main themes of self story and the coding of personal changes. Existence in this framework is considered a complex set of episodes that in an autobiographical act can be put in order and reconstructed of existential sense (Bauer, McAdams, & Pals, 2008). The therapeutic act of transforming life in a text contributes to provide stability in individuals' identity. Moreover, autobiography clarifies the cultural context which characterized individual path, and finally may lead to improvements in eudaimonic well-being (Bauer et al., 2008),

However, one important aspect of autobiography refers to the instability of autobiographical memory: people often misremember details of events over time (Schacter, 1996) or autobiography is influenced by distortion mechanisms. For this reason, the temporal instability of memories introduces changes in life story (McAdams, 2008); in addition to this, experiences are accumulated and every single event is considered less important over time compared to others. In this way, also meanings of life episodes may change across time. Consequently, some happenings are more salient than others because they assume different and multiple meanings in different life phases. They represent steps of a person's life that led to the present situation. Autobiography is thus useful not only to code events of self story, but it is also able to integrate different experiences and analyze the life trail, evidencing both continuity and changes. Accordingly, storytelling may be applied as an useful tool to foster identity development, which indeed may promote positive human functioning. Importantly, McAdams (2001) specified that a coherent narrative of self provides individuals with a sense of purpose in life and telling the story may boost such aim. It can be argued that any form of counselling and therapy, where clients can tell their stories, could be considered positive interventions that promote life purpose and well-being.

Thus, meaning making processes could be integrated and find a natural setting within any psychotherapeutic/counseling approach, either individual or in group setting. Useful examples that connect meaning and narratives are provided in the next paragraphs.

8.2.4 *Narrative Strategies in Clinical Settings: The Use of Fairytales*

The use of narrative strategies in clinical psychology and psychotherapy has a long tradition (Holmes, 2000). Following Jung (1964) and his theories on archetypes and myths, Jungian psychoanalysts have applied his formulations in the treatment of various emotional disorders (Kast, 1996). The importance of using narrative strategies in clinical domains has likewise been documented by many authors within the "narrative medicine" framework (Charon, 2006; Kleinman, 1988; Pennebaker, 2000; Riessman, 1990). This method calls for a holistic approach to patients that encompasses not just their illness, but also their biography, personal narration and cognitive interpretations of their illness, in line with the Terror Management Health Model (Goldenberg & Arndt, 2008) and its concept of mortality awareness.

Further, a widespread use of narration in the psychological sphere comes from Bettelheim's (1976, 1987) analytic interpretations of *fairy tales*. Accordingly, some clinicians in the psychoanalytic tradition employ folktales and their characters (hero/heroine) during sessions, as a means of discussing the tales' symbolic values with their patients (Jacobs, 2011).

Another specific application of narrative therapy in the psychotherapeutic domain, that makes use of the narrative structure of fairy tales as well as the metaphors they contain, has been recently developed and tested on patients with adjustment disorders. It was labeled "**Positive Narrative Therapy**" and was delivered in a group format to help people to solve problems in their daily life, to overcome stressful events and to increase their well-being (Ruini, Masoni, Ottolini, & Ferrari, 2014). The group intervention consisted of seven 2-h sessions, held once a week. The group was conducted by a folklorist and by a clinical psychologist. In each of the first five sessions ('lectures') a different fairy tale (or part of it), with related topics, was told and discussed with the participants. Specific topics were selected: age and gender-related conflicts and tensions among characters, the ability to cope with adversities and stressful situations, the use of inner resources and personal strengths, couple and family dynamics, the importance of cooperation (asking for and accepting help), and the role of helpers and magical gifts. In two concluding workshops, participants were asked to work as a group to write their own original fairy tale. Participants reported increased personal growth, self-acceptance, and an enhanced sense of appreciation of life and personal strengths, together with decreased levels of anxiety. This pilot investigation suggests the feasibility and positive effect of a group intervention based on narrative strategies for promoting well-being and growth in stressed women. The integration of narrative strategies based on fairytales within standard CBT was also performed in individual therapy for the treatment of panic disorder in a young patient (Ruini & Ottolini, 2014).

The novelty of this narrative approach relies on the use of the psycho-educational content of traditional fairy tales, their problem-solving approach and the process of maturation experienced by their characters inside a clinical intervention. In fact the narrative structure of the fairy tale (Propp, 1968) was used to help clients to write their own story, either individually or in group.

The structure of the fairy tales contains an initial stressful event, that could be compared to the critical life event described by Mc Adams (2008). This event significantly changes the protagonists' life conditions, and requires a process of assimilation and accommodation (Joseph & Linley, 2005) to find adjustment and a new personal identity. Thus, the use of fairy tales parallels Mc Adams approach to *self-identity construction* (Mc Adams, 2001; 2008). The difference, however, is the use of fiction characters and settings, rather than personal autobiographies In psychotherapy, autobiography is an essential content of session, whereas storytelling is an additive ingredient, which has a double function: primarily, the production of stories allows to take distance from inner feelings and it helps dissolving the typical tension of therapy situation where patient is asked to talk about personal troubles. Secondly, storytelling allows to discuss inner disturbance in a soften and distanced way, that yields a new awareness in clients. They are flooded in their story and internal representations of the event become explicitly concrete. This process is very useful to the development of constructive solutions to problems and to the transformation of destructive feelings (King, 2002). Fairytales can teach people to discover implicit meanings and they can learn from these stories. Furthermore, telling stories disclose individuals' thinking patterns and their connections between reality and imagination. There is also an interpersonal component in storytelling because the act of telling entails a relational position where each listener can feel connected to others and to the storyteller.

From a theoretical point of view, the use of fairy tales belongs to a specific domain of bibliotherapy, called *fairytale therapy*, whose aim is promoting personal growth and improving health. Lafforgue (2008) highlighted that fairytales are not therapeutic ingredient themselves, but a key role is covered by the therapist that must be able to work through them in order to have an impact on the client and show his/her problematic issues. With this purpose many elements are taken into account: the role of the hero/heroine, the concept of time, the use of myths, and the story development. All these aspects represent real and daily themes that can be dealt within the therapeutic work.

The part of the Positive Narrative Intervention where participants were encouraged to write their own narration can be considered as very creative and active. It was aimed at stimulating playfulness, at exercising in finding new logical and causal connections between events, and at increasing group cohesion (Proyer & Ruch, 2011; Treadwell, Reisch, Travaglini, & Kumar, 2011). At the same time, it contributed to improved awareness of problems in life and to find more flexible problem-solving techniques. Furthermore, participants' negative emotions were projected in a fictional, impossible setting, and this provided them with the right distance from problems, connected with a more effective cognitive engagement in problem solving. This emotional distance is an active ingredient also of Wisdom-Psychotherapy, as described in Chap. 6 of this book (Linden, Baumann, Lieberei, Lorenz, & Rotter, 2011).

Creativity, self-awareness, wisdom and flexibility (Kashdan & Rottenberg, 2010) are the focus of the majority of positive interventions nowadays (Seligman et al., 2006), as described in the previous chapters of this book. Therefore, these positive narrative interventions are in line with this trend of research and require future replications in larger controlled trials.

8.3 Conclusions and Therapeutic Recommendations

This chapter aimed at providing evidence of the beneficial implementation of transcendent aspects of human functioning, such as gratitude, spirituality and meaning, into the clinical domains. A brief description of psychotherapeutic interventions where such implementation occurs, such as MBCT, MBSR, ACT, and narrative strategies was provided.

However, despite these largely recognized beneficial effects of spirituality, meaning and gratitude, they were found to be potentially dysfunctional for physical and mental health in some circumstances. For instance, *gratitude* that showed controversial and *paradoxical effects* when promoted in mildly depressed college students (see Chap. 4 of this book) (Sergeant & Mongrain, 2011; Sin, Della Porta, & Lyubomirsky, 2011). Parks and Biswas-Diener (2014) examined this issue and analyzed different "types" of depressed individuals. They found that individuals whose depressive symptoms were more interpersonally oriented ("needy" rather than "self-critical") experienced no benefits, or in some cases, worsened when doing a gratitude activity. The more self-critical people, by contrast, benefitted more than average from doing the activity.

The same was found for individuals with severe psychiatric disabilities and/or medical conditions tend to be less spiritual/religious and perceive less spiritual well-being than healthy controls (Campbell, Yoon, & Johnstone, 2010; Fukui, Starnino, & Nelson-Becker, 2012). S/R was also found to reinforce rigid thinking and associated obsessive religious practices. It may promote feelings of fear, anxiety and guilty due to minor forms of disrespect of religious rules and traditions; or it may work as a negative emotion-oriented coping in terms of avoidance. The phenomena of *negative religious coping* or *religious alienation* were also described as maladaptive strategies applied in dealing with mental and physical illnesses (Aldwin et al., 2014; Koenig, 2009). Religious alienation refers to the state in which one feels disaffected from one's church and/or abandoned or even punished by one's God. In this case, spirituality and religiousness yield negative feedback in individuals when facing life adversities.

Similarly, a spiritual crisis, or the search for meaning following a negative event, such as an illness, was found to be associated with more distress, rather than well-being. Spiritual crisis (such as religious alienation) describes the loss of faith and a sense of alienation following a negative life event, which usually sheds negative light on God or other higher entities, responsible of such event. Similarly, the process of search for meaning was found to be linked to personal distress, rather than well-being. It is therefore essential for clinicians to be informed about these possible negative mechanisms related to gratitude, spirituality and meaning, as described in Fig. 8.1.

On the other hand, personal well-being may derive from the positive resolution of such crises, and clinicians may serve as facilitator in this process, either by using emphatic listening, narrative strategies, or by providing standard problem solving techniques.

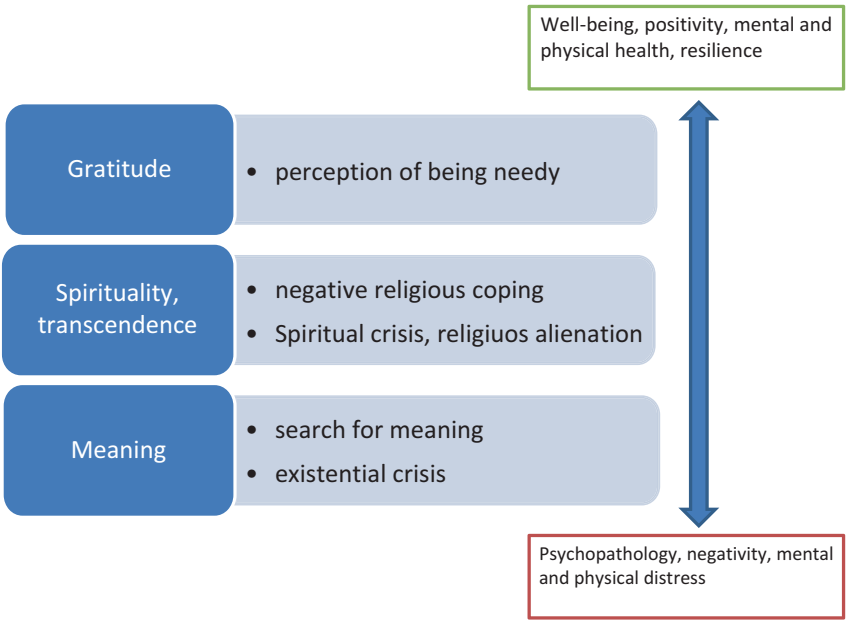

Fig. 8.1 Gratitude, spirituality and meaning: their nuances and their consequences

In conclusions, as for forgiveness, optimism, and other positive interventions, a particular caution should be used in promoting gratitude, spirituality, and meaning. Nevertheless, when these issues are properly addressed and promoted in clinical populations, the benefits are indeed worth the efforts. A fruitful collaboration between positive psychologists and researchers, clinicians, and psychiatrists is necessary to guarantee future effective applications of these positive concepts into the clinical settings.

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Concluding Remarks, Future Perspectives and Author's Comments

This book was born as a result of 10 years of parallel work in positive and clinical psychology. As a clinician and as a teacher of positive psychology, I have always been impressed by the fact that these two disciplines could be easily merged together. However, when I approached my professional career as a researcher and as a practitioner (back in 2000), positive psychology moved harsh criticism to traditional psychology that was based on medical models of research, intervention, and consideration of human beings. On the other hand, clinical psychology defended itself and refused the new paradigms proposed by positive psychology and accused positive psychology of reductionism and oversimplification.

At the very early stages of my career, it was difficult for me to take a rigid stand in favor of one or the other. Rather, I was deeply fascinated by both disciplines and did not want to give up one for the other. At that time, I really wanted to integrate positive psychology into my work as clinician and researcher in clinical psycology. However, it was not easy, since European academic world in social sciences was very traditional and judged positive psychology as another marketing product deriving from American/Western psychology.

The opportunity for a deeper reflection on positive and clinical psychology came when I was asked to open and teach a new course at the University of Bologna, School of Psychology. The course acted as a source of inspiration for the book. Planning the course syllabus gave me that chance of studying and selecting the several areas where positive psychology and clinical psychology actually met. Over the years, positive psychology research has been exponentially growing, and I had to reshape and reformulate the course syllabus. Indeed it was—and it still is—a process of learning by doing, and it is so exciting!

My experience as a clinician gave me other vital inputs on how to integrate the two disciplines in real practice. By working with patients over these years, I realized how complex the relationship between well-being and distress is. In most cases, distress finally leads to well-being (as in PTG or resilience models). Other times, distress is the result of having lost well-being or of being scared by positivity. Sometimes superficial positivity masks a profound and unconscious distress, as

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some of my patients taught me. In any case, analyzing the various nuances of well-being and negativity and working day by day within therapeutic relationships provided me with the theoretical and practical bases of this book.

If the fields of positive and clinical psychology keep growing and expanding with the same rapidity observed during the past years, their future common perspectives are reasonably optimistic. Positive clinical psychology and positive psychiatry recently received their scientific affirmations. New journals and an expanding number of articles appear regularly in scientific literature, and these are encouraging results. My wishes for future developments of the two disciplines are that current problems in positive psychology interventions (i.e., paradoxical effects, small effect size of intervention, rapid adaptation effect) could be effectively addressed by integrating previous research on psychotherapy, its ingredients, and its underlying mechanisms (as described in Chap. 4 of this book). On the other hand, I hope that clinical psychology and psychotherapy would take steps away from the medical model adopted insofar and would include the restoration of positivity and flourishing as a standard routine practice, in assessment methods, as well as in therapeutic protocols as described along the chapter of this book. Only with the full integration of positive psychology research, could this objective be fully accomplished.

In conclusion, according to my professional and personal experience positive psychology may benefit from including clinical perspective, as well as clinical psychology may improve the efficacy of its interventions by integrating positive approaches. This book may represent a contribution to this integration. I hope that current and future positive psychologists and clinical practitioners may have derived intellectual and practical benefits from reading this book.