Strategic Application of Human Development
Applying Positive Psychology

Subjective Measuring

2.1 Measuring Subjective Well-Being

Subjective well-being, defined as "a person's cognitive and affective evaluations of his or her life" is, strangely, seldom measured in studies of psychopathology. Considering the components of well-being—the presence of positive emotion, the absence of negative emotion, and a cognitive judgment of satisfaction and fulfillment—and its subjective importance to even the most troubled individuals, this omission is regrettable.

Lubin & Van Whitlock (2004), who recently developed a brief measure of life satisfaction specifically for the clinical setting, have observed that more commonly used symptom checklists are not always as productive as hoped: "Sometimes, patients later say that they thought of checking some items, but did not do so because they sounded too negative or self-condemnatory. On the other hand, areas rated high in satisfaction may indicate sources of potential resources, strengths, or supports that may be useful in building successful interventions."

Thus, one motivation for including well-being measures is that they bring to the attention of clients and therapists areas of high functioning easily overlooked or taken for granted. Another benefit, from a research perspective, is a more complete understanding of the psychological processes underlying disorders. For instance, in a clinical psychiatric sample, Heisel & Flett (2004) discovered that satisfaction with life accounts for significant additional variability in suicide ideation beyond what is accounted for by negative psychological factors. In a longitudinal study involving adolescents, Suldo & Huebner (2004) showed that youths who express positive life satisfaction are less likely to act out in the face of stressful life events.

Both measures are free and may be used without permission from the authors. Self-report scales are particularly appropriate given the privileged position of the individual in evaluating his or her own experience of well-being. However, given the possibility of response bias, memory bias, and other artifacts, we recommend a multi-method approach when practical. Clinical researchers in particular should

consider including informant reports, diaries, structured interviews, or other supplements to self-report questionnaires. Although global, retrospective reports of subjective well-being reveal how a person evaluates his or her life as a whole, they do not reveal the processes by which people construct such global judgments.

2.2 Measuring Strengths of Character

The second happy life, the engaged life, consists of using one's strengths and talents to achieve flow, and demands measuring positive character traits: talents, interests, and strengths. The measurement of talent and interest has been discussed at length elsewhere, so we focus on the measurement of strengths and virtues here. In 2004, Peterson & Seligman published the *Classification of Strengths*, a first attempt at a positive psychology classification to complement the *Diagnostic and Statistical Manual* (*DSM*) of the American Psychiatric Association (1994).

Following the example of the DSM, but attempting to correct for its shortcomings (e.g., overly heterogeneous diagnostic entities, categories rather than continua, in attention to the individual's setting and culture, and a subordination of validity issues to those of reliability), the *Classification of Strengths* proposes 10 criteria for the 24 human characteristics, of the hundreds initially considered, that were determined to be strengths of character. These criteria are neither necessary nor sufficient conditions for character strengths, but rather are pertinent features that, taken together, capture a "family resemblance" (cf. Wittgenstein 1953).

A character strength is valued in its own right, even in the absence of obvious beneficial outcomes; the display of a strength by one person does not diminish other people in the vicinity; and a character strength is embodied in consensual paragons, either real, apocryphal, or mythic, who exemplify the strength. The strengths are organized into six virtues, broad categories of moral excellence that emerged consistently from historical surveys: wisdom and knowledge, courage, love, justice, temperance, and transcendence. The *Classification of Strengths* can be distinguished from previous attempts to classify good character by its simultaneous concern with assessment. Two self-report inventories, the Values in Action Inventory of Strengths and the Values in Action for Young People, have been refined and validated using very large samples of English speaking respondents who accessed the surveys on the Internet.

Although the Values in Action Inventory of Strengths and Values in Action for Young People have not yet been used extensively in clinical populations, their potential as a diagnostic tool is easy to imagine. As a complement to self-report batteries quantifying weaknesses such as selfishness, narcissism, and delinquency,

these inventories may reveal to both client and therapist strengths upon which to build the foundations of a treatment strategy (Saleebey 1992, Seligman &Peterson 2003). In fact, Peterson & Seligman (2004) have suggested that the "real" psychopathologies, the ones that cut nature at the joints, are the absence of these strengths, and not congeries of symptoms like depression and substance abuse. But that deep question is for another day.

2.3 Measuring Engagement and Flow

The engaged life consists of using one's strengths and talents to meet challenges. Engagement and flow are the usual reward of deploying strengths and talents. Engagement does not generate pleasure in the hedonic sense, but is a qualitatively different sort of gratification. Flow is the experience associated with engaging one's highest strengths and talents to meet just-doable challenges.

Loss of consciousness characterizes such complete immersion: Time stops for us, we concentrate, we feel completely at home. Although we often say "Wow!" or "That was fun" afterward, we are not usually referring to a past hedonic event, but rather to the fact that we were totally engaged, completely focused on the endeavor, "one with the music," and that all thoughts and feelings were blocked.

Flow is devoid of thought and feeling. This void may be the result of the withdrawal of all psychological resources that sub-serve thought and feeling and their redeployment to concentration on the task. Importantly, flow is distinct from pleasure insofar as it is not introspect able in the moment. Although therapists are familiar with instruments to measure the contrasting states of boredom, anxiety, and apathy, flow is a construct whose potential application to the therapeutic setting is almost entirely unexplored.

2.4 Measuring Meaning

The happy life, is the meaningful life, consists of attachment to, and the service of, something larger than oneself. Baumeister & Vohs (2002) pointed out that the "something" to which individuals choose to connect varies widely. Some find meaning in their connection to family and friends or to church, synagogue, or mosque; others find greatest meaning in their work, or perhaps in a serious vocation. Individuals almost invariably seek meaning not from a single source, but rather from multiple, overlapping attachments. Although a common symptom of depression and substance abuse is emptiness, or the lack of perceived meaning in life, therapists outside of the humanistic-existential tradition are not trained to focus on meaning as a route to relieving disorder, and almost no therapists are trained to measure meaning.

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

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

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

2.5 Treatment & Prevention

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

Further, we believe that the job of the therapist of the future will not be simply to believe the negative, but to help clients build the pleasant life, the engaged life, and the meaningful life. We call the techniques that build these three lives "positive interventions."

Why We Think Positive Psychology Interventions Will Work

We believe that positive psychology interventions are worthwhile in therapy for two reasons. First, positive interventions, by definition, build pleasure, engagement, and meaning, and we believe they are therefore fully justifiable in their own right. Second, we believe that building positive emotion, engagement, and meaning may actually counter disorder itself. Evidence is mounting for the "undoing effect" of positive emotions. Fredrickson (1998) demonstrated that positive emotion induced in the lab caused negative emotion to dissipate more rapidly. In a subsequent study, Tugade & Fredrickson (2004) found that positive emotions also serve to undo the cardiovascular aftereffects of negative emotions (e.g., increased heart rate, increased blood pressure, increased vasoconstriction).

A final benefit of positive emotions, demonstrated by Tugade & Fredrickson (2004), is that they appear to help individuals find positive meaning in stressful situations. Frederickson & Joiner (2002) have speculated that there exists an "upward spiraling" effect of positive emotion and broadened thinking: Individuals who experience positive emotions are more likely to find meaning in negative events, and this meaning-making in turn leads to greater positive emotion.

More broadly, resilient individuals experience more positive emotions (Block & Kremen 1996, Klohnen 1996, Tugade & Fredrickson 2004). Resilient college students tested before and after the September 11, 2001, terrorist attacks provided a striking example of this association. In the wake of the attacks, they experienced gratitude, interest, love, and other positive emotions. Meditational analyses showed that these positive emotions buffered trait-resilient individuals against depression (Fredrickson 2003) and that positive emotion completely mediated resilience.

A review of the literature on resilience and positive emotions adds further support to the notion that positive emotions buffer individuals from stress (Folkman & Moskowitz 2000). A review of psychotherapy effectiveness research suggests that positive psychology may already be a critical and implicit (though unnamed and untrained) component of effective therapy as it is done now (Seligman & Peterson 2004). Large-scale outcome studies have shown that most individuals experience substantial benefits from therapy (Seligman 1995, 1996; Smith & Glass 1977). And, importantly, when one active treatment is compared with another active

treatment, specificity tends to disappear or is reduced to a small effect (Elkin et al. 1989, Luborsky et al. 1975, Smith & Glass 1977). Furthermore, there is a large placebo effect in almost all studies of psychotherapies and drugs (Kirsch & Saperstein 1998). What is going on? Many of the relevant explanations are called "nonspecific factors"; however, careful consideration of these nonspecific factors reveals that many are strategies suggested by positive psychology research and theory. One such strategy is instilling hope (Seligman 1991, Snyder et al. 2000).

Another is the building of buffering strengths such as courage, interpersonal skill, insight, optimism, authenticity, perseverance, realism, pleasure capacity, future-mindedness, personal responsibility, and purpose (Seligman 2002). A final illustrative strategy is narration. Telling the stories of one's life and retelling them from a new perspective can be a transformative experience (Pennebaker 1997).

With more systematic evaluation, new therapists can be taught what skilled therapists have learned through intuition or experience, and the positive psychology perspective provides a rich framework through which we can interpret these strategies. Could it be that these positive strategies are active, specific ingredients, and when they are tested empirically and in isolation, they will be found to relieve disorders? We think so, and thus we turn to a review of explicit, evidence-based positive interventions.

2.6 Evidence-Based Positive Interventions

At least one hundred positive interventions have been suggested, from the Buddha to Tony Robbins. Which ones actually work? Which make people lastingly happier and which actually relieve negative states? Several have been tested in controlled designs as well as in random-assignment placebo controlled designs, and have been found efficacious. Fordyce (1977, 1983) was among the first empirical researchers to develop and test a happiness intervention. Basing his intervention on the premise that "happy is as happy does," Fordyce surveyed research on characteristics of happy people, focusing in particular on habits within the short-term control of most individuals.

In one study, Fordyce randomly assigned intact community college classes to an intervention condition involving detailed instruction on strategies for increasing happiness (e.g., keep busy and be more active, spend more time socializing), and control groups who received no information at all or who received instruction about happiness-increasing strategies in summary form only. Students in the intervention condition were happier, less anxious, and less depressed at the end of the term than were participants in either control group. Among participants in the

intervention group who returned the survey 9 to 18 months later, most reported continued happiness increases. Fordyce's contribution to the field is substantial because he demonstrated the possibility of making people happier. And, although his follow-up sample may have been biased toward happier individuals, the results suggest that a lasting change in happiness is at least possible.

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

Emmons & McCullough (2003) found that participants randomly assigned to a gratitude intervention showed increased positive affect relative to control participants. Specifically, they asked participants in the gratitude condition to write about five things for which they were thankful, every week for 10 weeks. In two control conditions, participants wrote about either daily hassles or neutral life events. All participants were asked to complete weekly ratings of how they felt about life as a whole [from –3 (terrible) to +3 (delighted)]; weekly ratings about their expectations for the week to come [from –3 (pessimistic) to +3 (optimistic)]; and weekly ratings of how connected they felt to others [from –3 (isolated) to +3 (well-connected)].

Relative to the control groups, participants in the gratitude condition reported feeling better about their lives in general, more optimistic about the coming week, and more connected with others. They also demonstrated more positive affect and less negative affect (as measured by a 30-item survey). In a follow-up study, gratitude journals were kept daily for two weeks; control participants wrote about ways they were better off than were others, or about neutral events. In addition, the researchers collected observer reports of participants' positive affect, negative affect, and global life satisfaction. The positive effects found in the first study were replicated; in addition, the observer reports indicated that participants were higher in life satisfaction and positive affect (but not lower in negative affect).

Lyubomirsky (2005) explored a "count your blessings" intervention. Participants in a no-treatment control condition were compared with participants who either counted their blessings once per week or three times per week. At the end of the six-week study, only those participants who counted their blessings once per week were happier. The authors suggested that a "less is more" philosophy may prevent habituation in some happiness interventions. In a six-week kindness study (Lyubomirsky et al. 2005), participants in a no treatment control condition were compared with participants asked to perform five acts of kindness all in one day and another group of participants asked to perform five acts of kindness spread out over one week. Interestingly, only the students who performed acts of kindness all in one day were happier than were the others, as measured by Lyubomirsky's four-item Subjective Happiness Scale (Lyubomirsky & Lepper 1999).