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The Integrative Positive Psychological Intervention for Depression (IPPI-D)

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RUNNING HEAD: Integrative program for depression

The Integrative Positive Psychological Intervention for Depression (IPPI-D)

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Abstract

Despite the variety of empirically supported treatments for depression, many available evidence-based treatments do not satisfactorily promote or maintain clinically significant changes in patients. Moreover, treatments for depression have been primarily focused on reducing patients' symptoms or deficits and less concerned with building positive resources that seem to be of interest to depressed individuals. This paper describes a manualized protocol of a new empirically-validated positive psychological intervention for depression, which incorporates a balance between hedonic and eudaimonic components and a combination of in-session exercises and homework. The protocol is a 10-session program, in a group format, and includes interventions that have been shown to be effective in increasing well-being or alleviating depressive symptoms. The rationale for developing this protocol, the underlying theoretical framework and some general guidelines for its application are presented. Furthermore, the implications of this protocol are discussed, demonstrating how it overcomes some of the limitations of current, evidence-based psychological treatments for depression.

Key words: Positive psychological interventions; Major depression; Well-being; Positive emotions; Personal strengths.

The aim of this paper is to describe a manualized protocol for depression, which includes a structured combination of empirically-validated positive psychological interventions that have been proved to be effective in increasing well-being or alleviating depressive symptoms (Bolier et al., 2013; Sin & Lyubomirsky, 2009; Weiss, Westerhof, & Bohlmeijer, 2016). Positive results from this program have already been published (Chaves, Lopez-Gomez, Hervas, & Vazquez, 2017; Lopez-Gomez, Chaves, Hervas, & Vazquez, 2017a), although its specific contents have not been published so far.

Current treatments for depression and their limitations

Major depression is one of the most prevalent and seriously impairing psychological problems (Kessler & Bromet, 2013). Lifetime prevalence estimates of major depressive disorder (MDD) range from 4 to 10% (Kessler et al., 2009). Moreover, recent predictions estimate that by 2030 depression will be the leading cause of disease burden in high-income countries (Mathers, Fat, Boerma, & World Health Organization, 2008), and compared to other mental disorders, depression entails a significant reduction in happiness and life satisfaction (Vazquez, Rahona, Gomez, Caballero, & Hervas, 2015). Taking all of these findings into consideration, the accessibility of validated interventions for depression is as necessary as ever before (WHO, 2012).

Recent meta-analyses have shown the efficacy of a range of treatments for depression (e.g., cognitive-behavioral therapy, problem-solving therapy, interpersonal therapy) with comparable benefits (Barth et al., 2013; Cuijpers, Andersson, Donker, & van Straten, 2011). These are promising findings. However, despite the variety of empirically supported treatments for depression, many available evidence-based treatments do not fully promote clinically significant changes in the majority of patients (Cuijpers, van Straten, Andersson, & van Oppen, 2008). The high number of residual

symptoms after treatment (Paykel, 2008), the high relapse and recurrence rates (Vittengl, Clark, Dunn, & Jarrett, 2007) and the high dropout rates (Fernandez, Salem, Swift, & Ramtahal, 2015; Hans & Hiller, 2013) lead some experts to consider that the overall quality of available treatments for depression is unacceptably poor (McIntyre & O'Donovan, 2004). Thus, although some authors believe that extant treatments are sufficient alleviate depression (Cuijpers, 2015), the limitations of current treatments shed light on the importance of conducting research on new modalities of treatment (Stirman, Toder, & Crits-Christoph, 2010) or on improvements of current treatments based on advancements in the understanding of the science underlying depression (e.g., Beck & Bredemeier, 2016).

One way to improve treatments relates to shifting the focus of the intervention itself. Existing depression treatments have been primarily focused on alleviating symptoms and deficits while paying less attention to building positive resources (e.g., personal strengths, positive relationships) (Dunn, 2012). Yet, this classical, clinical focus seems to be at odds with patients' beliefs about the goals of therapy. For instance, it has been found that patients with major depression believe that what best defines 'remission' is the presence of positive mental health characteristics (i.e., optimism, general sense of well-being) (Zimmerman et al., 2006). Consequently, depressed patients consider that the main goal of therapy should be aimed at increasing their life satisfaction and general well-being (Demyttenaere et al., 2015a). However, doctors and psychiatrists' main aim has traditionally been reducing symptoms (Demyttenaere et al., 2015a). This discrepancy between professionals and patients has some practical effects. As Demyttenaere et al. (2015b) found in their study with a large sample of patients with major depression, the magnitude of that difference (i.e., the discrepancy between clinicians and their patients) positively predicts a worse response to treatment at 6 months. Taking into account aspects

of positive mental health in the treatment of mental disorders is important, as the absence of mental illness does not necessarily imply the presence of well-being (Keyes & Simoes, 2012). This model of positive mental health (Jahoda, 1958) also has profound implications for the treatment of depression. In fact, the efficacy of psychotherapy is typically assessed by symptom reduction, while variables such as quality of life or well-being are not commonly considered as core components of recovery in the scientific literature (Chambless & Ollendick, 2001).

Another way to improve treatments relates to optimizing the fit between treatment characteristics and patients' preferences. Recent evidence suggests that individual preferences may affect one's decision to enter into treatment and the therapeutic alliance generated (Gelhorn, Sexton, & Classi, 2011). For some clients with depression, pointing out deficits in their thinking as an exclusive focus of therapy may be counterproductive and may disrupt the therapeutic alliance (Castonguay et al., 2004) or may even increase treatment abandonment (Oei & Kazmierczak, 1997). Therefore, the integration of positive aspects may improve the acceptability of therapy for some patients as these aspects may better align with their expectations of the key therapeutic targets and may help them realize that psychotherapy is not only about reducing symptoms, but also about learning to use one's personal strengths, skills, and abilities to face challenges. Thus, new treatment alternatives should strive to cultivate individuals' well-being, along with ameliorating depressive symptoms. In doing so, these new empirically-validated options may extend the variety of intervention options available to accommodate clients' preferences (Lyubomirsky & Layous, 2013; Schueller, 2011).

Are positive variables relevant targets for depression treatment?

Classic psychological research on depression has been focused on negative emotions and cognitions (Gotlib & Hammen, 2010). However, in recent years, the substantial role of positive emotions and cognitions in different disorders is becoming increasingly recognized (Carl, Soskin, Kerns, & Barlow, 2013; Vazquez, 2017). Specifically, low positive affect has been found to characterize depression as compared to other emotional disorders like anxiety (Watson & Naragon-Gainey, 2010). Also, low positive affect is associated with a maladaptive regulation of positive emotions that seems to be persistent in recovery from depression and unique to symptoms of mood disorders (Werner-Seidler, Banks, Dunn, & Moulds, 2013). Some studies revealed that depressed individuals show difficulties to maintain, or amplify, positive emotions once they appear and have a greater tendency to dampen positive experiences (Werner-Seidler et al., 2013). In line with these results, both naturalistic and experimental studies have shown that depressive mood is consistently associated with a reduction in reward sensitivity rather than to increases in sensitivity to punishment (Hervas & Vazquez, 2013).

To develop more integrative models of vulnerability to depression, a dual perspective on depression (i.e., taking into account positive and negative aspects of functioning separately) may be relevant. For instance, in a longitudinal study, Wood and Tarrier (2010) showed that people who had low scores on characteristics related to psychological well-being (Ryff, 1989) such as self-acceptance, autonomy, purpose in life, positive relationships with others, environmental mastery, and personal growth were up to seven times more likely to meet the cut-off for clinical depression 10 years later.

In summary, these conceptual and empirical arguments highlight the importance of targeting positive emotional and cognitive functioning when designing new interventions for depressed patients.

Bases for positive psychological interventions' programs

Although interest in developing specific interventions to enhance psychological well-being is not new (e.g., Fordyce, 1977), there has been a recent upsurge of research aimed at increasing specific variables (e.g. subjective well-being, positive emotion, life meaning) that are intrinsically related to psychological well-being (Bolier et al., 2013; Sin & Lyubomirsky, 2009).

Over the past decade, research in this field has provided a growing body of evidence that supports the efficacy of well-being-promoting exercises not only to enhance well-being, but also to alleviate symptoms of depression. Although the majority of positive psychological interventions (PPI) have been tested using non-clinical samples (Wood & Tarrier, 2010), there is preliminary evidence of their efficacy for a wide spectrum of clinical problems (Bolier et al., 2013), mainly for depression (Seligman, Rashid, & Parks, 2006), but also for psychotic disorders (Meyer, Johnson, Parks, Iwanski, & Penn, 2012) or smoking (Kahler et al., 2014), among others. These positive psychological interventions have shown high rates of client satisfaction (Kahler et al., 2014; Lopez-Gomez et al., 2017b), attendance (Meyer et al., 2012), exercise completion (Huffman et al., 2014), and practice outside the session (Meyer et al., 2012). Moreover, positive exercises were perceived as easy to complete (Huffman et al., 2014) and enjoyable (Kahler et al., 2014), two important variables that have been positively associated with the extent of use of exercises during the follow-up period (Schueller, 2011).

With regard specifically to depression, three meta-analyses of PPI have been published including clinical and non-clinical samples, concluding that these interventions are effective in significantly decreasing symptoms of depression and enhancing well-being (Bolier et al, 2013; Sin & Lyubomirsky, 2009; Weiss et al., 2016). Furthermore, the efficacy of the interventions seems to be long-lasting. In their meta-analysis, Bolier et al. (2013) found that at the three to six month follow-up, effect sizes were small, but still significant for subjective well-being and psychological well-being, indicating that effects may be sustainable.

Even though PPI seem to be especially effective in improving depressive symptoms, very little research has been done to test PPI packages to treat clinical depression in comparison to appropriate control groups. There are few studies that have shown PPI to be effective for reducing depressive symptoms (Carr, Finnegan, Griffin, Cotter, & Hyland, 2017) and enhancing well-being (Seligman et al., 2006), treating residual symptoms (Fava, Rafanelli, Cazzaro, Conti, & Grandi, 1998a) or preventing future relapse (Fava, Rafanelli, Grandi, Conti, & Belluardo, 1998b). However, some of these studies present some limitations (e.g., small samples, unclear diagnostic procedures) (see Table 1). Taking into account the need for designing a study that addresses these limitations, a comparative study of the present intervention protocol with a well-validated treatment for depression, a cognitive-behavioral protocol (Muñoz, Aguilar-Gaxiola, & Guzman, 1995; Cuijpers, Muñoz, Clarke, & Lewinsohn, 2009), was conducted with an appropriate sample size of clinically depressed patients as their main psychotherapy (Chaves et al., 2017; Lopez-Gomez et al., 2017a). Both treatments were effective in reducing clinical symptoms and increasing well-being and no significant differences were found between them (see Chaves et al., 2017; Lopez-Gomez et al., 2017a). Furthermore,

client satisfaction and adherence to treatment were high for both conditions (Lopez-Gomez et al., 2017b).

The Integrative Positive Psychological Intervention for Depression (IPPI- D)

The aim of this paper is to describe a manualized protocol which includes a structured combination of a series of empirically-validated positive psychological interventions (see Table 2) that have been proved to be effective in increasing well-being or alleviating depressive symptoms (Bolier et al., 2013; Sin & Lyubomirsky, 2009). One of the distinctive features of this protocol is that it incorporated a balance between hedonic and eudaimonic components (see Table 2) as well as systematic in-session exercises and homework. It was applied in a group setting since the group format has been shown to be a cost-effective alternative to individual treatment (Tucker & Oei, 2007) and it provides some advantages in terms of promoting cohesion and a therapeutic context for recovery (Thimm & Antonsen, 2014). Moreover, the comprehensive assessment protocol designed to evaluate the efficacy of the intervention also maintains a balance between clinical and hedonic and eudaimonic measures. There are enough theoretical and empirical reasons to assert that positive and negative affect, distress and well-being or, even more generally, illness and health, are relatively independent of each other (Keyes & Waterman, 2003) (see Chaves et al., 2017).

This program consists of 10 weekly, two-hour sessions in a group format. We recommend a maximum of 15 participants per group. Therapists should follow a manualized protocol in which all sessions have the same general structure. The study protocol was approved by the Faculty Ethics Committee.

Conceptual framework

The current conceptualization of positive mental health challenges the extended notion that mental health is merely the opposite of mental disorder. Based on this idea, Keyes (2007) proposed a "complete state of mental health model" in which psychological well-being (i.e., positive emotions, coping resources, life satisfaction, strengths, etc.) may coexist with psychological difficulties (i.e., symptoms, deficits, disorders), and both aspects should be evaluated separately (Vazquez & Hervas, 2008).

Following the most prominent models of well-being (Ryff, 2014; Diener et al., 2016), the conceptual framework of the IPPI program considered well-being as a combination of hedonic components (e.g., positive affect) and eudaimonic components (e.g., self-acceptance, positive relations, autonomy, purpose in life, environmental mastery, personal growth; Ryff, 1989). The IPPI program was intentionally designed to nurture both components (see Table 2) that, despite being intrinsically interrelated (Waterman, 2008), need to be independently targeted in interventions aimed at improving well-being.

Moreover, although hedonic well-being may be considered transient, the broaden-and-build theory of positive emotions (Fredrickson, 1998) suggests that positive emotions may have a rather long-term effect on increasing or maintaining people's subsequent psychological well-being by building more durable physical, intellectual, and social resources that are essential to promoting adaptive coping responses (Tugade & Fredrickson, 2002). In turn, these enabling resources (e.g., personal strengths, positive emotions, positive cognitions, resilience) feed back into one's experience and cognitive judgments about life (Cohn, Fredrickson, Brown, Mikels, & Conway, 2009).

This framework guided the design of the protocol where sessions were sequenced to promote the experience and generation of positive emotions as early as possible in the program (sessions 2 to 4) while eudaimonic components were incorporated in the following sessions (sessions 5 to 9). In any case, they were not entirely separate sequences since patients were encouraged to continue practicing hedonic exercises throughout the whole program.

General structure of a session

Sessions start with a revision of previously assigned homework followed by an introduction to the topic of the day. Metaphors, poems, songs, and video-clips help to introduce the main topic of the session. After that, session goals and a brief psychoeducational module are presented and a brief discussion among participants is encouraged. Selected results from scientific studies are presented in an understandable manner to explain and counteract the effect of misconceptions about well-being. Then, participants receive guidance on how to carry out in-session exercises and practice new skills in the group. In-session exercises are relevant since this program tends to emphasize contextual and experiential change strategies in addition to more narrative and didactic ones. At the end of each session, therapists provide a summary of the key ideas and the goals of the homework assignments. Exercises are facilitated by handouts and worksheets provided during each session. Therapists try to generate a warm and supportive atmosphere during each session, making participants feel welcomed and accepted.

Description of Sessions Content

First session: Orientation to Treatment. The first session is dedicated to establishing the intervention goals and the treatment rationale. First, therapists welcome participants and highlight how important it is to attend treatment in order to help live a

better life. The importance of committing to the program in order to get better results is emphasized. As in similar group intervention programs (Muñoz et al., 1995), participants accept some rules (e.g, regular attendance, confidentiality) to ensure that the group functions well. Then, participants introduce themselves focusing on positive aspects (e.g., talking about their preferences, skills, etc.). This first session is focused mainly on generating a warm atmosphere to help participants feel comfortable. After this exercise, to formally start the meeting, therapists provide an outline and rationale for treatment, which includes a psychoeducational explanation of what depression is from a positive mental health perspective (*see* previous conceptual framework description) and emphasize the role of diminished positive emotions, cognitions and other resources (e.g., personal strengths, positive relationships) in depression maintenance (Seligman et al., 2006). Participants are asked to become aware of the positive events, and the positive emotions they may experience during the next week. A list of positive emotions is provided (e.g. joy, gratitude, serenity, love). Participants are encouraged to record them on a daily basis. A worksheet is provided for this exercise.

Second session: Positive Emotions. First, therapists explore how participants feel after the first session and they congratulate participants for their effort of coming to the treatment. This session is focused on learning to identify and name positive emotions (Seligman et al., 2006). Basic ideas about positive emotions and their benefits based on Fredrickson's theory (Fredrickson, 1998) are discussed in the group. Then, participants identify and name the positive emotions they feel when seeing different short emotional video-clips, with an emphasis on the low intensity emotions (to improve their ability to discriminate each emotion). Research has shown that the ability to name and differentiate positive emotions is related to higher well-being and resilience (Tugade, Fredrickson, & Barrett, 2004). Thus, the ultimate goal of this session is to increase participants' ability to

identify their positive emotions, broaden their emotional vocabulary and promote the experience of positive emotions during the session. This strategy aims to show participants that, although it may be difficult at first to detect positive emotions in their daily lives, they can train themselves to become aware of positive emotions and to not take them for granted or dampen them. Participants are asked to start this training by identifying and recording any small pleasures they experience in the following week. When identifying the experience, participants are asked to take a moment to name the emotion and actively experience it.

Third session: Savoring and Being Aware. This session was designed based on the idea that positive emotions can be maintained and even increased both in the short- and longer-term through attentional deployment (Quoidbach, Mikolajczak, & Gross, 2015). Attentional deployment is a deliberate attempt to make emotions last and minimize hedonic treadmill (Seligman et al., 2006). Savoring, mindfulness and emotion regulation are the topics of this session. Mindfulness may foster both savoring and emotion regulation. Participants also learn and practice mindfulness attitudes (e.g., acceptance, beginner’s mind, non-judging) in order to change their relationship to their emotional experiences and thoughts (Segal, Vincent, & Levitt, 2002) and prevent the experiential avoidance that characterizes depression (Cribb, Moulds, & Carter, 2006). In order to facilitate positive and negative emotion regulation processes, these attitudes are illustrated in the session through different exercises, such as brief practices of mindful breathing, body scan, or savoring a piece of chocolate and a raisin, as a way to cultivate mindful awareness and openness. The raisin exercise helps introduce the topic of negative emotion regulation strategies. Participants explore different negative emotions and their adaptive functions, as well as the possible emotion regulation strategies that may help to manage them. The goal is that participants learn the importance of embracing the whole

emotional experience (Kabat-Zinn, 2004). As part of their homework, participants are instructed to purposefully notice pleasurable features of their environment and practice attitudes of mindfulness in their daily lives (e.g., an attentive walk, a mindful meal or shower) (Kabat-Zinn, 1994). Participants are encouraged to use savoring techniques before, during, and after positive emotional events (Bryant & Veroff, 2007).

Fourth session: Gratitude and Optimism. Benefits of expressing gratitude and optimism have been broadly tested (e.g., Emmons & McCullough, 2003; Carver, Scheier, & Segerstrom, 2010; Malouff & Schutte, 2017; Weiss & Speridakos, 2011). Firstly, participants explore the effects of giving thanks and discuss their benefits on well-being and health. Participants write individually about three good things (small or big) for which they want to express gratitude and are then encouraged to share them aloud, noticing the effect on themselves (Seligman et al., 2006). To focus on interpersonal gratitude, participants have the option to write a gratitude letter to a person who has helped them, and to whom they have never properly thanked. After this activity on gratitude, the topic of optimism is introduced. Therapists briefly introduce the idea of locus of control and characteristics of an optimistic explanatory style (Seligman, 1998). Reframing things in a more positive way (e.g., finding silver linings) is often challenging for depressed people. This session helps participants perceive benefits from even negative situations (Sergeant & Mongrain, 2014). Therapists explicitly try to start by practicing the concept of reappraisal to help participants reframe small events from daily life (e.g., even though you missed the bus, you at least got some good exercise when you were running to catch it). After that, it will be easier – or even come naturally – to also find meaning or “look on the bright side” of more important negative life events. As part of their homework, participants start a gratitude journal in which they write down three good things that happened during the day. Participants also complete a journal of silver linings.

Fifth session: Positive Relationships. The characteristics and benefits of nurturing positive relationships (Lyubomirsky, 2007) are discussed based on scientific literature, participants' examples, and video-clips about lessons learned by people who have suffered difficult events and have learned the importance of positive relationships. Then, participants individually write their current strategies for cultivating positive relationships and share their ideas in the group. Key strategies highlighted during the session are expressing frequent positive affect to others, offering sincere compliments, mindful listening, expressing gratitude, responding actively and constructively to good news from others, or practicing acts of kindness. As homework, participants are asked to put into practice the acts of kindness in the list that they committed to performing (Boehm & Lyubomirsky, 2009). Two journals, one aimed at nurturing positive relationships and another focusing on kindness, are provided where personal and interpersonal consequences of the performed actions are recorded.

Sixth session: *Compassion.* This session focuses on the importance of cultivating a compassionate mind, and it is especially useful for people with high shame and self-criticism (Kirby, Tellegen & Steindl, 2017). Characteristics of a compassionate mind are explained (e.g., nonjudgmental nature, centered on personal strengths, desire to reduce suffering, and warmth) (Gilbert, 2012). The adaptive function of self-criticism is analyzed and compared with the benefits of a compassionate approach. First, participants identify and explore these characteristics when relating to others. Later, participants write a self-compassionate letter during the session (Neff & Germer, 2013). This exercise asks participants to write a letter to themselves expressing compassion for their own suffering. While participants write these letters, a mindfulness attitude, a feeling of common humanity, and self-kindness are promoted (Gilbert, 2012). As homework, participants complete a journal where their self-critical inner 'thinker' is analyzed in terms of its

adaptive function and it is reframed as a more compassionate and warm 'voice' (Gilbert, 2012). Also, as a link to the next session, participants are asked to complete the VIA-IS (VIA Inventory of Strengths; Peterson, Park, & Seligman, 2005) which identifies participants' signature strengths.

Seventh session: Personal Strengths. This session focuses on personal strengths and how people often give their weaknesses and limitations more attention than their strengths. Participants explore how thinking about their personal strengths can increase happiness and reduce depression (Seligman et al., 2006). Firstly, VIA classification and the definition of character strengths are presented (handouts are provided). Participants receive individualized feedback about their top five strengths (Peterson & Park, 2009). Working in pairs, participants are instructed to engage in an interview about their strengths (Tarragona, 2012). Participants share stories that illustrate their strengths in action, the impact that these strengths have had in their lives and what they do to nurture them. Participants complete the exercise 'at my best' (Seligman et al. 2006) where they are invited to share with their conversational partner a story that reflects a time that they were "at their best" – a time when they felt proud of themselves. Therapists help clarify the idea further by giving a personal example of an experience from a time when they were "at their best" to guide participants about the types of things they could think about (e.g., an excellent performance during a job interview). Partners are asked to listen carefully in order to identify the personal strengths in the story. Finally, participants are guided to formulate specific, concrete and achievable behaviors that promote the cultivation of signature strengths. Participants are asked to use one of these top strengths in a different way every day for one week (Seligman et al., 2006).

Eighth session: Personal Goals and Purpose in Life. In this session, the significance of defining one's purpose in life is discussed. Purpose in life represents a

stable and generalized intention to accomplish something that is both meaningful to the self and leads to productive engagement with some aspect of the world beyond the self (Damon, 2009). Firstly, participants complete the 110-year old you in a time machine activity (Ben-Shahar, 2007). Participants are asked to think what they would say to their today 'you' if they could call he/she when they were 110 years old. During this exercise, participants begin to reflect upon the essence of living a fruitful and satisfying life. Projecting oneself into the future is considered an antidepressant technique (Lazarus, 1989). Secondly, participants are told to imagine that they need to write their own biography from a realistic perspective. They are asked to write down what the title of that biography would be (e.g., *Mother Teresa of Calcutta: A Life of Love*). Participants are encouraged to share their titles and their means in terms of purpose (e.g., what you would like to be remembered for the most) and personal strengths. Awareness of one's purpose and making conclusions about oneself in terms of personal strengths encourage individuals to take steps so that their actions and relationships will be more aligned and congruent with their purposes in life (Kashdan & McKnight, 2009). The second part of this session is focused on setting goals, guided by purpose in life, but more specific and feasible than one's greater purpose in life. Purpose is a larger construct that motivates people to have goals and it organizes those goals (Steger, 2009). Key aspects of goal-setting are discussed (e.g., setting specific, challenging, and realistic goals) and barriers to achieving them (Locke & Latham, 1990). Participants start defining their goals in different areas (e.g., health, family, work, etc.) and strategies to face the difficulties in achieving goals are discussed (MacLeod, Coates, & Hetherton, 2008). During the following week, participants are encouraged to select one or two goals and plan the steps they must take to achieve them.

Ninth session: Resilience. The aim of the session is to describe central aspects of resilience and the factors that enable individuals to cope with life's adversities. Resilience has been described as a key concept in the prevention of the onset and maintenance of depression (Waugh & Koster, 2015). In the beginning of the session, some testimonial video-clips of resilient people facing adversity (e.g., severe illness, natural disasters) are displayed. Routes to resilience are subsequently explored following what research has revealed about those attributes and trajectories (Bonnano, 2004). Then, participants are asked to write about a personal past adverse situation where they utilized a resilient coping mechanism. Participants are asked to identify the factors that probably helped them to overcome these challenges. These factors typically include cognitive, emotional, social and behavioral skills. External or internal resources such as personal strengths, optimism, and spirituality are also discussed (Folkman & Moskowitz, 2000). Participants are encouraged to remember these stories and the resources that will probably help them cope with new adversities. As homework, participants are invited to write a letter to future members of this workshop. They are asked to share how they felt when they first began therapy, what their emotions were, what they have learnt, what helped them the most, what difficulties they had and how they overcame them.

Tenth session: Relapse prevention. Therapists introduce the last session focusing on how participants have changed and the importance of maintaining those improvements in order to continue to live better lives. Characteristics of relapse are discussed and ways of maintaining the gains achieved during the program are explored. A review of learned techniques is presented, focusing on the broad repertoire of positive techniques that the participants have learnt. To enhance the use of positive psychological interventions, participants are also reminded that a variety of exercises usually minimizes hedonic adaptation. Searching for an optimal person-activity fit is also encouraged (Lyubomirsky

& Layous, 2013). Therapists emphasize the importance of continuing to practice the activities that work better for each person in order to achieve sustainable results. To close the session participants are invited to read out their letters for future participants to the entire group. The ultimate goal is to help participants retrospectively analyze the changes they have undergone during this treatment and the main strategies that help them recover from depression. Feedback from the group is encouraged, reinforcing their achievements and strengths and promoting a sense of mutual help and belonging. Then, therapists reveal that the recipients of these letters are just themselves. They tell participants that they should keep their letters in case they ever need them. At the end of the session participants celebrate graduation, a time to recognize and celebrate their achievements.

Underlying philosophy and general guidelines for therapists

Addressing problems and symptoms is the most widespread conception of the role of psychotherapy among clinicians but also among some clients. Any perceived failure to take clients' troubles seriously may violate their expectations and can undermine the establishment of a good therapeutic alliance (Seligman et al., 2006). Therapists doing PPI interventions should keep this in mind, seeking a balance between nurturing positive resources and attending to and validating suffering. Negative emotions or clinical symptoms should be empathically attended to within the context of a holistic well-being framework. In addition to this attitude of acceptance and openness, therapists should also spend substantial time during the sessions reeducating patients' attention and memory to help them focus on what is good in their lives and new ways to increase well-being. This strategy fosters a transformation of the conventional language used during therapy towards a more positive and constructive dialogue and, over time, provides a more balanced context in which clients can cope with their problems. Another relevant aspect of the PPI framework that is rather unique is the group atmosphere generated. The positive

affect that arises when individuals reveal or (re)discover key intrinsic valuable aspects of their selves is far from something frivolous or light. Although this positive climate often greatly benefits patients, it is also relevant for explaining therapist engagement.

Although PPI protocol could share some formal similarities with other psychotherapies (e.g., CBT) in regard to its structure, general therapeutic targets (e.g., emotions, relationships, goal setting) or sequential strategies (e.g., psychoeducation, relapse prevention), PPI differ fundamentally in terms of their theoretical underpinnings and other relevant aspects, such as the framework, the therapist's approach, and the specific contents of the therapy and exercises. For instance, in terms of initial psychoeducation, while CBT frames depression as a result of behavioral inhibition, negative emotions and cognitive biases related to the processing of negative information (e.g., Beck & Bredemeier, 2016), the PPI approach frames depression by focusing on low levels of positive affect (e.g., dampening positive emotions) and psychological well-being (e.g., a diminished purpose in life or sense of growth) which are also well supported by the literature (e.g., Dunn, 2012; Admon & Pizzagili, 2015).

On the other hand, PPI also differ from other therapeutic frameworks in the way they address similar dimensions. For instance, while CBT is targeted at identifying and modifying negative thoughts and behaviors to indirectly increase positive affect, PPI directly identify and generate positive emotions during the sessions and homework assignments (e.g., gratitude, love) and help participants manage these emotions more effectively (Holmes, Lang, & Shah, 2009). Furthermore, the underlying philosophy and methods used in PPI are often more experiential than didactic. Moreover, whereas CBT promotes an intensification of positive experiences in general, PPI emphasizes the importance of investing in activities linked to intrinsic values and well-being dimensions (Ryff, 2014). Although some problem-solving and discussion of clinical symptoms does

occasionally take place in the course of PPI, the goal is to strengthen already existing positive aspects or build psychological resources, rather than teaching the reinterpretation of negative aspects (Rashid, 2015). Similarly, whereas in CBT the focus is aimed at changing the content of emotions, in the current PPI program the focus is on encouraging patients to embrace negative thoughts and feelings, such as anxiety, pain, and guilt. This approach is also applied to address self-criticism. Although self-compassion and self-criticism could be seen as two sides of the same coin, developing loving-kindness toward others and oneself is a positive outcome in its own right, not just the reduction of self-criticism (Gilbert, 2012).

Discussion and conclusions

There is emerging evidence on the adequacy of structured PPI programs in the treatment of clinical depression (Carr & Finnegan, 2015; Seligman et al., 2006). If the efficacy of IPPI is supported by further research, it would add IPPI to the list of empirically validated therapies for depression and extend the range of intervention options available to accommodate clients' needs and preferences (Lyubomirsky & Layous, 2013). Since acceptability of treatments is an essential aspect of their effectiveness (Moher, Schulz, & Altman, 2001) and preference may affect the efficacy of treatments (Schueller, 2011), the development of new interventions based on positive psychology principles is an excellent opportunity to provide professionals with a wider range of effective therapeutic options. Although there are few primary studies that are explicitly designed to explore the impact of clients' preferences on intervention outcomes (Proyer, Wellenzohn, Gander, & Ruch, 2015; Schueller, 2011), it is plausible that, in many cases, interventions focused on positive emotions and positive traits could help to destigmatize patients' feelings towards being in psychological treatment (Rashid, 2015). Results from a trial using this protocol have shown that it was highly acceptable for

participants and more satisfactory than CBT in some parameters (Lopez-Gomez et al., 2017b). On the contrary, for patients who are reluctant to experience positive emotions (Gilbert et al., 2012) or for those whom positive exercises are perceived as 'trivial', perhaps PPI should not be a front-line strategy or should be adapted. Otherwise, the credibility of the intervention could be compromised which, consequently, would lead to high dropout rates (Uliaszek, Rashid, Williams, & Gulamani, 2016). To minimize participants' possible misconceptions, our IPPI program made sure to present a credible rationale for its aims and strategies in its first module.

Potential future research should consider the weight of the program components in relation to their contribution to clinical improvement, the specific details of their administration (e.g., order of components, duration of the sessions) or the combination of this program with other types of psychotherapy. It is possible that a combination of PPI with other approaches (e.g., CBT plus hedonic-oriented exercises) could boost the therapeutic impact of known therapies (Dunn & Roberts, 2016). In this line of reasoning, some preliminary research has shown evidence that personalizing treatments to clients' strengths led to better results than personalizing treatments to clients' deficits (Cheavens, Strunk, Lazarus, & Goldstein, 2012). Another option could be tailoring treatments according to patients' depression presentations, applying CBT, PPI or a personalized combination of both. Personalizing treatments for specific clients is an area of research that awaits further exploration. It seems plausible that creating intervention programs specifically tailored to the specific needs of clinical populations (e.g., Lopez-Gomez et al., 2017b; Carr et al., 2017) may increase their acceptability.

Finally, it should be emphasized that the current PPI program was based on techniques and interventions that have been successfully used to improve mood in patients and healthy individuals. It would be useful if future developments of PPI in

depression, and other disorders, took into account other techniques inspired by basic research on emotions and psychopathology. For instance, based on current research on cognition and emotion in depression, it is possible that in the near future interventions may include modules targeting, for instance, positive components of imagery (Holmes, Blackwell, Burnett Heyes, Renner, & Raes, 2016), future directed thinking (Vilhauer et al., 2013), positive specific memories (Romero, Vazquez, & Sanchez, 2014), or benign interpretation biases (Yiend et al., 2013). The field of positive psychological interventions is a promising new area. Yet, it will allow advancements in the treatment of depression and other mental disorders only as long as it is deeply rooted in sound findings from basic and applied research and the design of the interventions follows the strictest rules required to validate psychological treatments (Vazquez, 2017; Dunn, 2017). To sum up, we believe that PPI will favor the emergence of ideal therapeutic settings where therapists will integrate the handling of symptoms and strengths, vulnerabilities and resources. This will allow therapists to better understand the inherent complexities of human experience in a more comprehensive and balanced way, leading to better treatment.

Compliance with Ethical Standards

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Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research

committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed consent

Informed consent was obtained from all individual participants included in the study.

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Table 1. *Studies on positive psychotherapy as a packaged treatment for depression (clinical sample, published in peer review journals)*

Authors and year	Intervention description	Sample	Intervention group	Key findings	Limitations
Seligman et al. (2006)	PPT. Three main components: (1) Positive emotions, (2) Engagement, (3) Meaning	MDD	PPT (N=11); TAU (N=11) vs. TAU plus antidepressant medication (N=11)	PPT resulted in more symptomatic improvement, increased remission from depressive disorder and enhanced happiness levels than TAU and TAU + medication	Compared to TAU Inclusion criteria based on BDI; no diagnostic process Small sample size No follow-up
Moeenizadeh & Salagame, 2010	WBT. Based on the multidimensional Ryff's model (1989).	Dysthymic disorder	WBT (N=20) vs. CBT (N=20)	WBT is more effective than CBT	Unknown diagnostic process; Dysthymic disorder Unclear intervention protocol No follow-up
Cuadra-Peralta et al. (2010)	PPT. Gratitude, optimism, forgiveness, personal strengths, savoring, active/constructive responding.	Depression	PPT (N=8) vs. TAU (N=10)	Post happiness levels were higher for PPT than CBT. On depression both treatments did not differ.	Small sample Unknown diagnostic process Compared to TAU Time x Group effects were not analyzed. No follow-up
Asgharipoor et al. (2012)	PPT. Based on Seligman et al., 2006	MDD	PPT (N=9) vs. CBT (N=9)	Happiness levels were higher for PPT than CBT. On most measures both treatments did not differ.	Small sample size No follow-up
Carr et al., (2017)	SYTL. A combination of CBT and PPT	MDD	SYTL (N=40) vs. CBT (N=42)	72% SYTL treatment-completers were recovered after therapy (vs. 28% TAU treatment-completers)	Compared to TAU Absence of data on participants' well-being.
Treating residual symptoms and preventing relapses					
Fava et al., 1998a; Fava et al., 1998b; Fava & Ruini, 2003	WBT. Based on the multidimensional model of psychological well-being proposed by Ryff (1989).	Fava et al., 1998a: patients in the residual phase of affective disorders who had been treated	WBT (N=10) vs. CBT (N=10)	Fava et al., 1998a: Significant reduction of residual symptoms	Fava et al., 1998a: Different affective disorders, not only depression Intervention protocol unclear

		by behavioral or pharmacological methods. Fava et al., 1998b: 40 patients with recurrent (3 or more episodes) major depression, who had been successfully treated with antidepressant drugs.	CBT+WBT (N=20) vs. Clinical management (N=20)	Fava et al., 1998b: Cognitive behavioral package including well-being therapy resulted in a significantly lower relapse rate (25%) at a 2-year follow-up than did the group of clinical management (80%)	Fava et al., 1998b: Since WBT was only a part of cognitive behavioral package, it is not possible to know from this study whether it yielded a significant contribution
Teasdale et al., 2000	MBCT. A combination of cognitive strategies, meditative practices and attitudes based on the cultivation of mindfulness.	Patients with 3 or more previous episodes of depression	MBCT (N=60) vs. TAU or TAU plus medication (N=60)	MBCT significantly reduced relapse rates.	Compared to TAU It was designed to prevent relapses in depression.

Note. PPT = Positive psychotherapy; MDD = Major depression disorder; TAU = Treatment as usual; BDI = Beck Depression Inventory; WBT = Well-being therapy; CBT = Cognitive behavioral therapy; SYTL = Say Yes to Life; MBCT = Mindfulness-based cognitive therapy.

Table 2. *Positive psychological interventions included in the study*

Module	Description of the session	Previous empirically-validated studies	Well-being dimension
1	Objectives, expectations and attitudes on treatment. What is depression? Rationale for treatment from a positive psychology perspective	Based on Keyes (2007), Seligman et al. (2006), Gilbert (2012), among others.	
2	Positive emotions: identify and name positive emotions and learn to promote them.	Seligman et al. (2006)	Hedonic
3	Savoring to amplify the intensity and duration of positive emotions Emotion regulation through mindfulness attitudes	Bryant (1989) Kabat-Zinn (1990)	Hedonic
4	Gratitude. Counting one's blessings Optimism	Emmons & McCullough (2003) Seligman et al. (2006)	Hedonic
5	Positive relationships Kindness. Counting kindnesses	Lyubomirsky et al. (2005), Boehm & Lyubomirsky (2009)	Eudaimonic: Positive relationships
6	Self-compassion	Gilbert (2012)	Eudaimonic: Self-acceptance
7	Personal strengths. Complete VIA-IS and using one's signature strengths	Seligman et al. (2005)	Eudaimonic: Autonomy, Self-acceptance
8	Sense of living. Obituary/Biography Goal Setting	Seligman et al. (2005) MacLeod et al., (2008), Sheldon et al. (2002)	Eudaimonic: Purpose in life, Personal growth
9	Resilience	Based on Folkman & Moskowitz (2000)	Eudaimonic: Environmental mastery
10	Relapse prevention	Following same rationale as CBT	

Note. VIA-IS = VIA Inventory of Strengths (Peterson & Park, 2009). CBT = cognitive-behavioral therapy.