

The Application of Positive Psychotherapy in Mental Health Care: A Systematic Review

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Objective: Positive psychotherapy (PPT) stems from the positive psychology movement and is a multicomponent model promoting therapeutic change by developing engagement, pleasure, and meaning. There is some evidence it is effective for depression. PPT is recommended as a flexible model that can be applied to other patient groups alongside other treatments approaches. However, it remains unclear which of the many components are applied. The study aimed to identify how PPT is applied in mental health care. **Method:** We systematically searched online databases, including Medline, Embase, PsycINFO, British Nursing Index, Cumulative Index of Nursing and Applied Health, and Cochrane registers (CENTRAL), and completed complementary hand and citation searches. Narrative synthesis was used for analysis. **Results:** A total of 12 papers (from 9 studies) widely applied some PPT components (e.g., blessings journal, character strengths) and scarcely applied others (e.g., satisficing plan or family strengths tree). However, papers poorly described the intervention and rationale for applying components. **Conclusion:** Given the lack of rationale for applying PPT, further research is needed to establish which components are acceptable and feasible for use in different patient groups and settings. © 2016 Wiley Periodicals, Inc. *J. Clin. Psychol.* 73:638–651, 2017.

Positive psychotherapy (PPT) originates from the positive psychology movement (Seligman, Rashid, & Parks, 2006), a discipline that promotes well-being and flourishing in individuals, institutions, and society (Seligman & Csikszentmihalyi, 2000). The focus of the movement is to not only treat mental distress but also ensure people's lives are productive and fulfilling and they are using talents (Seligman & Csikszentmihalyi, 2000). The conceptual framework of PPT, therefore, focuses on treating depression by promoting engagement (involvement in daily life), pleasure (positive emotions), and meaning (belonging to and serving something greater than the self; Rashid, 2015; Seligman et al., 2006). This is in contrast to some traditional psychotherapies, which focus on problems or changing maladaptive patterns of thoughts and behaviors (Seligman et al., 2006). PPT is therefore recognized as a resource-oriented approach aiming to use patients' personal and social resources to promote therapeutic change (Priebe, Omer, Giacco, & Slade, 2014).

There is some evidence that PPT is effective. The complex and multicomponent intervention model, shown in Table 1, was trialed with major depressive disorder and significantly improved symptoms of depression and well-being, compared to treatment as usual or treatment as usual with medication (Seligman et al., 2006). A shorter version of the model also was piloted as group therapy and improved depressive symptoms in students with mild-to-moderate depression

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Table 1
Positive Psychotherapy Model Described in Seligman et al. (2006)

Session	Content	Homework
1. Orientation	Guidelines, homework, journaling introduced and discuss lack of positive emotions, strengths, and meaning in depression	Positive introduction—clients write short story at their ‘best’
2. Character strengths	Identify strengths from positive introduction; pathways to happiness (pleasure, engagement, meaning)	Online strengths questionnaire (VIA-IS) and family/friend shorter questionnaire
3. Signature strengths	Plan to develop identified strengths	Blessings journal—three good things each day
4. Good vs. bad memories	Negative memories in reinforcing distress, positive memories benefit	Writing memories: three bad memories and distress
5. Forgiveness	Transform anger and bitterness to neutral or positive emotion	Forgiveness letter (delivered if appropriate)
6. Gratitude	Enduring thankfulness, and the role of good and bad memories is highlighted, and positive reframing is introduced	Gratitude letter to someone never properly thanked
7. Midtherapy check	Revisit signature strengths plan, blessings journal, forgiveness, and gratitude letters; progress discussed	
8. Satisficing vs. maximizing	Settling for good enough compared to trying to find the ‘best’ option	Personal satisficing plan
9. Hope and optimism	Thinking of times when something important did not happen but other opportunities arose	One door closes, one door opens
10. Love and attachment	Active constructive responding (ACR) as being enthusiastic and supportive of others’ meaningful and important news; clients encouraged to recognize others strengths	ACR and strengths date
11. Signature strengths of others	Significance of recognizing signature strengths of family members is discussed	Family strengths tree, using VIA-IS online and discussion
12. Savoring	Awareness of pleasure and attempts to make it last using techniques	Planned savoring activity
13. Gift of time	Using strengths in service of others	Giving the gift of time
14. Full life	Integrating pleasure, engagement, and meaning; therapeutic gains and ways to maintain are discussed	

(Seligman et al., 2006). Both versions of PPT are described in detail in the original paper (Seligman et al., 2006) and elsewhere (Rashid & Seligman, 2014; Rashid, 2008, 2015).

However, further systematic trials are lacking. One impediment to further trials is that there is no clear model of processes or mechanisms of change (Rashid, 2015), which is necessary for the evaluation of complex interventions (Craig et al., 2008). This is important because it can help to clarify how effective different stages of the intervention are likely to be and how each component may contribute to improving outcomes. Although the authors suggest the model is flexible and can be adapted to different patient groups (Rashid, 2008) or applied alongside other treatment approaches (Rashid & Seligman, 2014), there is no guidance on this. This had led to adaptations for different populations that vary considerably in structure and content (Schrank, Brownell, Tylee, & Slade, 2014). Accordingly, the aim of the present study is to systematically review how PPT is applied in mental health care, including modifications to the model.

Method

A systematic review was conducted in April 2015 to identify papers using PPT in mental health-care. A protocol informed by PRISMA guidelines (Moher & Liberati, 2009) was used for the electronic database search and hand searches in key journals. Search terms were a combination of MeSH and keywords amended for each database and included positive psychotherapy terms ("positive psychotherapy," "positive psychology," "positive psychology interventions") and key words related to mental illness ("schizophrenia," "affective disorder," "anxiety disorder").

Eligibility Criteria

Studies were included if the majority (at least 50%) of the participants were working age adults (18–65 years) and had either (a) a diagnosis of a mental health condition classified by the treating clinician or researcher or (b) met criteria for clinical symptoms of a mental health condition on a recognized scale. The cutoff scores used were 16 for the Center for Epidemiologic Studies Depression Scale (20 items; Radloff, 1977; Ware, Kosinski, Turner-Bowker, & Gandek, 2002) and 42 for the Short-Form Health Survey Mental Component Summary (Gill, Butterworth, Rodgers, & Mackinnon, 2007).

To ensure that included papers were similar to the original model, a minimum of two components of the original multicomponent PPT (Seligman et al., 2006) had to be present. There was no limitation on study design, comparator, or outcome measurement. The papers had to be in English and published in a peer-reviewed journal.

Search Strategy and Screening

The databases searched were MEDLINE, Embase, PsycINFO, British Nursing Index, Cumulative Index of Nursing and Applied Health, and Cochrane registers (CENTRAL). Databases were searched from 1998 onward because this was the inception of the positive psychology movement (Seligman & Csikszentmihalyi, 2000). Web of Science and Google Scholar were used for forward citation searching of the included papers and the original PPT paper (Seligman et al., 2006). The reference lists of all included papers and any systematic reviews also were screened. Secondary hand searches were completed in the following journals: *Journal of Positive Psychotherapy*, *Journal of Happiness Studies*, *Psychology of Well-Being*, and *International Journal of Wellbeing*.

After removing duplicates, we used a two-stage screening process: first, the first author screened all titles and abstracts while a second independent researcher (MC) screened a random selection of 25% of titles and abstracts to ensure the consistency of screening. Second, full texts were accessed and both researchers independently reviewed all papers. Any disagreements were resolved through discussion. In a number of cases, the authors had to be contacted to provide clarification on whether the paper met the eligibility criteria or to provide additional detail. Some authors confirmed this (Cohn, Pietrucha, Saslow, Hult, & Moskowitz, 2014) and the information provided is included in the analysis (Asgharipour et al., 2012).

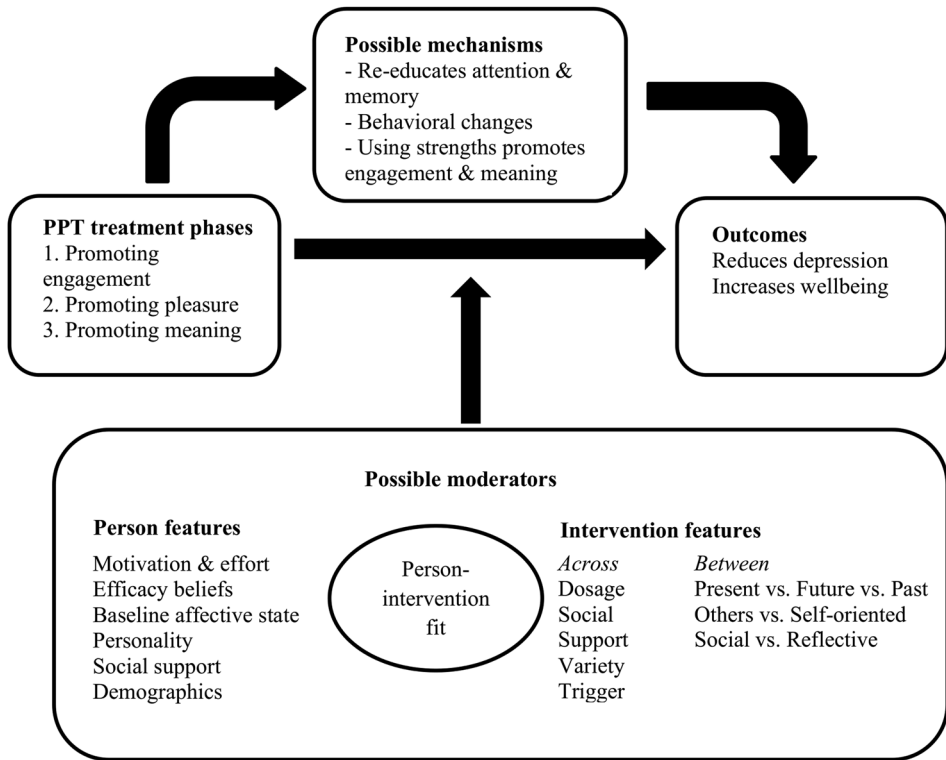


Figure 1. Theory of positive psychotherapy.

Data Extraction

Data from each study including details on study design and the intervention were extracted into a Microsoft Excel spreadsheet. Study data included design, recruitment, population, number of participants, comparators, methods, and outcomes. Intervention data were informed by the Template for Intervention Description and Replication (TIDieR) checklist (Hoffmann et al., 2014) and included name, materials, provider, delivery mode, location, duration, intensity, and modification.

Critical Appraisal

The TIDieR checklist also was used to assess the quality of the intervention reporting (Hoffmann et al., 2014). Study quality was assessed using tools recommended for qualitative evidence synthesis (Noyes et al., 2015): The Quality Assessment Tool for Quantitative Studies (Effective Public Health Practice Project, 1998) and the Qualitative Checklist (Critical Appraisal Skills Programme, 2014).

Analysis

Narrative synthesis was used to analyze the data, which involves four elements: theory development, preliminary synthesis, exploring relationships within and between studies, and assessing robustness of synthesis (Popay et al., 2006). These elements were not undertaken sequentially but in an iterative process, described below.

Some mechanisms of the intervention have been identified (Lyubomirsky & Layous, 2013; Rashid, 2015; Seligman et al., 2006) and were depicted in Figure 1. Tabulation and grouping data were used to create a preliminary synthesis of how the PPT model was used, including

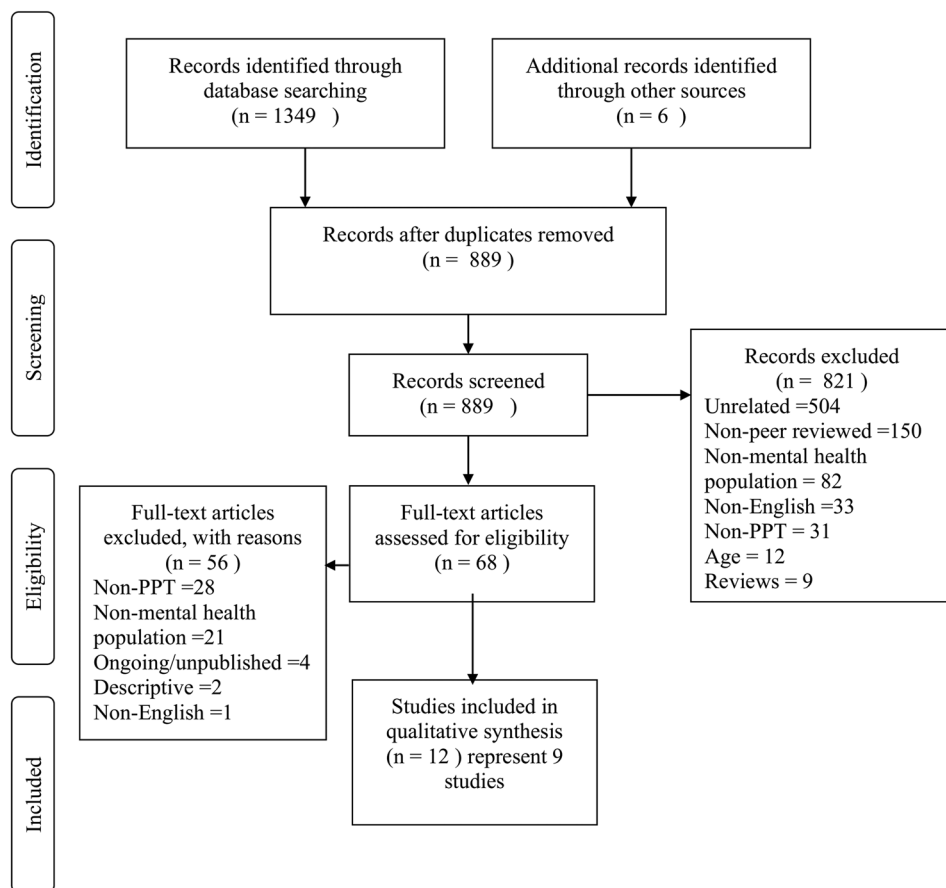


Figure 2. Study selection.

modifications and additions. This preliminary synthesis was shared among the study authors for discussion and refinement. The relationships within and between studies were then explored using the visual approach of idea webbing (spider diagram). This helped to conceptualize the application of the components and the similarities and differences between changes to the model across studies. Critical reflections were recorded throughout the synthesis and are reported along with the results, as recommended (Popay et al., 2006).

Results

A total of 889 unique references were retrieved and the inclusion process is depicted in Figure 2. After titles and abstracts were screened, 821 articles were excluded largely on the basis that they were unrelated ($n = 504$), were not peer reviewed ($n = 150$), were not a mental health population ($n = 82$), were not in English ($n = 33$), were not PPT ($n = 31$), did not meet the age criterion ($n = 12$), or were commentaries or reviews ($n = 9$). Sixty-eight full texts were examined, 12 of which were included. (A list of excluded studies and reasons for exclusion from this screening stage are available from the authors on request.) The 12 papers represent nine unique studies, as the WELLFOCUS study was evaluated in four separate papers (Schrang, Riches et al., 2014; Schrang et al., 2015; Brownell, Schrang, Jakaite, Larkin, & Slade, 2015; Riches, Schrang, Rashid & Slade, 2015).

The study characteristics, treatment protocol, and description of findings are outlined in Table 2. The following results compare the eight PPT adaptations (Asgharipoor et al., 2012;

Table 2
Study Characteristics

Study, Design	Design	N	Clinical status	Additional interventions	Delivery	Sessions, duration	Findings
Seligman (2006 Study 2)	RCT comparing 1. PPT 2. TAU 3. TAU + antidepressant	45	DSM-IV criteria for major depressive disorder	— ^a	Individual	14, over 12 weeks	Depression, functioning, and happiness significantly improved; no difference in life satisfaction
Asgharipoor (2012)	RCT comparing 1. Adapted PPT 2. Group CBT	18	DSM-IV criteria for major depressive disorder	Activity scheduling; behavioral commitment to values	Group	12, 2 hours, over 12 weeks	Happiness significantly improved in PPT; significant decrease in distress in CBT; no group differences in well-being or depression
Carr & Finnigan (2014)	Protocol of adapted PPT	— ^b	Major depressive disorder	CBT including cognitive restructuring, self-talk, anxiety and anger management, and assertiveness; goal setting; meditation; physical exercise	Group	20, 2 hours, unknown duration	— ^b
Meyer (2012)	Single arm pilot of adapted PPT	16	Current diagnosis of schizophrenia or schizoaffective disorder	Mindfulness minute; positive goal	Group	10, 1.5 hours, over 10 weeks. Additional booster after 6 weeks	Significant improvement in well-being, hope, savoring, self-esteem, symptoms but no effect on social functioning
Schrank (2015)	RCT comparing 1. Adapted PPT 2. TAU	94	Clinical diagnosis of psychosis	Mindful music listening	Group	11, 1.5 hours, over 11 weeks	No significant effect on primary outcome well-being; significant effect on psychiatric symptoms, depression, and another well-being measure

(Continued)

Table 2
Continued

Study, Design	Design	N	Clinical status	Additional interventions	Delivery	Sessions, duration	Findings
Roepke (2015) RCT	RCT comparing 1. PPT exercises 2. General SuperBetter 3. Waiting list	283	Meeting criteria for clinically significant depression (≥ 16 CES-D)	CBT; activity scheduling; acceptance content	App	Daily, 10 minutes, over 4 weeks	Depression improved in conditions 1 and 2 relative to the waiting list; similar pattern in secondary outcomes life satisfaction, social support, self-efficacy Significant effect on depression; no effect on secondary outcomes perceived stress, positive and negative affect, diabetes-specific psychological measures, health behavior
Cohn (2014)	RCT comparing 1. PPT exercises 2. Emotion reporting	49	Target group people with type 2 diabetes and depression (53% ≥ 16 CES-D)	Activity scheduling; mindful breathing; positive reappraisal; acts of kindness; character strengths journal	Online	5, over 5 weeks	Significant reduction in participants at risk for depression; significant changes in secondary outcomes including physical, mental, and general health
Lambert D'raven (2015)	Single arm pilot of PPT exercises	318	Target group mild to moderate depressive symptoms (> 42 mental health component of SF-12)	Mindfulness; goal setting; positive writing; reducing overthinking; self-talk; optimism	Group	6, 2 hours, over 6 weeks	Optimism and hopelessness improved significantly for all exercises except forgiveness letter
Huffman (2014)	Single arm pilot of PPT exercises	61	Admission to inpatient psychiatric unit for passive or active suicidal ideation or suicide attempt	Activity scheduling; acts of kindness; best possible self; behavioral commitment to values	Individual	9, over 9 days	

Note. RCT = randomized clinical trial; PPT = positive psychotherapy; TAU = treatment as usual; CBT = cognitive behavioral therapy; SF-12 = Short-Form Health Survey; DSM-IV = *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*; CES-D = Center for Epidemiologic Studies Depression Scale.
^aThis paper describes the original intervention; therefore, no amendments were made.
^bThis paper describes the intervention; therefore, no data are provided on design, sample size, or findings.

Table 3
Intervention Components From Positive Psychotherapy

Study	Therapy phase																								Total		
	Engagement								Pleasure								Meaning										
Seligman (2006)	Orientation	Positive introduction ^a	Character strengths assessment	Character strengths	Signature strengths	Blessings journal ^a	Good vs. bad memories	Writing memories ^a	Forgiveness	Forgiveness letter ^a	Gratitude	Gratitude letter ^a	Midtherapy check	Satisficing vs. maximizing	Satisficing plan ^a	Hope and optimism	One door closes, one door opens ^a	Love & attachment	Active constructive responding strengths date ^a	Others' signature strengths	Family strengths tree ^a	Savoring	Savoring activity ^a	Gift of time	Giving the gift of time ^a	Full life	
As-gharipoor (2012)	✓		✓	✓	✓	✓					✓														✓	7	
Carr (2014)	✓		✓	✓		✓			✓	✓	✓	✓										✓	✓	✓	✓		12
Meyer (2012)			✓	✓		✓						✓	✓						✓	✓		✓	✓	✓	✓		11
Schrank (2015)	✓	✓	✓		✓	✓			✓	✓	✓	✓				✓	✓	✓	✓	✓	✓	✓	✓				16
Roepke (2015)				✓	✓	✓																					3
Cohn (2014)			✓			✓																✓					3
Lambert D'Raven (2015)	✓					✓					✓	✓							✓		✓	✓			✓	8	
Huffman (2014)	✓		✓	✓	✓	✓			✓	✓	✓	✓															9
Total	5	1	6	5	4	8	0	0	3	3	6	5	0	0	0	1	1		2	3	1	0	5	4	2	2	2

^aPositive psychotherapy treatment exercise.

Carr & Finnegan, 2014; Cohn et al., 2014; Huffman et al., 2014; Lambert D'raven et al., 2015; Meyer, Johnson, Parks, Iwanski, & Penn, 2012; Roepke et al., 2015; Schrank et al., 2015) to the original model (Seligman et al., 2006).

Application of the PPT Model

Papers often used a different format than the original model, which delivered individual therapy (Seligman et al., 2006). Instead, the model was modified for use as group therapy in community mental health settings for people with a diagnosis of depression (Asgharipoor et al., 2012; Carr & Finnegan, 2014) or psychosis (Brownell et al., 2015; Riches et al., 2015; Schrank et al., 2015). Components of the model were delivered as a smartphone application (app) for those with depressive symptoms (Roepke et al., 2015). The briefer group therapy model outlined in the original paper (Seligman et al., 2006) was modified for psychosis (Meyer et al., 2012).

Table 3 shows how the original intervention components, 14 therapy sessions and 12 corresponding homework activities, were applied in the studies. It is clear that although these papers all modified PPT, they offered fewer components than the original (median 11, range 3–16) over a similar number of sessions (median 12, range 11–28).

The remaining studies did not reference the PPT model but used some of its components alongside interventions from the wider positive psychology movement. Interventions were delivered in a group setting in primary care to those with depressive symptoms (Lambert D'raven et al., 2015). They also were delivered individually with brief therapist guidance on an inpatient ward to people hospitalized due to suicidal ideation or a suicide attempt (Huffman et al., 2014), or without therapist support on a website for people with diabetes who had depressive symptoms (Cohn et al., 2014). On average, these studies offered few PPT components (median 8, range 5–6) over a small number of sessions (median 6, range 3–9).

Table 3 shows that the most often applied components of PPT were the *blessings journal*, which all studies used and the *character strengths* and *gratitude* sessions, which most studies used. Some original intervention components were not applied at all, including *good versus bad memories*, *satisficing versus maximizing* and the *family strengths tree*. It is also clear from Table 3

that studies mostly used interventions focusing on promoting engagement (median 3.5, range 2–5) rather than promoting pleasure (median 2 range 0–6) or meaning (median 2.5 range 0–6).

Modifications to the PPT Model

Of the studies applying the PPT model (Asgharipoor et al., 2012; Brownell et al., 2015; Carr & Finnegan, 2014; Meyer et al., 2012; Roepke et al., 2015) few provided a rationale for modifying the PPT model (Carr & Finnegan, 2014; Meyer et al., 2012; Schrank et al., 2015). Those that made amendments did so to make the intervention suitable for psychosis (Brownell et al., 2015; Schrank et al., 2015) and schizophrenia (Meyer et al., 2012) or incorporate it with group cognitive behavioral therapy (CBT; Carr & Finnegan, 2014). Adaptations were guided either by a literature review (Carr & Finnegan, 2014; Meyer et al., 2012) or by a review supplemented by qualitative interviews and expert consultation (Riches et al., 2015).

For those with psychosis and schizophrenia, the resulting adaptations involved omitting interventions that were challenging and possibly unsuitable for this patient group (e.g., savoring, gift of time) and developing an order of sessions that focused on easier interventions first (e.g., *savoring* before *forgiveness*; Riches et al., 2015). Given the possible history of trauma in this patient group, the *forgiveness* letter and *optimism* exercises were modified to focus more on day-to-day disappointments, rather than more serious transgressions, with a view to minimizing potential distress (Riches et al., 2015).

Studies also accommodated more general psychosis-specific challenges such as cognitive impairments, by providing additional experiential and interactive, rather than literacy-based, exercises. For example, the *blessings journal* was changed to a *good things box* for storing mementoes or notes of positive daily events (Brownell et al., 2015), and images were used to elicit character strengths, rather than using the *character strengths assessment* (Riches et al., 2015). In-session practice also was greatly encouraged. For example, the skill of *active-constructive responding*, i.e., responding enthusiastically to others' good news, was broken into smaller steps, demonstrated, and then role-played during the session (Meyer et al., 2012) or at an end of therapy celebration (Riches et al., 2015).

Where PPT was integrated with CBT, modifications to PPT included focusing the savoring exercise on rediscovering nature and focusing the gift of time exercise on connecting with the community to increase social networks (Carr & Finnegan, 2014). Although this study incorporated these components, the paper does not report how these modifications were decided or why other components were not used. The remaining studies that altered the PPT model provided no rationale for inclusion or exclusion of components. For example, where PPT was adapted to a smartphone app for depression, only three components were offered, though no rationale was given for this selection (Roepke et al., 2015). Where PPT was offered as a group therapy for depression (Asgharipoor et al., 2012), the *full life* session was replaced by an alternative model of happiness; its origins are not referenced, nor is a rationale provided for why this component was amended or why other components were not used.

Where studies offered some components of PPT but did not reference the model, the selection of intervention was usually guided by literature reviews (Cohn et al., 2014; Huffman et al., 2014; Lambert D'raven et al., 2015), supplemented by expert consultation (Huffman et al., 2014). However, only one study (Cohn et al., 2014) provided reference to a methodology paper detailing the development of the intervention (Moskowitz et al., 2012).

Additions to the PPT Model

All studies offered additional interventions not present in the original PPT model. Most of the additional interventions could be conceptualized as promoting engagement, pleasure, or meaning, similar to components from the original model (Seligman et al., 2006)

Engagement. Participants' involvement with their lives or absorption in work, leisure, or relationships was promoted through interventions such as goal setting, i.e., setting an appropriately challenge yet feasible goal, with the aim of increasing the relevance of and active

participation in treatment (Carr & Finnegan, 2014; Cohn et al., 2014; Lambert D'raven et al., 2015; Meyer et al., 2012). To increase positive interactions with the environment, participants were encouraged to schedule important, enjoyable, or meaningful activities (Asgharipoor et al., 2012; Cohn et al., 2014; Huffman et al., 2014; Roepke et al., 2015), a technique from behavioral activation (Mazzucchelli, Kane, & Rees, 2010). To increase awareness of character strengths, some participants were encouraged to keep a daily strengths journal (Carr & Finnegan, 2014; Cohn et al., 2014). Another addition was to teach participants about the concept of flow, where time passes quickly when one is fully immersed in an engaging activity (Csikszentmihalyi, 1990), followed by practicing time control, i.e., attending to one's experience of the passing of time (Lambert D'raven et al., 2015).

Pleasure. Additional interventions focusing on developing positive emotions in the here and now used positive reappraisal, i.e., changing interpretations of daily stressors (Cohn et al., 2014). Another study encouraged participants to use humor in daily life (Carr & Finnegan, 2014). Positive emotions about the future were developed through the "best possible selves" exercise, in which participants wrote their vision and goals for the future and how their character strengths may help to achieve this (D'raven et al. 2014; Huffman et al. 2014) or through an undefined optimism exercise (Lambert D'raven et al., 2015). Occasionally, studies tried to promote positive feelings about things that have happened in the past, through the use of positive writing tasks (Lambert D'raven et al., 2015) or considering what they have learned from grieving following loss (Carr & Finnegan, 2014).

Meaning

Additional interventions sometimes encouraged participants to connect with something greater than themselves. Most often this was through kindness interventions, termed as "acts of kindness" (Cohn et al., 2014; Huffman et al., 2014) or "good deeds" (Lambert D'raven et al., 2015). These were prosocial tasks such as donating blood or helping a person in difficulty, sometimes recorded in a reflective journal (Cohn et al., 2014; Huffman et al., 2014). The behavioral commitment to a value-based activity also was used in which participants selected a guiding principle for their life, such as creating beauty, and documented how to achieve this (Asgharipoor et al., 2012; Huffman et al., 2014). Some studies offered alternative interventions for promoting positive relationships (Carr & Finnegan, 2014; Huffman et al., 2014). For example, identifying (Carr & Finnegan, 2014) or envisaging (Huffman et al., 2014) their best possible social and interpersonal relationships and planning how to achieve these.

Other interventions. A number of other interventions were offered that differ conceptually from the PPT model. Some of these were components of traditional CBT, such as reducing overthinking (Lambert D'raven et al., 2015), challenging negative core beliefs and self-statements, and managing catastrophizing or anger (Carr & Finnegan, 2014). Others were from different theoretical orientations such as from the field of coaching (e.g., "self-talk"; Lambert D'raven et al., 2015). Physical activity also was promoted in some studies (Carr & Finnegan, 2014; Lambert D'raven et al., 2015).

Many interventions could be conceptualized as third wave CBT approaches (Hunot et al., 2013) because they included forms of acceptance and commitment therapy (Roepke et al., 2015) and mindfulness (Bolier et al., 2013; Brownell et al., 2015; Carr & Finnegan, 2014; Cohn et al., 2014; Lambert D'raven et al., 2015; Meyer et al., 2012). Authors included mindfulness due to its usefulness for managing psychotic symptoms (Meyer et al., 2012), chronic stress (Cohn et al., 2014), and depression (Carr & Finnegan, 2014). It also was suggested that practicing mindfulness may facilitate the PPT components, allowing participants to more easily recognize and appreciate positive events (Cohn et al., 2014) and more easily participate in the savoring activity (Meyer et al., 2012).

Robustness of Synthesis

An important factor in a robust synthesis is having clear information on the complex intervention. Although we aimed to minimize bias by clearly defining the intervention, using the TIDieR checklist (Hoffman et al., 2014) identified that many of the primary studies did not provide full information on the intervention rationale or procedures. Although poor intervention reporting is generally an issue across healthcare research, which is why the checklist was recently produced (Hoffmann et al., 2014), it nevertheless limits the robustness of this synthesis. The overall strength of the evidence is moderate.

Discussion

Main Findings

This systematic review aimed to identify how PPT is applied in mental health care, including modifications to the model. The main finding is that some PPT components were widely applied (e.g., blessings journal, character strengths, gratitude), while others were not applied beyond the original study (e.g., satisficing vs. maximizing, good vs. bad memories, family strengths tree). Furthermore, PPT components targeting engagement were applied more often than those promoting pleasure or meaning. It could therefore be concluded that the components of PPT that target engagement, particularly the blessings journal and character strengths, are acceptable and feasible. A secondary finding is that PPT was integrated with a range of additional interventions, many of which were conceptually similar. These may be useful complements to the PPT model.

Strengths and Limitations

This study is the first to systematically explore how PPT is applied in clinically relevant populations. The advantages are that it is replicable and provides a critical consideration of the quality of intervention reporting. However, the synthesis is only moderately robust and was limited by the fact that few papers provided rationale for applying (or not) or modifying components of PPT.

A second limitation is that the study was not able to investigate the factors (as depicted in Figure 1) related to person and intervention features and person–intervention fit, which could inform how the PPT model is applied (Lyubomirsky & Layous, 2013; Rashid, 2015). For example, baseline affective state may influence the extent to which people can engage with and use certain PPT components. However, a scoping exercise of the data reported in the identified papers found only two moderate quality studies that specifically investigated such factors (Brownell et al., 2015; Huffman et al., 2014); therefore, there was insufficient evidence to consider this in the present study. Consequently, further research is needed to understand the application and modification of the PPT model and whether particular components are more acceptable and feasible than others.

Despite these limitations, the study adds to the literature on PPT and identifies some candidate interventions that may complement the model, which are likely to be of use for future researchers and clinicians.

Comparison With Original Model

This paper provides support for the idea that PPT is a flexible model that can be applied with various diagnoses alongside other treatment approaches as intended (Rashid & Seligman, 2014; Rashid, 2008). However, it has been acknowledged that the mechanisms by which PPT operate have not been systematically identified (Rashid, 2015). The findings support this and indicate that much work needs to be done to establish a model of processes and outcomes necessary for the evaluation of complex interventions (Craig et al., 2008). The following uncertainties need to be addressed.

First, the importance of the therapist was originally emphasized (Seligman et al., 2006), but this review identified interventions reporting adapting PPT without any therapist support

(Roepke et al., 2015). By definition, not having interpersonal contact is not psychotherapy, so the original model must be explicit about the therapist role. Second, PPT aims to attend to both negative and positive emotions (Rashid, 2015), mainly through components such as good versus bad memories, forgiveness and hope, and optimism. However, because these components were rarely, or never, applied in the included studies, their importance is unclear and the mechanism related to them is called into question.

Third, the conceptual similarity between PPT components and practices from other movements such as mindfulness, goal pursuit, values (Schueller & Parks, 2014), behavioral activation (Layous, 2014), and acceptance-based approaches (Parks & Biswas-Diener, 2013) has previously been acknowledged and is further supported by the review findings. However, if such interventions are to be substituted with the PPT model, the processes and outcomes must be mapped to ensure that any modifications or additions are appropriate. Finally, it is interesting to note that the most often applied components (e.g., blessings journal, character strengths, gratitude, savoring) mainly constitute those in the group model of PPT (Seligman et al., 2006). It may be that this model is more acceptable or feasible than the longer individual version, but this needs to be established.

Implications for Research and Practice

The main implication for research is that the PPT processes and outcomes need to be mapped. Following this, systematic research must explore how the application of PPT may be affected by person features, intervention features, and a person-intervention fit (Lyubomirsky & Layous, 2013; Rashid, 2015) and whether certain components are more feasible and acceptable for some people. This is likely to involve in-depth interviews with patients of varying clinical profiles in different settings. Only once an appropriate and acceptable PPT model is established can it be rigorously tested in effectiveness trials. This is to ensure good adherence during a clinical trial so that we can obtain rigorous, high-quality evidence on the effectiveness of PPT. The main implication for practice is that PPT can be modified for a range of patients and treatment modalities and applied alongside other interventions. However, as the evidence has not yet firmly established effectiveness, the clinical utility of PPT remains uncertain.

Conclusion

Further systematic research is needed to establish which PPT components are acceptable and feasible across diagnostic groups and modalities of delivery. Once the appropriateness of the model is established, and there is a clear model of processes or mechanisms of change, rigorous, high-quality efficacy trials can definitively establish whether or not PPT is effective and can enhance mental health care.

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