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Positive Psychotherapy

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Positive psychotherapy (PPT) contrasts with standard interventions for depression by increasing positive emotion, engagement, and meaning rather than directly targeting depressive symptoms. The authors have tested the effects of these interventions in a variety of settings. In informal student and clinical settings, people not uncommonly reported them to be "life-changing." Delivered on the Web, positive psychology exercises relieved depressive symptoms for at least 6 months compared with placebo interventions, the effects of which lasted less than a week. In severe depression, the effects of these Web exercises were particularly striking. This address reports two preliminary studies: In the first, PPT delivered to groups significantly decreased levels of mild-to-moderate depression through 1-year follow-up. In the second, PPT delivered to individuals produced higher remission rates than did treatment as usual and treatment as usual plus medication among outpatients with major depressive disorder. Together, these studies suggest that treatments for depression may usefully be supplemented by exercises that explicitly increase positive emotion, engagement, and meaning.

Keywords: positive psychology, depression, psychotherapy, strengths

For over 100 years, psychotherapy has been where clients go to talk about their troubles. In addition to trying many brands of psychotherapy, every year hundreds of thousands

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Editor's Note
Martin E. P. Seligman received the Award for Distinguished Scientific Contributions. Award winners are invited to deliver an award address at the APA's annual convention. A version of this award address was delivered at the 114th annual meeting, held August 10–13, 2006, in New Orleans, Louisiana. Articles based on award addresses are reviewed, but they differ from unsolicited articles in that they are expressions of the winners' reflections on their work and their views of the field.

of people attend retreats, workshops, camps, and courses where the focus is nearly always on repairing negatives—symptoms, traumas, wounds, deficits, and disorders. These activities are based on a bold (but largely untested) axiom that talking about *troubles* is curative. Be that as it may, positives are rarely the focus of therapy, and never are they systematically so.

In its emphasis on troubles, psychology has done well in ameliorating a number of disorders but has seriously lagged behind in enhancing human positives. Mental health in the hands of talk therapy is all too often seen as the mere absence of symptoms. Although notions such as individuation, self-realization, and peak experiences (Maslow, 1971), full functioning (Rogers, 1961), maturity (Allport, 1961), and positive mental health (Jahoda, 1958) dot the literature, these are mostly viewed as by-products of symptom relief or as clinical luxuries that, in this rushed age of managed care, clinicians cannot afford to address head on.

Indeed, therapies that attend explicitly to the positives of clients are few and far between. The first we know of was created by Fordyce (1977), who developed and tested a "happiness" intervention consisting of 14 tactics, such as being more active, socializing more, engaging in meaningful work, forming closer and deeper relationships with loved ones, lowering expectations, and prioritizing being happy. He found that students who received detailed instructions on how to do these were happier and showed fewer depressive symptoms than a control group (Fordyce, 1977, 1983). More recently, Fava and colleagues (Fava, 1999; Fava & Ruini, 2003) developed well-being therapy (WBT), which is based on the multidimensional model of psychological well being proposed by Ryff and Singer (1998). It consists of building environmental mastery, personal growth, purpose in life, autonomy, self acceptance, and positive relations with others, and is provided after patients with affective disorder have successfully completed a regime of drugs or psychotherapy. Similarly, Frisch (2006) proposed quality of life therapy, which integrates a life satisfaction approach with cognitive therapy. Both Fava's and Frisch's approaches explicitly target faulty cognitions, troubling emotions, or maladjusted relationships, offering a well-being component as a supplement.

This article narrates the story of our using positive psychology to relieve depression. We call this approach *positive psychotherapy* (PPT). PPT rests on the hypothesis that depression can be treated effectively not only by reducing its negative symptoms but also by directly and primarily building positive emotions, character strengths, and meaning. It is possible that directly building these positive resources may successfully counteract negative symptoms and may also buffer against their future reoccurrence. In the last six years, the field of positive psychology, from which PPT emerged, has made significant scientific gains in analyzing the nature and benefits of these targets (e.g., Fredrickson & Losada, 2005; Haidt, 2006; Joseph & Linley, 2005; Seligman, 2002; Seligman, Steen, Park, & Peterson, 2005). In doing so, positive psychology has drawn on traditional scientific methods to understand and treat psychopathology.

Although we believe that PPT may be an effective treatment for many disorders, depression is our primary empirical target now. The symptoms of depression often involve lack of positive emotion, lack of engagement, and lack of felt meaning, but these are typically viewed as consequences or mere correlates of depression. We suggest that these may be causal of depression and therefore that building positive emotion, engagement, and meaning will alleviate depression. Thus PPT may offer a new way to treat and prevent depression.

Anecdotal Evidence and Exploratory Research

We began by developing pilot interventions over the past six years with hundreds of people, ranging from undergraduates to unipolar depressed patients. Martin E. P. Seligman taught five courses involving a total of more than 200 undergraduates, with weekly assignments to carry out and write up many of the exercises described below. These seemed remarkably successful. Seligman cannot resist mentioning that he has taught psychology, particularly abnormal psychology, for 40 years and has never before seen so much positive life change in students: *Life-changing* was a word not uncommonly heard when students described their experience with the exercises. The popularity of the Positive Psychology course at Harvard (855 undergraduates enrolled in spring 2006; Goldberg, 2006) is likely related to the impact of this material on the lives of students.

In the next phase of piloting interventions, Seligman taught more than 500 mental health professionals (clinical psychologists, life coaches, psychiatrists, educators); each week for 24 weeks, "trainees" heard a one-hour lecture and then were assigned one exercise to carry out in their own lives and with their patients or clients. Once again, at the anecdotal level, we were astonished by the feedback from mental health professionals about how well these interventions "took," particularly with their clinically depressed patients. This feedback was not entirely surprising, and, indeed, the application of a positively focused therapy for depression is a natural extension of the work that successfully builds optimism to treat and prevent depression among children and young adults (Buchanan, Rubenstein, & Seligman, 1999; Gillham & Reivich, 1999; Gillham, Reivich, Jaycox, & Seligman, 1995; Seligman, Schulman, DeRubeis, & Hollon, 1999). These pilot endeavors yielded so many powerful "case histories" and testimonials that we decided to try out positive psychology interventions in more scientifically rigorous designs.

We developed detailed instructions for how to teach these exercises. We then administered several of them sin-

gly on the Web in a random-assignment placebo-controlled study. Almost 600 Web users volunteered to be randomly assigned to one of six interventions—five from our battery of exercises and one placebo exercise. They did that one assigned exercise over one week. Three of these exercises (the gratitude visit, the three blessings exercise, and the "use your strengths" exercise; see Table 1) significantly lowered depressive symptoms and increased happiness compared with the placebo, which required participants to record their earliest memories each night. These effects lasted for six months for the blessings and strengths exercises. Two of the exercises—taking a strengths questionnaire alone, and writing an essay about oneself at one's best—had, like the intended placebo, only transient effects.

In January of 2005, an exercise Web site, www.reflectivehappiness.com, was opened. This site has a book club, a newsletter, and forum discussion of positive psychology each month, but most important, one new positive psychology exercise is posted each month. The first month's exercise is the three blessings ("Write down three things that went well today and why they went well"), and the first month's subscription to the Web site is free (thereafter it costs $10 per month). In the first month of operation, 50 subscribers had scores in the range of severe depression, scoring 25 or higher on their Center for Epidemiological Studies—Depression Scale (CES–D; Radloff, 1977) pretests. Their mean was 33.90, close to what might be termed *extremely* depressed. Each of them then did the three blessings exercise and returned to the Web an average of 14.8 days later. At that time, 94% of them were less depressed, with a mean score of 16.90, which is down into the border of the mild-to-moderate range of depression. We replicated these findings several months later with essentially the same substantial results. Although this was an uncontrolled study, such a dramatic decrease in depression over a short period of time compares favorably to medication and to psychotherapy. These interventions, moreover, cost only a small fraction of therapy; they are self-administered; they can be done without the stigma of pathology; and they are accessible anywhere the Web reaches to the many people who cannot find face-to-face treatment nearby.

Remember that all of the preceding tests consisted only of single exercises. We then packaged exercises together in order to create PPT for treating depression. We identified a core of the 12 best-documented exercises and then wrote detailed instructions for how to administer PPT in groups and a detailed manual for individual PPT (Rashid & Seligman, in press). Following is the theoretical rationale for the construction of the packages.

Theoretical Background

Seligman (2002) proposed that the unwieldy notion of "happiness" could be decomposed into three more scientifically manageable components: positive emotion (the pleasant life), engagement (the engaged life), and meaning (the meaningful life). Each exercise in PPT is designed to further one or more of these.

The Pleasant Life

The pleasant life is what hedonic theories of happiness endorse. It consists in having a lot of positive emotion about the present, past, and future and learning the skills to amplify the intensity and duration of these emotions. The positive emotions about the past include satisfaction, contentment, fulfillment, pride, and serenity, and we developed gratitude and forgiveness exercises that enhance how positive memories can be (e.g., Lyubomirsky, Sheldon, &

Table 1
Week-by-Week Summary Description of Group Positive Psychotherapy Exercises

Session	Description
1	*Using Your Strengths:* Take the VIA-IS strengths questionnaire to assess your top 5 strengths, and think of ways to use those strengths more in your daily life.
2	*Three Good Things/Blessings:* Each evening, write down three good things that happened and why you think they happened.
3	*Obituary/Biography:* Imagine that you have passed away after living a fruitful and satisfying life. What would you want your obituary to say? Write a 1–2 page essay summarizing what you would like to be remembered for the most.
4	*Gratitude Visit:* Think of someone to whom you are very grateful, but who you have never properly thanked. Compose a letter to them describing your gratitude, and read the letter to that person by phone or in person.
5	*Active/Constructive Responding:* An active-constructive response is one where you react in a visibly positive and enthusiastic way to good news from someone else. At least once a day, respond actively and constructively to someone you know.
6	*Savoring:* Once a day, take the time to enjoy something that you usually hurry through (examples: eating a meal, taking a shower, walking to class). When it's over, write down what you did, how you did it differently, and how it felt compared to when you rush through it.

Note. VIA-IS = Values in Action Inventory of Strengths.

Schkade, 2005; McCullough, 2000; Seligman et al., 2005). Positive emotions about the future include hope and optimism, faith, trust, and confidence, and these emotions, especially hope and optimism, are documented to buffer against depression (Seligman, 1991, 2002). To address these in our interventions, we used modified versions of optimism and hope interventions that have been found to counteract pessimism in previous studies (Seligman, 1991, 2002; Snyder, 2000). Positive emotions about the present include satisfaction derived from immediate pleasures, and PPT contains exercises for learning to savor experiences that one often rushes through (e.g., eating).

More positive emotion is often associated with lower depression and anxiety. Is this merely a correlation, or could it be causal? Barbara Fredrickson and colleagues have provided evidence that positive emotions counteract the detrimental effects of negative emotion on physiology, attention, and creativity (Fredrickson & Branigan, 2005; Fredrickson & Levenson, 1996; see Fredrickson, 2000, for a review). They also contribute to resilience in crises (Fredrickson, Tugade, Waugh, & Larkin, 2003; Tugade & Fredrickson, 2004). The cognitive literature on depression documents a downward spiral in which depressed mood and narrowing thinking perpetuate each other. In contrast, Fredrickson and Joiner (2002) reported that positive emotions and a broad thought–action repertoire amplify each other, leading to an *upward* spiral of well-being. These data support the hypothesis that low positive emotion may be causal in depression and that building positive emotions will buffer against depression.

The Engaged Life

The second "happy" life in Seligman's theory is the engaged life, a life that pursues engagement, involvement and absorption in work, intimate relations, and leisure (Csikszentmihalyi, 1990). *Flow* is Csikszentmihalyi's term for the psychological state that accompanies highly engaging activities. Time passes quickly. Attention is completely focused on the activity. The sense of self is lost (Moneta & Csikszentmihalyi, 1996). Seligman (2002) proposed that one way to enhance engagement and flow is to identify people's highest talents and strengths and then help them to find opportunities to use these strengths more. We call the highest strengths *signature strengths* (Peterson & Seligman, 2004). This view is as old as Aristotle and consonant with more modern psychological notions such as Rogers's (1951) ideal of the fully functioning person, Maslow's (1971) concept of self-actualization, and Ryan and Deci's (2000) self-determination theory. We believe not only that depression correlates with lack of engagement in the main areas of life but that lack of engagement may cause depression.

The Milan Group built a program of therapeutic interventions aimed at transforming the structure of daily life toward more engagement. Among the reported benefits are reduced levels of depression and anxiety (Nakamura & Csikszentmihalyi, 2002). For example, a client with the signature strength of creativity is encouraged to take a pottery, photography, sculpture, or painting class, or someone with the signature strength of curiosity is encouraged to make a list of things he or she would like to know, to identify ways to find them out, and to meet someone else who has successfully marshaled curiosity to create engagement. We hypothesize that identifying the signature strengths of clients and teaching practical ways to use these strengths more will significantly relieve the negative symptoms of depression, and we have developed such exercises.

The Meaningful Life

The third "happy" life in Seligman's theory involves the pursuit of meaning. This consists in using one's signature strengths and talents to belong to and serve something that one believes is bigger than the self. There are a large number of such "positive institutions:" religion, politics, family, community, and nation, for example. Regardless of the particular institution one serves in order to establish a meaningful life, doing so produces a sense of satisfaction and the belief that one has lived well (Myers, 1992; Nakamura & Csikszentmihalyi, 2002). Such activities produce a subjective sense of meaning and are strongly correlated with happiness (Lyubomirsky, King, & Diener, 2005). A consistent theme throughout meaning-making research is that the people who achieve the greatest benefits are those who use meaning to transform the perceptions of their circumstances from unfortunate to fortunate (McAdam, Diamond, de St. Aubin, & Mansfield, 1997; Pennebaker, 1993). We suggest that lack of meaning is not just a symptom but a cause of depression, and it follows that interventions that build meaning will relieve depression.

Data on the Three Lives

We tested the robustness of the correlation of the lack of positive emotion, lack of engagement, and lack of meaning with depression. We studied the pleasant, engaged, and meaningful lives of 327 young adults at the University of Pennsylvania (mean age = 23.51 years, $SD = 6.63$; 53% women, 69% Caucasian); the sample included clinically depressed ($n = 97$), nondepressed psychiatric ($n = 46$), and nondepressed nonpsychiatric ($n = 184$) students. Clinically depressed students experienced significantly fewer positive emotions, less engagement, and less meaning in their lives than did nondepressed psychiatric ($d = 0.37$) and nondepressed nonpsychiatric samples ($d = 1.17$). In 15 replications, Huta, Peterson, Park, and Seligman (2006) measured life satisfaction as a function of pursuing each of these three lives. They found that the pursuit of meaning and engagement were robustly ($p < .0001$) correlated with higher life satisfaction (rs = .39 and .39, respectively) and

lower depression (rs = .32 and .32, respectively), whereas the pursuit of pleasure, surprisingly, was only marginally correlated with higher life satisfaction (r = .18) and lower depression (r = −.15).

At this point, we were sufficiently intrigued by the robustness of the correlations with depression to intervene, hypothesizing that moving the "empty life" (lack of pleasure, lack of engagement, and lack of meaning) in the direction of the "full life" (presence of positive emotion, engagement, and meaning) would relieve depression. This has been the focus of our work for the last three years.

Testing PPT

We conducted two face-to-face studies of PPT, one with mildly to moderately depressed young adults and the other with severely depressed young adults, to examine the causal effect of enhancing positive emotion, engagement, and meaning. We now present a summary of these two therapy studies.

Study 1: Group PPT With Mild-to-Moderate Depressive Symptoms

Our first therapy study involved mildly to moderately depressed students treated in group therapy and followed for one year. Group PPT included the following exercises: using signature strengths, thinking of three blessings, writing a positive obituary, going on a gratitude visit, active–constructive responding, and savoring (see Table 1). PPT was a six-week, two-hours-per-week intervention administered in two groups of 8–11 clients. One group was led by Acacia C. Parks, and the other was led by a clinical psychology postdoctoral fellow. Each session was evenly split between a group discussion of the previous week's exercise and a lecture-style introduction to the current week's exercise that included explicit instructions for how to do the exercise. At each of the six weekly sessions, participants were asked to complete homework exercises and then to return to the group with a completed worksheet outlining what they did. Unlike individual PPT (see below), the bulk of group PPT was not custom-tailored to each participant, and all participants received the same homework exercises in a fixed sequence. The final session focused on maintenance and individual customizing of the exercises in order to promote maintenance after termination.

Participants were 40 students at the University of Pennsylvania. The only inclusion criterion was a score in the mild-to-moderate symptom range (10–24) on the Beck Depression Inventory–II (BDI; Beck & Steer, 1992). Eligible students were given a thorough description of the study and then were asked to give written consent. They then completed a baseline assessment and were randomly assigned to either group PPT (n = 19) or a no-treatment control group (n = 21). The PPT group was 42% female and 26% Caucasian, and the control group was 43% female and 52% Caucasian.

We used two outcome measures: the BDI to assess depressive symptoms and the Satisfaction With Life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985) to assess changes in well-being. Both measures were administered in a Web-based format prior to and immediately following the six-week period during which PPT was administered and again three months, six months, and one year following the postintervention assessment.

Overall, group PPT worked well compared with no treatment. Substantial symptom relief lasted through one year of follow-up. One year after the end of treatment, PPT participants scored, on average, in the nondepressed range on depressive symptoms, whereas controls remained in the mild-to-moderate range (see Table 2 and Figure 1).

We used a hierarchical linear model (HLM; Hedeker & Gibbons, 1997) to estimate the effect of PPT on the rate of change in depression and well-being experienced by participants. A piecewise linear model with two legs (see Table 3) allowed us to look at change in treatment versus control between pre- and posttreatment (Leg 1) as compared with the rate of change between posttreatment and subsequent follow-ups (Leg 2). In Leg 1, we expected to see a large positive change in the PPT group and no change in the control group, resulting in a significant difference between groups in rate of change. In Leg 2 we expected to see no change in either group as the PPT group maintained its gains over follow-up and the control group remained symptomatic as it was in Leg 1.

During Leg 1, clients who received PPT experienced significant decreases in depressive symptoms and increases in life satisfaction over the course of the intervention, whereas control participants did not. PPT clients experienced a significant BDI score reduction of 0.96 points per week ($p < .003$), a rate of change that was significantly greater than that of the control clients ($p < .05$), whose change estimate did not differ significantly from zero. SWLS scores also changed as expected, increasing by 0.77 points per week in the PPT group ($p < .001$) but not changing in the control group. Over the course of Leg 2 (three-month, six-month, and one-year follow-ups), neither group experienced changes in depression, suggesting that the PPT participants maintained their gains through one-year follow-up whereas control participants' moderate-to-mild depression remained at their baseline levels. Life satisfaction increased in both groups over time, but the PPT group maintained its advantage over the control group throughout.

In our experience, the maintenance of gains for a year after psychotherapy for depression is unusual in the absence of booster sessions. This leads us to believe that important self-maintaining factors are imbedded in our exercises.

Table 2
Means, Standard Deviations, Significance Levels, and Effect Sizes for Group Positive Psychotherapy (PPT) and Control Participants at All Time Points

	PPT			Control						
Time point	*N*	*M*	*SD*	*N*	*M*	*SD*	*df*	*F*	*p*	*d*
					Beck Depression Inventory[a]					
Baseline	16	14.94	6.26	21	13.81	5.25	1, 35	0.36	.56	
Posttest	14	9.57	6.32	20	13.10	8.29	1, 31	2.15	.15	0.48
3-month	13	8.69	6.73	19	13.95	8.79	1, 29	3.89	.06	0.67
6-month	13	8.21	4.66	18	13.33	8.15	1, 29	4.87	.04	0.77
1-year	14	7.57	5.08	19	11.32	7.38	1, 30	4.40	.04	0.59
					Satisfaction With Life Scale[b,c]					
Baseline	16	12.25	6.22	21	15.05	6.24	1, 35	1.83	.19	
Posttest	14	14.29	7.40	20	14.40	6.36	1, 31	1.35	.25	0.30
3-month	13	21.15	7.73	19	19.26	6.29	1, 29	5.26	.03	0.27
6-month	13	20.92	6.96	18	20.44	5.98	1, 28	3.23	.08	0.08
1-year	14	23.80	7.58	19	22.05	6.15	1, 30	4.17	.05	0.29

[a] Higher scores mean more depression. [b] Higher scores mean more life satisfaction. [c] Although the difference between the control and PPT groups at baseline was not significant, it may have contributed to the small effect sizes for absolute mean differences. Marginal means controlling for baseline provided a more convincing group comparison, with effect sizes more comparable with those found for depression.

Study 2: Individual Positive Psychotherapy With Unipolar Depression

Participants in our individual PPT pilot study were 46 clients seeking treatment at Counseling and Psychological Services (CAPS) at the University of Pennsylvania. Inclusion criteria were as follows: (a) being between 18 and 55 years old, (b) fulfilling *DSM–IV* (fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders*; American Psychiatric Association, 2000) criteria for major depressive disorder (MDD), (c) having a score of at least 50 on the Zung Self-Rating Scale (ZSRS; Zung, 1965), and (d) having a score of at least 50 on the Outcome Questionnaire (OQ; Lambert et al., 1996). Exclusion criteria included (a) current treatment for depression (b) substance abuse disorder for the last 12 months, panic disorder, manic or hypomanic episodes (past or present), or psychotic disorder (past or present); and (c) refusal to participate in a 10–12-week individual psychotherapy treatment.

Figure 1
Mean Beck Depression Inventory (BDI) Scores for Group Positive Psychotherapy (PPT) and Control Participants at All Time Points

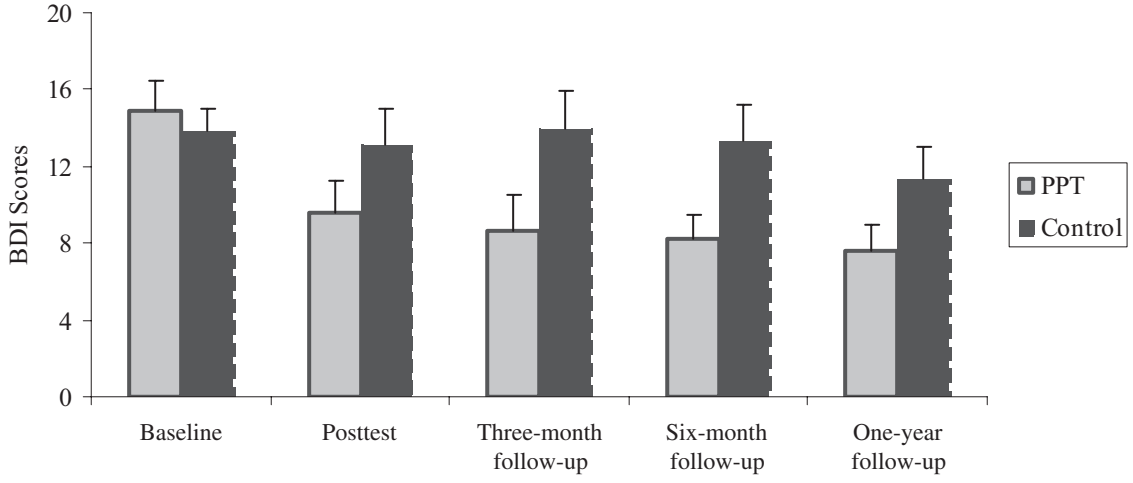


Table 3
Hierarchical Linear Model Estimates of Change on Outcome Measures During and After 6-Week Intervention Period and Effects of Group in Mildly to Moderately Depressed Patients Receiving Group Positive Psychotherapy or No Treatment

	Positive psychotherapy		No-treatment control	
Variable	Change estimate	t[a]	Change estimate	t
BDI[b]				
Treatment period	−.957	−3.05**	−.053	−0.20
Follow-up period	−.039	−0.98	−.036	−1.09
SWLS[c]				
Treatment period	.774	3.69**	.229	1.30
Follow-up period	.162	5.43**	.126	4.98**

	Beck Depression Inventory		Satisfaction With Life Scale	
Variable	Estimate	*SE*	Estimate	*SE*
Change rate during Leg 1 (pre- to posttreatment)				
Effect of condition	.905*	.411	−.544*	.274
Change rate during Leg 2 (posttreatment to follow-ups)				
Effect of condition	.002	.052	−.036	.039

[a] Test statistic evaluates whether change estimate is significantly greater than zero. [b] BDI = Beck Depression Inventory–II; change over time was estimated in a two-piece hierarchical linear model with $df = 76$ for change during treatment and $df = 120$ for change after treatment in both conditions. [c] SWLS = Satisfaction With Life Scale; change over time was estimated in a two-piece hierarchical linear model with $df = 100$ for change during treatment and $df = 54$ for change after treatment in both conditions.
* $p < .05$. ** $p < .001$.

The study was approved by the University of Pennsylvania's Internal Review Board, and it followed guidelines regarding consent and confidentiality.

After the initial intake assessment, if a student met inclusion criteria he or she was contacted by the project manager and was provided with the details regarding study participation. This included a description of the measures, an introduction to the various treatment conditions, and the taping of the treatment. If the client showed interest and signed the consent form, he or she was randomly assigned to either individual PPT ($n = 13$) or treatment as usual (TAU; $n = 15$). PPT clients were also compared with a nonrandomized matched group receiving TAU and antidepressant medications during the same time period (TAUMED; $n = 17$). Clients in the TAUMED group were matched with PPT participants on diagnosis, time of start of treatment, and both ZSRS and OQ scores. We did not randomize patients to the TAUMED group, because we have doubts about the ethics and the scientific logic of assigning patients to medication regardless of their preferences for drugs or psychotherapy.

Thirteen participants (2 in PPT [13%], 6 in TAU [40%], and 5 [29%] in TAUMED) dropped out before the end of treatment, but this was not statistically significant, nor were there significant differences between dropouts and completers in terms of demographic variables and baseline assessments in the treatment groups. A total of 11 participants in the PPT condition, 9 in the TAU condition, and 12 in the TAUMED condition were therefore included in the final analyses.

Process of PPT for unipolar depression. In our treatment of mild-to-moderate depression (see Table 1), the sessions concentrate heavily on the positive rather than the negative symptoms of depression. With unipolar depression, however, we introduce a balance between focusing on positive symptoms and focusing on negative symptoms, and we regard PPT as a supplement to more traditional treatment approaches. We have two considerations in mind: On the one hand, patients have long been socialized into believing that therapy entails talking about troubles. Any perceived failure to take their troubles seriously violates these expectations and can undermine good rapport. On the other hand, there is a noticeable dropout rate in traditional cognitive–behavioral therapy (CBT) for depression: At the very onset of CBT, the therapist asks clients to record their pessimistic, self-critical, and globally negative thoughts and then helps them to identify how such thinking causes and maintains depression. For some depressed clients, pointing out deficits in their thinking, as an exclusive focus, may be counterproductive and may rupture the therapeutic alliance (Burn & Nolen-Hoeksema, 1992; Castonguay et al., 2004). This may be one reason for some adults to prematurely terminate CBT treatment (Oei & Kazmierczak, 1997; Persons, Burns & Perloff, 1988; Robins & Hayes, 1993).

From the onset, PPT, in contrast, builds a congenial and positive relationship by asking clients to introduce themselves through telling a real-life story that shows them at their best. This is followed by clients' identifying signature strengths and the therapist coaching them to find practical ways of using these strengths more often in work, love, play, friendship, and parenting. Clients set goals of using and enhancing their signature strengths through real-life exercises. Substantial time is spent coaching clients to reeducate their attention and memory to what is good in their lives, with the goal of providing them a more balanced context in which to place their problems. Although some problem-solving and discussion of troubles does take place in PPT, the goal is to keep the positive aspects of the clients' lives in the forefront of their minds, to teach behaviors that bring positive feedback from others, and to strengthen already existing positive aspects, rather than teaching the reinterpretation of negative aspects. When clients report negative emotions or troubles, however, they

are empathically attended. This balanced process enables the therapist to become a witness to the client's deepest positive characteristics rather than just an authority figure who highlights faulty thinking, negative emotions, and maladjusted relationships. Usually there are already plenty of such critical individuals in clients' lives, and this can be the very reason clients seek therapy.

PPT took place over up to 14 sessions over at most 12 weeks and was conducted by Tayyab Rashid, who has a doctorate in clinical psychology. He followed a manualized protocol (Rashid & Seligman, in press; see Table 4 for the session-by-session structure). Supervision—provided by Ilene Rosenstein, a licensed clinical psychologist and the director of CAPS—consisted of randomly sampled reviewing of therapy tapes as well as ongoing individual supervision throughout treatment. PPT was custom tailored to meet clients' immediate clinical needs (e.g., romantic break-up, conflict with significant others, or career-related issues), and the order of the exercises varied with each client's circumstances and the feasibility of completing the exercise. Homework assignments were selected from the pool of potential exercises in Table 4, and the exercises were tailored to the individual.

Treatment as usual (TAU) at CAPS consisted of an integrative and eclectic approach administered by five doctoral-level licensed psychologists, two licensed social workers, and two graduate-level interns supervised by licensed psychologists. The therapists performing TAU were instructed to provide whatever treatment they deemed appropriate for their clients without following a particular theoretical orientation or a treatment protocol. Clients in the TAUMED group were offered antidepressant medication, in addition to the TAU provided at CAPS, as an adjunct to their psychotherapy. We matched TAUMED clients to PPT clients on the diagnosis and the severity of depression. Psychopharmacotherapy followed a standardized protocol including review of symptoms, adverse events, illnesses, and concomitant medication (Fawcett, Epstein, Fiester, Elkin, & Autry, 1987).

We assessed four kinds of outcomes: The first one was symptomatic, including depressive symptoms as measured by the ZSRS, a 20-item self-report scale, and the Hamilton Rating Scale for Depression (HRSD; Hamilton, 1960), a 17-item version administered by an independent clinician at the end of the treatment (see Figure 2). The second domain assessed more global improvement as measured by the OQ (Lambert et al., 1996), a self-report measure widely used with college-age students, and by *DSM–IV*'s Global Assessment of Functioning (GAF) rated by an independent clinician who was blind to treatment condition. The third domain was happiness and well-being, assessed by the Positive Psychotherapy Inventory (PPTI), a 21-item PPT outcome measure we created and validated (Rashid, 2005), and by the SWLS.

Fourth, and perhaps most important, we examined remission, defined as a composite of the following strong, joint criteria: (a) a ZSRS score < 50 (Oei & Yeoh, 1999); (b) an HRSD score ≤ 7 (Santor & Kusumakar, 2001; Zimmerman, Posternak, & Chelminski, 2005); (c) at least a 15-point pre- to posttreatment decline in OQ scores, and posttest scores of < 63 (Kadera, Lambert, & Andrews, 1996); and (d) a GAF score ≥ 70 (Erikson, Feldman, & Steiner, 1997). If a client met all four of these criteria at the end of treatment, we termed them *in remission*. Client characteristics are presented in Table 5. The three groups did not differ at baseline on any outcome measure.

Pre- and posttreatment means, standard deviations, significance levels, and effect sizes are presented in Table 6. Overall, the three treatments differed significantly in all four domains: On self-report measures (the ZSRS and the OQ), PPT significantly exceeded TAUMED, with large effect sizes ($d = 1.22$ and 1.13, respectively). On clinician-rated measures (the HRSD and the GAF), PPT did significantly better than TAU, with large effect sizes ($d = 1.41$ and 1.16, respectively) as well. On well-being measures, the three groups did not differ significantly on the SWLS, but PPT differed significantly from both TAU and TAUMED on the PPTI, our measure of happiness, with large effect sizes ($d = 1.26$ and 1.03). On the basis of the fourfold remission criteria described above, 7 of 11 (64%) clients in PPT, 1 of 9 (11%) in TAU, and 1 of 12 (8%) in TAUMED remitted by the end of treatment, $\chi^2(2, N = 32) = 10.48$, $p < .005$.

Overall, these results indicate that PPT did better than two active treatments with large effect sizes. Thus, systematically enhancing positive emotions, engagement, and meaning was quite efficacious in treating unipolar depression.

To summarize these two therapy studies: Individual PPT with severely depressed clients led to more symptomatic improvement and to more remission from depressive disorder than did treatment as usual and treatment as usual plus antidepressant medication. It also enhanced happiness. Group PPT given to mildly to moderately depressed students led to significantly greater symptom reduction and more increases in life satisfaction than in the no-treatment control group. This improvement, moreover, lasted for at least one year after treatment. The effect sizes in both studies were moderate to large, and in the outpatient study, all indices of clinical significance showed a substantial advantage for PPT.

How Does PPT Work?

The negative quite easily attracts human attention and memory, and the large literature on "bad is stronger than good" (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001) testifies to this. It makes evolutionary sense that negative emotions, tied as they are to threat, loss and trespass,

Table 4
Idealized Session-by-Session Description of Positive Psychotherapy

Session and theme	Description
1: Orientation	*Lack of Positive Resources Maintains Depression* The role of absence or lack of positive emotions, character strengths and meaning in maintaining depression and empty life is discussed. The framework of PPT, therapist's role and client's responsibilities are discussed. *Homework:* Clients write a one-page (roughly 300-word) positive introduction, in which they tell a concrete story illustrating their character strengths.
2: Engagement	*Identifying Signature Strengths* Clients identify their signature strengths from the positive introduction and discuss situations in which these signature strengths have helped previously. Three pathways to happiness (pleasure, engagement, and meaning) are discussed in light of PPTI results. *Homework:* Clients complete VIA-IS questionnaire online, which identifies clients' signature strengths.
3: Engagement/pleasure	*Cultivation of Signature Strength and Positive Emotions* Deployment of signature strengths is discussed. Clients are coached to formulate specific, concrete and achievable behaviors regarding cultivation of signature strengths. Role of positive emotion in well-being is discussed. *Homework (ongoing):* Clients start a Blessings Journal in which three good things (big or small) that happened during the day are written.
4: Pleasure	*Good Versus Bad Memories* Role of good and bad memories is discussed in terms of maintenance of symptoms of depression. Clients are encouraged to express feelings of anger and bitterness. Effects of holding onto anger and bitterness on depression and well-being are discussed. *Homework:* Clients write about three bad memories, anger associated with them, and their impact in maintaining depression.
5: Pleasure/engagement	*Forgiveness* Forgiveness is introduced as a powerful tool that can transform anger and bitterness into feelings of neutrality or even, for some, into positive emotions. *Homework:* Clients write a forgiveness letter describing transgression, related emotions, and pledge to forgive transgressor (if appropriate) but may not deliver the letter.
6: Pleasure/engagement	*Gratitude* Gratitude is discussed as enduring thankfulness, and the role of good and bad memories is highlighted again with emphasis on gratitude. *Homework:* Clients write and present a letter of gratitude to someone they have never properly thanked.
7: Pleasure/engagement	*Mid-therapy Check* Both Forgiveness and Gratitude homework are followed up. This typically takes more than one session. Importance of cultivation of positive emotions is discussed. Clients are encouraged to bring and discuss the effects of the Blessing Journal. Goals regarding using signature strengths are reviewed. The process and progress are discussed in detail. Clients' feedback toward therapeutic gains is elicited and discussed.
8: Meaning/engagement	*Satisficing Instead of Maximizing* Satisficing (good enough) instead of maximizing in the context of the hedonic treadmill is discussed. Satisficing through engagement is encouraged instead of maximizing. *Homework:* Clients write ways to increase satisficing and devise a personal satisficing plan.
9: Pleasure	*Optimism and Hope* Clients are guided to think of times when they lost out at something important, when a big plan collapsed, and when they were rejected by someone. Then clients are asked to consider that when one door closes, another one almost always opens. *Homework:* Clients identify three doors that closed and three doors that then opened.

Table 4 (*continued*)

Session and theme	Description
10: Engagement/meaning	*Love and Attachment* Active-constructive responding is discussed. Clients are invited to recognize signature strengths of a significant other. *Homework 1 (on-going):* Active-constructive feedback—clients are coached on how to respond actively and constructively to positive events reported by others. *Homework 2:* Clients arrange a date that celebrates their signature strengths and those of their significant other.
11: Meaning	*Family Tree of Strengths* Significance of recognizing the signature strengths of family members is discussed. *Homework:* Clients ask family members to take VIA-IS online and then draw a tree that includes signature strengths of all members of their family including children. A family gathering is to be arranged to discuss everyone's signature strengths.
12: Pleasure	*Savoring* Savoring is introduced as awareness of pleasure and a deliberate attempt to make it last. The hedonic treadmill is reiterated as a possible threat to savoring and how to safeguard against it. *Homework:* Clients plan pleasurable activities and carry them out as planned. Specific savoring techniques are provided.
13: Meaning	*Gift of Time* Regardless of their financial circumstances, clients have the power to give one of the greatest gifts of all, the gift of time. Ways of using signature strengths to offer the gift of time in serving something much larger than the self are discussed. *Homework:* Clients are to give the gift of time by doing something that requires a fair amount of time and whose creation calls on signature strengths—such as mentoring a child or doing community service.
14: Integration	*The Full Life* The concept of a full life that integrates pleasure, engagement, and meaning is discussed. Clients complete PPTI and other depression measures before the final session. Progress is reviewed, and gains and maintenance are discussed.

Note: PPT = Positive psychotherapy; PPTI = Positive Psychotherapy Inventory; VIA-IS = Values in Action Inventory of Strengths.

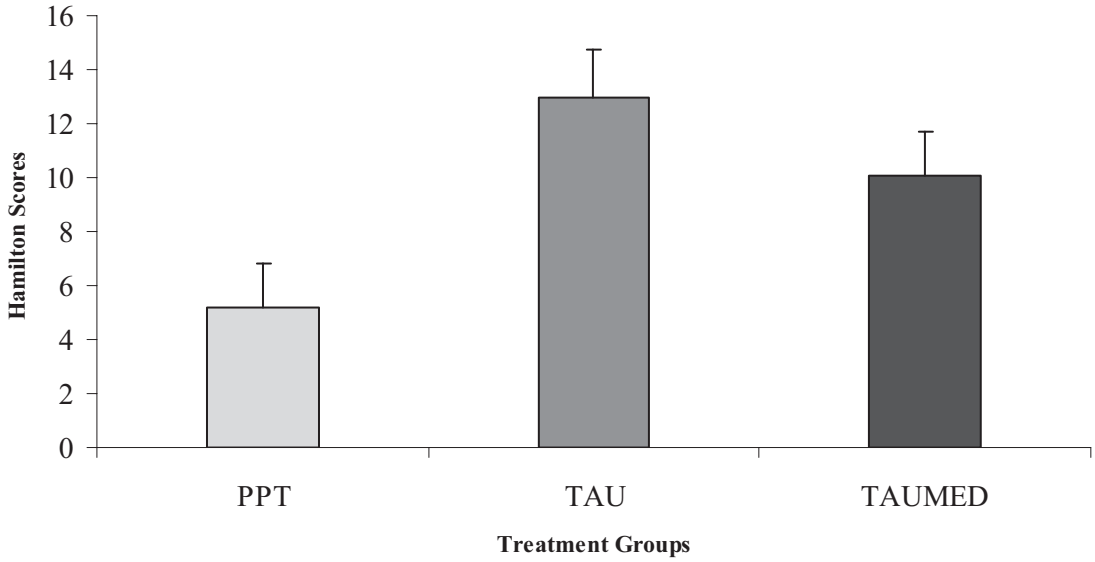
should trump happiness. Emergencies have first call in survival selection. What kind of brain survived the ice ages? The one that assumed the good weather would last, or the one that was strongly biased toward anticipating disaster any moment now?

Human beings are naturally biased toward remembering the negative, attending to the negative, and expecting the worst. Negative emotion is most proximally driven by negative memories, attention, and expectations, and depressed individuals exaggerate this natural tendency. They strongly gravitate toward attending to and remembering the most negative aspects of their lives, and several of our exercises aim to re-educate attention, memory, and expectations away from the negative and the catastrophic toward the positive and the hopeful. For example, when a client does the "three good things" exercise ("Before you go to sleep, write down three things that went well today and why they went well"), the depressive bias toward ruminating only about what has gone wrong is counteracted. The client is more likely to end her day remembering positive events and completions rather than her troubles and her unfinished business. The gratitude visit, similarly, may shift memory away from the embittering aspects of the client's past relationships to savoring the good things that her friends and family have done for her.

The mechanism of other PPT exercises is likely more external and behavioral. For example, increasing clients' awareness of their signature strengths likely encourages them to more effectively apply themselves at work by approaching tasks in a way that better uses their abilities. Having more flow at work and doing better work can lead to an upward spiral of engagement and positive emotion. Similarly, teaching clients to respond in an active and constructive manner to good news from co-workers, friends, and family teaches a social skill that likely improves most relationships (Gable, Reis, Impett, & Asher, 2004).

Another possible mechanism is PPT's sustained emphasis on strengths as a way to have more engagement and

Figure 2
Mean Hamilton Rating Scale for Depression (Hamilton) Scores and Standard Errors at the End of Treatment for Individual Positive Psychotherapy (PPT), Treatment as Usual (TAU), and TAU Plus Antidepressant Medication (TAUMED) Groups



meaning in life. Throughout therapy, PPT clients are encouraged and assisted in identifying their signature strengths: Near the onset of the therapy, clients are asked to introduce themselves through a real-life story about their highest character strength. Then the client takes the Values in Action Inventory of Strengths (VIA-IS; Peterson & Seligman, 2004; see www.authentichappiness.org), a well-validated test that identifies clients' signature strengths. Therapist and client collaboratively devise new ways of using clients' signature strengths in work, love, friendship, parenting, and leisure. Further, we ask clients to tell us detailed and rich narratives about what they are good at.

Table 5
Characteristics of Clients With Major Depressive Disorder Receiving Individual Positive Psychotherapy (PPT), Treatment as Usual (TAU), or TAU Plus Antidepressant Medication (TAUMED)

	PPT (n = 11)		TAU (n = 9)		TAUMED (n = 12)	
	n	%	*n*	%	*n*	%
Women	8	73	7	78	7	58
Caucasians	6	55	6	67	5	42
Undergraduates	5	46	6	73	9	75
Previous episodes of depression	7	64	2	18	5	42
Comorbid diagnosis	9	82	3	27	8	67
Previous treatment	6	55	2	18	7	58

Although we do not ignore clients' concerns about their "deficiencies," lest as therapists we may seem unfeeling and unsympathetic toward troubles, we emphasize identifying, attending to, remembering, and using more often the core positive traits that clients already possess. This may produce "end-runs" around their perceived faults, faults they know all too well. One newspaper article headlined this approach as "You already have a life, now use it." In addition, we emphasize using signature strengths to solve problems.

In addition to increasing clients' general awareness of strengths, we coach them on how to explicitly employ their signature strengths to counter depression. For example, one client devised several new, specific ways of using her signature strength of appreciation of beauty to manage negative moods. She rearranged her room in the way that she found to be most aesthetically pleasing and decorated her wall with a print by her favorite artist, so that she woke up to beauty. She had always wanted to do poetry but never had time for it, and she was able to find a poetry club. For one week, she wrote three experiences of beauty every day in her journal; some of her entries were watching the sunset at the Schuylkill River near Fairmont Park, noticing beauty on the face of a child, and seeing how happy and beautiful her dog looked while they were playing. She also loved hiking, and so she took a hiking trip and climbed Mount Washington.

Another client used his signature strength of love to undo his depression: His girlfriend was away in Europe for the spring semester, and he was quite depressed on Valentine's Day. He decided to arrange a long-distance Valen-

Table 6
Means, Standard Deviations, Significance Levels, and Effect Sizes on Outcome Measures for Individual Positive Psychotherapy (PPT), Treatment as Usual (TAU), or TAU Plus Antidepressant Medication (TAUMED)

	PPT (n = 11)		TAU (n = 9)		TAUMED (n = 12)			Effect size (Cohen's d)	
Outcome measure	M	SD	M	SD	M	SD	$F(2, 32)$	Between PPT and TAU	Between PPT and TAUMED
Symptomatic									
ZSRS (Higher is more depressed)									
Pre	63.91	7.71	64.33	9.10	63.83	11.07	*ns*		
Post	43.27_a	11.21	54.67_b	9.85	55.50_b	9.86	5.02*	1.12	1.22
HRSD (Higher is more depressed)									
Post	5.13_a	3.89	13.00_b	6.80	10.08_a	5.90	5.28*	1.41	*ns*
Overall functioning									
OQ (Lower is better functioning)									
Pre	76.27	12.86	72.44	29.92	63.83	21.07	*ns*		
Post	45.82_a	25.15	63.67_a	25.15	55.50_b	9.86	3.81*	*ns*	1.13
GAF (Higher is better functioning)									
Pre	61.18	6.60	63.00	6.60	60.58	5.43	*ns*		
Post	75.73_a	9.05	67.67_b	7.78	69.00_a	7.05	3.79*	1.16	*ns*
Well-being									
SWLS (Higher is more satisfaction)									
Pre	19.22	5.02	20.00	5.00	17.50	4.32	*ns*		
Post	21.91	4.76	19.00	7.71	18.50	4.25	2.21		
PPTI (Higher is more happiness)									
Pre	28.27	6.45	29.33	9.14	27.67	6.11	*ns*		
Post	35.00_a	8.11	28.33_b	7.14	28.75_b	5.43	4.46*	1.26	1.03

Note. Posttreatment significant differences and effect sizes were adjusted for pretreatment scores. Significant differences between pretreatment OQ scores were explored by mixed-model analysis of variance, because data did not meet the assumption of homogeneity of variance, Levene $F(2, 29) = 4.51$, $p < .05$. The HRSD was administered only at the end of treatment. Pretreatment scores on the ZSRS for Depression were entered as a proxy covariate. Posttreatment HRSD and ZSRS, controlling for pretreatment ZSRS, correlated .54 ($p < .01$, two-tailed). Within each row, means with different subscripts differ at the .05 level of significance. Because of the exploratory nature of the study and the small sample size, pairwise correction was not applied. ZSRS = Zung Self-Rating Scale for Depression; OQ = Outcome Questionnaire; GAF = Global Assessment of Functioning (*DSM–IV* Axis V) clinician rating; SWLS = Satisfaction With Life Scale; PPTI = Positive Psychotherapy Inventory, PPT outcome measure (details regarding its psychometric properties are available by e-mail from Martin E. P. Seligman).
* $p < .05$.

tine's dinner. They each independently acquired their favorite foods and talked via internet phone as they ate together, listened to their favorite songs together, and each talked about their appreciation for the other's character strengths. Then during spring break, he traveled to Europe, took her to a surprise dinner at her favorite restaurant, and read out his gratitude letter. At the end of the therapy, their relationship, which had been on the brink of break-up, was flourishing.

Although the exercises presented on the Web with no human hands are efficacious, we suspect that individual PPT for severe depression is much more effectively delivered with the basic therapeutic essentials: warmth, empathy, and genuineness. Hence, when these "nonspecifics" are integrated with PPT exercises and are supplemented with documented techniques such as CBT, interpersonal therapy, and antidepressant medication, we expect that efficacy will be better.

Conclusions and Limitations

Although PPT led to clinically and statistically significant decreases in depression, we view these results as highly preliminary, and we urge caution on several grounds. First, both therapy trials had small samples, but we note that our sample size is on a par with those of most psychotherapy outcome studies. For example, in a meta-analysis conducted by Kazdin and Bass (1989), the median sample size was 12. Similarly, Shapiro and Shapiro (1982) included only 28% studies that contained 13 or more clients. Second, the clients in both of our studies were university or professional students. This may well limit the generalizability of PPT to other populations varying in age, ethnicity, socioeconomic status, and IQ. Currently, Lisa Lewis and her colleagues at the Menninger Clinic are comparing PPT with a traditional psychotherapy with a larger inpatient sample ($N = 100$). We hope that such endeavors will help us to unearth important questions regarding PPT's generalizability, specificity, and response rate. Third, we doubt that the effects of PPT are specific to depression, and we expect that increasing positive emotion, engagement, and meaning promote highly general ways of buffer-

ing against a variety of disorders and troubles. Fourth, we did not counterbalance therapists, and so we don't know if we have "talented" therapist effects. Finally, the mechanisms by which PPT operates, including the moderating role of therapists and the commonalities of PPT and other therapeutic approaches, are matters for further research.

Nevertheless, we are encouraged by the potency of positive psychology exercises delivered on the Web with no human hands, by the congeniality of the approach to young depressed students, by how long the benefits lasted after treatment ended, and by the sheer effect size of PPT when delivered by a skilled therapist. Should these results be replicated, we speculate that future therapy for depression may combine talking about troubles with understanding and building positive emotion, engagement, and meaning.

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