

Virtue, Flourishing, and Positive Psychology in Psychotherapy: An Overview and Research Prospectus

Peter J. Jankowski
Bethel University

Steven J. Sandage and Chance A. Bell
Boston University

Don E. Davis
Georgia State University

Emma Porter, Mackenzie Jessen,
Christine L. Motzny, Kaitlin V. Ross, and
Jesse Owen
University of Denver



Researchers have increasingly called for the examination of both mental health symptoms *and* well-being when providing and evaluating psychotherapy, and although symptoms and well-being are typically inversely related, these appear to be distinct constructs that may require distinct intervention strategies. Positive psychology interventions, virtue-based treatments, and psychotherapies explicitly focused on promoting well-being have emerged in response to, or perhaps in concert with, the calls for attention to symptoms and well-being. Our review of the relevant and vast research pockets revealed that these treatments demonstrated relative efficacy in promoting well-being, whereas evidence for relative efficacy when reducing symptoms was largely inconclusive, particularly in psychotherapy contexts. We organized our review around the virtue-ethics notion that growth in virtuousness fosters flourishing, with flourishing consisting of more than the absence of symptoms, and specifically, that flourishing also involves increased well-being. The lack of evidence for relative efficacy among active alternative treatment conditions in promoting flourishing may suggest equal effectiveness, and yet, this also suggests that there are yet-to-be-identified moderators and mechanisms of change and/or insufficient use of research designs and/or statistical procedures that could more clearly test this major tenet of the virtue-ethics tradition. Nevertheless, we know that evidence-based problem-focused psychotherapies are effective at reducing symptoms, and our review showed that positive psychology interventions, virtue-based treatments, and psychotherapies explicitly focused on well-being promote well-being and/or virtue development. We encourage researchers and psychotherapists to continue to integrate symptom reduction and well-being promotion into psychotherapy approaches aimed at fostering client flourishing.

Clinical Impact Statement

Question: How does psychotherapy promote client flourishing? **Findings:** We suggest that psychotherapy inherently, and most often, implicitly, conveys a vision of the good life, that is, psychotherapy cannot avoid communicating to clients what it means to flourish. Flourishing is more than symptom reduction and consists of improved well-being. Positive psychology interventions, virtue-based treatments, and psychotherapies explicitly focused on promoting well-being have emerged in response to, or perhaps in concert with, calls for greater attention to symptom reduction and well-being promotion in psychotherapy. Our review revealed that these treatments demonstrated relative efficacy in promoting well-being, whereas evidence for their efficacy at reducing symptoms was largely inconclusive. **Meaning:** Our conclusion is that promoting flourishing in psychotherapy likely requires a dual focus that uses distinct interventions to target symptoms and well-being. **Next Steps:** The lack of evidence for relative efficacy in promoting flourishing suggests that there are yet-to-be-identified moderators and mechanisms of change and/or insufficient use of research designs and statistical procedures that could more clearly test the major tenet of the virtue-ethics tradition that virtues are constitutive of client flourishing. The latter also highlights the need for effectiveness studies involving diverse clients receiving routine care in outpatient community-based clinics, that is, practice-based designs, with much greater attention to therapist effects.

Keywords: virtues, well-being, flourishing, positive psychology, psychotherapy

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 Peter J. Jankowski, Counseling Program, Bethel University; Steven J. Sandage and Chance A. Bell, Daniels Institute, Boston University; Don E. Davis, Department of Counseling and Psychological Services, Georgia State University; Emma Porter, Mackenzie Jessen, Christine L. Motzny,  Kaitlin V. Ross, and Jesse Owen, Department of Counseling Psychology, University of Denver.

Chance A. Bell is now at Department of Family Studies, University of Nebraska at Kearney.

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Correspondence concerning this article should be addressed to Peter J. Jankowski, Counseling Program, Bethel University, 3900 Bethel Drive, St. Paul, MN 55112. E-mail: pjankows@bethel.edu

“We cannot conduct psychotherapy without some sense of how life is best lived.”

—Jon Allen (2008, p. 166)

The World Health Organization (WHO, 2014) defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (para. 1). The WHO definition resonates strongly with the holistic virtue-ethics notion of *the good life* advanced by many different cultural, philosophical, and religious traditions, and this developmental, generative, and communal view of *well-being* contrasts with the deficit-based, symptom-alleviating focus that has historically prevailed in mental health care in the United States (Peteet, 2018; VanderWeele, McNeely, & Koh, 2019). Deficit-based views of health “fall short of capturing what is most important to people in their daily lives” such as “being happy, having meaning and purpose, being a ‘good person’, and having fulfilling relationships” (VanderWeele et al., 2019, p. E1).

Some clinicians would balk at the idea that psychotherapy conveys an idea about *the good life*, as suggested by Allen (2008); however, contemporary perspectives generally acknowledge that psychotherapy is inherently value laden and founded on largely implicit views of what constitutes healthy living (Fowers, 2005; Proctor, 2019; Tjeltveit, 2004). Healers throughout time have offered rituals, practices, and folk therapies aimed at cultivating particular virtues thought to contribute to *the good life*. In fact, many different virtue-ethics traditions have advanced a general thesis that growth in virtues is a component of *the good life* (Allen, 2008; Banicki, 2014; Cloninger & Cloninger, 2016; Proctor, 2019), yet this key idea of virtue-ethics theories has never been fully empirically tested in psychotherapy treatment contexts. There are, however, signs that this virtue-ethics thesis is gaining traction through partial tests of the main thesis and garnering increased research attention. Positive psychology researchers, for example, have advanced a significant body of empirical research on virtues and well-being. In addition, calls have increased to examine both mental health symptoms (heretofore just symptoms) and well-being when providing and evaluating psychotherapy (Trompeter, Lamers, Westerhof, Fledderus, & Bohlmeijer, 2017; Wood & Johnson, 2016). Furthermore, Peteet (2018) suggested that a fourth wave of psychotherapies has emerged, and rather than correct “deficits responsible for dysfunction,” these psychotherapies explicitly promote well-being (p. 90). For others, attending to symptoms and well-being involves integrating positive psychology with evidence-based mainstream psychotherapies (Wood & Johnson, 2016).

The WHO definition and virtue-ethics advancements invite complex and important questions about the contemporary practice of psychotherapy. First, if psychotherapy does convey teleological visions of *the good life* (see also, Fowers, 2005; Peteet, 2018; Proctor, 2019), then what are the differing accounts of *the good life* and how do these accounts consider client diversity (i.e., construct clarification and cultural generalizability)? Second, psychotherapy is generally effective at reducing symptoms, and yet, what do we know about the extent to which psychotherapy can improve clients’ well-being (i.e., relative efficacy and effectiveness)? We use the term *relative efficacy* to refer to randomized controlled trial

(RCT) research designs that compare an intervention with either no-treatment control conditions (e.g., waitlist) or alternative active treatment conditions (e.g., treatment as usual [TAU]; bona fide treatments, i.e., treatments intended to be therapeutic, see Goldberg & Tucker, 2019; “non-specific active” conditions, see Goldberg & Tucker, 2019, p. 2). At the same time, we acknowledge that some use a more limited definition for relative efficacy applied to active conditions alone, whereas the term *absolute efficacy* is applied to RCT designs using no-treatment conditions (Munder et al., 2019). Effectiveness refers to evidence that an intervention alleviated symptoms or improved well-being, apart from design, that is, effectiveness can be demonstrated in RCTs when no posttest difference is found among comparison conditions (i.e., interventions were equally effective) or when the design did not use a comparison condition (i.e., single, within-group only design). Third, what do we know about the conditions and mechanisms of change that facilitate improvement in symptoms and well-being (i.e., for whom, when, where, and why is psychotherapy effective)? Our own consideration of these questions led us to conclude that there is no single, well-organized body of psychotherapy literature but rather several vast “pockets” that bear upon these questions. We offer key definitions and then an overview of the relevant research pockets before summarizing a clinical research prospectus.

Key Definitions for the Good Life in Psychotherapy

Virtues

Sandage and Hill (2001) defined virtues as “qualities of human character and excellence which enhance the capacity to live well, to live ‘the good life’” (p. 243). They went on to describe virtues as (a) an integration of ethics and well-being, (b) embodied dispositions, (c) sources of resilience for coping with stress and suffering, (d) embedded in diverse sociocultural contexts and traditions, (e) linked to a *telos* that defines meaningful life purpose, and (f) grounded in a reflective capacity for practical wisdom (*phronesis*). Some may prefer the term *character strengths*, as the word *virtue* might connote moral rigidity, sexual “purity,” or perfectionism, although most virtue traditions construe virtues as flexible capacities that generally promote personal and relational health rather than external conformity. Virtuous behavior springs from intrinsic motivation and dispositions that also require wise deliberation on appropriate actions in particular contexts (Fowers, 2005). Thus, virtues synthesize cognitive, affective, motivational, contextual, and behavioral dimensions of psychosocial functioning and, as such, align well with the ways in which psychotherapists commonly conceptualize clients and seek to help them develop constructive motivations and behaviors in particular contexts.

Virtues are also developmental and involve a *personal striving* to perform *virtuous acts* and construct “meaning from the resulting personal growth” (Lambert, Passmore, & Holder, 2015, p. 313). Battaly (2016), however, suggested that, intentional self-cultivation of virtues is limited, and virtuous development requires sociocultural support and facilitation, and in fact, the environment may (or may not) foster growth apart from the individual’s intentionality. This has been a particular concern in feminist approaches to virtue ethics (Dillon, 2018). Others point out that virtuous actions will not always immediately lead to the good life and that

the good life may involve suffering or negative emotion, particularly in the short term (Lambert et al., 2015; Lomas & Ivtzan, 2016). Lambert et al. (2015) further noted that over the long haul, virtuousness might result in “fatigue and a loss of perspective” requiring “hedonic activity for rejuvenation” (Lambert et al., 2015, p. 313). Lomas and Ivtzan (2016) suggested that the good life is inherently uncertain and ever evolving and involves a dialectic between negative and positive experiences. Furthermore, virtuousness lies in the middle, between two extremes, a balanced position between excess and deficiency (e.g., humility is the mean, servility the excess, and arrogance the deficiency; Haggard et al., 2018). Integrating virtues into psychotherapy therefore is complex, requiring client self-determination, psychotherapist intentionality and cultural sensitivity, and larger system and relational support. Yet, virtue-related themes (e.g., hope, forgiveness, self-control, justice, compassion) likely emerge regularly in psychotherapy, and virtues hold potential as change mechanisms toward greater symptom reduction and well-being (Rusk, Vella-Brodrick, & Waters, 2018). Actualizing these changes may involve a curvilinear pattern of “ups and downs” over an extended period, requiring therapist virtues such as patience and humility, which, however, may not be afforded in every clinical context.

Well-Being

Well-being is a construct defined in a multitude of ways, from multiple disciplines and philosophical traditions (Lambert et al., 2015), and as such presents challenges when making sense of existing empirical findings. Subjective well-being, for example, “is a broad umbrella term that refers to all different forms of evaluating one’s life or emotional experience, such as satisfaction, positive affect (PA), and low negative affect” (Diener et al., 2017, p. 87). However, others define subjective well-being as a synthesis of Diener et al.’s (2017) definition, labeled emotional well-being, with *positive functioning*, which is composed of the dimensions of psychological and social well-being (Magyar-Moe, Owens, & Conoley, 2015). Yet, subjective well-being is most frequently operationalized in the outcome literature as distinct from positive functioning and, as such, fits best with Diener et al.’s (2017) definition mentioned above or the dimension of emotional well-being within other conceptualizations. Psychological well-being, on the other hand, can broadly refer to positive functioning (Magyar-Moe et al., 2015) and is most closely associated with Ryff’s (1989) developmental model, consisting of six dimensions: (a) autonomy, (b) environmental mastery, (c) personal growth, (d) positive relations with others, (e) purpose in life, and (f) self-acceptance. Other dimensions of positive functioning consist of spiritual (Wong, 2011) and social well-being (Keyes, 1998).

Well-being has also been conceptualized as *quality of life* (QoL) and its derivative health-related QoL. QoL research represents a distinct tradition, largely unintegrated with positive psychology and lacking definitional and measurement clarity (Marujo & Neto, 2016; Park, 2015). QoL is generally considered a multidimensional construct (i.e., “social relationships, physical health, economic status, and functioning in daily activities and work,” Hofmann, Wu, & Boettcher, 2014, p. 374, and spirituality, Marujo & Neto, 2016). Some dimensions reflect positive functioning, whereas others emphasize experiencing positive or pleasurable emotions, consistent with meta-analytic classifications that specify

either positive functioning or subjective well-being as outcomes indicating QoL (Hendriks, Schotanus-Dijkstra, Hassankhan, de Jong, & Bohlmeijer, 2019). Marujo and Neto (2016) noted, however, that QoL conceptualizations tend to place greater emphasis on positive or pleasurable emotions and, therefore, overlap considerably with the construct of subjective well-being. QoL also appears to be the primary way a well-being focus is being integrated into psychotherapy for substance use disorders, with some advocating for broadening the definition of *recovery* to include subjective well-being and positive functioning along with reduced levels of substance use (Witkiewitz et al., 2019). The call for clinicians treating substance use disorders to attend to both substance use and well-being parallels that within the psychotherapy literature on treating symptoms (i.e., anxiety, depression), and yet, the integration of well-being in these respective psychotherapy literatures seems to be occurring largely distinct from each other, perhaps reflecting the way QoL research and positive psychology remain largely unintegrated.

Flourishing

Flourishing means to grow or prosper (VanderWeele et al., 2019), tends to be used synonymously with the good life, and refers to a holistic, multidimensional, developmental understanding of well-being. Aristotle used the term *eudaimonia* (translated as happiness or flourishing) to refer to the good life and argued that *eudaimonia* is achieved through an integration of virtue, practical wisdom, and moral strength or commitment. Our view of flourishing encompasses subjective well-being but moves beyond and is informed by contemporary theories of eudaimonic well-being characterized by relational maturity, meaningful life purpose, self-determination, virtue, and communal concern through prosocial behavior (Lambert et al., 2015). Wong (2011) offered a shorthand definition of *eudaimonia* as “meaning plus virtue” (p. 75) and suggested that resilience, that is, adapting and growing through suffering, is an important aspect of flourishing. In contrast, the term *hedonic well-being* is used synonymously with subjective well-being to capture positive or pleasurable emotional experiences. Life satisfaction, for example, is a frequently used indicator of subjective well-being. Yet, life satisfaction, much like QoL, is also conflated with indicators of *eudaimonia*, and therefore, it may reflect hedonic and/or eudaimonic well-being depending on whether the operationalization includes items solely about felt satisfaction or whether the operationalization includes items about life meaning/purpose (Proctor, Tweed, & Morris, 2015). Clearly, views of flourishing also differ across cultures and reflect culture-laden values. It can be valuable for clinicians to reflect on their own assumptions about well-being in relation to these aforementioned constructs.

Some have expanded the term *flourishing* to include the dimension of symptoms such that flourishing refers to not only high eudaimonic and hedonic well-being but also low levels of symptoms (O’Connor et al., 2012; Trompetter et al., 2017). It is in this way that we use the term *flourishing* throughout the remainder of the article. The dimensions of symptoms and well-being are regarded as independent yet typically inversely related (O’Connor et al., 2012), with some suggesting that virtues may moderate the association between symptoms and well-being (Hall-Simmonds & McGrath, 2019). For example, it may be that a client high in

forgiveness feels compelled to work at forgiving a partner who has hurt them and, thus, simultaneously experiences sadness and distress from facing the hurt, and yet, this may lead to positive functioning in the form of behaviors conducive to (a) reducing the negative impact of unforgiveness and (b) possibly repairing the relational rupture (e.g., willingness to talk about the hurt, listen to the other and perspective-take). Others refer to this dialectic relation between symptoms and well-being as resilience, that is, symptoms and well-being may be copresent and codependent (Lomas & Ivtzan, 2016) and may be deemed a special case of flourishing, particularly in the presence of risk factors (Newcomb-Anjo, Barker, & Howard, 2017). A client, for example, high in gratitude who recently experienced job loss amid ongoing chronic physical health concerns may experience symptoms of anxiety in response to the stressors and, yet, may also experience appreciation for accruing “on-the-job training” and optimism about that training being rewarded through active job searching. Thus, gratitude might facilitate agency and resilience while including self-awareness of anxiety, and this is important for clinicians who may worry that virtues could involve maladaptive defense mechanisms (e.g., reaction formation).

Overview of Relevant Research

Our review of existing literature involved electronic database searches using combinations of the key terms: virtues, well-being, flourishing, positive psychology interventions (PPIs), symptoms, and psychotherapy, which then focused our review on meta-analyses of RCTs. Our review was prompted by the virtue-ethics notion that virtues might both foster and comprise flourishing, which then brought focus to positive psychology as the broad domain where aspects of this virtue-ethics premise were most centrally examined. We then created categories of interventions that tapped into aspects of the virtue-ethics premise based on foundational observations about PPIs noted in the literature. First, the use of PPIs emerged as a response to the neglect of well-being promotion in psychotherapy (Bolier et al., 2013; Hendriks et al., 2019). Second, PPIs have taken several forms: (a) supplements to evidence-based treatments, (b) stand-alone treatments, or (c) integrated into other treatment approaches (Chakhssi, Kraiss, Sommers-Spijkerman, & Bohlmeijer, 2018; Parks & Schueller, 2014; Wood & Johnson, 2016). Third, consensus seems to be emerging on the three criteria for defining a PPI, that is, the PPI (a) explicitly promotes positive emotion, cognition, and/or behavior; (b) uses identifiable, evidence-based pathways; and (c) is theoretically grounded in the discipline of positive psychology (Hendriks et al., 2019). Pathways refer to activities, delineated as savoring, gratitude, kindness, forgiveness, empathy/social connection, meaning, strengths, and/or optimism (Parks & Schueller, 2014; Parks & Titova, 2016). The pathways are largely behavioral tasks or exercises (e.g., writing a kindness or memorable event list, character strengths use homework assignments such as practicing courage by initiating conflict resolution with a friend), and yet, the tasks use different change mechanisms, including experiential (e.g., savoring), cognitive (e.g., future-oriented thinking), and interpersonal (e.g., kindness; Parks & Titova, 2016). These observations formed the basis of our framework for organizing the meta-analytic findings into intervention categories: (a) explicit PPIs, (b) non-PPI psychotherapies with an explicit well-being

focus, (c) virtue-based treatments, and (d) non-PPI yet bona fide treatments, with the latter emerging as a key comparison condition in efforts to examine relative efficacy.

PPI Psychotherapies

PPIs may typically be an adjunct to evidence-based treatment, and yet, some have incorporated PPIs into distinct psychotherapeutic models (e.g., well-being therapy [WBT], Fava et al., 2005; positive psychotherapy [PPT], Seligman, Rashid, & Parks, 2006). For example, WBT involves an additive component to cognitive-behavioral therapy (CBT) that uses homework assignments (e.g., daily diary) to focus client self-observation. Treatment progresses through noticing moments of well-being, identifying cognitions that interfere with well-being, and encouraging activities that promote mastery and pleasure. Fava et al. (2005) found that a CBT + WBT sequential treatment showed greater improvement in observer-rated anxiety and Ryff's (1989) six dimensions of well-being relative to a CBT-only condition.

By comparison, PPT makes explicit use of PPIs to promote aspects of Seligman's (2011) PERMA model (i.e., positive emotion, engagement, relationships, meaning, and accomplishment). PPT involves exploring client strengths, using the Values in Action (Peterson & Seligman, 2004) framework and assessment instrument of 24 strengths arranged under six virtues (i.e., wisdom, courage, humanity, justice, temperance, and transcendence). Individuals' self-identified character strengths are then formulated into treatment goals and action plans to put the strengths to use to achieve treatment goals. Seligman et al. (2006) found that individual PPT showed greater improvements in depression and happiness (i.e., PPT Inventory, with three subscales: Pleasant Life, Engaged Life, and Meaningful Life) relative to TAU (i.e., “integrative and eclectic approach,” p. 781) and TAU + medication. Building upon these early exemplars of integration, a number of practical resources have advanced for psychotherapists who want to incorporate PPIs into their clinical work with a particular client, including PPI psychotherapies and explicit strengths interventions (Magyar-Moe, 2009; Niemiec, 2018; Parks & Schueller, 2014).

Non-PPI Psychotherapies With a Well-Being Focus

Although not fully meeting the criteria defining a PPI, in large part because these emerged within traditions outside of positive psychology, treatments that explicitly aim to promote well-being have demonstrated effectiveness (e.g., acceptance and commitment therapy [ACT], mindfulness-based interventions [MBIs]; Trompetter et al., 2017; Weiss, Westerhof, & Bohlmeijer, 2016; existential therapies, Vos, Craig, & Cooper, 2015), and there is evidence that psychotherapies aimed at improving interpersonal functioning are effective (e.g., interpersonal therapy, emotion-focused therapy, McFarquhar, Luyten, & Fonagy, 2018). Non-PPI psychotherapies can be distinguished by the extent to which hedonic and/or eudaimonic well-being undergird the treatment focus, with interpersonal treatments typically lacking an overt conception of well-being to frame therapeutic goals and intervention strategies, despite the focus on improving interpersonal functioning. MBIs, on the other hand, have an explicit well-being foundation and focus, and yet, the clinical application of MBIs has emphasized symptom reduction (Ivtzan et al., 2016). MBIs have been

incorporated into various psychotherapies, including, for example, ACT and mindfulness-based cognitive therapy, and MBIs can be readily integrated into other therapeutic approaches (Gu, Strauss, Bond, & Cavanagh, 2015; Spijkerman, Pots, & Bohlmeijer, 2016; Vøllestad, Nielsen, & Nielsen, 2012). Thus, although MBIs have a well-being foundation, and dispositional mindfulness has been conceptualized as a virtue within Buddhist traditions (MacKenzie, 2018), MBIs are typically not regarded as PPIs (Bolier et al., 2013; Chakhssi et al., 2018). Efforts to integrate positive psychology and MBIs have occurred with an emphasis on (a) conceptualizing dispositional mindfulness as a synthesis of the character strengths of self-regulation (i.e., the virtue of temperance) and curiosity (i.e., the virtue of wisdom) within the Values in Action framework, and (b) focusing the intervention on the promotion of positive emotion, cognition, and behavior, using, for example, the PPI pathway of savoring (Ivtzan et al., 2016; Littman-Ovadia & Niemiec, 2016).

MBIs are multifaceted and consist of meditative or contemplative practices (e.g., breathing meditation, guided meditation, silent meditation, mantra repetition, body scan, movement-based exercise [i.e., yoga]) but may also involve psychoeducation, group discussion, group cohesion, and social support (Blanck et al., 2018; Goyal et al., 2014). Mindful practice is thought to foster dispositional mindfulness, which in turn is thought to reduce symptoms and improve well-being, and there is empirical evidence supporting dispositional mindfulness as a change mechanism (Blanck et al., 2018), whereas support for other mechanisms, such as decreases in emotional reactivity and repetitive negative thoughts, seems limited to reducing symptoms (Gu et al., 2015). Numerous meta-analyses of RCTs reveal that MBIs reduce symptoms and improve well-being among clinical samples (i.e., mental and/or physical health symptoms; Goldberg et al., 2018; Goyal et al., 2014; Spijkerman et al., 2016). Goyal et al. (2014), for example, found a moderate effect size for MBIs in the reduction of anxiety and small effect sizes for improved depression and QoL relative to the nonactive condition, whereas effect sizes were nonsignificant relative to the active control condition. Spijkerman et al. (2016) examined online MBIs and found small effect sizes for improved depression, anxiety, and well-being (i.e., QoL, eudemonic well-being, life satisfaction) and increased dispositional mindfulness, relative to a combined waitlist and active condition. In addition, effect sizes did not differ by population type (i.e., community vs. clinical sample). By comparison, effect sizes among nonclinical samples were somewhat larger, as Khoury, Sharma, Rush, and Fournier (2015) found moderate effect sizes for anxiety, depression, and QoL relative to predominantly nonactive conditions (i.e., one active comparison condition of the 18 studies with a between-groups comparison, and studies included non-RCTs with within-group comparisons only [$n = 11$]).

Previous research has also delineated psychotherapies as to whether there is an overt problem focus (i.e., mental health symptom or interpersonal difficulties), with evidence that overt-focused treatments are more effective at reducing symptoms, relative to more diffuse-focused treatments (Yulish et al., 2017). At the same time, Yulish et al. (2017) found mixed support for the effectiveness of overt-focused treatments to improve well-being (i.e., QoL). Overt-focused treatments differed from diffuse-focused treatments at posttest on well-being; however, conclusions about the relative efficacy of overt treatments on improving well-being were limited by (a) including “bona fide treatments” and those that were not in

the relative efficacy comparison, and (b) overt-focused change mechanisms were inconsistent predictors of QoL. The former is limiting because significant posttest differences are more likely to be observed when the comparison condition includes non-bona fide treatments (p. 327), whereas for the latter limitation, the mechanisms of (a) expectancy through problem/change sense-making and (b) utilization of specific therapeutic actions each predicted the relative efficacy of overt-focused treatments for well-being when examined individually; however, when entered simultaneously into the regression model, neither was significant. It seems therefore that similar to the way overt problem-focused treatment is more effective at reducing symptoms relative to diffuse-focused treatment, an explicit well-being focus may promote greater gains in hedonic and/or eudaimonic well-being relative to diffuse- or overt problem-focused treatment. Furthermore, this conclusion is consistent with the notion that symptom reduction and well-being “are distinct outcomes that interact in more complex ways . . . [and] tailored intervention strategies that [overtly] address both . . . are thus likely to be needed” (O’Connor et al., 2015, p. 606). Nevertheless, Yulish et al. (2017) did find some evidence that problem-focused treatments may improve well-being.

Similarly, Kolovos, Kleiboer, and Cuijpers (2016) also found evidence that non-PPI psychotherapies that have an explicit problem focus may reduce symptoms and improve QoL. Kolovos et al. conducted a meta-analysis of RCTs examining the effectiveness of psychotherapy for depression (e.g., CBT, life review, ACT, and interpersonal psychotherapy) on QoL (i.e., “perceived health status, well-being or effective performance in daily life,” p. 460). Kolovos et al. reported a moderate effect size for global QoL relative to the waitlist condition and a small effect size relative to the care-as-usual condition (i.e., “psychotherapy, antidepressant medication or combination treatments,” p. 461). A large effect size for depression was observed in the studies on global QoL. However, Kolovos et al. also found that “changes in QoL were not fully explained by changes in depressive symptoms . . . [and concluded that] this is an indication that QoL and depressive symptoms are two different constructs” (p. 466), which is consistent with O’Connor et al.’s (2015) suggestion that tailored interventions overtly targeting both symptoms and well-being may be needed to enhance the promotion of flourishing.

Virtue-Based Treatments

Distinct from PPIs and non-PPI psychotherapies overtly focused on well-being, some treatments explicitly seek to foster the development of specific virtues. The term *virtue-based treatments* (McMinn, McLaughlin, Johnson, & Shoup, 2016) may better distinguish these interventions. Virtue-based treatments (e.g., REACH forgiveness model, Wade, Hoyt, Kidwell, & Worthington, 2014) promote virtuous actions consistent with PPIs, and yet, interventions are also guided by a developmental telos. For example, in the REACH model, clients are guided through five steps: (a) recalling the hurt and associated emotions, (b) empathizing with and taking the perspective of the offender, (c) forgiving as an altruistic gift within the victim’s control, (d) committing to forgive, and (e) holding to the decision to forgive; all with the caveat that forgiving is not “condoning the other’s actions or invalidating the often-strong feelings of the offended person” (Wade et al., 2014, p. 155).

REACH aims to not only reduce symptoms (i.e., negative thoughts and emotions, such as hurt, anger, and bitterness) but also help “clients move toward more positive, even optimal functioning” (Wade et al., 2014, p. 155).

Virtues are thus both process and outcome variables, and as such in part define *the good life*, “both for the individual and the common good” (Banicki, 2014; Wong, 2011, p. 73). Virtue-based treatments are amenable to systemic formulations of change, such as the synergistic change model (Rusk et al., 2018), in which virtues foster “upward spirals”; that is, virtues may interact in complex ways with each other or other change mechanisms (i.e., positive emotions, positive expectancy, intrinsic motivation, and pathway activities) to promote well-being (p. 411). Thus, virtues as change mechanisms consist of repeated *acts* of virtuousness and growing levels of *dispositional virtuousness* over time, and virtue-based treatments are defined by an explicit intervention aimed at developing the virtue(s) and measuring change in both the virtue(s) and symptoms as outcome variables, although such a theory of change may not always be clearly articulated in the research. Whether in the form of (a) integrating PPIs as adjunctive interventions or PPI psychotherapies, (b) psychotherapies explicitly focused on well-being, or (c) offering an explicit virtue-based intervention, psychotherapists have numerous avenues for considering and potentially incorporating virtues into their clinical work. Yet, while avenues for integration proliferate, questions remain about the empirical research undergirding these avenues, and along these lines, we critically summarize the meta-analytic findings of the empirical research examining PPIs and virtue-based treatments (see Tables 1 and 2).

Meta-Analyses of PPIs

Two primary conclusions can be drawn from the studies summarized in Table 1. First, when criteria for assessing the quality of RCTs were considered (e.g., using Cochrane criteria, such as intention-to-treat analysis, group equivalency at pretest, adequate power; Chakhssi et al., 2018), lower quality studies yielded larger effect sizes, and the removal of these studies altered the observed effects. For example, Chakhssi et al. (2018) observed that the effect size for well-being remained small after the removal of low-quality studies, yet significant, whereas for depression and anxiety, the effect sizes became nonsignificant. On the other hand, Hendriks et al. (2019) observed that the moderate effect sizes for hedonic and eudaimonic well-being remained significant but changed from moderate to small. Consistent with that reported by Chakhssi et al. (2018), the small effect size for depression observed by Hendriks et al. (2019) became nonsignificant after removal of low-quality studies, whereas unlike that reported by Chakhssi et al. (2018), the moderate effect size for anxiety remained moderate. In sum, high-quality studies supported the relative efficacy of PPIs for improving well-being, whereas results supporting the relative efficacy for reducing symptoms were mixed. Second, results suggested that the well-being effect size for PPIs with therapist guidance was significantly greater than the effect size for nontherapist-guided PPIs and larger for individual face-to-face interventions, and findings pointed to PPIs being more effective when delivered over longer periods (Bolier et al., 2013; Chakhssi et al., 2018; Weiss et al., 2016; see also, Sin & Lyubomirsky, 2009).

Meta-Analyses of Virtue-Based Interventions

Meta-analyses have also been conducted for interventions explicitly targeting virtues (see Table 2), and although there is emerging support for the effectiveness of virtue-based interventions to foster growth in virtues, reduce symptoms, and increase well-being, the evidence is less convincing than that for PPIs. In fact, several themes emerged from the meta-analyses that highlight the potential challenge of effectively integrating virtues into psychotherapy. First, Wade et al. (2014) distinguished among comparison conditions and noted larger effect sizes for comparisons between forgiveness interventions and no-treatment control groups, relative to alternative active control conditions. In fact, the comparisons for the outcomes of symptoms only involved no-treatment controls. Wade et al. also observed that there was greater change in forgiveness for longer treatments and with more severe offenses.

Second, Kirby, Tellegen, and Steindl (2017) observed moderate effect sizes for compassion-based interventions when comparisons involved nonactive conditions, and when the four active comparisons were included along with the nonactive conditions, moderate effect sizes were still noted; however, for most of the outcomes, a single study provided the active comparison condition and likely had little influence on the initial observed effect sizes. More recently, in their meta-analysis of self-compassion-related therapies, Wilson, Mackintosh, Power, and Chan (2019) observed moderate effect sizes for the outcomes of improved self-compassion, depression, and anxiety relative to a passive comparison condition. There was no difference between the self-compassion intervention and the active control condition. Similarly, Galante, Galante, Bekkers, and Gallacher (2014), in their meta-analysis of kindness-based meditation interventions, found no difference on compassion when the comparison involved an active condition, whereas there was a large effect size when the comparison involved a passive condition. A large effect size was observed for depression and a moderate effect size for self-compassion relative to the passive condition, whereas the outcomes of life satisfaction and stress showed no difference between the kindness intervention and the passive condition. The studies reviewed by Kirby et al. (2017) and Galante et al. (2014) were almost exclusively in nonclinical settings, whereas Wilson et al. (2019) included clinical samples. Echoing Wade et al. (2014), Kirby et al. (2017) also noted the need for research to address change mechanisms “underpinning . . . these interventions” (p. 787).

Third, two meta-analyses for gratitude interventions further call attention to the importance of considering the comparison condition when determining relative efficacy. Davis et al. (2016) found significant effects on gratitude and well-being relative to a measurement-only condition, whereas a significant effect for gratitude remained relative to an alternative activity condition, and there was no difference between conditions on anxiety and well-being. When the alternative activity condition was further distinguished by matched activity (e.g., hassles list, daily activity list) versus the PPI condition (e.g., kindness list, memorable event list, best possible self), the gratitude condition scored higher on well-being than the matched activity condition but not the PPI condition. Davis et al. concluded that their results demonstrated “weak evidence for the efficacy of gratitude interventions” (p. 25). By comparison, Dickens (2017) found largest effect sizes for compar-

Table 1
Summary of Meta-Analytic Findings for Positive Psychology Interventions

Study	Treatment	Designs	Comparison	Sample	Outcomes	Effect size ^a
Schutte and Malouff (2019)	Character strengths interventions	RCTs, and nonrandomly assigned comparison groups	Active and nonactive (e.g., waitlist)	N = 2,174 Student, employee, and community	Hedonic well-being (i.e., positive affect, happiness; n = 9) ^b Depression (n = 7) Life satisfaction (n = 7) Flourishing (i.e., eudaimonic well-being [e.g., meaningful life]; n = 2) Strengths use (n = 2)	Small (.32) Small (.21) Medium (.42) Medium (.36)
Chakhssi, Kraiss, Sommers-Spijkerman, and Bohlmeijer (2018)	PPIs	RCTs	Active and nonactive	N = 1,864 Clinical (i.e., psychiatric [n = 15] or physical health disorder)	Well-being (n = 33; i.e., "social, emotional, and/or psychological well-being," p. 3; comprising indicators of hedonia [e.g., positive affect] and/or eudaimonia [e.g., Ryff's psychological well-being] from the individual studies) Depression (n = 26) Anxiety (n = 14) Hedonic well-being (n = 28; i.e., subjective well-being, life satisfaction) Eudaimonic well-being (n = 20; e.g., Ryff's psychological well-being) Depression (n = 14)	Medium (.55) Small (.24)
Bolter et al. (2013)	PPIs	RCTs	Active and nonactive	N = 6,139 Clinical (i.e., psychiatric [n = 4]), student, community, organization	Depression (n = 26) Anxiety (n = 14) Hedonic well-being (n = 28; i.e., subjective well-being, life satisfaction) Eudaimonic well-being (n = 20; e.g., Ryff's psychological well-being) Depression (n = 14)	Small (.23) Medium (.36) Medium (.34) Small (.20)

(table continues)

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Table 1 (continued)

Study	Treatment	Designs	Comparison	Sample	Outcomes	Effect size ^a
Hendriks, Schotanus-Dijkstra, Hassankhan, de Jong, and Bohlmeijer (2019)	Multicomponent ^c PPIs	RCTs	Active and nonactive	<i>N</i> = 6,141 Clinical (<i>n</i> = 24; <i>n</i> = 8 mental health clinical sample), nonclinical (<i>n</i> = 26)	Hedonic well-being (<i>n</i> = 39; i.e., positive affect, life satisfaction) Eudaimonic well-being (<i>n</i> = 24; measured by a formal assessment of eudaimonia [e.g., Ryff's psychological well-being, the PPTI, or indicators of meaning in life, self-efficacy]) Depression (<i>n</i> = 25)	Medium (.34) Medium (.39)
Weiss, Westerhof, and Bohlmeijer (2016)	PPIs, and non-PPI treatments explicitly focused on well-being	RCTs	Active and nonactive	<i>N</i> = 3,579 Clinical (<i>n</i> = 13) and nonclinical (<i>n</i> = 14)	Anxiety (<i>n</i> = 11) Stress (<i>n</i> = 8) Eudaimonic well-being (<i>n</i> = 27; e.g., Ryff's psychological well-being)	Small (.29) Medium (.35) Medium (.35) Medium (.44)

Note. RCTs = randomized controlled trials; PPIs = positive psychology interventions, which include stand-alone interventions and PPI psychotherapies; PPTI = Positive Psychotherapy Inventory. Effect size: 0–.32 = small; .33–.55 = medium; > .56 = large (Hendriks et al., 2019; Weiss et al., 2016).

^a Posttest comparison for the calculation of effect size (i.e., standardized mean difference), without adjustment for quality of studies. ^b Number of comparisons/studies. ^c Multicomponent = used at least two PPIs aimed at improving at least two domains, that is, symptoms and/or aspects of hedonic and/or eudaimonic well-being.

Table 2
Summary of Meta-Analytic Findings for Virtue-Based Interventions

Study	Treatment	Designs	Comparison	Sample	Outcomes	Effect size
Wade et al. (2014)	Forgiveness interventions	RCTs, single-group pre-posttest comparisons (n = 7) ^a	Active and nonactive (e.g., waitlist)	N = 2,323 Clinical, nonclinical	Forgiveness (n = 53)	Large ^b (.56)
Kirby et al. (2017)	Compassion-based interventions ^d	RCTs	Active (n = 4) Nonactive (n = 17)	N = 1,285 Clinical, nonclinical	(n = 22)	Medium ^c (.45)
					Depression (n = 10)	Medium ^b (.34)
					Anxiety (n = 7)	Large ^b (.63)
					Hope (n = 6)	Large ^b (1.00)
					Compassion (n = 4)	Medium ^b (.55)
					Self-compassion (n = 13)	Large ^b (.70)
					Mindfulness (n = 6)	Medium ^b (.54)
					Depression (n = 9)	Large ^b (.64)
Anxiety (n = 9)	Medium ^b (.49)					
Well-being (n = 8; i.e., hedonic indicators such as positive affect, subjective happiness, or life satisfaction, and n = 1 for PWB)	Medium ^b (.51)					
Wilson et al. (2019)	Compassion-based interventions	RCTs	Active (n = 11), nonactive (n = 11)	N = 1,172 Clinical (i.e., mental health disorder), subclinical (i.e., mental health symptoms)	Self-compassion (n = 26) Depression (n = 22) Anxiety (n = 17)	Medium ^b (.52) Medium ^b (.40) Medium ^b (.46)
Davis et al. (2016)	Gratitude interventions	RCTs	Active and nonactive	N = 1,175 Student, community, clinical	Gratitude (n = 15) Anxiety (n = 5) Well-being (n = 20; i.e., composite of life satisfaction, purpose in life, depression)	Medium ^c (.46) Nonsignificant ^e (.11) Small ^e (.17)

(table continues)

Table 2 (continued)

Study	Treatment	Designs	Comparison	Sample	Outcomes	Effect size
Dickens (2017)	Gratitude interventions	RCTs	Active and nonactive	<i>N</i> = 5,233 Student, community, clinical (<i>n</i> = 2), mental health clinical sample, <i>n</i> = 3 physical health condition)	Happiness (<i>n</i> = 5) Depression (<i>n</i> = 5) Well-being (<i>n</i> = 2; i.e., composite of hedonic [e.g., positive affect, life satisfaction] or eudaimonic indicators [e.g., psychological functioning], distinguishable from the single indicator outcomes of happiness, positive affect, and life satisfaction) Positive affect (<i>n</i> = 11) Dispositional gratitude (<i>n</i> = 3) Grateful mood (<i>n</i> = 5) Life satisfaction (<i>n</i> = 8) Hope (<i>n</i> = 22) Life satisfaction (<i>n</i> = 10) Psychological distress (<i>n</i> = 9)	Small ^f (.25) Small ^f (.13) Small ^f (.30)
Weiss and Speridakos (2011)	Hope interventions	RCTs (<i>n</i> = 12), single-group pre-posttest comparisons (<i>n</i> = 15)		<i>N</i> = 2,154 Clinical (<i>n</i> = 17; <i>n</i> = 5 psychiatric, <i>n</i> = 12 physical health condition), nonclinical (<i>n</i> = 10)		Small ^f (.18) Small ^f (.23) Small ^f (.31) Small ^f (.17)
Galante et al. (2014)	Kindness-based meditation	RCTs (<i>n</i> = 22)		<i>N</i> = 1,747 Student, community (i.e., adult general population), clinical (<i>n</i> = 1), mental health clinical sample, <i>n</i> = 2 physical health condition sample)	Depression (<i>n</i> = 2) Mindfulness (<i>n</i> = 2) Compassion (<i>n</i> = 2) Self-compassion (<i>n</i> = 4) Life satisfaction (<i>n</i> = 2) Stress (<i>n</i> = 3)	Nonsignificant ^g (.04) Large ^f (-.61) Large ^f (.63) Large ^f (.61) Medium ^f (.45) Nonsignificant ^f (.19) Nonsignificant ^f (-.29)

Note. RCTs = randomized controlled trials; *n* = number of studies or comparisons; PWB = psychological well-being. Effect size: 0–.32 = small; .33–.55 = medium; >.56 = large (Hendriks et al., 2019; Weiss et al., 2016).

^a “Imputed control group data” (Wade et al., 2014, p. 154). ^b Pre-posttest standardized difference and then “comparison of change in the treatment group to change in the control group” (Wade et al., 2014, p. 158) relative to no-treatment comparison. ^c Relative to alternative treatment comparison. ^d Multiple treatment models, such as compassion-focused therapy, mindful self-compassion, and loving kindness meditation. ^e Posttest comparison for the calculation of effect size, relative to alternate activity condition. ^f Posttest comparison, relative to neutral or passive condition (i.e., nonactive). ^g Posttest comparison, or pre-post standardized mean difference.

isons between gratitude interventions and negative activity conditions, with the gratitude condition showing higher levels of life satisfaction, positive affect, optimism, and grateful mood and lower levels of depression, negative affect, and stress. In contrast, when comparing gratitude interventions and the alternative PPI condition (i.e., acts of kindness, best possible self, using strengths), the single significant effect showed the gratitude condition scoring higher on well-being. Dickens, like Davis et al. (2016), was cautious in her conclusion, suggesting that “gratitude interventions can have positive benefit for people . . . [and yet] should not necessarily be promoted above other types of positive interventions” (p. 204).

Last, a meta-analysis of hope interventions by Weis and Speridakos (2011) revealed that the interventions were more effective for students and the general community than psychiatrically or medically referred participants. Weis and Speridakos noted the challenge of demonstrating effectiveness in “real-world contexts” (p. 12) and the need to clarify change mechanisms, particularly because hope has been posited as an important common factor in therapeutic effectiveness. Taken together, virtue-based interventions hold the potential to promote well-being in psychotherapy, although to date the effects have not necessarily been any greater than PPIs. Findings were limited by the small number of studies using clinical samples, the relative short duration of most treatments, and a lack of examination of theoretically grounded change mechanisms. As clinicians can choose among many empirically supported treatments, findings that virtue-based interventions outperform no-treatment controls or negative conditions offer little to psychotherapists seeking to integrate virtue interventions in everyday practice.

In addition, as noted by Kirby et al. (2017), questions about dosage persist, with available evidence suggesting that greater treatment length corresponds to greater gains in virtuousness (Wade et al., 2014). Those who enroll in studies on virtue-based interventions in university contexts may also be motivated to develop those particular virtues, whereas the integration of virtue interventions in naturalistic clinical contexts requires therapist flexibility and other treatment negotiation skills with clients who may not have planned on working on virtues. Although virtue-based interventions can be complicated to deliver in clinical contexts, it is possible that the largest gains might be seen in populations that suffer from significant struggles in areas such as unforgiveness, hopelessness, envy, and/or self-criticalness, suggesting that clinicians may need to assess for the relevance and appropriateness of PPIs and virtue-based interventions.

Comparisons of PPIs With Alternative Treatments Among Clinical Samples

As informative as meta-analyses might be for summarizing empirical findings across multiple studies, aggregate findings can obscure important differences between individual studies and overlook contradictory evidence from direct critical review of individual studies (Butler, Chapman, Forman, & Beck, 2006). As such, a brief review of select recent studies examining the relative efficacy of multicomponent PPIs that integrate virtue-based interventions with clinical samples is offered to highlight the primary theme emerging from our review of meta-analyses. Evidence of relative efficacy is influenced by the type of the comparison

condition, with nonactive conditions tending to show superior effectiveness for PPIs and virtue-based treatments, whereas for active control conditions, there appears to be nothing uniquely effective about PPIs or virtue-based treatments relative to other active or bona fide treatments.

Celano et al. (2016), for example, using a sample of inpatient clients diagnosed with depression and who expressed suicidal ideation, compared a cognitive-focused intervention (i.e., “emotionally neutral memory recall,” p. 815) with a six-component PPI treatment. The components included a gratitude intervention (i.e., recall and write about three positive events from the past week), strengths identification and use, a gratitude letter (i.e., write and possibly send a letter to someone you have not yet thanked), engaging in enjoyable and meaningful activities, a “leveraging past success” intervention (i.e., recall a previous success and use that success to recover from the present depression), and performing three acts of kindness (or choosing to repeat one of the five prior PPIs). In contrast to the researchers’ stated expectations, Celano et al. found that the cognitive-focused intervention resulted in significantly greater improvements than the PPI in hopelessness, suicidal ideation, depressive symptoms, optimism, and gratitude. Celano et al. (2016) speculated that the findings could be due to participants’ symptom severity and destabilization that prevented clients from focusing on positive aspects of themselves or positive feelings, or perhaps, clients “focused instead on the discrepancy between those positive feelings and their current negative ones” (p. 819). This finding might support the concern of some clinicians that explicit PPIs seem too positive and insensitive in tone for clients who are suffering, and as such, focusing on virtues and well-being might be better facilitated through careful pacing within the practice of mainstream psychotherapies.

In a study involving female clients with severe depression, Chaves, Lopez-Gomez, Hervas, and Vazquez (2017) found no difference between group CBT and a PPI-based group treatment in the reduction of depression symptoms and no difference in improvement on the symptom dimension (i.e., multiple outcomes) and well-being dimension (i.e., multiple hedonic and eudaimonic outcomes). The multicomponent PPI included identifying and promoting positive emotions, savoring (i.e., attending and reflecting on the positive experience to enhance the positive emotion), mindfulness practices, counting one’s blessings (i.e., gratitude intervention), best positive self exercises (i.e., optimism), fostering positive relationships, counting kindnesses, self-compassion exercises, identifying and using strengths, writing obituary/biography, and goal setting.

González-Robles, García-Palacios, Baños, Quero, and Botella (2019) compared a transdiagnostic protocol (TP), based on Barlow et al.’s (2017) unified protocol, with a TP + PPI condition among clients diagnosed with a mood disorder. In an earlier study, Carl, Gallagher, and Barlow (2018) found moderate-to-large effect sizes from pretreatment to follow-up for positive affect, anxiety, depression, and QoL among clients ($n = 9$) completing an outpatient CBT protocol followed by a four-session module to enhance positive emotion. González-Robles et al. (2019) described the difference between their protocols as a focus on regulating negative affect in the TP condition and a focus on regulating both negative and positive affect in the TP + PPI condition. The PPI component consisted of four additional modules that focused on daily diary writing linking meaningful activities and mood, reflect-

ing on “smiling days” compared with “no-smiling days,” savoring, engaging in and reflecting on enjoyable activities, identifying and using strengths, engaging in meaningful activities tied to personal values, and gratitude (i.e., expressing gratitude), hope (i.e., best possible self), and curiosity (i.e., nurturing interest) exercises. Within-group effects for each condition were large for depression, anxiety, negative affect, and life satisfaction, whereas for positive affect, the within-group effect was significant in the TP + PPI condition but not in the TP condition. In addition, there were no between-groups differences on any of the outcomes at posttest.

Taken together, we suggest that the meta-analytic and individual study findings highlight the need for further research with clinical samples involving comparisons of bona fide treatments with tailored intervention components to target symptoms *and* well-being as separate-yet-related dimensions. Specifically, the question about whether symptom-focused treatments can improve well-being, or well-being-focused treatments can reduce symptoms, remains largely unanswered (O'Connor et al., 2015), given the limitations of low-quality studies and lack of clinical samples. In addition, the question remains as to which ingredients of symptom-focused and well-being-focused interventions account for change, and as such highlights the need for mediation and dismantling designs (Gu et al., 2015; Kirby et al., 2017; Yulish et al., 2017).

Positive Psychology and Phases of Treatment

Changes in symptoms, well-being, and virtue have also been examined from a phases of treatment perspective. Howard, Lueger, Maling, and Martinovich (1993) developed an influential three-phase model of psychotherapy with the initial phase involving improved subjective well-being and hopefulness (*remoralization*) followed by a phase of reduced symptoms (*remediation*) and then enhancement in life functioning (*rehabilitation*; e.g., improved interpersonal relationships, work, physical health, self-management). Howard et al. found empirical support for the model with the majority of change in subjective well-being occurring during early treatment. A significant percentage of improvement in symptoms and life functioning also tended to occur early in treatment but not to the same degree as subjective well-being. Irving et al. (2004) tested the influence of hope on symptoms and subjective well-being across time, finding that increase in the agency dimension of hope (i.e., motivation for goal attainment) was associated with improvements in symptoms and subjective well-being in early treatment, whereas the pathways dimension of hope (i.e., plan for goal achievement) was associated with subjective well-being at the final session (i.e., Session 11).

The phase model is particularly relevant to our considerations in this article because the first phase highlights a role for virtue in promoting change, and, specifically, builds upon classic works suggesting that psychotherapists must “arouse hope” (Frank & Frank, 1991, p. 44; see also, Yalom, 1970) about the possibility for change (i.e., *remoralization*). In addition, Wampold and Imel (2015) pointed out the importance of clients’ hopeful expectations and therapists’ capacities to form collaborative and hope-instilling working alliances; although, see Table 2 and the meta-analysis by Weis and Speridakos (2011), meta-analytic findings for the influence of hope enhancement interventions on symptoms and well-being outcomes have received mixed support. Last, the life functioning or eudaimonic phase addresses outcomes beyond a focus on reducing symptoms to include improved relationships, work

functioning, and physical health and may involve expressions of virtuous development.

These phase model findings have generally been replicated in subsequent research, albeit with mixed results (Budge et al., 2013); however, two important caveats are worth noting. First, Stulz and Lutz (2007) identified three different subgroups of outpatient clients ($N = 1128$) based on distinct patterns of change, with the largest group (63%) following the phase model, a second group (17%) showing rapid improvement in subjective well-being and symptoms but no change in life functioning, and a third group (20%), with the highest initial impairment in all three dimensions, showing changes in subjective well-being and symptoms that frequently violated the predicted model sequence. Many clinicians likely observe these kinds of different client trajectories during treatment. Nevertheless, phase model research does suggest that growth in some virtues could occur in early phases of treatment (e.g., hope) rather than simply being addressed later in treatment. At the same time, we acknowledge the conclusions from the meta-analyses we reviewed that longer term interventions seem more effective at promoting virtue and well-being. Second, Budge et al. (2013) found that intern/postdoctoral psychotherapists achieved greater effectiveness with university counseling center clients than more experienced psychologists on subjective well-being, symptoms, and life functioning. When considered in light of research showing a decline in therapist effectiveness over time (Goldberg et al., 2016), the findings (a) suggest experience may not reliably predict effectiveness and (b) invite exploration of other therapist factors beyond experience that might affect treatment outcomes.

Summary and Research Prospectus

PPIs, virtue-based interventions, and psychotherapies explicitly focused on well-being as a clinical outcome have demonstrated relative efficacy in promoting hedonic and eudaimonic well-being. In addition, virtue-based interventions have demonstrated relative efficacy at fostering growth in virtues. Similarly, PPIs, virtue-based interventions, and psychotherapies explicitly focused on well-being have demonstrated relative efficacy to reduce symptoms. However, when adjustments for study quality are considered, findings more accurately suggest uniform efficacy in reducing symptoms, that is, PPIs were equally effective relative to combined active and nonactive conditions in high-quality studies. Furthermore, when comparisons were analyzed relative to alternative active treatment conditions, the findings more accurately depicted the uniform efficacy of PPIs, explicit virtue-based interventions, and psychotherapies explicitly focused on well-being to reduce symptoms and promote hedonic and/or eudaimonic well-being. In addition, the available relative efficacy evidence largely pertains to nonclinical samples. As such, additional research is needed to examine the effectiveness of interventions to promote well-being and reduce symptoms, and particularly so among diverse clinical samples and those presenting with more severe symptoms (Chakhssi et al., 2018; Chaves et al., 2017; Hendriks et al., 2019). In addition, given that a large percentage of the research involving clinical samples consisted of self-help or group interventions, and the limited evidence available suggests that therapist-guided, individual, and longer term interventions may be more effective (Bolier et al., 2013; Chakhssi et al., 2018; Hendriks

et al., 2019; Sin & Lyubomirsky, 2009; Weiss et al., 2016), future research should focus on clients receiving community-based individual psychotherapy, rather than self-help or group treatment; although, there is also a need for research focusing on couple/family modalities in clinical contexts.

Very little attention has also been given to diversity factors that may influence effectiveness (Bolier et al., 2013), although studies included in meta-analytic reviews increasingly include samples outside of North America (i.e., non-Western samples; Hendriks et al., 2018, 2019). In fact, findings revealed larger effect sizes for PPIs at posttest relative to comparison conditions in studies from non-Western countries for the outcomes of symptoms and hedonic and eudaimonic well-being (Hendriks et al., 2018, 2019). Hendriks et al. (2018) attributed the larger effect sizes to the lower quality of the non-Western RCTs, and their smaller study sample sizes relative to Western studies. Alternatively, Hendriks et al. (2018) suggested that PPIs may simply be more acceptable to many individuals because they provide “a good cultural fit . . . through collective pathways that aim to improve interdependent relationships . . . stimulate low arousal emotions such as kindness . . . [and] aim to increase awareness,” all of which seem compatible with Eastern religious and cultural beliefs and practices (p. 87). On the one hand, PPIs have been critiqued as overly individualistic (Banicki, 2014; Lomas & Ivtzan, 2016; Wong, 2011), and Boehm, Lyubomirsky, and Sheldon (2011) suggested that “Western culture’s emphasis on self-improvement and personal agency—and a fixation with the pursuit of happiness in particular” likely explained their finding that PPIs resulted in greater gain in life satisfaction among Anglo Americans relative to Asian American participants (p. 1267). Yet, as Hendriks et al. (2018, 2019) noted, researchers are increasingly carrying out PPI investigations in non-Western countries, and there is evidence that researchers have responded to critiques, attending more to the sociocultural context, evidenced by advancing community-level interventions and viewing well-being and change as dialectic (Lomas, 2015; Lomas & Ivtzan, 2016). There is also emerging evidence that the construct of flourishing, measured by VanderWeele et al.’s (2019) flourishing index, for example, may generalize across cultures (Weziak-Białowolska, McNeely, & VanderWeele, 2019), and holistic measures such as the flourishing index might simply fit better for many cultures than symptom alleviation-focused assessments based on the Western medical model.

Naturalistic Clinical Research

According to Hone, Jarden, and Schofield (2015), “synthesizing efficacy trials of PPIs reveals little evidence that these interventions translate into sustained . . . change when applied beyond the tightly controlled conditions” of RCTs (p. 303). In fact, findings from RCTs suggest that PPIs *work for most people on average*, and yet, what remains unclear is when and where PPIs work, and for whom PPIs work and do not work, especially under “real-world” clinical conditions (Hone et al., 2015). Furthermore, because non-PPI psychotherapies with and without an explicit well-being focus may promote well-being (Chaves et al., 2017; Kolovos et al., 2016; Weiss et al., 2016), investigation of other non-PPI yet evidence-based psychotherapies should take place, with particular attention

to real-world practice. RCTs that use an implementation science framework to attend explicitly to “issues beyond efficacy, in particular, those related to intervention generalizability” or “real-world dissemination” (Hone et al., 2015, pp. 303–304), along with effectiveness (Hone et al., 2015) or practice-based designs (Barkham, Stiles, Lambert, & Mellor-Clark, 2010), can address the remaining real-world practice questions. It might be that PPIs and virtue-based interventions are easier to disseminate, as evidenced by the development of “positive technologies” and research on the effectiveness of phone- and Web-delivery modalities (Bolier et al., 2013; Botella, Banos, & Guillen, 2017, p. 219; Celano et al., 2016; Schueller & Parks, 2012).

Real-world practice questions can also be answered by person-centered data analytic procedures that identify “subgroups of individuals who respond very well to treatment and subgroups who do not respond well” (Frankfurt, Frazier, Syed, & Jung, 2016, p. 623). In fact, increased recognition of the heterogeneity in individuals’ experience has resulted in, or perhaps, corresponded to, increased utilization of person-centered analyses for examining symptoms and well-being (Newcomb-Anjo et al., 2017; O’Connor et al., 2012), at least in the developmental literature. Very little research has examined trajectories of change for symptoms and well-being outcomes, including virtues, among clinical samples, despite increased use of person-centered analyses in psychotherapy outcome studies (Frankfurt et al., 2016; Jankowski et al., 2019; Owen, Adelson, et al., 2015). Clinicians need to tailor treatments to particular clients, and practice-based research can facilitate this kind of evidence-informed treatment planning over time.

Last, answering the when, where, and for whom, that is, the conditions under which, PPIs, virtue-based treatments, and non-PPI treatments improve well-being and reduce symptoms, involves greater attention to predictors and moderators of change. For example, Wade et al. (2018) found that an explicit forgiveness intervention was more effective than no treatment and equally effective as a process-group condition in improving forgiveness outcomes (i.e., empathy, rumination, revenge, benevolence). There was no difference, however, between conditions on symptoms, as all three conditions improved over time. When considering conditions of change, specifically client characteristics of attachment avoidance and anxiety, the forgiveness intervention was more beneficial than the process-group psychotherapy condition in improving benevolence for those high in avoidant attachment and improving rumination for those high in anxious attachment. This suggests that certain client factors might lead to some treatment approaches being more effective than other treatments when fostering virtue development and improved well-being, and which would require careful clinical assessment and treatment decision-making about these client factors.

Publication bias was noted as a potential concern in numerous meta-analyses (Bolier et al., 2013; Chakhssi et al., 2018; Davis et al., 2016; Galante et al., 2014; Hendriks et al., 2019), and this concern has prompted calls for increased transparency and reproducibility in clinical research (Galante et al., 2014; Hopwood & Vazire, 2018). As such, researchers are encouraged to preregister (i.e., a priori documentation of) their hypotheses, including expected predictors of change and moderation hypotheses, report all findings whether significant or not, and/or explicitly identify their study as exploratory (Hopwood & Vazire, 2018). The same trans-

parency and reproducibility ethic applies to studies examining mechanisms of change.

Mechanisms of Change

In addition to conditions of change, questions also remain about the mechanisms for reducing symptoms and promoting well-being. The importance of clarifying mechanisms of change centers on the potential for enhancing the active ingredients of an intervention to improve effectiveness and when identified in conjunction with expected moderators, permits therapists to match interventions to particular client concerns (Gu et al., 2015). Future research involving both RCTs and practice-based designs should include empirical examination of the mechanisms by which pathway activities deliver their effect and examine other evidence-based mechanisms (e.g., affect regulation, therapeutic alliance; Chakhssi et al., 2018; Ruini, 2017; Schutte & Malouff, 2019; Wade et al., 2014) and theorized roles for virtues as change mechanisms in the upregulation of positive functioning (Cloninger & Cloninger, 2016; Rusk et al., 2018; Waring, 2016). Cloninger and Cloninger (2016) suggested that “recognition of what is good and wholesome guides a person’s conduct so that he or she can function in a healthier way . . . it is necessary . . . [therefore] to function in ways consistent with our goals and values” (p. 253). Virtuous development deemed essential to change contrasts with virtuous activities simply aimed at symptom reduction and/or hedonic well-being and/or eudaimonic formulations devoid of virtue. McMinn et al. (2016) alluded to virtuous activities that do not seek to promote virtuous development as *virtue lite* interventions. A client, for example, can practice acts of kindness because of valuing kindness and a desire to become kinder. Alternatively, a client can engage in kindness because it will ease relational tension and bring greater felt satisfaction. The latter signifies a *virtue lite* approach, which rests on subjective instrumentalism, with virtuous actions performed to reach self-defined goals of hedonic well-being rather than growth in virtuousness as an explicit treatment goal (Proctor, 2019). In contrast, explicit virtue-based interventions posit virtuousness as a process (i.e., change mechanism) and an outcome (i.e., treatment goal; Proctor, 2019), or alternatively, that growth in virtues facilitates relationally robust and socially generative forms of well-being (i.e., eudaimonic well-being; Banicki, 2014; Proctor, 2019). In our experience, these differences seem heavily philosophical and uninteresting to some clinicians, whereas others find it valuable to reflect on whether treatment should simply improve symptoms and subjective well-being or also cultivate eudaimonia, including virtue development.

Therapist Effects

One emerging extension of practice-based research involves attention to therapist effects. Therapist effects research represents a shift away from an emphasis on RCTs focused on *intervention efficacy* toward practice-based designs explaining the variance in client outcomes attributable to between-therapist differences, that is, a focus on *therapist effectiveness* (Johns, Barkham, Kellett, & Saxon, 2019). RCTs, by design, seek to control the influence of therapists on treatment outcomes, whereas therapist effects research explicitly models therapist variability in the data analysis. RCTs tend to be underpowered to find therapist effects, and thus,

practice-based designs “appear better suited to the study of therapist effects” (Johns et al., 2019, p. 90).

A recent meta-analysis of 19 studies finding evidence of therapist effects in individual psychotherapy, 17 of which were practice-based designs, found an effect of 5% (Johns et al., 2019), which was comparable with previous meta-analytic findings of 3% for RCTs and 7% for practice-based designs (Baldwin & Imel, 2013). The importance of considering therapist effects was highlighted by Owen, Drinane, Idigo, and Valentine’s (2015) reanalysis of data from 17 meta-analyses in which posttest differences were found between treatment and an active control condition on the outcome of symptoms. Because these meta-analyses did not adjust their findings for therapist effects, Owen et al. used estimates of therapist effects (5% [small], 10% [medium], 20% [large]), representative of the wide range of therapist effects found in meta-analyses of therapist effects in RCTs (e.g., 1%–29%; Johns et al., 2019), and recalculated the effect sizes. Based on estimates for therapist effects and number of psychotherapists, when the therapist effect was large and the therapist–client ratio was 30:1, “only 20% of the original treatment effects were still statistically significant,” compared with 80% when the therapist effect was small and the therapist–client ratio was 15:1 (p. 325). After adjusting for therapist effects, effectiveness among treatment conditions was more consistent with the typical meta-analytic findings of no difference between actual active treatment conditions. Similar reductions in effect sizes can be seen when researcher allegiance is included in the meta-analysis. For example, Goldberg and Tucker (2019) found evidence for the superiority of MBIs relative to a bona fide treatment condition (i.e., combined active control conditions and evidence-based treatment conditions) to alleviate symptoms. However, the evidence favoring MBIs was attributable to researcher allegiance. Thus, “uniform efficacy” appears to be the norm when active treatments are compared (Goldberg & Tucker, 2019, p. 9), that is, treatments are equally effective; again, consistent with typical meta-analytic findings of no difference between actual active treatment comparisons (Wampold & Imel, 2015).

Client symptom severity is a consistent predictor of therapist effects (Johns et al., 2019), and there is evidence that therapist effects differ by outcome domain (Constantino, Boswell, Coyne, Kraus, & Castonguay, 2017; Owen, Adelson, Budge, Kopta, & Reese, 2016). Owen, Adelson, et al. (2016) found less variability between therapists on the outcome of well-being, that is, a therapist effect of 0.4% (i.e., life satisfaction, global distress), whereas the effect for life functioning (i.e., relationships, work/school) was 7.5% and for symptoms was 4.6%. Owen, Adelson, et al. (2016) also found that life functioning remained stable across time regardless of the number of sessions, and they concluded that life functioning may take “longer to obtain through psychotherapy, versus symptom reduction and well-being” (p. 28). Taken together, domain specificity and symptom severity (a) suggest that more complex client outcomes may require longer treatment duration, (b) tend to yield more variability among therapists (Johns et al., 2019; Owen, Adelson, et al., 2016), and (c) suggest that therapist effects are best understood as “a multicomponent phenomenon” (Johns et al., 2019, p. 91).

Therapist effects can be divided into (a) therapist characteristics, delineated further as facilitative interpersonal skills (e.g., empathy, hope) and deliberative practices, and (b) therapist–client relational

process (e.g., therapist–client bond, goal agreement; Constantino et al., 2017). Examining process requires distinguishing each dyad members' contribution, which relies upon data analytic decisions reflective of the use of multilevel modeling as the analytic choice best suited to therapist effects research (Constantino et al., 2017). As an emerging focus, it is perhaps not surprising that few studies have attended to the integration of therapist effects and PPIs or positive psychology constructs, although the dimension of facilitative interpersonal skills seems conducive to a role for therapist virtues in psychotherapy outcome research.

There is some evidence that therapist virtues may affect treatment. Greater client-rated therapist empathy was indirectly associated with improvement in client well-being and symptoms through higher client ratings of the working alliance (McClintock, Anderson, Patterson, & Wing, 2018). By comparison, only therapist-rated hope in their clients, pre- and posttreatment, significantly predicted symptom reduction, whereas client-rated hope did not (Coppock, Owen, Zagarskas, & Schmidt, 2010). In addition, clients' perceived level of therapists' cultural humility predicted retrospective ratings of improvement in functioning (i.e., symptom distress, relationships, work/school; Owen, Tao, et al., 2016). Future research should unpack correlations such as these, as correlations are not necessarily therapist effects (Constantino et al., 2017). Therapist effects emerge from particular data analytic strategies (i.e., multilevel modeling) that isolate the therapists' contribution to change, and potentially additional predictors are required to explain between-therapists differences (Constantino et al., 2017). In fact, very little research has explored therapist differences that account for therapist effects, and as such, we know very little about "true therapist level predictors . . . to explain . . . therapist differences" (Constantino et al., 2017, pp. 58–59).

Conclusion

The historical virtue-ethics thesis across numerous traditions that growth in virtues is a component of human flourishing (Allen, 2008; Banicki, 2014; Cloninger & Cloninger, 2016; Proctor, 2019; Rusk et al., 2018) has gone largely empirically untested with clinical samples in psychotherapy contexts. As highlighted in our review, virtue-based treatments may best test this idea, and existing findings suggest a *possibility* for virtues to foster flourishing. We use the term *possibility* because existing findings seem to suggest that there is nothing particularly advantageous to virtue-based treatments, nor PPIs for that matter, relative to alternative treatments overtly focused on well-being or alternative bona fide treatments in their effectiveness to promote flourishing. Lack of evidence for relative efficacy suggests uniform efficacy but also seems to suggest that there are yet-to-be-identified moderators and mechanisms of change and/or insufficient use of research designs and statistical procedures that could more clearly address the virtue-ethics theory. The latter also highlights the need for practice-based studies involving diverse clients receiving routine care in outpatient community-based clinics, with much greater attention to therapist effects. We emphasize *diverse* because of the need to clarify further the cultural generalizability of the constructs of well-being and flourishing, and the interventions offered to reduce symptoms and promote well-being, using diverse U.S. samples and in cross-cultural contexts. Lack of evidence for relative efficacy is also consistent with the evidence supporting com-

mon change factors in psychotherapy (Wampold & Imel, 2015), that is, therapist characteristics and behaviors that cut across explicit PPIs, virtue-based treatments, psychotherapies with an explicit well-being focus, and non-PPI alternative treatments that account for change in flourishing. For example, instilling hope, providing empathy, and encouraging clients "to do something that is salubrious" may not be unique to explicit PPIs and virtue-based treatments (Wampold & Imel, 2015, p. 60) and may explain improvements in flourishing observed among a variety of treatments, including non-PPI psychotherapies. Even so, for whom, when, where, and why virtues may foster flourishing remains largely unanswered.

We began our review by suggesting that psychotherapy inherently, and most often, implicitly, conveys a vision of *the good life*, that is, psychotherapy cannot avoid communicating to clients what it means to flourish. Historically, the practice of psychotherapy has defined flourishing as symptom reduction, and our review highlighted the shift that has and is currently occurring whereby flourishing is understood to be much more than symptom reduction and, specifically, that flourishing also involves well-being. We also pointed out that flourishing involves virtuous acts and ongoing virtuous development and, specifically, that flourishing consists of a telos that motivates and focuses client intentionality toward change. Psychotherapy remains a primary context where individuals turn to make meaning of and construct self-narratives about their problems and experiences of suffering (Schnitker, King, & Houlberg, 2019). As such, psychotherapy holds potential to offer clients more than symptom reduction, and integrating a virtuous telos may be a way that psychotherapy can foster flourishing. We realize that the ideas in this review may challenge the dominant assumption that clinicians should reduce symptoms as a way to improve well-being (e.g., positive social and occupational functioning [or get it back to baseline]), and yet, we believe that our review also challenges the reverse assumption inherent in explicit PPIs and virtue-based treatments that would suggest clinicians should focus instead on enhancing strengths and virtues as a means to reduce symptoms and improve well-being. Rather, our conclusion is that promoting flourishing in psychotherapy likely requires a dual focus that uses distinct interventions to explicitly target symptom reduction *and* positive functioning (e.g., interventions to change dysregulated negative affective processes and interventions to change dysregulated positive affective processes; Boettcher, Sandage, Latin, & Barlow, 2019). Future research with this dual focus involving differing clinical contexts and treatment models can perhaps better test the virtue-ethics thesis and the effectiveness of integrating PPIs in psychotherapy.

References

- Allen, J. G. (2008). Psychotherapy: The artful use of science. *Smith College Studies in Social Work*, 78, 159–187. <http://dx.doi.org/10.1080/00377310802111888>
- Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 258–297). New York, NY: Wiley.
- Banicki, K. (2014). Positive psychology on character strengths and virtues. A disquieting suggestion. *New Ideas in Psychology*, 33, 21–34. <http://dx.doi.org/10.1016/j.newideapsych.2013.12.001>

- Barkham, M., Stiles, W. B., Lambert, M. J., & Mellor-Clark, J. (2010). Building a rigorous and relevant knowledge base for psychological therapies. In M. Barkham, G. E. Hardy, & J. Mellor-Clark (Eds.), *Developing and delivering practice-based evidence* (pp. 21–61). West Sussex, United Kingdom: Wiley and Sons. <http://dx.doi.org/10.1002/9780470687994.ch2>
- Barlow, D. H., Farchione, T. J., Sauer-Zavala, S., Latin, H. M., Ellard, K. K., Bullis, J. R., & Cassiello-Robbins, C. (2017). *Unified protocol for transdiagnostic treatment of emotional disorders: Therapist guide*. New York, NY: Oxford University Press.
- Battaly, H. (2016). Developing virtue and rehabilitating vice: Worries about self-cultivation and self-reform. *Journal of Moral Education, 45*, 207–222. <http://dx.doi.org/10.1080/03057240.2016.1195732>
- Blanck, P., Perleth, S., Heidenreich, T., Kröger, P., Ditzgen, B., Bents, H., & Mander, J. (2018). Effects of mindfulness exercises as stand-alone intervention on symptoms of anxiety and depression: Systematic review and meta-analysis. *Behaviour Research and Therapy, 102*, 25–35. <http://dx.doi.org/10.1016/j.brat.2017.12.002>
- Boehm, J. K., Lyubomirsky, S., & Sheldon, K. M. (2011). A longitudinal experimental study comparing the effectiveness of happiness-enhancing strategies in Anglo Americans and Asian Americans. *Cognition and Emotion, 25*, 1263–1272. <http://dx.doi.org/10.1080/02699931.2010.541227>
- Boettcher, H. T., Sandage, S. J., Latin, H. M., & Barlow, D. H. (2019). Transdiagnostic treatment for enhancing positive affect and well-being. In J. Gruber (Ed.), *Positive emotion and psychopathology* (pp. 525–538). New York, NY: Oxford University Press.
- Bolier, L., Haverman, M., Westerhof, G. J., Riper, H., Smit, F., & Bohlmeijer, E. (2013). Positive psychology interventions: A meta-analysis of randomized controlled studies. *BMC Public Health, 13*, 119. <http://dx.doi.org/10.1186/1471-2458-13-119>
- Botella, C., Banos, R. M., & Guillen, V. (2017). Positive technologies for improving health and well-being. In C. Proctor (Ed.), *Positive psychology interventions in practice* (pp. 219–234). Cham, Switzerland: Springer. http://dx.doi.org/10.1007/978-3-319-51787-2_13
- Budge, S. L., Owen, J. J., Kopta, S. M., Minami, T., Hanson, M. R., & Hirsch, G. (2013). Differences among trainees in client outcomes associated with the phase model of change. *Psychotherapy, 50*, 150–157. <http://dx.doi.org/10.1037/a0029565>
- Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26*, 17–31. <http://dx.doi.org/10.1016/j.cpr.2005.07.003>
- Carl, J. R., Gallagher, M. W., & Barlow, D. H. (2018). Development and preliminary evaluation of a positive emotion regulation augmentation module for anxiety and depression. *Behavior Therapy, 49*, 939–950. <http://dx.doi.org/10.1016/j.beth.2017.11.008>
- Celano, C. M., Beale, E. E., Mastromauro, C. A., Stewart, J. G., Millstein, R. A., Auerbach, R. P., . . . Huffman, J. C. (2016). Psychological interventions to reduce suicidality in high-risk patients with major depression: A randomized controlled trial. *Psychological Medicine, 47*, 810–821. <http://dx.doi.org/10.1017/S0033291716002798>
- Chakhssi, F., Kraiss, J. T., Sommers-Spijkerman, M., & Bohlmeijer, E. T. (2018). The effect of positive psychology interventions on well-being and distress in clinical samples with psychiatric or somatic disorders: A systematic review and meta-analysis. *BMC Psychiatry*. Advance online publication. <http://dx.doi.org/10.1186/s12888-018-1739-2>
- Chaves, C., Lopez-Gomez, I., Hervas, G., & Vazquez, C. (2017). A comparative study on the efficacy of a positive psychology intervention and a cognitive behavioral therapy for clinical depression. *Cognitive Therapy and Research, 41*, 417–433. <http://dx.doi.org/10.1007/s10608-016-9778-9>
- Cloninger, C. R., & Cloninger, K. M. (2016). Person-centered psychotherapy. In J. Mezzich, M. Botbol, G. Christodoulou, C. Cloninger, & I. Salloum (Eds.), *Person centered psychiatry* (pp. 247–261). Cham, Switzerland: Springer. http://dx.doi.org/10.1007/978-3-319-39724-5_19
- Constantino, M. J., Boswell, J. F., Coyne, A. E., Kraus, D. R., & Castonguay, L. G. (2017). Who works for whom and why? Integrating therapist effects analysis into psychotherapy outcome and process research. In L. G. Castonguay & C. E. Hill (Eds.), *How and why are some therapists better than others? Understanding therapist effects* (pp. 55–68). Washington, DC: American Psychological Association. <http://dx.doi.org/10.1037/0000034-004>
- Coppock, T. E., Owen, J. J., Zagarskas, E., & Schmidt, M. (2010). The relationship between therapist and client hope with therapy outcomes. *Psychotherapy Research, 20*, 619–626. <http://dx.doi.org/10.1080/10503307.2010.497508>
- Davis, D. E., Choe, E., Meyers, J., Wade, N., Varjas, K., Gifford, A., . . . Worthington, E. L., Jr. (2016). Thankful for the little things: A meta-analysis of gratitude interventions. *Journal of Counseling Psychology, 63*, 20–31. <http://dx.doi.org/10.1037/cou0000107>
- Dickens, L. R. (2017). Using gratitude to promote positive change: A series of meta-analyses investigating the effectiveness of gratitude interventions. *Basic and Applied Social Psychology, 39*, 193–208. <http://dx.doi.org/10.1080/01973533.2017.1323638>
- Diener, E., Heintzelman, S. J., Kushlev, K., Tay, L., Wirtz, D., Lutes, L. D., & Oishi, S. (2017). Findings all psychologists should know from the new science on subjective well-being. *Canadian Psychology, 58*, 87–104. <http://dx.doi.org/10.1037/cap0000063>
- Dillon, R. S. (2018). Feminist approaches to virtue ethics. In N. E. Snow (Ed.), *The Oxford handbook of virtue* (pp. 377–397). New York, NY: Oxford University Press.
- Fava, G. A., Ruini, C., Rafanelli, C., Finos, L., Salmaso, L., Mangelli, L., & Sirigatti, S. (2005). Well-being therapy of generalized anxiety disorder. *Psychotherapy and Psychosomatics, 74*, 26–30. <http://dx.doi.org/10.1159/000082023>
- Fowers, B. J. (2005). Psychotherapy, character, and the good life. In B. D. Slife, J. S. Reber, & F. C. Richardson (Eds.), *Critical thinking about psychology: Hidden assumptions and plausible alternatives* (pp. 39–59). Washington, DC: American Psychological Association.
- Frank, J. D., & Frank, J. B. (1991). *Persuasion and healing: A comparative study of psychotherapy* (3rd ed.). Baltimore, MD: Johns Hopkins University Press.
- Frankfurt, S., Frazier, P., Syed, M., & Jung, K. R. (2016). Using group-based trajectory and growth mixture modeling to identify classes of change trajectories. *The Counseling Psychologist, 44*, 622–660. <http://dx.doi.org/10.1177/0011000016658097>
- Galante, J., Galante, I., Bekkers, M.-J., & Gallacher, J. (2014). Effect of kindness-based meditation on health and well-being: A systematic review and meta-analysis. *Journal of Consulting and Clinical Psychology, 82*, 1101–1114. <http://dx.doi.org/10.1037/a0037249>
- Goldberg, S. B., Rousmaniere, T., Miller, S. D., Whipple, J., Nielsen, S. L., Hoyt, W. T., & Wampold, B. E. (2016). Do psychotherapists improve with time and experience? A longitudinal analysis of outcomes in a clinical setting. *Journal of Counseling Psychology, 63*, 1–11. <http://dx.doi.org/10.1037/cou0000131>
- Goldberg, S. B., & Tucker, R. P. (2019). Allegiance effects in mindfulness-based interventions for psychiatric disorders: A meta-re-analysis. *Psychotherapy Research*. Advance online publication. <http://dx.doi.org/10.1080/10503307.2019.1664783>
- Goldberg, S. B., Tucker, R. P., Greene, P. A., Davidson, R. J., Wampold, B. E., Kearney, D. J., & Simpson, T. L. (2018). Mindfulness-based interventions for psychiatric disorders: A systematic review and meta-analysis. *Clinical Psychology Review, 59*, 52–60. <http://dx.doi.org/10.1016/j.cpr.2017.10.011>
- González-Robles, A., García-Palacios, A., Baños, R., Quero, S., & Botella, C. (2019). Upregulating positive affectivity in the transdiagnostic treat-

- ment of emotional disorders: A randomized pilot study. *Behavior Modification*, 43, 26–55. <http://dx.doi.org/10.1177/0145445517735631>
- Goyal, M., Singh, S., Sibinga, E. M., Gould, N. F., Rowland-Seymour, A., Sharma, R., . . . Haythornthwaite, J. A. (2014). Meditation programs for psychological stress and well-being: A systematic review and meta-analysis. *Journal of the American Medical Association Internal Medicine*, 174, 357–368. <http://dx.doi.org/10.1001/jamainternmed.2013.13018>
- Gu, J., Strauss, C., Bond, R., & Cavanagh, K. (2015). How do mindfulness-based cognitive therapy and mindfulness-based stress reduction improve mental health and wellbeing? A systematic review and meta-analysis of mediation studies. *Clinical Psychology Review*, 37, 1–12. <http://dx.doi.org/10.1016/j.cpr.2015.01.006>
- Haggard, M., Rowatt, W. C., Leman, J. C., Meagher, B., Moore, C., Fergus, T., . . . Howard-Snyder, D. (2018). Finding middle ground between intellectual arrogance and intellectual servility: Development and assessment of the Limitations-Owning Intellectual Humility Scale. *Personality and Individual Differences*, 124, 184–193. <http://dx.doi.org/10.1016/j.paid.2017.12.014>
- Hall-Simmonds, A., & McGrath, R. E. (2019). Character strengths and clinical presentation. *The Journal of Positive Psychology*, 14, 51–60. <http://dx.doi.org/10.1080/17439760.2017.1365160>
- Hendriks, T., Schotanus-Dijkstra, M., Hassankhan, A., de Jong, J., & Bohlmeijer, E. (2019). The efficacy of multi-component positive psychology interventions: A systematic review and meta-analysis. *Journal of Happiness Studies*. Advance online publication. <http://dx.doi.org/10.1007/s10902-019-00082-1>
- Hendriks, T., Schotanus-Dijkstra, M., Hassankhan, A., Graafsma, T., Bohlmeijer, E., & de Jong, J. (2018). The efficacy of positive psychology interventions from non-Western countries: A systematic review and meta-analysis. *International Journal of Wellbeing*, 8, 71–98. <http://dx.doi.org/10.5502/ijw.v8i1.711>
- Hofmann, S. G., Wu, J. Q., & Boettcher, H. (2014). Effect of cognitive-behavioral therapy for anxiety disorders on quality of life: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 82, 375–391. <http://dx.doi.org/10.1037/a0035491>
- Hone, L. C., Jarden, A., & Schofield, G. M. (2015). An evaluation of positive psychology intervention effectiveness trials using the re-aim framework: A practice-friendly review. *The Journal of Positive Psychology*, 10, 303–322. <http://dx.doi.org/10.1080/17439760.2014.965267>
- Hopwood, C. J., & Vazire, S. (2018). Reproducibility in clinical psychology. *PsyArXiv Preprints*. Advance online publication. <http://dx.doi.org/10.31234/osf.io/g76yd>
- Howard, K. I., Lueger, R. J., Maling, M. S., & Martinovich, Z. (1993). A phase model of psychotherapy outcome: Causal mediation of change. *Journal of Consulting and Clinical Psychology*, 61, 678–685. <http://dx.doi.org/10.1037/0022-006X.61.4.678>
- Irving, L. M., Snyder, C. R., Cheavens, J., Gravel, L., Hanke, J., Hilberg, P., & Nelson, N. (2004). The relationships between hope and outcomes at the pretreatment, beginning, and later phases of psychotherapy. *Journal of Psychotherapy Integration*, 14, 419–443. <http://dx.doi.org/10.1037/1053-0479.14.4.419>
- Ivtzan, I., Young, T., Martman, J., Jeffrey, A., Lomas, T., Hart, R., & Eiroa-Orosa, F. J. (2016). Integrating mindfulness into positive psychology: A randomised controlled trial of an online positive mindfulness program. *Mindfulness*, 7, 1396–1407. <http://dx.doi.org/10.1007/s12671-016-0581-1>
- Jankowski, P. J., Sandage, S. J., Bell, C. A., Rupert, D., Bronstein, M., & Stavros, G. S. (2019). Latent trajectories of change for clients at a psychodynamic training clinic. *Journal of Clinical Psychology*, 75, 1147–1168. <http://dx.doi.org/10.1002/jclp.22769>
- Johns, R. G., Barkham, M., Kellett, S., & Saxon, D. (2019). A systematic review of therapist effects: A critical narrative update and refinement to Baldwin and Imel's (2013) review. *Clinical Psychology Review*, 67, 78–93. <http://dx.doi.org/10.1016/j.cpr.2018.08.004>
- Keyes, C. L. M. (1998). Social well-being. *Social Psychology Quarterly*, 61, 121–140. <http://dx.doi.org/10.2307/2787065>
- Khoury, B., Sharma, M., Rush, S. E., & Fournier, C. (2015). Mindfulness-based stress reduction for healthy individuals: A meta-analysis. *Journal of Psychosomatic Research*, 78, 519–528. <http://dx.doi.org/10.1016/j.jpsychores.2015.03.009>
- Kirby, J. N., Tellegen, C. L., & Steindl, S. R. (2017). A meta-analysis of compassion-based interventions: Current state of knowledge and future directions. *Behavior Therapy*, 48, 778–792. <http://dx.doi.org/10.1016/j.beth.2017.06.003>
- Kolovos, S., Kleiboer, A., & Cuijpers, P. (2016). Effect of psychotherapy for depression on quality of life: Meta-analysis. *The British Journal of Psychiatry*, 209, 460–468. <http://dx.doi.org/10.1192/bjp.bp.115.175059>
- Lambert, L., Passmore, H.-A., & Holder, M. D. (2015). Foundational frameworks of positive psychology: Mapping well-being orientations. *Canadian Psychology*, 56, 311–321. <http://dx.doi.org/10.1037/cap0000033>
- Littman-Ovadia, H., & Niemiec, R. M. (2016). Character strengths and mindfulness as core pathways to meaning in life. In P. Russo-Netzer, S. E. Schulenberg, & A. Batthyany (Eds.), *Clinical perspectives on meaning: Positive and existential psychotherapy* (pp. 383–405). Cham, Switzerland: Springer. http://dx.doi.org/10.1007/978-3-319-41397-6_19
- Lomas, T. (2015). Positive social psychology: A multilevel inquiry into sociocultural well-being initiatives. *Psychology, Public Policy, and Law*, 21, 338–347. <http://dx.doi.org/10.1037/law0000051>
- Lomas, T., & Ivtzan, I. (2016). Second wave positive psychology: Exploring the positive-negative dialectics of wellbeing. *Journal of Happiness Studies*, 17, 1753–1768. <http://dx.doi.org/10.1007/s10902-015-9668-y>
- MacKenzie, M. (2018). Buddhism and the virtues. In N. E. Snow (Ed.), *The Oxford handbook of virtue* (pp. 153–170). New York, NY: Oxford University Press.
- Magyar-Moe, J. (2009). *Therapist's guide to positive psychological interventions*. Burlington, MA: Academic Press.
- Magyar-Moe, J. L., Owens, R. L., & Conoley, C. W. (2015). Positive psychological interventions in counseling: What every counseling psychologist should know. *The Counseling Psychologist*, 43, 508–557. <http://dx.doi.org/10.1177/0011000015573776>
- Marujo, H. À., & Neto, L. M. (2016). Quality of life studies and positive psychology. In L. Bruni & P. L. Porta (Eds.), *Handbook of research methods and applications in happiness and quality of life* (pp. 279–306). Northampton, MA: Edward Elgar Publishing. <http://dx.doi.org/10.4337/9781783471171.00018>
- McClintock, A. S., Anderson, T., Patterson, C. L., & Wing, E. H. (2018). Early psychotherapeutic empathy, alliance, and client outcome: Preliminary evidence of indirect effects. *Journal of Clinical Psychology*, 74, 839–848. <http://dx.doi.org/10.1002/jclp.22568>
- McFarquhar, T., Luyten, P., & Fonagy, P. (2018). Changes in interpersonal problems in the psychotherapeutic treatment of depression as measured by the Inventory of Interpersonal Problems: A systematic review and meta-analysis. *Journal of Affective Disorders*, 226, 108–123. <http://dx.doi.org/10.1016/j.jad.2017.09.036>
- McMinn, M. R., McLaughlin, P. T., Johnson, B. C., & Shoup, R. (2016). Psychotherapy and the theological virtues. *Open Theology*, 2, 424–435. <http://dx.doi.org/10.1515/oph-2016-0035>
- Munder, T., Flückiger, C., Leichsenring, F., Abbas, A. A., Hilsenroth, M. J., Luyten, P., . . . Wampold, B. E. (2019). Let's distinguish relative and absolute efficacy to move psychotherapy research forward. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*, 65, 178–182. <http://dx.doi.org/10.13109/zptm.2019.65.2.178>
- Newcomb-Anjo, S. E., Barker, E. T., & Howard, A. L. (2017). A person-centered analysis of risk factors that compromise wellbeing in emerging

- adulthood. *Journal of Youth and Adolescence*, 46, 867–883. <http://dx.doi.org/10.1007/s10964-016-0603-2>
- Niemiec, R. M. (2018). *Character strengths interventions: A field guide for practitioners*. Boston, MA: Hogrefe Publishing.
- O'Connor, M., Sanson, A., Hawkins, M., Olsson, C., Frydenberg, E., Toumbourou, J., & Letcher, P. (2012). The relationship between positive development and psychopathology during the transition to adulthood: A person-centered approach. *Journal of Adolescence*, 35, 701–712. <http://dx.doi.org/10.1016/j.adolescence.2011.10.006>
- O'Connor, M., Sanson, A., Toumbourou, J., Hawkins, M., Letcher, P., Williams, P., & Olsson, C. (2015). Positive development and resilience in emerging adulthood. In J. Arnett (Ed.), *The Oxford handbook of emerging adulthood* (pp. 601–614). Oxford, United Kingdom: Oxford University Press.
- Owen, J. J., Adelson, J., Budge, S., Kopta, S. M., & Reese, R. J. (2016). Good-enough level and dose-effect models: Variation among outcomes and therapists. *Psychotherapy Research*, 26, 22–30. <http://dx.doi.org/10.1080/10503307.2014.966346>
- Owen, J., Adelson, J., Budge, S., Wampold, B., Kopta, M., Minami, T., & Miller, S. (2015). Trajectories of change in psychotherapy. *Journal of Clinical Psychology*, 71, 817–827. <http://dx.doi.org/10.1002/jclp.22191>
- Owen, J., Drinane, J. M., Idigo, K. C., & Valentine, J. C. (2015). Psychotherapist effects in meta-analyses: How accurate are treatment effects? *Psychotherapy*, 52, 321–328. <http://dx.doi.org/10.1037/pst0000014>
- Owen, J., Tao, K. W., Drinane, J. M., Hook, J., Davis, D. E., & Kune, N. F. (2016). Client perceptions of therapists' multicultural orientation: Cultural (missed) opportunities and cultural humility. *Professional Psychology: Research and Practice*, 47, 30–37. <http://dx.doi.org/10.1037/pro0000046>
- Park, C. L. (2015). Integrating positive psychology into health-related quality of life research. *Quality of Life Research: An International Journal of Quality of Life Aspects of Treatment, Care and Rehabilitation*, 24, 1645–1651. <http://dx.doi.org/10.1007/s11136-014-0889-z>
- Parks, A. C., & Schueller, S. M. (Eds., 2014). *The Wiley Blackwell handbook of positive psychological interventions*. Chichester, United Kingdom: Wiley-Blackwell. <http://dx.doi.org/10.1002/9781118315927>
- Parks, A. C., & Titova, L. (2016). Positive psychological interventions: An overview. In A. Wood & J. Johnson (Eds.), *The Wiley handbook of positive clinical psychology* (pp. 305–320). Chichester, United Kingdom: Wiley. <http://dx.doi.org/10.1002/9781118468197.ch21>
- Peteet, J. R. (2018). A fourth wave of psychotherapies: Moving beyond recovery toward well-being. *Harvard Review of Psychiatry*, 26, 90–95. <http://dx.doi.org/10.1097/HRP.0000000000000155>
- Peterson, C. E., & Seligman, M. E. P. (2004). *Character strengths and virtues*. New York, NY: Oxford University Press.
- Proctor, C. (2019). Virtue ethics in psychotherapy: A systematic review of the literature. *International Journal of Existential Psychology and Psychotherapy*, 8, 1–22. Retrieved from <http://journal.existentialpsychology.org/index.php/ExPsy/article/view/237>
- Proctor, C., Tweed, R., & Morris, D. (2015). The naturally emerging structure of well-being among young adults: "Big two" or other framework? *Journal of Happiness Studies*, 16, 257–275. <http://dx.doi.org/10.1007/s10902-014-9507-6>
- Ruini, C. (2017). *Positive psychology in the clinical domains: Research and practice*. Cham, Switzerland: Springer. <http://dx.doi.org/10.1007/978-3-319-52112-1>
- Rusk, R. D., Vella-Brodrick, D. A., & Waters, L. (2018). A complex dynamic systems approach to lasting positive change: The synergistic change model. *The Journal of Positive Psychology*, 13, 406–418. <http://dx.doi.org/10.1080/17439760.2017.1291853>
- Ryff, C. D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. *Journal of Personality and Social Psychology*, 57, 1069–1081. <http://dx.doi.org/10.1037/0022-3514.57.6.1069>
- Sandage, S. J., & Hill, P. C. (2001). The virtues of positive psychology: The rapprochement and challenges of an affirmative postmodern perspective. *Journal for the Theory of Social Behaviour*, 31, 241–260. <http://dx.doi.org/10.1111/1468-5914.00157>
- Schnitker, S. A., King, P. E., & Houtberg, B. (2019). Religion, spirituality, and thriving: Transcendent narrative, virtue, and telos. *Journal of Research on Adolescence*, 29, 276–290. <http://dx.doi.org/10.1111/jora.12443>
- Schueller, S. M., & Parks, A. C. (2012). Disseminating self-help: Positive psychology exercises in an online trial. *Journal of Medical Internet Research*, 14, e63. <http://dx.doi.org/10.2196/jmir.1850>
- Schutte, N. S., & Malouff, J. M. (2019). The impact of character strengths interventions: A meta-analysis. *Journal of Happiness Studies*, 20, 1179–1196. <http://dx.doi.org/10.1007/s10902-018-9990-2>
- Seligman, M. E. P. (2011). *Flourish: A visionary new understanding of happiness and well-being*. New York, NY: Simon & Schuster.
- Seligman, M. E. P., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American Psychologist*, 61, 774–788. <http://dx.doi.org/10.1037/0003-066X.61.8.774>
- Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of Clinical Psychology*, 65, 467–487. <http://dx.doi.org/10.1002/jclp.20593>
- Spijkerman, M. P. J., Pots, W. T. M., & Bohlmeijer, E. T. (2016). Effectiveness of online mindfulness-based interventions in improving mental health: A review and meta-analysis of randomised controlled trials. *Clinical Psychology Review*, 45, 102–114. <http://dx.doi.org/10.1016/j.cpr.2016.03.009>
- Stulz, N., & Lutz, W. (2007). Multidimensional patterns of change in outpatient psychotherapy: The phase model revisited. *Journal of Clinical Psychology*, 63, 817–833. <http://dx.doi.org/10.1002/jclp.20397>
- Tjeltveit, A. C. (2004). The good, the bad, the obligatory, and the virtuous: The ethical contexts of psychotherapy. *Journal of Psychotherapy Integration*, 14, 149–167. <http://dx.doi.org/10.1037/1053-0479.14.2.149>
- Trompeter, H. R., Lamers, S. M. A., Westerhof, G. J., Fledderus, M., & Bohlmeijer, E. T. (2017). Both positive mental health and psychopathology should be monitored in psychotherapy: Confirmation for the dual-factor model in acceptance and commitment therapy. *Behaviour Research and Therapy*, 91, 58–63. <http://dx.doi.org/10.1016/j.brat.2017.01.008>
- VanderWeele, T. J., McNeely, E., & Koh, H. K. (2019). Reimagining health—Flourishing. *Journal of the American Medical Association*, 321, 1667–1668. <http://dx.doi.org/10.1001/jama.2019.3035>
- Vøllestad, J., Nielsen, M. B., & Nielsen, G. H. (2012). Mindfulness- and acceptance-based interventions for anxiety disorders: A systematic review and meta-analysis. *British Journal of Clinical Psychology*, 51, 239–260. <http://dx.doi.org/10.1111/j.2044-8260.2011.02024.x>
- Vos, J., Craig, M., & Cooper, M. (2015). Existential therapies: A meta-analysis of their effects on psychological outcomes. *Journal of Consulting and Clinical Psychology*, 83, 115–128. <http://dx.doi.org/10.1037/a0037167>
- Weziak-Białowolska, D., McNeely, E., & VanderWeele, T. J. (2019). Human flourishing in cross cultural settings. Evidence from the US, China, Sri Lanka, Cambodia and Mexico. *Frontiers in Psychology*, 10, 1269. <http://dx.doi.org/10.3389/fpsyg.2019.01269>
- Wade, N. G., Cornish, M. A., Tucker, J. R., Worthington, E. L., Jr., Sandage, S. J., & Rye, M. S. (2018). Promoting forgiveness: Characteristics of the treatment, the clients, and their interaction. *Journal of Counseling Psychology*, 65, 358–371. <http://dx.doi.org/10.1037/cou0000260>
- Wade, N. G., Hoyt, W. T., Kidwell, J. E. M., & Worthington, E. L., Jr. (2014). Efficacy of psychotherapeutic interventions to promote forgiveness: A meta-analysis. *Journal of Consulting and Clinical Psychology*, 82, 154–170. <http://dx.doi.org/10.1037/a0035268>

- Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). New York, NY: Routledge/Taylor & Francis. <http://dx.doi.org/10.4324/9780203582015>
- Waring, D. R. (2016). *The healing virtues: Character ethics in psychotherapy*. New York, NY: Oxford University Press. <http://dx.doi.org/10.1093/med/9780199689149.001.0001>
- Weis, R., & Speridakos, E. C. (2011). A meta-analysis of hope enhancement strategies in clinical and community settings. *Psychology of Well-being: Theory, Research and Practice*, 1, 5. <http://dx.doi.org/10.1186/2211-1522-1-5>
- Weiss, L. A., Westerhof, G. J., & Bohlmeijer, E. T. (2016). Can we increase psychological well-being? The effects of interventions on psychological well-being: A meta-analysis of randomized controlled trials. *PLoS ONE*, 11, e0158092. <http://dx.doi.org/10.1371/journal.pone.0158092>
- Wilson, A. C., Mackintosh, K., Power, K., & Chan, S. W. Y. (2019). Effectiveness of self-compassion related therapies: A systematic review and meta-analysis. *Mindfulness*, 10, 979–995. <http://dx.doi.org/10.1007/s12671-018-1037-6>
- Witkiewitz, K., Wilson, A. D., Pearson, M. R., Montes, K. S., Kirouac, M., Roos, C. R., . . . Maisto, S. A. (2019). Profiles of recovery from alcohol use disorder at three years following treatment: Can the definition of recovery be extended to include high functioning heavy drinkers? *Addiction*, 114, 69–80. <http://dx.doi.org/10.1111/add.14403>
- Wong, P. T. P. (2011). Positive psychology 2.0: Towards a balanced interactive model of the good life. *Canadian Psychology*, 52, 69–81. <http://dx.doi.org/10.1037/a0022511>
- Wood, A. M., & Johnson, J. (2016). Positive clinical psychology: An introduction. In A. M. Wood & J. Johnson (Eds.), *The Wiley handbook of positive clinical psychology* (pp. 1–17). Chichester, United Kingdom: Wiley-Blackwell. <http://dx.doi.org/10.1002/9781118468197.ch1>
- World Health Organization. (2014). *Mental health: A state of well-being*. Retrieved from https://www.who.int/features/factfiles/mental_health/en/
- Yalom, I. D. (1970). *The theory and practice of group psychotherapy*. New York, NY: Basic Books.
- Yulish, N. E., Goldberg, S. B., Frost, N. D., Abbas, M., Oleen-Junk, N. A., Kring, M., . . . Wampold, B. E. (2017). The importance of problem-focused treatments: A meta-analysis of anxiety treatments. *Psychotherapy*, 54, 321–338. <http://dx.doi.org/10.1037/pst0000144>

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