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The question "What is wrong with people?" has guided the thinking of many psychologists and dominated countless scientific studies during the 20th century. It is hard to deny that it is an important question. In our attempts to answer the question, we have gained insight into many illnesses and have developed effective treatments for a wide range of problems. However, focusing on disease and deficit has limited our understanding and knowledge-base to pathology, and as a consequence, we have devoted relatively little attention to factors that make life worth living.

A WEAKNESS FOCUS

Focusing on what is wrong with an individual is what we call a weakness focus. We place direct attention on negative aspects of an individual. In the context of work and performance, a weakness focus means that we are primarily concerned with behavior that is causing suboptimal or low performance. For example, during a performance evaluation, the employer is only focused on why an employee is not reaching his sales targets, or why he is not able to communicate well with customers.

> A weakness focus means a focus on what is wrong rather than what is right.

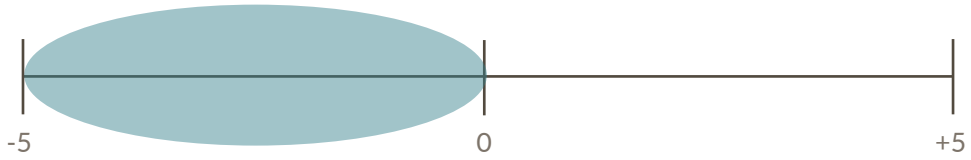
In a clinical context, this means that the focus is on behavioral or cognitive patterns that cause suffering and reduce well-being. Consider a psychologist who focusses only on the problems that a client experiences as an example. From this perspective, the psychologist may discover that the client thinks negatively about the past and these thoughts cause negative consequences in dealing with the present. The idea behind the weakness focus may seem intuitive: by fixing the weakness, we aim to increase well-being. However, as we will see, this view is far from complete and includes fundamental misconceptions about well-being.

A WEAKNESS FOCUS IN PSYCHOLOGY

After World War II, psychology became a science largely devoted to curing illness. As a consequence, a disproportionate amount of studies in psychology focused on psychopathology and factors that make life dysfunctional. In contrast, little research in the years that followed World War II focused on the factors that promote psychological well-being. For instance, an analysis of the ratio of positive to negative subjects in the psychology publications from the end of the 19th century to 2000 revealed a ratio greater than 2:1 in favor of the negative topics (Linley,

2006). This focus on psychopathology and markers of psychological disease has been referred to as the disease model of human functioning. The disease model can be easily explained by the picture in fig. 2.1.

Fig. 2.1 a focus on repairing weakness



In this picture, -5, represents suffering from problems, 0 represents not suffering from these problems anymore, and +5 represents a flourishing, fulfilled life. The disease model is focused on the -5 to 0 section. Interventions that are grounded in this model have the goal of helping people move from -5 to 0. In a clinical context, this could mean that a therapist aims to reduce symptoms and to prevent relapse. The end goal (0-point) is achieved when the client is no longer experiencing diagnosable symptoms of psychopathology as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

MISCONCEPTIONS RESULTING FROM THE DISEASE MODEL

Although the disease model has been the dominant view for many researchers and practitioners, there are some important misconceptions that are often neglected or overlooked. The awareness of these misconceptions has contributed to the development of positive psychology as we know it today. In this section, we discuss some essential misconceptions that are based on the focus of the disease model.

MISCONCEPTION #1: FIXING WHAT IS WRONG LEADS TO WELL-BEING

Underlying the weakness focus of the disease model is the belief that fixing what is wrong will automatically establish well-being. However, as counterintuitive as it may sound, happiness and unhappiness are not on the same continuum. Positive affect is not the opposite of negative affect (Cacioppo & Berntson 1999). Getting

rid of anger, fear, and depression will not automatically lead to peace, love, and joy. In a similar way, strategies to reduce fear, anger, or depression are not identical to strategies to maximize peace, joy, or meaning. Indeed, many scholars have argued that health is not merely the absence of illness or something negative, but instead is the presence of something positive. This view is illustrated in the definition of mental health by the World Health Organisation (2005): "a state of well being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (p. 18).

In support of this view, a growing body of research shows that the absence of mental illness does not imply the presence of mental health; and, the absence of mental health does not imply the presence of mental illness (Keyes, 2005; Keyes et al., 2008; Lamers et al., 2011). Keyes (2005) found that although a higher score on subjective well-being correlates with less psychological complaints and vice versa, this relationship is far from perfect. In other words, there are people who suffer from a disorder, but still experience a relatively high level of subjective well-being, and there are people who report low levels of subjective well-being but experience little psychopathological symptoms. This finding has been replicated in other studies using different measures and populations, for instance, in American adolescents between 12 and 18 years (Keyes, 2005), South African adults (Keyes et al., 2008), and Dutch adults (Lamers et al., 2011).

▶ MISCONCEPTION #2: EFFECTIVE COPING IS REFLECTED BY A REDUCTION IN NEGATIVE STATES

Typically, psychological interventions aim to reduce aversive states, like negative emotions or stress. Consistent with the disease model, such an aim is based on the assumption that a reduction in aversive states reflects both effective coping and enhanced well-being (or fewer problems). Interestingly, previous findings have repeatedly shown that effective coping does not necessarily mean a reduction in aversive states, like stress or negative emotions. An elegant illustration of this principle is found in the literature on dieting; research has revealed that it is not the absence of stress that is related to successful weight maintenance, but rather the ability to effectively deal with stress (see, for instance, Gormally, Rardin & Black, 1980). Similar findings have been obtained in the domain of work, with numerous studies highlighting the negative consequences of stress in the workplace (see, for instance, Fletcher & Payne, 1980). Interestingly, research has also shown that it is not the experience of stress that is responsible for its acclaimed negative effect on health, but the way employees deal with perceived stress. For some individuals, stress can lead to positive consequences. In this case, stress is referred to as eustress, defined as a positive response to a stressor, as indicated by the presence of positive psychological states (Nelson & Simmons, 2003, 2011).

Research on eustress shows that when a stressor is being evaluated as positive in terms of its potential implications for well-being, a different psychological and physiological response follows than occurs with a negative assessment. In this case, stress can result in improvement in, rather than a decline in, well-being (Nelson & Simmons, 2006). Past studies have indicated support for a direct link between eustress and health (cf. Edwards & Cooper, 1988; Simmons & Nelson, 2007). These findings suggest that the way people deal with and perceive difficult experiences (eustress versus distress), rather than their occurrence, is a valuable indication of successful coping.

Further support for the idea that it is not merely a reduction in negative states that reflects effective coping comes from the literature on post-traumatic growth. Post-traumatic growth is the development of a positive outlook following trauma (Tedeschi & Calhoun, 1996, 2004). Positive changes may include a different way of relating to others, awareness of personal strength, spiritual changes, and increased appreciation for life (Tedeschi & Calhoun, 2004). Post-traumatic growth can be perceived as an effective way of coping with adversity. It can emerge following a variety of traumatic events, including war and terror (Helgeson, Reynolds & Tomich, 2006). Growth following adversity, however, is not the absence of post-traumatic stress reactions, but the presence of positive states.

In sum, these findings suggest that there is clinical advantage in focusing on building people's strengths so that they can cope with difficult experiences as opposed to purely focusing on reducing negative experiences. Rather than solely trying to eliminate negative experiences (moving from -5 to 0), it seems important also to employ coping skills that promote well-being, despite the negative experiences (moving towards +5). In support of this notion, existing research demonstrates that irrespective of the level of stress, personal resources are associated with psychological well-being (Cohen et al., 1982; Holahan & Moos, 1986; Kobasa, Maddi, & Kahn, 1982; Nelson & Cohen, 1983).

▶ MISCONCEPTION #3: CORRECTING WEAKNESS CREATES OPTIMAL PERFORMANCE

According to Clifton and Nelson (1996), the behavior and mindset of many teachers, employers, parents, and leaders is guided by the implicit belief that optimal performance results from fixing weaknesses. Indeed, to promote professional development, employees are typically exposed to training programs that focus on correcting their weakness. In a similar vein, evaluation interviews often focus on areas that need improvement and aspects of work that employees are typically struggling with. A similar pattern can be found at many schools. Typically, the number of mistakes are highlighted when work is corrected and when report cards are brought home, the lower grades tend to attract more attention. According to Clifton and Nelson (1996), fixing or correcting weakness will not result in an

optimally functioning person or organization. In their view, fixing weakness will at best help the individual or organization to become normal or average.

Research findings show that the opportunity to do what one does best each day (that is, using one's strengths) is a core predictor of workplace engagement (Harter, Schmidt, & Keyes, 2002); and workplace engagement, in turn, is an important predictor of performance (see, for instance, Bakker & Bal, 2010; Salanova et al, 2005). These findings indirectly support Clifton and Nelson's (1996) claim that boosting the use of strengths, rather than improving weaknesses, will contribute to optimal performance.

▶ MISCONCEPTION #4: WEAKNESSES DESERVE MORE ATTENTION BECAUSE STRENGTHS WILL TAKE CARE OF THEMSELVES

Another misconception that contributes to an excessive focus on weakness involves the belief that strengths do not need much attention because they will take care of themselves and develop naturally. Just like skills, strengths can be trained and developed deliberately (Borghans, Duckworth, Heckman, & ter Weel, 2008; Peterson & Seligman, 2004). For instance, research has shown that, through practice, people can learn to be more optimistic (Meevissen, Peters & Alberts, 2011). In general, these studies show that over time, practice and effort can help to build new habits that boost strength use. Boosting strengths means that not only is the frequency of use increased, but also the number of different situations in which the strength is applied. When strengths are not used or trained, their potential impact on well-being remains limited. When a child who is very creative is not at all or is minimally exposed to activities that call upon creativity, the child is unlikely to develop skills, knowledge, and experience that will maximize his creative potential. Although many strengths are already present at a very young age, they need to be nurtured to realize their full potential.

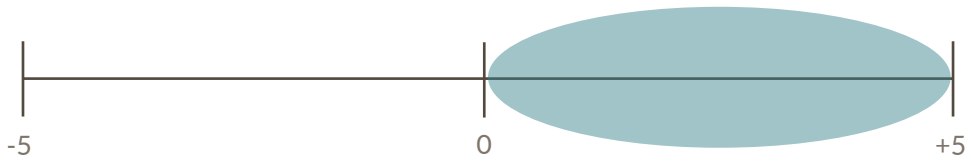
▶ MISCONCEPTION #5: A DEFICIT FOCUS CAN HELP TO PREVENT PROBLEMS

If we keep focusing on repairing weakness, we will increase our understanding of weaknesses. A focus on repairing weakness will bring forward more ways to decrease the gap between -5 and 0 (see fig. 2.1). Indeed, during the past 40 years, many interventions have been developed that aimed to cure mental illness or other problems. These interventions are primarily aimed at fixing things when they already have gone wrong.

Obviously, it is important to have different interventions and treatment programs to deal with problems and setbacks. However, what we have learned over 50 years is that the disease model has not moved us closer to the prevention

of problems. When it comes to prevention, the question is not "How can we treat people with problem X effectively?" but "How can problem X be prevented from occurring?" Working exclusively on personal weakness and disorders has rendered science poorly equipped to design effective prevention programs. We are minimally closer to preventing serious problems like burnout, depression, or substance abuse. It seems that major advances in prevention occur when the view is to systematically build competency rather than correct weakness (see, for instance, Greenberg, Domitrovich, & Bumbarger, 1999, for a review of effective prevention programs for youths). To design effective prevention programs, we must also focus on the +5 part (see fig. 2.2) and ask questions like: Why do some people flourish despite difficult circumstances? How do some employees avoid burnout symptoms? Why do some employees show a high level of work engagement? What are the characteristics of resilient and flourishing individuals, and what can we learn from them? How can we use this knowledge to design interventions that help people become resilient so that they are capable of bouncing back when the going gets tough?

Fig. 2.2 a focus on building strengths



THE POSITIVE PSYCHOLOGY PERSPECTIVE

In 1998, Martin Seligman strongly encouraged the field of psychology to widen its scope and move beyond human problems and pathology to human flourishing. According to Seligman (2002), positive psychology aims to move people not from -5 to 0 but from 0 to +5 (see fig. 2), and to do this, a different focus is needed. Rather than merely focusing on what is wrong with people and fixing their problems, the focus should also be on what is right with people and boosting their strengths.

The questions that positive psychology aims to answer are: What characteristics do people with high levels of happiness possess? And, what qualities do people who manage their troubles effectively have? In other words, what strengths do these people possess? These questions do not fit the disease model. These questions force us to consider the bigger question of "What is right with people?" If we learn what differentiates happy and resilient people from

unhappy and unresilient people, then we can use this knowledge to increase happiness and boost the resilience of others.

An important mission of positive psychology research is, therefore, to investigate human behavior using a strengths approach. This focus on human flourishing and markers of psychological well-being has been referred to as the health model of human functioning (see fig. 2.2).

CRITICAL NOTES

At first sight, the previously discussed misconceptions about a deficit focus may give rise to the idea that one should predominantly focus on human strengths, rather than weaknesses. While it may be true that correcting weakness will not create optimal performance or well-being, it is also true that only focusing on human strengths while ignoring weaknesses will not automatically lead to optimal performance or well-being. Especially when weaknesses cause problems or hinder optimal strength use, they need to be addressed and managed. While traditional psychologists may falsely believe that taking away negatives will automatically create positives, positive psychologists and practitioners must avoid the trap of believing that creating positives will automatically take away the negatives. As discussed above, the positive and negative are on two separate continua. Attention must be paid to processes for building the positive and to processes for coping with the negative. For this reason, positive psychology can best be considered as an addition to existing psychology, not a replacement. It can best be considered as an enrichment of the field, rather than a rejection of it. Or, to use Seligman's words: "Positive psychology is not just happyology" and "is not meant to replace psychology as usual" (Seligman, 2001).

Although a great amount of research has addressed aspects of human functioning that are linked with lower levels of well-being, it is incorrect to categorize psychological research in terms of positive and negative. These are evaluative terms and raise the false impression that research can be categorized as 'good' and 'bad' or 'right' and 'wrong.' First, psychological research aims to shed more light on human functioning in general; it is not devoted to positive or negative human conditions. Moreover, increasing insight as to aspects that hinder well-being is equally valuable to insights into aspects that promote well-being. Categorizing studies on human dysfunction as 'negative psychology' should therefore be avoided.

When examining psychological research of the past 40 years in the domains of psychopathology and clinical psychology, one could conclude that this research has mainly adopted a 'negative' side of human functioning. However, the field of psychology reaches far beyond the subdomains of psychopathology and clinical psychology. Examples of other fields include health psychology, social psychology, developmental psychology, and organizational psychology. Many

studies in these other domains have focused on well-being for years, even before the introduction of Positive Psychology in 2000. These studies have addressed topics like job satisfaction, safe sex practices, and high self-esteem and primarily focused on the positive side of human functioning.

DEFINING THE FIELD OF POSITIVE PSYCHOLOGY

Positive psychology can be described as a field dedicated to the study, development, and application of positive interventions that are aimed at increasing well-being through factors under voluntary control (Pawelski, 2003). Both research and practice are at the core of positive psychology. In this section, we address the contributions of both components to the field.

PROVING EFFECTIVENESS

Since the introduction of positive psychology, countless studies have revealed actions and interventions that significantly improve well-being. These studies are guided by questions like:

- Which personal qualities help buffer against stress and illness?
- How can we increase happiness?
- Which characteristics of people and environments are related to a high level of well-being?
- How can we develop valid measurement tools?
- What is the role of positive emotions and experiences?
- How can we best embrace the existence of and deal with negative experiences?
- How can we create healthy self-esteem?

By addressing these questions, numerous studies have revealed concrete actions that lead to improved human functioning. The results from these studies offer direct proof for the effectiveness of interventions and help us understand the difference between what we believe might contribute to enhanced well-being and what enhances it. For instance, writing about and imagining a best possible self has repeatedly been demonstrated to increase people's mood and well-being (King, 2001; Peters et al., 2010; Sheldon & Lyubomirsky, 2006). Moreover, research on gratitude shows that gratitude can be trained and increased. In a study by McCullough & Emmons (2003), participants were randomly assigned to one of three groups. Participants completed an extensive daily journal in which they rated their moods, physical health, and overall judgments concerning how their lives were going. Each participant kept a brief weekly journal for ten weeks. They either described, in a single sentence, five things they were grateful for that had occurred

in the past week (the gratitude condition); or they did the opposite, describing five daily hassles (irritants) that had displeased them in the past week (the hassles condition). The neutral group was asked to simply list five events or circumstances that affected them in the last week, and they were not told to accentuate the positive or negative aspects of those circumstances (the events condition). Those in the gratitude condition reported fewer health complaints and even spent more time exercising than control participants did. The gratitude group participants experienced fewer symptoms of physical illness than those in either of the other two groups. Lastly, people in the gratitude condition spent significantly more time exercising (nearly 1.5 hours more per week) than those in the hassles condition. In one of our own studies (Smeets, Neff, Alberts & Peters, 2014), we investigated the effectiveness of a 3-week self-compassion group intervention. Participants were randomly assigned to either an intervention designed to teach skills of self-compassion or an active control group intervention in which general time management skills were taught. Both interventions comprised of 3 group meetings held over three weeks. Results showed that the self-compassion intervention led to significantly greater increases in self-compassion, mindfulness, optimism, and self-efficacy, as well as significantly greater decreases in rumination, in comparison to the active control intervention. In summary, these findings demonstrate that research can help differentiate between effective and less effective interventions and thus serve as a valuable guide for practitioners.

▶ UNDERLYING MECHANISMS

In addition to testing the effectiveness of interventions, studies have also provided insight into the working mechanisms underlying these actions. Simply put, these studies have not only shown that well-being can be increased by applying certain strategies but have also offered insight as to why these strategies contribute to well-being. For instance, in one of the author's own studies (Alberts, Schneider & Martijn, 2007), different emotion regulation strategies and their impact on cognitive resources were addressed. Previous studies have repeatedly shown that when people exert self-control, this results in decreased self-control performance on a subsequent task. Thus, when a dieter who tries to quit smoking says "no" to a tempting piece of pie, he is more likely to fail in refusing a cigarette at a later moment. The idea is that controlling oneself, in this case controlling the urge to eat, requires cognitive resources that, after using, are not available for later attempts. In our study, participants were asked to watch a distressing video. Three groups were created. One group was asked to apply self-control; the instructions were to suppress all the emotions felt during the video. One group was asked to apply mindful acceptance; the instructions were to allow the emotions to be present and to observe them. The last group did not receive any instructions and were just asked to watch the movie. After the movie, all participants completed

a computer task that required self-control. We found that participants who suppressed their emotions performed the worst on this second self-control task. In contrast, participants who accepted their emotions outperformed both groups. These findings provide insight into a potential mechanism underlying mindful acceptance, namely that it probably conserves regulatory resources. In a similar vein, other studies have revealed valuable insights as to why certain strategies and interventions might work.

▶ MEASUREMENT TOOLS

Finally, research has offered many valuable measurement tools to address complex constructs like happiness, optimism, and resilience. For example, in 2004, Peterson and Seligman developed the Values In Action Inventory of Strengths (VIA-IS), which brings together the six most valued virtues, operationalized into 24 different character strengths. By completing this assessment, respondents gain insight into the extent to which they possess these 24 character strengths (Peterson & Seligman, 2004). Other examples of measurement tools that have been developed over the years include the Flourishing Scale (Diener et al., 2009), the Subjective Happiness Scale (Lyubomirsky & Lepper, 1999), the Adult Dispositional Hope Scale (Snyder et al., 1991) and the Brief Resilience Scale (Smith et al., 2008).

These assessment tools are valuable for a variety of reasons. First, they provide a way to gain insight into the extent to which certain constructs characterize people. Using them, we can, for example, determine the level of optimism of a person, or the ability to deal with difficult thoughts. Second, the scores on assessment tools can be compared to mean scores. Many assessment tools have been used in a wide range of populations, providing information on general means per country, age group or other population characteristics. In this way, the score of one single person can be compared to a mean score, which provides additional information on the relative score of this individual. Third, assessment tools can be used as repeated measures. For instance, by administering a questionnaire at multiple times during an intervention, the progress of a client can be tracked. Moreover, repeated administration can provide information on the stability of characteristics. One may complete the aforementioned VIA-IS now and a year later and discover that the strengths that were identified on both occasions remain very similar. Lastly, insight into the relationship between different constructs can be obtained by comparing the correlation between the scores on different assessment tools. Using this method, research has revealed that people who score high on mindfulness also use their strengths more, for instance (Alberts, Peters, Niemec, Muschalik, 2017).

▶ PRACTICE

The many interventions and actions that are proven to enhance well-being are a rich source for practitioners who aim to apply positive psychology. The insights from positive psychological research can be applied directly in different ways. First, existing treatment programs can integrate positive psychology interventions into the treatment protocol. For example, a cognitive behavioral therapist may use positive interventions like gratitude practice as an addition to the regular intervention program. Many positive interventions are useful as homework for clients. Rather than passively waiting for the next meeting, they can actively work on their personal development. Second, during the past two decades, new interventions have been developed that strongly rely on the insights and principles from positive psychology. A few examples of these interventions are listed below.

- *Appreciative Inquiry*. This approach appeared in the 1980s. Appreciative inquiry (AI) involves 'searching for the best' in people, organizations and communities, through the discovery of 'what gives life' to a system when it is at its most effective and most economically, ecologically, and socially capable (Cooperrider & Whitney, 2001). AI shares the strengths-based approach of positive psychology (Boyd & Bright, 2007). Similar to strengths in positive psychology, appreciative inquiry focusses on what's already working inside families, organizations or communities.
- *Positive Psychotherapy*. This is an empirically validated approach to psychotherapy that aims to reduce psychopathology by predominantly focusing on building strengths and enhancing positive emotions and engagement (Rashid, 2015). Seligman and colleagues (2006) showed significant, long-lasting decreases in depression after positive psychotherapy.
- *Positive Cognitive Behavioral Therapy*. The focus of positive cognitive behavioral therapy is not on pathology, but like positive psychology itself, on building clients' strengths and what works for them. This form of therapy draws on research and applications from positive psychology and solution-focused brief therapy.
- *Strengths-Based Counselling*. This is a model for conducting therapy based on the premises of positive psychology, counseling psychology, positive youth development, social work, narrative therapy and solution-focused therapy (Smith, 2006). The model was created specifically for use with adolescents and aims to increase growth by helping clients use strengths to overcome problems. Strengths-based counseling uses a strength-perspective and guides the psychologist who "searches for what people have rather than what they do not have, what people can do rather than what they cannot do, and how they have been successful rather than how they have failed" (Smith, 2006, p. 38).
- *Strength-Centered Therapy*. This is a psychotherapeutic approach which heavily

focusses on building strengths in the change process (Wong, 2006). Strength-centered therapy is characterized by the social constructivist notion that the subjective views of clients regarding their own pathology and well-being are more important in therapy than the expert opinions of mental health providers.

- *Solution-focused therapy*. This therapy was developed by de Shazer, Berg, and colleagues (Berg, 1994; Berg & Miller, 1992; Cade & O'Hanlon, 1993; DeJong & Berg, 2001; de Shazer et al., 1986; O'Hanlon & Weiner-Davis, 1989), and stresses the strengths people possess and how these can be applied to the change process. A key ingredient of solution-focused therapy is the use of positive language. By using language that focuses on possibilities and positive exceptions, the therapist influences the way clients perceive their problems, assists them in seeing the potential for solutions, and creates an expectancy for change (Berg & DeJong, 1996).

A BRIEF HISTORY OF POSITIVE PSYCHOLOGY

Many have argued that Martin Seligman, in his 1998 APA Presidential Address, introduced positive psychology to the American Psychological Association. Although Seligman should definitely be credited for his renewed introduction of a positive outlook in psychology, other researchers have adopted a similar approach by studying mental health rather mental illness (see, for instance, Jahoda, 1958), and maturity and growth (e.g., Erikson, 1959) even before the introduction of positive psychology. For instance, in 1979, Antonovsky coined the term salutogenesis to describe an approach focusing on factors that support human health and well-being, rather than on factors that cause disease. In fact, the very foundation of positive psychology dates back to 500 BC. Below we present a very global timeline.

+/- 500 BC ANCIENT PHILOSOPHERS

Many of the questions that are addressed by positive psychologists were also raised by ancient Greek philosophers like Socrates, Plato and Aristotle, and eastern philosophers like Confucius and Lao-Tsu (Dahlsgaard, Peterson & Seligman, 2005). At around 500 BC, these philosophers were already concerned with questions like: What does happiness mean? How can happiness be achieved? What is a virtuous life?

1842 – 1910 WILLIAM JAMES

The psychologist William James was interested in the study of optimal human functioning and considered the consideration of subjective experience as highly

important. He argued that objectivity is based on subjectivity. His interest in optimal human functioning was reflected by the questions he raised during the American Psychological Association in 1906. He believed that to maximize human potential, we must gain insight into both the limits of human energy and ways to stimulate and optimally use this energy (Rathunde, 2001, p. 136). Some have argued that William James should be considered "America's first positive psychologist," (Taylor, 2001, p.15).

1950 - HUMANISTIC PSYCHOLOGY

Humanistic psychology started in the 1950's in Europe and the United States. Many of the views and concerns of humanistic psychology are similar to those of positive psychology. Both humanistic psychology and positive psychology are concerned with the quality of human experience and the ability to self-actualize; to reach the highest potential (Moss, 2001). Humanistic psychology has been defined as "... an orientation toward the whole of psychology rather than a distinct area or school ... concerned with topics having little place in existing theories and systems: e.g., love, creativity, growth, self-actualization, peak experience, courage, and related topics" (Misiak & Sexton, 1966, p. 454). Two of the most influential humanistic psychologists were Carl Rogers and Abraham Maslow.

The term positive psychology was first used by Maslow in his book Motivation and Personality (1954). In this book, he wrote a chapter called "Toward a Positive Psychology." In this chapter, Maslow wrote: "The science of psychology has been far more successful on the negative than on the positive side; it has revealed to us much about man's shortcomings, his illnesses, his sins, but little about his potentialities, his virtues, his achievable aspirations, or his full psychological height. It is as if psychology had voluntarily restricted itself to only half its rightful jurisdiction, and that the darker, meaner half" (Maslow, 1954, p. 354).

Humanistic psychology was a reaction to the view of human functioning reflected by psycho-analysis and behaviorism. According to humanistic psychology, individuals are shaped by an innate drive to make themselves and the world a better place. Moreover, whereas psycho-analysis was predominantly concerned with the negative side of human functioning, addressing topics like neurosis and psychosis, humanistic psychology mainly focusses on the positive side of human functioning. The field of humanistic psychology has been criticized for its lack of scientific rigor. Critics state that the field has relied too much on introspective, qualitative research methods. Positive psychology shares the same view on human functioning but uses quantitative and reductionistic methods to address its claims.

1998 - MARTIN SELIGMAN

Martin Seligman is often referred to as the "father of positive psychology". Seligman was the founder of the theory of 'learned helplessness'. He argued that clinical depression and other related mental illnesses are caused by non-control over the outcome of a situation. Later, Seligman became interested in how to minimize or reduce depression. He realized that he and other psychologists were guided by a disease model that was focused on repairing damage rather than promoting well-being. After being elected President of the American Psychological Association in 1996, he chose positive psychology as the central theme of his term. With the introduction of positive psychology, he wanted to start a new era of psychology that focusses on the factors that contribute to well-being.

BARBARA HELD

Back in 2004, Held (2004) wrote a critical paper on the viewpoints and ideas of positive psychology. In this paper, she argued that the current movement of positive psychology has presented itself as a separate field of psychology which is characterized by a negativity about negativity itself. In her opinion, it would benefit both psychology in general and positive psychology in particular for it to become more integrated into psychology as a whole rather than separated out. She advocates the importance of an "open acknowledgment and appreciation of the negative side of human existence/nature, a side that has heretofore been denied or dismissed by promoters of the movement's dominant Message" (Held, 2004, p.40). She labeled this more nuanced approach to the notions of 'positive' and 'negative' as the 'second wave' of Positive Psychology. Others have referred to this integration of the positive and negative of human experience as Positive Psychology 2.0 (see for instance Wong, 2011). Recently, scholars within Positive Psychology have begun to adopt a more nuanced approach to the notions of 'positive' and 'negative' and have worked on a new mature synthesis of positive and negative within the field.

CRITICAL NOTE

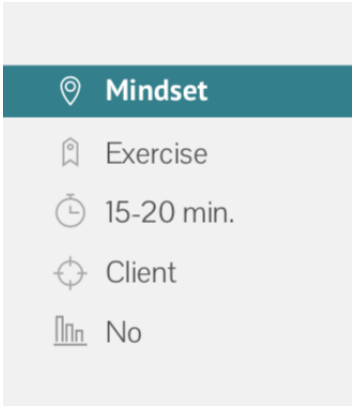
The above described timeline provides a very general overview of the people and developments that have influenced positive psychology as we know it today. Obviously, this overview represents just a very limited selection of influential people. There have been many more pioneers who greatly influenced the development of positive psychology. Examples include, Mihaly Csikszentmihalyi with his work on flow, Carol Dweck with her theory and research on mindsets and Ed Diener with his essential work on well-being.

THIS PRODUCT

This product contains 17 different mindfulness exercises. Each exercise is structured in the same way, consisting of a background section, a goal description, advice for using the exercise and suggested readings.

UNDERSTANDING THE ICONS

On the first page of every exercise, a legend is shown, consisting of several icons:



- The first icon displays the main category the exercise belongs to.
- The second icon shows the type of exercise. The following options are available:

  - » Exercise (an exercise that describes an activity that is done once, during a session)
  - » Assessment (an exercise that aims to assess a trait or characteristic of a person)
  - » Overview (an exercise that provides an overview or list of something; research findings, facts, etc.)
  - » Advice (an exercise that is directed at the helping professional providing advice on how to carry out a certain activity)
  - » Meditation (an exercise that describes a form of meditation)
  - » Intervention (an exercise that describes an activity that needs to be done more than once during a certain period)

- The third icon provides an estimation of the duration of the exercise. In other words, how long it takes to complete the exercise. This is always an estimation of the total time it takes. Note that for some exercise types, like overview,

advice, protocol and intervention it is difficult if not impossible to provide an estimation of the duration. In these cases n/a (not available) is written.

- The fourth icon describes the intended audience for this exercise; available options include client, coach or group.
- The last icon indicates whether this specific intervention has been tested at least once in a scientific study and has been published in a peer reviewed journal (yes or no). Note that if there is a strong theoretical and scientifically tested basis underlying the tool, but the tool itself in its current form has not been directly addressed in research, the icon will still indicate "no".

▶ USING THE EXERCISES

Please note that the exercises in this product are not a substitute for a coaching certification program, which we recommend you take before you call yourself an official 'positive psychology coach' and before you see clients or patients.

Note that you are advised to use these exercises within the boundaries of your professional expertise. For instance, if you are a certified clinician, you are advised to use the exercises within your field of expertise (e.g. clinical psychology). Likewise, a school teacher may use the exercises in the classroom, but is not advised to use the exercises for clinical populations. Positive Psychology Program B.V. is not responsible for unauthorized usage of these exercises.

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