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Editorial

The issue of well-being, sometimes also referred to as happiness, is one that is becoming increasingly important in Britain. The previous British government, in a major policy document, *New Horizons* (DH, 2009), set out the direction of travel for mental health services. Well-being is a central part of that strategy. The current coalition government has continued this trend and, as predicted (Carson, 2010), has now added questions on well-being to the annual household survey, showing its concern not just for the country's Gross National Product, but also with its Gross National Happiness.

Given the increasing importance of well-being, I felt it was timely to consider the links between groupwork and well-being. Indeed this was the main theme of the 2010 European Groupwork Conference in York. The idea for a Special Issue of *Groupwork* on this topic, was originally conceived by Dr Ilona Boniwell and myself. Dr Boniwell is one of the leading positive psychology researchers in Europe (Boniwell, 2006), and helped establish the first ever masters degree programme in Britain in positive psychology, at the University of East London. She has co-authored two of the papers in this Special Issue and commissioned two additional papers from other colleagues at the University of East London.

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In the first paper, Miriam Akhtar and Dr Boniwell describe a group based intervention for alcohol misusing adolescents, that is based on positive psychology principles. The intervention comprised eight workshops that incorporated happiness, strengths, optimism and gratitude. The group receiving the intervention, showed significant increases in well-being. They also decreased their levels of alcohol consumption. These gains were maintained at three month follow-up. A comparison group showed no changes.

In the second paper, Kevin Sheridan, Faye Adams-Eaton, Alison Trimble, Adrian Renton and Marcello Bertotti, describe the use of the World Café approach as part of the Well London Project. They discuss

how best to engage with local communities, focussing on building collaborative partnerships, working with whole systems, privileging community knowledge and working with the deficit of experience. They used the World Café method, as a way of eliciting the views of local communities in London to the question, 'What do you understand as the health needs of your community?' Some 40 cafés were held, reaching almost 1400 residents. They found a lack of community spirit amongst the groups surveyed and particular concerns around antisocial behaviour in young people and a lack of purposeful activity.

Charlotte Style and Dr Boniwell looked at the effectiveness of Nina Grunfeld's Life Clubs in the third paper. They showed that a group who attended Life Club workshops over a six week period, showed improved happiness and well-being in comparison with another group, who spent an equivalent amount of time engaged in unstructured conversational sessions. The Life Clubs group showed significant improvements both at the end of the workshops, and again at follow-up. Given the brevity of the intervention, this is a very positive finding.

In the next paper, along with Margaret Muir, Sherry Clark, Elizabeth Wakely and Anant Chander, I describe a gratitude intervention that we piloted with nine people attending a community mental health teambase. The intervention comprised two short workshops, a month of daily gratitude monitoring, a meal and a £10 gift voucher. Participants improved significantly on 4/14 comparisons and reported feeling grateful for more things in their life after the monitoring period, than they had before. While there were changes in 'state' gratitude, 'trait' gratitude stayed the same.

In the fifth paper Nash Popovic describes the Personal Synthesis programme that he has developed over a number of years. He tells how he applied this comprehensive human development programme with groups of individuals who were HIV positive. The programme comprises weekly two hour sessions held over an entire academic year, and has been running for over six years. Nash describes the background to the programme and also presents some findings on its efficacy.

The final paper, offers a critique of the fields of recovery and positive psychology from Christopher Scanlan and John Adlam. Amongst other things they argue that

> The recovery approach is in grave danger of becoming a professionally

> governed fig-leaf to cover up ... our chronically under-funded mental health system.

They also point out the paradox of the much heralded Improving Access to Psychological Therapies initiative, that it excludes those, whose problems are too complex. They also provide a powerful critique of positive psychology.

I hope groupworkers will find much to interest them in this diverse collection of papers. Well-being in an idea whose time has come. However to come to full fruition, its proponents will need to harness the benefits of groupwork.

Jerome Carson
April 2011

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Applying positive psychology to alcohol-misusing adolescents: A group intervention

Miriam Akhtar[1] and Dr Ilona Boniwell[2]

Abstract: *Adolescent alcohol misuse is associated with many adverse consequences for well-being (Viner & Taylor, 2007). Positive psychology has pledged to improve adolescent well-being, so what can the field contribute to the treatment of alcohol-misusing young people? This mixed methods study evaluates a pilot group application of positive psychology to alcohol-misusing adolescents, examining its effects on adolescent well-being and alcohol habits. The intervention consisted of eight workshops based on positive psychology models including happiness, strengths, optimism and gratitude. The participants were adolescents attending an alcohol and drug treatment service for young people. The experimental group (n = 10) participated in weekly workshops while a control group (n = 10) received no treatment. The results suggested that the group intervention led to an increase in adolescent well-being and decrease in alcohol consumption. In the quantitative study the results indicated significant increases in happiness, optimism and positive emotions and a significant decline in alcohol dependence. In the qualitative study the main themes were a rise in happiness and other positive emotions; the development of a future goal orientation; a decline in alcohol and drug use and an escalation of change amounting to transformation. The investigation concludes that a positive psychology group intervention can make an effective contribution to the treatment of alcohol-misusing adolescents with a recommendation to take the current pilot forward to a full study.*

Key words: *positive psychology; well-being; adolescents; alcohol-misuse; happiness; strengths; optimism; gratitude*

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Introduction

Adolescence is a time in life that harbours many risks and dangers for well-being (Kleinert, 2007). Alcohol is a particular hazard for adolescents, contributing to 18.5% of death and disease amongst young people in developed nations (Toumbourou et al, 2007). Britain's teenagers are amongst the heaviest drinkers in Europe with a range of mental, social and physical problems caused by their drinking (Hibell et al, 2009). Adolescent 'binge drinking' (defined as the consumption of more than five units of alcohol on a single occasion) is associated with significant later adversity including mental health problems, alcohol dependency, lack of qualifications, criminal convictions, homelessness and social exclusion (Viner & Taylor, 2007). The current outlook for adolescent well-being in the UK is pessimistic. Young people born in the 1990s are the first generation whose health is predicted to be worse than that of their parents, reversing the long-term trend of ever-rising good health. Every marker of well-being, from mental health to obesity, is either negative or static (Patton & Viner, 2007).

The desire to drink is driven by four major motivational processes; conforming to norms, individuating identity, escaping distress and self-management and regulation (Toumbourou, 2005). Of these, conforming to norms is the most prevalent motivation with young people adhering to the patterns of substance use (which refers to both alcohol and drugs in this paper) amongst their peers. Positive psychology has yet to develop an intervention to address the well-being of alcohol-misusing adolescents, but given that individually-based reasons for young people to drink include to be happy, to change mood and deal with stress (Honess et al, 2000), the science is arguably well placed to demonstrate alternative routes to happiness, positive emotions and resilience, all constructs at the core of the subject.

Current interventions to tackle adolescent drinking range from the psychosocial to the educational, medical and legal. Prevention strategies to reduce demand for alcohol make up the bulk of approaches worldwide. Primary prevention aims to reduce risk and prevent new cases, secondary prevention seeks to limit harm in the early stages of a disorder and tertiary prevention treats the consequences of disorders (Toumbourou et al, 2007).

Psychosocial interventions aim to develop psychological and social

skills in young people so they are less likely to misuse alcohol and are frequently paired with educational interventions, which raise awareness of the dangers of alcohol misuse. The empirical basis for both is limited, to the extent that a Cochrane systematic review of over 200 studies called for an international register to be established and criteria agreed for rating interventions in terms of safety, efficacy and effectiveness (Foxcroft et al, 2003). A mere three interventions in the study were deemed effective over the long term (4+ years) and only one of these, the Strengthening Families Programme (Kumpfer et al, 1989) 'showed promise' as an effective intervention for the primary prevention of alcohol misuse.

Positive psychology and adolescent well-being

Adolescent well-being has been high on the agenda of positive psychology, responding to the shift in mental health which has seen depression become a disorder of the early teenage years rather than one that starts in middle age (Seligman, 1999). Martin Seligman, the co-founder of the field, has focused attention on 'positive prevention', arguing that building strengths such as optimism, future-mindedness and perseverance, acts as a buffer against mental illness and is more successful in the prevention of serious health problems than disease model approaches (Seligman, 2005).

Positive psychology's contribution to adolescent well-being so far has been both general and specific. It has had a general influence in paediatric psychology, which is starting to move away from an exclusive focus on children's deficits or pathology towards a more affirming and strength-building approach (Roberts et al, 2005). However the field's specific contribution has been in the development of interventions, designed to facilitate an aspect of well-being such as happiness or optimism.

The best known of these interventions is the Penn Resilience Programme (PRP; Gillham et al, 1990), a group intervention whose primary purpose is to prevent depression in children and adolescents. At its core is an adaptation of Ellis' ABC model (Ellis, 1962), which encourages children to dispute negative beliefs associated with adverse events and generate alternative, more optimistic explanations. The PRP

has been widely evaluated; of the 13 studies included in a 2007 review, five reported improvement and prevention of depression symptoms with a further five reporting mixed results (Gillham et al, 2007a, 2007 b). The PRP has been applied to 'problem adolescents' and was found to be especially efficacious in preventing depression symptoms in young adolescents with elevated levels of behavioural problems (Cutuli et al, 2006).

A recent meta-analysis of positive psychology interventions (PPIs; Sin & Lyubomirsky, 2009) included two PPIs aimed at groups of children. Froh et al, (2008) tested the effects of a single intervention, gratitude, on school classes of early adolescents. The study found that gratitude induction was related to enhanced well-being, gratitude and reduced negative affect and noted a significant change in optimism and life satisfaction at the follow-up. In Italy researchers developed 'well-being therapy' (WBT; Fava et al, 1998), based on the multidimensional model of psychological well-being proposed by Ryff and Singer (1996), which consists of personal growth, self-acceptance, autonomy, purpose in life, positive relationships and environmental mastery. A pilot study applied WBT to early adolescents in a school setting with the aim of helping pupils recognise and experience positive emotions and compared it to a parallel CBT intervention. Both produced significant and comparable improvements in terms of an increase in psychological well-being and symptom reduction (Ruini et al, 2006). These PPIs demonstrate the feasibility of group programmes based on positive emotions for promoting optimal functioning in adolescents, drawing on Barbara Fredrickson's body of work on the broaden-and-build theory of positive emotions (Fredrickson, 1998, 2001; Frederickson and Joiner, 2002; Frederickson and Losada, 2005).

So far positive psychology has focused its interventions on general rather than specific adolescent populations. However in recognition of the extent and severity of teenage alcohol misuse, the present study sought to advance knowledge by piloting a group intervention with an aim of increasing adolescent well-being and decreasing alcohol dependence in a population of alcohol-misusing adolescents.

Method

Intervention

The researcher consulted with positive psychology practitioners and health professionals in the addictions field to develop a PPI targeting alcohol-misusing adolescents. The programme consisted of eight weekly sessions or 'zones' grounded in well-being research (Table 1) with groupwork and discussion.

Table 1
The Happiness Zones

Session	Zones	Principal Themes
Week 1	Feel Good Zone	Positive Emotions, Savouring
Week 2	Future Zone	Gratitude, Optimism
Week 3	Me Zone	Strengths
Week 4	Chill Zone	Relaxation, Meditation
Week 5	Change Zone	Change, Goal-setting
Week 6	Me to You Zone	Relationships
Week 7	Body Zone	Nutrition, Physical Activity
Week 8	Bounce back Zone	Resilience, Growth Mindset

Each session began with a gratitude exercise where participants appreciated the good things in their lives, followed by activities related to that week's themes. In keeping with the health model approach, the programme did not focus on the pathology of the sample in contrast to 'treatment as usual'. The exception came in the Change Zone, which addressed alcohol misuse in the context of being the starting point for change. This session incorporated coaching techniques to set goals to work towards in the second half of the programme, so from session five each participant had individual coaching at the end of each session in order to report back on goal progress and identify next steps.

Participants

The participants were a convenience sample attending an alcohol and drug treatment service for young people in Bath. All had issues of substance misuse and were in 'at risk' categories. Most of the participants were currently 'not in education, employment or training' (referred to in Britain as NEETs). The experimental group (n = 10) consisted of 7 girls and 3 boys with an age range of 14 to 20 (M = 17.5). The upper age limit of 20 allowed for the assessment of some participants as being emotionally and mentally under-developed for their age, due to their vulnerability and possible cognitive deficits arising from substance misuse. A control group (n = 10) was also recruited from the same treatment service and received no intervention.

Data collection

Semi-structured interviews exploring well-being, the experience of the programme and substance habits were recorded on completion of the intervention at T2, six weeks later (T3) and a final follow-up 12 weeks post-intervention (T4). For the purpose of triangulation, interviews were also recorded with staff at the treatment service, who facilitated or observed the intervention. The researcher kept a reflective diary throughout the process. In the quantitative study four reliable, validated scales were chosen for their ease of application. These were the Subjective Happiness Scale (SHS; Lyubomirsky & Lepper, 1999), a measure of dispositional optimism, the Life Orientation Test-Revised (LOT-R; Scheier et al, 1994), the Positive and Negative Affect Schedule (PANAS; Watson et al, 1988) and the Short Alcohol Dependence Data (SADD; Raistrick et al, 1983).

Data analysis

The interviews were transcribed verbatim and analysed by thematic analysis, a method for identifying, analysing and reporting repeated patterns of meaning (themes) within data (Braun & Clarke, 2006). Thematic analysis is not wedded to any pre-existing theoretical framework, which fits the pragmatic epistemological position of the study. The transcripts were read and themes identified at the semantic

level primarily by inductive analysis, using a 'bottom up' approach where the themes are strongly linked to the data itself (Patton, 1990). After initial coding of the transcripts by hand, the most prevalent codes in terms of frequency or importance were then inputted into NVivo2 software to collate data relevant to the potential themes. These were then defined and refined into sub-themes which were then grouped into four overarching themes.

In the quantitative study, data from the four measures were inputted into SPSS software and a series of tests carried out. Repeated measures between-participants ANOVAs were carried out across T1 & T2 with happiness, optimism, positive emotions and negative emotions as the dependent variable and time and group as independent variables. MANOVA tests were used for a simple effects analysis. One-way within-participants ANOVAs were carried out across T1, T2, T3 and T4 with follow-up paired t-tests to determine significance. In the case of the SADD, which did not fulfil the assumptions necessary for parametric testing, Wilcoxon and Mann Whitney U tests were carried out.

Results: Qualitative findings

Thematic analysis of the data yielded four distinct overarching themes as the main outcomes with 13 sub-themes. The criteria for the themes were according to their prevalence within the data and their importance to the evaluation of how the intervention impacted on adolescent well-being and alcohol habits.

Present happiness: 'Feeling better'

Eight out of 10 participants reported feeling happier and experiencing more positive emotions at T2. By T4 happiness was increasingly linked to things going well – achievements and improving circumstances. The positive emotions most frequently mentioned were feeling grateful, calm, positive, hopeful, optimistic, enthusiastic, confident and proud. Participants also reported being less stressed, depressed, angry, anxious and paranoid. A third of the group said that they felt more in control of their emotions.

Gratitude was arguably the most successful intervention. It was the

activity that made the biggest impact on happiness, the most widely-used technique post-intervention and one of the most frequently experienced positive emotions. The concept of appreciation for the good things in life was previously alien to the group, whose collective mindset was one of deprivation. Gratitude continued to be used as a way to improve mood without being dependent on others or resorting to stimulants.

The most popular session with the group was the Chill Zone on relaxation, which included a guided meditation. It dawned on the group that here was an alternative route to relaxation without needing recourse to drink or drugs. Many of the service staff highlighted this workshop as one of the most impactful, where they observed a marked contrast between the usually volatile participants and a noticeable calm after the session.

Relationships were named as one of the main sources of happiness for the group and many participants came to value the relationships more highly and noted an improvement in them. Participants felt better able to talk to their partners, some mentioned having fewer arguments with family and fewer episodes of violence. Gratitude acted as a social lubricant; as the participants expressed thanks to those who gave them support, their friends and family responded positively. One activity that had a big impact was where participants queried whether their peers might be 'frenemies' – friends behaving as an enemy by encouraging them to do risky things. It led to the participants querying the nature of their friendships and their own behaviour.

A rise in confidence was the most noticeable development at the final assessment. Some participants reported a return of confidence as a result of feeling better about themselves, others expressed new confidence about their capabilities. It was the session on strengths which probably had the most influence on this development. Most of the group had little sense of having natural talents and had been excluded from school or dropped out of education. For Danni, 16, discovering she had 'people skills' increased her confidence in her ability to achieve her ambition of becoming a youth worker. For Holly, 20, confidence returned as she realised that she still has capabilities despite her alcohol misuse. This led to her resurrecting long-lost ambitions and re-engaging with education. Identifying strengths helped the participants to a more positive view of themselves and to have the confidence that they could be themselves

rather than put on a front or play up to the tabloid label of 'feral youth'. Discovering their strengths generated confidence about their future, the subject of the second overarching theme.

Future goals: 'Getting Better'

> *… six months ago, all I was interested in was drinking and smoking weed. But now I'm interested in making a life for my kids.* (Ashlee)

The development of a future goal orientation was one of the main outcomes of the study. Some participants had been loathe to contemplate the future because they anticipated something bad occurring. Others had given little thought to their future due to their immaturity and hedonistic behaviour. Goal-setting and optimism, the sub-themes, both facilitated the development of a future orientation.

The Change Zone was rated as one of the most useful sessions, in which the group were introduced to the coaching technique of 'life-planning', where they identified goals for various areas of life and then broke them down into smaller steps so that they could clarify the sequence of actions needed to achieve that goal. The goals were self-generated rather than being imposed in the form of a 'must do', which gave the participants a stronger motivation to work towards them. Furthermore they were broken down into a 'manageable size' which made them easier to tackle. It worked for 14-year old Geri, a persistent truant, who triumphed in her small goal of attending school every day, knowing that this was a step towards her bigger goal of training as a dancer. Goal-setting was related to a rise in motivation to 'sort' their lives out with frequent mention of having a 'plan'. From T2 to T4, the developments reported in the participants' lives were mostly connected to the goals they had set. Over half achieved goals which ranged from attending school to handing in assignments, bidding for accommodation and improving relationships. The participants showed signs of maturity by taking some responsibility for their lives, accompanied by an awareness of the dangers of apathy and pessimism. Goal-setting also facilitated the shift from pessimism to optimism about the future.

> *I know I'm going to have a good future now whereas before I was about 50:50... I just noticed basically that I've got to get my act in gear on that and keep going to*

college, and doing what I'm doing now in order to make a better life for my future and hopefully for when I have kids. (Ashlee)

Optimism as a technique was particularly popular amongst the boys such as 17-year-old Jamie, who quickly became competent at 'reframing', looking for the positive in a negative. He was threatened with eviction from the hostel he was living in, but still managed to see positives in no longer having to endure a hostel he didn't like and that being in a B&B instead would mean free breakfasts. Having reframed a difficult situation, Jamie had vanished by T3. Staff later found out that he was living with his mother so he had ended up with a positive outcome to his negative housing situation.

Drink and drugs down

Most of the group had been heavy users of both alcohol and drugs. Reasons given for their alcohol habits were drinking to block out depression, shy away from chores and escape the 'mess' of their lives. By T2 eight out of the 10 reported that they had cut down substantially on their alcohol consumption with three stating that they no longer drank. Further interrogation revealed that 'I stopped drinking' meant that they had ceased to be regular binge drinkers but would still allow themselves a drink on a 'special occasion'. For most of the group drinking went from being a full-time activity to an evening or weekend one. By T4 only one of the participants was still drinking heavily while the rest had cut down to occasional drinking. 'Weed' (cannabis) was the most common drug used with a purpose of relaxation. Like alcohol drugs went from being a full-time to a part-time activity. By T4 four of the group had stopped smoking cannabis altogether and all bar one had cut down substantially on drug consumption.

As alcohol and drug consumption declined, there were consequences for the emotions, on activity levels and on the body. Around half of the group reported that they began to feel better as their substance use declined. The perception of alcohol and drugs shifted for many, from a belief that they brought on happiness to considering that they might act as a block to well-being. As drug use declined, the participants also noticed a reduction in paranoia and anxiety, with several mentioning that they had become less suspicious and more social. One girl stated that cutting out cannabis had stopped her mood swings.

The participants also became conscious of alcohol and drugs acting as obstacles to their goals. Danni, 16, cut down on cannabis when she realised it left her depressed, which got in the way of taking steps towards becoming a youth worker. Emma, 17, stopped misusing when she achieved her dream job working in children's theatre and realised that she couldn't afford to be hung-over in the role. Geri, 14, realised that she wouldn't achieve her goal of training as a dancer if she continued with alcohol and drug misuse, which led to her stopping.

A rise in activity was another consequence of the decline in consumption. One of the boys, who usually attended in a 'wasted' state, began to make changes in his life such as applying to college and expressed a desire to have more from life.

Increased activity was in turn related to greater happiness. Fliss, 19, cut down on cannabis and helped her alcoholic mother through a 'detox'. As a distraction activity they set about decorating their homes, which gave them a sense of achievement that increased their happiness. The decline in substance misuse was also apparent in the participants' physicality. At T3 there were signs of clearer skin, higher energy levels and greater physical fitness in several individuals, which reflected the presence of fewer toxins in the body.

The service manager reported that there was no longer the trail of crisis and chaos that accompanies heavy alcohol consumption and that it was now possible to 'close the book' on many of the group since their substance misuse was no longer a cause for concern. There were two exceptions to this, both of whom were in 'a state of denial' about their alcohol dependency according to their key-worker. Although their consumption remained high, the key-worker observed changes on a 'personal and emotional level' with each. One of these was 20-year-old Holly. At T2 her relationship had broken down which led to an increase in substance use. By T4 she was still a heavy drug user, but her alcohol consumption had reduced, partly as a consequence of feeling better.

> *I just feel happier, it's not really much to block out at the moment, I feel happier in myself, so I don't really need the alcohol as much.*

In Holly's case the impact of the intervention was more on her emotional well-being and life choices rather than on her substance use.

Transformation

The rise in happiness, the development of a future goal orientation and the decline of alcohol and drug consumption contributed to the final overarching theme, that of transformation. One of the most remarkable outcomes of the study was the scale of change in the participants, both internally in their mindset and externally in their circumstances.

> *I've changed a lot for the better… I feel like a completely different person to be honest.* (Ashlee)

> *It's been really a life-changing experience.* (Fliss)

The service manager summed up the intervention as 'transformational', her co-manager noted 'significant changes in each participant' with 'far better engagement. There's a warmth, there's an openness that they didn't have before.' Many of the internal changes have already been documented, what was also remarkable were the external changes that occurred. Eight out of the 10 re-engaged with education, four gained new jobs and four were rehoused into more suitable accommodation. Emma, 17, was one of those who flourished. She had been one of the most disaffected and defensive, however at T3 the researcher encountered a changed individual. Life had gone from strength to strength - she had gained paid work, passed an exam and had an audition to go to drama school. What's more she had achieved her goal of having her own place to live. Her support worker had noticed that she had begun to engage more and it was this new attitude which won her new accomodation.

The biggest change, inevitably, was for pregnant Cassie. This was a girl, whom her key-worker described as incredibly negative, 'almost afraid to think of what good can happen… for fear of what bad might happen.' Cassie held to her resolution to stay sober during her pregnancy and changed her mind about returning to alcohol as she had planned once she became a mother. This was a sign of her caring more about her future.

> *I think the future's good for me whereas before I thought oh no, nothing's going to turn out alright but I changed.*

Two months after the study Cassie, the participant who had lacked faith in her future, gave birth to a baby girl and named her… Faith.

Results: Quantitative findings

Subjective happiness

Table 2
Mean subjective happiness responses as a function of time

	Experimental		Control	
	Mean	SD	Mean	SD
T1	3.80 (n=10)	.81	3.88 (n=10)	.64
T2	4.52 (n=10)	.70	3.55 (n=9)	.62
T3	4.63 (n=9)	.60		
T4	4.31 (n=9)	.62		

The data were analysed with a 2x2 split-plot ANOVA with condition (experimental v control) and Time (Time1 v Time 2) as factors. The main effect for time was $F(1,17) = 1.28$, $p = .274$. The main effect for group was $F(1,17) = 2.63$, $p = .123$. Neither of these effects were significant. There was however a significant interaction of group varying as a function of time ($F(1,17) = 9.38$, $p = .007$) therefore it is possible to reject the null hypothesis that this could have arisen due to sampling error.

A simple effects analysis was carried out on the interaction data, with the criterion value for significance set to .0125 to control the familywise error rate. This revealed a significant difference between groups at T2 ($F(1,17) = 9.26$, $p = .007$) and within the experimental group from T1 to T2 ($F(1, 17) = 10.05$, $p = .006$). No other comparisons achieved significance.

A one-way ANOVA compared the experimental group at T1, T2, T3 and T4 and showed a significant difference in the means ($F (3, 24) = 4.409$, $p = .013$). Paired t-tests revealed a significant difference between T1 ($M = 3.80$) and T2 ($M = 4.52$), $t (9) = 3.7$, $p = .005$ two-tailed. No other comparisons achieved significance.

The results would appear to indicate that whilst happiness increased across time in the experimental group, no such beneficial effect was observed in the control group, whose happiness declined slightly.

Optimism

Table 3
Mean optimism responses as a function of time

	Experimental		Control	
	Mean	SD	Mean	SD
T1	16.25 (n=10)	4.09	16.88 (n=10)	4.01
T2	20.40 (n=10)	4.88	13.00 (n=9)	4.82
T3	22.11 (n= 9)	3.91		
T4	20.61 (n= 9)	4.16		

The data were analysed with a 2x2 split-plot ANOVA with condition (experimental v control) and Time (Time1 v Time 2) as factors. The main effect for time did not achieve significance ($F(1,17) = .022$, $p = .883$), neither did the main effect for group ($F(1,17) = 3.308$, $p = .087$). However a significant interaction was found for group varying as a function of time ($F(1, 17) = 21.076$, $p = <.01$). A simple effects analysis on the interaction data revealed a significant difference in optimism between T1 and T2 in both the experimental group ($F(1,17) = 11.86$, $p = .003$) and control group ($F(1,17) = 9.37$, $p = .007$). There was also a significant effect within the experimental group from T1 to T2 ($F(1,17) = 11.01$, $p = .004$).

A one-way ANOVA compared the experimental group means at T1, T2, T3 and T4 and showed a significant difference ($F(3,24) = 6.416$, $p = .002$). Paired t-tests revealed a significant difference between T1 ($M = 16.25$, $SD = 4.09$) and T2 ($M = 20.40$, $SD = 4.88$), $t(9) = 5.56$, $p = <.001$ two-tailed and also between T1 ($M = 16.61$, $SD = 4.17$) and T3 ($M = 22.11$, $SD = 3.92$), $t(8) = 4.225$, $p = .003$ two-tailed. No other comparisons achieved significance. The results would appear to indicate that whilst optimism increased across time in the experimental group, no such beneficial effect was observed in the control group, whose optimism declined.

Positive and negative emotions

Table 4
Mean positive and negative emotion responses as a function of time

	Experimental		Control	
	Mean	SD	Mean	SD
Positive emotions				
T1	22.10 (n=10)	6.92	28.78 (n=10)	9.93
T2	29.80 (n=10)	7.97	23.44 (n=9)	9.70
T3	29.44 (n= 9)	5.98		
T4	31.44 (n= 9)	5.79		
Negative emotions				
T1	23.80 (n=10)	7.41	24.55 (n=10)	9.84
T2	18.40 (n=10)	8.63	23.55 (n=9)	11.72
T3	17.44 (n= 9)	2.88		
T4	17.56 (n= 9)	5.58		

In the experimental group mean positive emotions rose while mean negative emotions declined across the study. There were two extreme scores for negative emotions (at T4 in the experimental group and T2 in the control group) and these were trimmed to the next highest value in order to run the parametric analysis.

Positive emotions

The main effect for time did not achieve significance ($F(1,17) = .325$, $p = .576$), neither did the main effect for group ($F(1,17) = .002$, $p = .963$). However a significant interaction was found for group varying as a function of time ($F(1,17) = 9.854$, $p = .006$) and therefore it is possible to reject the null hypothesis that this could have arisen due to sampling error.

A simple effects analysis was carried out on the interaction data, which showed that the two groups differed significantly at T2 with a marginally significant effect ($F(1,17) = 7.26$, $p = .015$). No other comparisons achieved significance.

A one-way ANOVA showed a significant difference in the experimental group means ($F(3, 24) = 4.363$, $p = .014$). Paired t-tests

revealed a marginal significant difference between T1 (M = 22.33) and T3 (M = 29.44), t (8) = 3.159, p = .013 two-tailed. No other comparisons achieved significance.

Negative emotions

Neither of the main effects nor the interaction were significant. The effect for time was F(1,17) = 1.47, p = .242. The effect for group was F (1, 17) = .835, p = .374. The interaction of time and group was F(1,17) = .282, p = .602. A related t-test showed that mean negative emotions declined in the experimental group across time from 23.44 (SD = 7.76) at T1 to 16.33 (SD = 2.74) at T4 but this was not a significant result.

Alcohol dependence

Table 5
Mean alcohol responses as a function of time

	Experimental					Control				
	Mean		SD	median	range	Mean		SD	median	range
T1	20.78	(n=10)	9.52	24.00	37.00	22.67	(n=10)	13.28	25.00	47.00
T2	12.78	(n=10)	10.27	13.00	42.00	19.67	(n=9)	11.29	17.00	33.00
T3	12.56	(n=9)	9.98	15.00	31.00					
T4	10.89	(n= 9)	10.93	7.00	36.00					

Alcohol dependence had dropped to half of its T1 level in the experimental group by T2, from a median of 24.00 (range = 37.00) to a median of 13.00 (range = 42.00) and by T4 it had fallen to a third of its original level at a median of 7.00 (range = 36.00). In the control group the median was 25.00 at T1 (range = 47.00) and at T2 with one dropout this declined marginally to a median of 17.00 (range = 33.00).

Due to the presence of extreme scores, which ranged from heavy drinkers to teetotallers, the SADD data did not fit the assumptions for parametric testing. A Wilcoxon signed-rank test showed that the experimental group's SADD scores had more than halved by T4 (M = 10.90, SD = 10.94) compared to T1 (M = 23.00, SD = 11.40) and that this was a statistically significant result (Z = -2.55, exact p = .004 one-tailed). There was one other marginally significant result from T1 (M = 23.00, SD = 11.40) to T3 (M = 12.56, SD = 9.99), Z = -2.371, exact p = .008 one-tailed. No other comparison achieved significance.

A Mann-Whitney U test was used to compare the experimental and control group at T1 and T2. This showed that U = 31.5; exact p = .284 two-tailed and therefore it is not possible to reject the null hypothesis that the difference in conditions could have occurred by chance.

Discussion

Both qualitative and quantitative findings suggest that the intervention was related to a significant increase in well-being and a significant decline in alcohol consumption.

The experience of a group intervention played a role in the rise in positive emotions. Friendships formed and the group were mutually supportive. There were indications of participants becoming more sociable in general and this may be explained by the increase in happiness, as depression tends to cause people to withdraw whereas happiness facilitates its opposite.

Well-being

The rise in happiness and other positive emotions seen in the qualitative themes was supported by the quantitative findings with a significant increase in happiness at T2 in the experimental group and a significant effect between groups. There was also a significant increase in optimism in the experimental group at T2 and a significant effect between groups, implying that the development of future goal orientation was supported by a strong optimistic belief that things will work out.

Mean positive emotions in the experimental group rose by approximately a third during the study (from M = 22.10 at T1 to M = 31.44 at T4) whereas negative emotions shrank by a quarter (from M = 23.80 at T1 to M = 17.55 at T4), indicating that the ratio of positive to negative emotions doubled from approximately 1:1 to 2:1. The broaden-and-build theory of positive emotions suggests that people go into upwards spirals of development when their ratio of positive to negative emotions bypasses the tipping point of 2.9 to 1, which divides flourishing from languishing (Fredrickson & Losada, 2005). It is possible that this theory was fuelling the theme of transformation, which spawned multiple successes ranging from gaining new jobs

and accommodation, to passing exams and completing educational assignments. This also concurs with meta-analysis findings that happiness is both the cause and consequence of success (Lyubomirsky et al., 2005). This suggests a potential for using positive emotions as a vehicle to facilitate optimal functioning in adolescents and builds on the findings of Ruini et al, (2006) and Froh et al, (2008). Further research is necessary to establish the relationship between positive emotions and optimal functioning in this population.

It was evident from the qualitative interviews that gratitude had the strongest effect of all the interventions, confirming its reputation as a 'meta-strategy for achieving happiness' (Lyubomirsky, 2007, p.88). This study supports other findings that counting blessings is associated with enhanced optimism, life satisfaction and decreased negative affect (eg. Froh et al., 2008). Gratitude was especially popular with the female participants, concurring with other findings that women seem more likely to express gratitude than men and derive more benefit from it (Kashdan et al., 2009). The popularity of gratitude was such that this study recommends that it should be a cornerstone of future PPI programmes aimed at disaffected youth, who tend towards a mindset of deprivation.

The nature of the happiness experienced by the group varied. Initially it was based more on feeling good, evidenced by the rise in positive emotions, which corresponds to the notion of hedonic well-being, characterized by frequent positive affect and low levels of negative affect (Waterman, 1993). In the latter stages, there were also signs of a different form of happiness, based more on things going well and expressed through the rise of confidence. This is related more to eudaimonic well-being or realising one's potential (Ryan & Deci, 2001).

The shift from hedonic to eudaimonic forms of well-being paralleled another transition, that of time perspective. The dominant time perspective shifted from present-hedonistic, characteristic of children but with a risk of unfortunate consequences such as addictions and academic failure (Boniwell & Zimbardo, 2004), to a future time perspective (Zimbardo & Boyd, 1999). This was most evident in the case of Ashlee, whose horizons shifted from the next drink to wanting to build a future for her as yet unborn children. People with a future time perspective tend to be more successful in life and have an eye on the probable outcomes of present actions (Boniwell & Zimbardo,

2004). Seligman (1999) describes future-mindedness as a strength and argues that a teenager who is future-minded is not at risk of substance abuse. A future time perspective would seem therefore to be a capacity worth cultivating in adolescents and may have a secondary benefit in developing awareness of the impact of present drinking habits on future achievement.

Identifying their strengths had a positive influence on the participants, most of whom had been excluded from mainstream education. Failure to thrive in the classroom raises the risk of disaffection, learned helplessness (Seligman, 1975) and substance abuse. Discovering their natural talents boosted self-efficacy (Bandura, 1977), helped clarify the participants' choice of future direction and stimulated taking steps towards that future. Eight out of the 10 re-engaged with education in the wake of the intervention. This shows how individual strengths can be harnessed to serve a purpose and concurs with Cox's (2006) work with youths with behavioural problems, in which she identified benefits from using the strengths of adolescents in the service of treatment goals. Oman et al. (2004) report on a branch of social work which uses a model of assets that includes the internal resources of strengths but also external sources such as positive family communication. Their work with adolescents linked with alcohol and drug abuse showed that young people who were able to draw upon assets and aspirations for the future were linked to a lower prevalence of youth alcohol and drug abuse.

According to Rath (2007) when people have an opportunity to focus on strengths daily, they are six times more likely to be engaged in their jobs. A strengths approach could be the means of helping excluded young people to engage with the workplace. Policymakers addressing the growing number of NEETs should consider the strengths approach as a means of helping excluded young people to identify work in which they can excel. Further research is required to quantify the benefits of using the strengths approach with disaffected adolescents.

Alcohol misuse

The intervention adhered to its positive focus of building well-being rather than reducing drinking. This indirect approach worked well as alcohol dependence halved from T1 to T2 and by T4 it was down to a third of its original level (from a median of 24 at T1 to 13 at T2 and

7 at T4 respectively). An inferential test - the Wilcoxon matched pairs test - confirmed that alcohol dependence had more than halved by T4 (M = 10.898, SD = 10.936) compared to T1 (M = 23.00, SD = 11.40) and this was a significant result (Z = -2.55, exact p = .004 one-tailed). The large standard deviations reflect the diversity within this small group which ranged from teetotallers to a heavy drinker. As drinking declined, there was a noticeable improvement in physical well-being, which was visible in the young people's appearance but also manifested in the rise of activity.

This finding begs the question of how an intervention, that largely 'parked' the drinking problems of its participants, still managed to achieve a substantial decline in alcohol dependence? The researcher observed two factors. Firstly as the young people began to feel happier, they expressed less need to drink in order to escape difficulty. Secondly, as they developed a future goal orientation, they began to see that their alcohol habits were a hindrance to the realisation of their ambitions. This suggests the potential for using a positive focus to reduce negative behaviours such as substance misuse, and also confirms the potential for using positive psychology in the secondary prevention of adolescent alcohol misuse for young people with established patterns of misuse. Additionally this raises the possibility of taking positive psychology from the prevention arena into a treatment capacity. As this was a preliminary study further research is required to test the precedents observed here.

The intervention

This trial application of positive psychology had strengths and weaknesses. Operating as a group enabled the possibility of peer support, an important factor when considering how much drinking is due to peer pressure. It also facilitated an improvement in social well-being with one participant acknowledging that it was taking part in a group intervention that gave her the confidence to be in other social situations. A group intervention has advantages in terms of cost compared to more expensive one-to-one interventions.

For the participants it was a case of learning through doing – the activities worked well but they were resistant to any form of teaching, possibly because it reminded them of the unfavoured classroom

scenario. Varying the themes each week maintained interest in the sessions but at two hours in duration, the participants began to lose concentration as the desire for a nicotine fix rose. Future roll-out of the intervention would benefit from having a longer run, say of 12 and keeping the sessions to an hour apiece.

The researcher, as co-facilitator of the intervention, was fortunate to engage the 'hardest group to reach' but acknowledges that the positive results could have an element of 'teacher effects'. While this is not necessarily a disadvantage, consideration should be paid to the likelihood of future facilitators being therapists who may have only worked in the disease model and for whom a positive intervention such as this could represent a paradigm shift in practice.

Operating within the health model was an effective practice, even allowing for the scale of alcohol problems, which positioned the participants firmly within the disease model spectrum of treatment services. Coaching, the form of mentoring which serves as the tool of the health model, worked well with adolescents. The basic coaching question of 'what do you want?' pointed the participants towards articulating ambitions for their lives, in contrast to the therapy question of 'what is the problem?' which maintains the individual within the disease model. Many of the goals set during the intervention were achieved and the fact that they were self-generated rather than imposed goals, may have given the young people an intrinsic motivation (Ryan & Deci, 2000) to achieve them. Youth coaching is still in its infancy in the UK, but having established that coaching was an effective process for this client group, the study strongly recommends that coaching become part of the repertoire of interventions with young people.

Limitations

Due to the preliminary nature of this study and convenient sample involved, there are a number of limitations to consider. The sample's small size and gender imbalance restricts the external validity of the results. It was noticeable that well-being fell slightly amongst the control group and there was a statistically significant decline in their optimism between T1 and T2. The small size of the group may have led to an undue influence of one or two members, but another explanation may

be resentment felt by the control group, who received no intervention and filled in questionnaires without reward although they were assured that they would be eligible for a later intervention.

As a general observation much of positive psychology research relies on self-report measures. Disaffected adolescents lead chaotic lives which may influence their reliability as study participants. They also tend to dislike questionnaires as they have to fill in forms in order to access services and benefits. It may be necessary to supplement self-report measures when studying this population. Triangulation was useful in this respect to assess change from multiple perspectives. Other objective measures could include blood and breathalyser tests to assess alcohol levels and maybe external measures such as attendance records. Neither is likely to be popular but they would mitigate against the reliance on self-report measures.

It is possible that some of the changes observed in the participants could have been the result of maturation effects, as adolescence is a period of rapid change. However the scale of change, which some rated as transformational, implies that the intervention had a greater effect than normal maturation processes. Equally there is the question of the 'Hawthorne effect' (Landsberger, 1955) whereby the participants improve because they are the centre of attention (and certainly the control group may have experienced its opposite). T4 was a late addition to the study in order to assess longer-term effects and this showed that the effects of the intervention were still in evidence, five months after baseline.

As with any intervention, the question arises of how to sustain the effects over the long term. This is especially important in a population who return to the influence of their environments. In this respect the friendships that developed amongst the group may help through peer support. It is also possible that having entered an upwards spiral and re-engaged with education and life generally, the group will have more of a chance of transcending their circumstances. The programme would benefit from having post-intervention coaching sessions or group reunions to maintain the effects long-term.

Conclusion

This mixed methods study was a preliminary investigation into applying positive psychology to alcohol-misusing adolescents in a 'real world context'. Both qualitative and quantitative results indicated that the intervention was associated with a significant increase in adolescent well-being and a significant decrease in alcohol consumption. The effects were still in evidence three months after completion of the intervention. As well as demonstrating the value of applying positive psychology to alcohol-misusing adolescents, the study extends the reach of positive psychology programmes beyond primary prevention into secondary prevention for people who already have symptoms of a disorder. It shows the potential of positive psychology as treatment for populations who have moved beyond risk into the reality of health, social and educational problems. Traditionally prevention research has been pathology-oriented, focusing on the reduction of risk factors within the individual. The present study demonstrates the value of working within the health model for established clients of the disease model. Given the benefits observed to hedonic, eudaimonic, social and physical well-being, the final recommendation of this investigation is to take the current pilot forward to a full study.

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Community engagement using World Café:

The Well London experience.

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***Abstract**: The Well London programme was launched across twenty boroughs in London during late 2007 to improve the health and well-being of residents living in some of the most deprived communities in London. Well London employed a multi-stage community engagement process which informed the overall project strategy for each intervention area. In this article we establish and describe the key principles that guided the design of this innovative community engagement process. Principles included building collaborative partnerships, working with whole-systems, privileging community knowledge and working with the deficit of experience in each area. The article then describes in detail how these principles were operationalised throughout the preparation and delivery of forty World Cafes, which were the first open community activities of the Well London community engagement process. Finally, this article reflects on and summarises the lessons learned when employing innovative, inclusive and transparent community engagement for health promotion.*

***Key words**: Health improvement; community engagement; whole-systems; methodologies; World Café*

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Introduction

In 2006, the Big Lottery advertised a call for proposals for intervention programmes to promote well-being in communities, with a special focus on increasing the uptake of healthy eating choices, increasing levels of healthy physical activity, and enhancing mental health and well-being. The London Health Commission brought together a partnership (the Well London Alliance) which involved six other organisations, including the University of East London (UEL), which prepared and delivered a proposal called *Well London*.

The aim of the *Well London* programme was to use community engagement and development approaches to design and deliver a three year programme of coordinated project interventions targeted at twenty of the most deprived Lower Super Output Areas (LSOAs) across twenty London boroughs. The target LSOAs were matched with a control LSOA within each borough as part of a wider complex evaluation RCT (Wall et al, 2009).

In July 2007, funding of £9.4m was awarded. The first stage of the programme was to design and deliver the Well London Community Engagement Process (WLCEP) to involve the targeted communities in identifying the important challenges they faced in improving their well-being and in developing a portfolio of projects which would address these. The Institute for Health and Human Development at UEL, in partnership with Allison Trimble[1], developed an approach which built on best practice, and the experience of key organisations with a reputation for effective models of engagement and relationship building including the Bromley-by-Bow centre in Tower Hamlets[2]. WLCEP used elements of Whole Systems thinking and Future Methods including the World Café (Brown and Isaacs, 2005) and Appreciative Inquiry (Cooperrider and Srivastva, 1987).

In this paper, we describe the principles which lay behind our approach and how these were elaborated into an effective community engagement process in practice. The paper then focuses on how the first component of WLCEP, a series of World Cafés was delivered and draws out some of the lessons learned.

Key principles

Build a collaborative relationship with local communities

The phrase *community ownership* is often used by external providers who are funded to deliver community development in deprived communities. Sadly it is frequently a misnomer for simply involving local people in the activities, rather than offering any real power or control to the community. Conflict typically arises when a project has to be led by the external provider because they are accountable to the funder. Inevitably this locates ownership and balance of power with the external provider rather than the community, particularly as issues around perceived lack of skill and capacity within the community often arise (Ansari et al, 2002). Accepting this pitfall, a more honest approach may be to work in partnership between the external provider and the community employing the principle of mutuality. The project then becomes a partnership led exploration of how to creatively meet the communities' needs and at the same time meet unavoidable funding or research method constraints. Within this a working relationship can develop that implements partnership principles. Levy et al (2003) describe these principles within a university and community organisation research context which includes a shared commitment to collective decision making and collective action.

A collaborative partnership with local communities can be developed through the direct engagement with locally based community organisations that have existing and long-term relations within the community. Building on existing social capital in this way provides access to trusted relationships and local intelligence. The partnering external organisation brings with it fresh ideas, skills, approaches and funding to complement the learning that already exists within the community.

Discover what is unheard

The needs of a community can be understood through collection and interpretation of information from multiple sources. Because statutory agencies typically own the power to define legitimate needs, needs assessment and the design of a response to those needs is

often based on analysis of routine statistics, consultations among local professionals and partners, and technical information about the effectiveness of interventions (Stevens and Rafferty, 2004). In consequence the 'unheard' knowledge of communities about their own needs remains 'unknown' to those commissioning or delivering interventions. 'Unheard' knowledge is often located in the experience of communities and individuals who have, for whatever reason, been excluded or have excluded themselves from the ongoing discussions and assessments. These are often communities and individuals which statutory bodies and third sector organisations find difficult to reach or hear. Services and interventions may as a result be inappropriate, inaccessible and underperform. More recently, and in recognition of this, the perspectives of members of the community concerned have been more widely recognised as representing another form of expert knowledge which may be key for understanding complex needs and for the design and delivery of effective services. This co-production approach is now advocated by Government including through the Duty to Involve (DCLG, 2007) and NICE Guidelines for Community Engagement (NICE, 2008), and also aligns with the Big Society agenda (Conservative Party, 2009).

A key principle, therefore, in the design of any community engagement approach is to ensure that this local knowledge is surfaced, and that hard-to-reach groups are engaged in a way which teases out the most useful information, while avoiding consultation fatigue (Cropper et al, 2000).

Privilege community knowledge and experience

Once communities have been engaged with, it is necessary to privilege their knowledge and experience and to enable their free expression without the influence of existing power relationships or pre-existing knowledge.

Traditional methods of consultation such as focus groups, questionnaire surveys, or consultation events begin with professional knowledge. This is used to design the questionnaires, or set the tone of focus groups. This pre-existing knowledge, presented in various and sometimes subtle forms then requires a response from the target community. The tone of the consultation is, therefore, already set with

the professional knowledge leading. It is necessary to counteract this by encouraging the exploration of individual and collective community perspectives before they are defined and assumed into professional agendas (Johnson, 2009) and without undue influence from those who have most power (usually professionals, experts or heroic leaders), even when those who have most power to define knowledge act in facilitative way (Attwood et al, 2003).

Clearly, professionals do have a legitimate perspective and often have critical expertise. An appropriate opportunity must be created to allow these perspectives to shape the work and to foster mutual understanding. In some cases this may require that the community are offered the chance to explore their own learning in a challenging but supportive environment. This enables community members to critique and practice articulating their needs before they share their understanding with professionals. Ideally community perspectives are further developed through ongoing and supportive dialogue with service and intervention providers, statutory agencies and others at later stages in the community engagement process. The key principle here is that local community knowledge is privileged – it sets the agenda.

Address the deficit of experience and generate aspiration

Good community engagement recognises the deficit of experience among many people in understanding and analysing need and in developing ideas for service improvement and intervention design. This is particularly relevant in underprivileged areas. Insensitive or ill-conceived consultations and needs assessment often leads to impoverished responses which relate only a community's current experience of services and interventions and current capacity to imagine how these might be different. The opportunity to develop new ideas and creative solutions is thus frequently lost.

Consultations which typically ask for a response to proposals or ideas, for example: 'what do you think about homework support classes?', or which ask people what they need; for example: 'what activities do you want in the community room of the children's centre', will typically only get a response based on what people already know has been delivered elsewhere, rather than what they believe would really work. Unless the deficit of experience is explicitly recognised and addressed, then

the community engagement process may fail to surface the 'unheard', and fail to bring into play the community's expert knowledge of the nature and dynamic of its own needs, and its creativity in generating ways to meet these. The end result is services and interventions which are suboptimal in terms of relevance, accessibility and effectiveness.

It is therefore important to create an environment and processes for engagement which not only value the current knowledge and experience of participants but also raises their levels of aspiration and knowledge. Raising aspiration is a fundamental aspect of empowerment where relevant alternatives and novel approaches are shared with the target community to expand, challenge and support their current level of understanding (Mills, 2005). Incorporating an aspirational element broadens the thinking of the group and sparks a greater potential for generating creative insights and solutions. The outcome of such a community engagement process is then informed, aspirational and change focused.

Utilise a *Dual Task* approach

In any context where engagement of end users is a core task there is the opportunity to generate a range of integrated outcomes in addition to the primary outcome. These core tasks include, *inter alia*, needs assessments, consultations, designing and building community facilities, and development or redesign of service and intervention delivery. This is the *Dual Task* approach (Trimble, 2006) where processes are put in place to build the capacity of the community to participate in design and delivery of the core task as it is being delivered. This approach offers additional integrated outcomes for all those who participate as exemplified in White (2006), who describes an arts based participation fused with health promotion and community capacity building. Dual task outcomes might, for example, include personal development for community members or training and employment in the delivery of services interventions; thus maximising sustainable benefits for all involved.

Work with *Whole Systems*

A whole systems approach considers the interrelations among what is

considered a living system. In this case a whole community, including the social, physical, economic and cultural environment, and the residents, service providers, strategic policy makers and businesses who are the actors within it. A whole systems approach does not focus on specific units or a specific outcome. Instead, it creates an environment for new thinking and ideas to emerge from interrelated components intelligently adapting together (Pratt et al, 1999). A whole systems approach encourages creativity and learning among its participants, using collaborative methods which place equal value on all knowledge and offer a vehicle for engaging diverse groups of people in a way which develops shared understanding of the issues and builds collective (rather than individual) knowledge. For instance, within an appreciative inquiry, the process relies on conversation and stories from personal experience to understand what principles were driving successful work in the community. These principles can then be brought together to build a picture of what actions, beliefs and drivers support and maintain the community when it is working well.

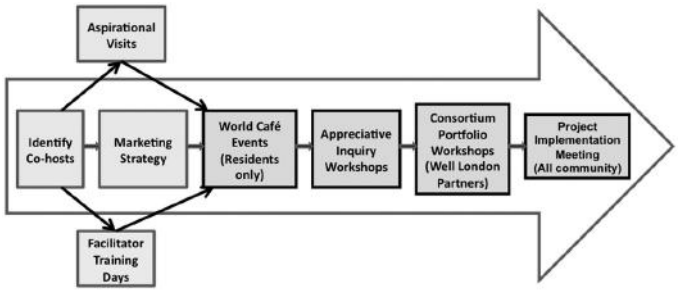
Overview of the community engagement model

In order to operationalise the 6 principles elaborated above, the Well London community engagement team (CET) needed to build collaborative relationships with the communities in each of the Well London (WL) target areas within 20 London boroughs, and in doing this the team had to ensure that the so called 'hard-to-reach' could be included in the process. The team needed to 'privilege' the knowledge of the target communities thus allowing these communities to set the agenda without pressure from professional service providers or elected politicians. Recognising the deficit of experience and opportunity of many people in the target areas, all of which fall within the most deprived 11% of LSOAs in London, the WLCEP needed to include work to raise aspirations. To maximise additional benefit and learning to participants – the Dual Task - the CET needed to involve community members in a range of activities involved in making the World Cafés a success.

The CET therefore developed a comprehensive community engagement process based on the principles described above and other

practical considerations to engage residents in each of the 20 WL target communities in two staggered six month phases in 2008.

Figure 1.
Overview of the Well London Community Engagement Process



As illustrated in Figure 1, the community engagement model began by identifying and building relationships with a local community organisation (Co-host) in each LSOA. Co-hosts' personnel attended facilitator training and aspirational visits and worked in partnership with the CET to develop a strategy to market WL and the WLCEP. Two Community Cafés were designed and delivered in each LSOA. These were for residents only, and other statutory and voluntary sector stakeholders were deliberately not invited to the Cafés in order to privilege communities' knowledge and analytic frameworks in setting the agenda for the rest of the process. Findings from the Cafés were summarised in a written report which also incorporated summaries of routine health and socio-economic statistics and a description and mapping of relevant local services and amenities, both of which had been carried out by the CET in a separate work stream. This report was printed and distributed to local statutory sector stakeholders (Local Authorities and Primary Care Trusts), voluntary and community sector organisations, service providers and residents who had indicated a desire to be included in the next stage of the process. The report formed the point of departure for the next stage of the process: the Appreciative Inquiry Workshop (AIW).

In each LSOA, these organisations and residents were invited to an AIW which brought all stakeholders together. At this workshop, the findings from the Cafés were presented, principles and priorities for intervention were identified using the appreciative inquiry approach.

Discussions were carefully recorded and summarised and a final report integrating these AIW findings with Café findings and service and amenity maps was prepared.

When all AIWs were complete, and integrated reports had been prepared, a two day-long action planning event involving all the WL partners was held. This used the integrated reports as a basis for setting priorities and intervention plans for each LSOA and to negotiate resource allocations across all LSOAs. Finally, Project Implementation Meetings were held in each LSOA with all stakeholders. These were events in each LSOA to feed-back and refine priorities and intervention plans. Afterwards a Project Implementation Document, setting out the priorities and plans and specifying the first year's activities was distributed.

Designing and delivering the Community Café events

As described above the Community Café events were the first open community activities of the WLCEP and used the World Café method. As noted these events were for local residents in order to ensure that the knowledge and perspective of local people was foregrounded at the start of the process and that voices which are often not heard had an opportunity to be expressed without influence from others.

World Café events host informal, relaxed conversations about questions which participants identify as really mattering. The method is based on the realisation that the best ideas and solutions often emerge, not from formal processes but from informal ones; such as coffee breaks, over dinner, at the photocopying machine and so on. Café conversations aim to recreate such informal environments within which a structured conversation focused on one key question can take place. The participants are allowed to set their own direction in response to the main café question, therefore no perspective is privileged over any others. Cafés thus build a collective network of authentic knowledge amongst the participant community (Brown and Isaacs, 2005).

In what follows we consider how the underlying principles and values of good community engagement facilitated the *design and delivery* of the WLCEP Community Café events.

Engage a co-host: Building a collaborative relationship

WL identified potential co-hosts to ensure a partnership approach to delivery. This collaboration also enabled WL to build on what was already happening on the ground rather than duplicating it. Local stakeholders suggested possible organisations as co-hosts, and these were invited to apply for the role, which was to help facilitate the delivery of the WLCEP in their area. Co-hosts were paid, were given a guide book and were able to contact WL partners throughout the process for guidance and support. The co-host's role was crucial in ensuring high turn-outs to and smooth running of the actual events. Where co-hosts had deep knowledge of and contacts in the target community, event attendance was stronger, and conversely where connections to the area were weaker, the corresponding participant numbers proved smaller. The lesson here is to ensure the right co-host is selected.

Marketing: Finding the unheard voices

Co-hosts were asked to organise the marketing of the WLCEP events. A Mental Well-being Impact Assessment (Cooke and Stansfield, 2009) was carried out on WLCEP plans and this particularly identified the need to ensure inclusion of every section of the community. Thus the target communities were segmented by, for instance, age, gender, ethnicity, and physical and mental disability. The CET worked with co-hosts to develop an appropriate marketing strategy for each identified segment of the community.

Marketing included multiple methods including word of mouth, street interviews, advertising through local organisations and newsletters, area specific leaflets and posters, and multiple direct mailing close to the event dates. Leaflets were translated into ten of the top spoken community languages throughout the WL areas, as identified by the co-hosts, and incentives (or rather actions to remove barriers) to participation included free crèches, food and translators. The CET also used on the day opportunist marketing by speaking to people in the streets and outside schools to encourage them to come into the café.

The dual task approach

As part of the dual task approach, WL invited all co-hosts to learn new skills and build networks of learning across the pan-London project. A Co-host introduction day was held at the start of the project to bring the whole WL team together. This event offered opportunities for long term networking and learning. Co-hosts, other known local organisations, and residents were also invited to attend training sessions in World Café facilitation, which was led by experienced facilitator Allison Trimble. This training is expensive and rarely offered outside of the private sector. As a result, WL was able to leave a legacy of group facilitation skills and whole-systems learning within each community. After completion of the training, co-hosts were invited to gain experience by co-facilitating the café events in their areas, though only a few of the more experienced co-hosts took this offer up. Further, residents were engaged in the marketing process, in providing food and crèche facilities or to act as translators or scribes at the café events.

Aspirational visits: Addressing the deficit of experience

The CET's original plan to take residents on visits to sites of good practice, especially around health, well-being and community development practice, proved expensive and impractical. A visit was arranged to Bromley-by-Bow but was poorly attended. Building relationships in the LSOAs was still nascent and organising and gathering participants from across London proved too huge a task. Instead, acknowledging the deficit of experience, the CET brought the aspiration *to* the community. Good practice examples and stories were gathered from Well London partners and were designed into an exhibition as part of the community café events (see Designing and setting up the community cafés below).

Designing and setting up the community cafés: Bringing all the principles in practice

Achieving high levels of attendance at the cafés required a strong collaborative effort by the CET and the co-host. To begin with, the Community Cafés needed to take place in local venues. These venues needed to be known, welcoming, accessible and acceptable to all the community. We tried to avoid venues with religious affiliations, and

those that were inaccessible to physically disabled members of the community. This wasn't always possible. In several areas, venues that met all our criteria were impossible to identify. The least successful were those some distance from the target community. Venues came in all sorts of shapes, sizes and states of disrepair. Many were old dank community centres that had seen better days, and in order to follow the advice of creating a comfortable ambience[3], the CET engaged Uscreates[4], a social design agency, to create a back drop exhibition illustrating WL themes, good practice stories and visuals. The exhibition was designed to be easy to set up and strike, and flexible in a number of settingsgs. The large but light boards used, easily joined together, and transformed otherwise drab settings. The exhibition included interactive games, blackboards for comments, a space for videos, and a laptop mapping exercise, staffed by one of the team, where individuals could make comments about specific geographic locations. Welcome boards were placed outside the venue and at the entrance to the café to direct people.

Tables were set up in a higgledy-piggledy café style around the spaces, with 6 chairs around each table. The tables were dressed with colourful table cloths, covered themselves with paper table clothes to write on, coloured marker pens, flowers and electric candles, and a menu of café 'etiquette' rules. Plentiful healthy hot and cold food and drinks were provided at all cafés, taking care to provide a variety of cultural styles, including Halal and vegetarian options. The food and refreshments were available throughout the cafés, and participants could help themselves as they pleased. This was a key element to helping participants feel relaxed and wanting to continue in conversations. Gentle ambient music was played throughout. Residents often expressed pleasant surprise when they entered the transformed environment and readily got involved.

Wherever possible a separate crèche area with local crèche assistants was provided. Where this was not possible an area of the café space was screened off for children. In one instance, so many children arrived that the crèche was soon full, and children overflowed into the main café area and 'ran free'. This added to the social atmosphere and emphasised the need for flexibility. Where necessary, local interpreters were also invited to translate contemporaneously. In one example, a translator for a group of Eritrean women had a direct conversation with a translator for a group of Somali women thus joining the two groups in dialogue.

Cafés lasted around two hours and delivered four rounds of discussion. Round one posed the key question. Round two posed the same question but mixed table participants. Round three was an open plenary round where the facilitator asked questions to each table and provoked an open discussion. Round 4 returned to round table discussions to set priorities for actions. In some cases, residents trickled in over extended periods and it was impossible to have a 'pure' café. In these instances, the CET got tables going and then added new tables as additional residents arrived. In some cases, the team had to run facilitated tables similar to focus groups.

The construction of the main question asked was key to the success of the discussions and to getting useful data to carry forward to the remainder of the WLCEP. Much thought was put into crafting an appropriate question. The final question decided on was 'what do you understand as the health needs of your community?' The presentation of such an open ended question allowed participants a great deal of scope to surface their own theories and knowledge. In almost all Cafés, participants quickly linked health to issues of community cohesion, the physical environment, community safety, youth and others, driving conversations which truly addressed the whole system.

Record, analyse and report: Discover what is unknown

Scribes were present at each table to record the discussions. Scribes were provided by the co-host from local residents or members of staff, and from Well London partners. They were trained before the event. Scribes were encouraged to avoid directing discussions, although in some instances questions were asked to get participants to elaborate on a particular point or to encourage everyone at the table to contribute. Apart from this scribes didn't take part but concentrated on recording everything that was said. Each line of recorded conversation was typed up electronically and numbered by the scribe. Raw data, carefully anonymised, was later included in appendices to reports so that recipients could trace back the origins of the interpreted findings, using the line numbering system, and this ensured transparency throughout.

The data from the street interviews and community cafés were analysed thematically within each LSOA in two stages. First, a pre-determined coding framework was applied to the textual data. This

organised text into several categories according to its content pertaining to Well London themes: 'healthy eating', 'physical activity', 'mental well-being', 'arts and culture', 'open space', 'cross cutting themes' and 'miscellaneous'. Using the Well London themes as an analysis framework allowed us to collate and compare the data across all twenty areas. New categories emerging during analysis included 'community building', 'safety', 'communication' and 'youth'; again reflecting the natural tendency of people to understand how health is located in a whole system context (Adams-Eaton et al, 2010). To ensure coherence and consistency, the coding was reviewed by a second researcher and any disagreements were discussed and data re-coded as necessary.

Second, text coded under each theme was combined across all LSOAs. From this a narrative was written under each heading with tracked references back to original raw data. The narrative was added to existing mapping data to form a report for the next stage of the WLCEP, the Appreciative Inquiry Workshops, and the key findings were presented verbally at the start of each workshop. Thus data and priorities generated first from the residents were privileged and used to set the agenda for the following stages of the WLCEP, and could be tracked up to the final plans for intervention.

Overview of participation and learning

Forty Community Cafés were held across the 20 boroughs. Cafés averaged around 46 residents, ranging between 25 and 99 adults in attendance. In all, including street interviews used during the marketing phase, almost 1400 residents or circa 5% of all adults in the target LSOAs were engaged. Observations from research staff noted a broad range of demographic characteristics among the participants with an over-representation amongst women, with young people and older men under-represented..

Residents tended to remain throughout the Café process, and expressed pleasure at the chance to socialise, chat and eat with neighbours at the same time as conducting a useful exercise. Some residents asked 'if they could have more of these'. The data collected from these events were, as discussed above, analysed and fed back to the communities throughout the process.

As well as identifying key perceived proximal barriers to healthy eating, physical activity and mental well-being such as cost or lack of understanding, the most significant findings from the Cafés across all WL target areas was the view that a lack of community spirit and cohesion had a strong negative effect on residents' feelings of mental and physical well-being. Residents felt that their communities were fragmented across age and cultural lines, and between established residents and newcomers. There was a lack of communication, a gap in knowledge about what was going on, a lack of coordination between services, and a strong perception of lack of safety, particularly attributed to the anti-social behaviour of youth, who were perceived as having 'nothing to do' (Bertotti et al, 2010). In short, residents expressed a desire to live in a community which they felt part of and safe in. Residents welcomed the opportunities to take part in projects such as healthy eating, physical activities or arts as a way of bringing the community together across inter-generational and inter-cultural lines, and getting to know their neighbours better. The purpose of this paper is not to discuss the findings of the Community Cafés or overall WLCEP. But it is important to note that these were key in shaping intervention delivery and in bringing together themes to make projects relevant and attractive on the ground. The WLCEP revealed a deeper understanding of how the interrelationship of the physical and social environment that the residents inhabited acted as barriers to health. This knowledge continues to be invaluable in building the WL project across all twenty LSOAs. Residents naturally understand health within a whole systems context and are able to describe in detail how that whole system works.

Conclusion

The WL programme has set out to promote healthier lifestyles among some of London's poorest neighbourhoods through an intervention programme tailored to the needs and assets of each LSOA. In order to understand those needs and assets in a way that was to be truly effective in terms of community buy-in, it was necessary to design an inclusive and transparent community engagement process.

The CET used knowledge and experience from pathfinder organisations to identify principles that were essential to observe when

engaging with communities. These included: building collaborative relationships with the community based on trust in order to hear and record the unheard; privileging the communities' knowledge and experience to address the power imbalance in agenda setting, analysis and intervention design; building capacity to participate and raising aspiration; using methods that allowed the widest range of community voices to be heard; and adding legacy skills and resident involvement in the process itself. Further, to enhance trust and to ensure that the community voices were genuinely heard, the CET added the principles of transparency and inclusiveness as clear design criteria. The communities themselves drove an analysis within the context of the whole system without prompting from the team.

The CET worked to apply these principles to the WLCEP throughout, and, in particular to the Community Cafés, which formed the first open community activities of the WLCEP, and included the design of its marketing strategies.

Evidence of the success, although not perfect, is shown by the large numbers engaged compared with normal community events and subsequent numbers who have participated in the planned programmes, devised largely from knowledge surfaced from the WLCEP, where the Well London Alliance has more than met its planned targets.

Challenges included the expense of aspirational visits, the choice of the wrong Co-hosts and difficulty in finding appropriate venues in a few areas, the failure to engage some sections of the community, and some Café events having people trickling in and out, which prevented delivery of the ideal Café process. The first challenge was overcome by bringing the aspirational stories to the community through the design of the café back-drop exhibition. The second challenge taught the team how essential it was to find the right co-host and not always accept the first offer. Co-hosts must have genuine connections with their area. Perfect venues are not always possible to get for a host of reasons but the closer and more comfortable to the community the better the result. Certain sections of the community take more time to engage. In WL community engagement is ongoing and a community development approach is used throughout, and further efforts have been made in later stages to engage with those who may have initially been left out. The final challenge was overcome by remaining flexible with the team adapting its engagement style to circumstances.

The Community Cafés provided a safe and informal space for groups of residents to challenge and learn from each other, providing a communication environment that rarely exists in the everyday world. It was a space where people could move beyond their normal complaints to talk about what they really cared about without a fixed structure. This in turn enabled deep rooted issues to be surfaced and understood which in turn contributed to effective planning and intervention design.

The wider determinants of health and well-being are now understood to represent a dynamic arrangement of interrelated environmental, social and structural barriers and facilitators. Consequently, working in isolation to tackle a single health or well-being issue may not be the most effective approach. WL seeks to address, at the same time, the areas of physical activity, healthy eating and mental health and well-being by influencing the system of determinants and their interactions which are common across these areas. In order to understand this system, partnership, interdisciplinary and joined-up working across planning and delivery agencies and communities is required. A prerequisite of this approach is that everyone serves as equal and valued contributors.

Truly participative and transparent community engagement can, as in the example of Well London, bring significant improvements in health interventions and wider benefits to communities by supporting the development of unrecognised community assets. This can unleash communities' energy and capacity to help themselves, dramatically reducing the burden for the original delivery organisation and therefore improving efficiency. Thus high quality, innovative and transparent community engagement is a critical task, if current health services are to adapt to the changing financial climate, rather than an optional add-on. As our understanding of health and well-being and their determinants continues to evolve, we suggest that the methods of engaging the community need to evolve alongside.

Notes

1 Allison Trimble was a founding member of the Bromley-by-Bow Centre team and worked with a group of local residents and members of the community care group to develop the distinctive model of participation which underpins the Centre's approach to community engagement. Allison worked as CEO of the Centre and developed this model of local engagement to inform participatory management and inclusive leadership development processes. She now works with Leading Room, a cross sector and leadership development organisation specialising in work with public and community based leaders.

2 http://www.bbbc.org.uk/

3 http://www.theworldcafe.com/

4 See http://www.uscreates.com/about/

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The effect of group-based life coaching on happiness and well-being

Charlotte Style[1] and Ilona Boniwell[2]

***Abstract**: This study set out to test the hypothesis that overall well-being and happiness can be affected by a structured, supportive, peer coaching group that facilitates, the positive aspects that contribute to happiness and well-being. This study examined the effects of a coaching workshop that takes an integrated and self-directed focus towards achievable congruent goals in all areas of life. The workshops encourage intrinsic motivation, self-knowledge, positive feeling, self-efficacy and growth. In a quasi-experimental two-factor design, 40 self-selected participants were randomly assigned to attend either a coaching workshop run once a week over a six-week period (experimental group n=23), or a control group (control group n=17). A series of 2x3 split plot analyses of variance were carried out with Time (pre v post v follow up) as the within participant factor and Group (experimental v control) as the between participants factor. All participants completed self-report measures for general happiness, psychological well-being, satisfaction with life, self-efficacy, positive emotion and hope. These measures were completed before and after the experimental intervention and then again three months later. The experimental group attended at least four public life-coaching workshops over a six-week period. The control group also met once a week as an unstructured group in general discussion over the same time period and again were required to attend at least four times. The results for those in the experimental coaching group showed a significant effect compared to the control group. The number of participants was small yet the study produced some significant results, which were sustained for three months. Group life coaching can certainly be said to effect aspects of being that are known to be important contributors to intrinsic motivation, happiness and well-being.*

***Key words**: life clubs; life coaching; happiness workshops; well-being*

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Introduction

Life coaching is an emerging and fast growing field that claims to support and facilitate change and personal development in all areas of life. It draws from a number of disciplines, including psychology, counselling, and sports coaching and uses methods from all these areas to support clients and help them move forward and achieve success and happier lives. The number of life coaching resources available is huge, however the research on coaching is limited compared with the growth in the industry, and studies on life coaching in particular are scarce (Grant, 2003; Linley, 2006). Life coaching is most often offered as an expensive commodity for individual clients. However the tools and methods can be experienced and practised in a workshop format, where people can experience coaching as a group. This can include peer coaching as well as individual reflection and insight. It is life coaching in a group format that this study was interested in examining.

Coaching and positive psychology

Positive psychology examines all of the tenets that coaching claims to facilitate. 'Coaching serves as a perfect testing ground for the theories and scholarly ideas of positive psychology,' (Boniwell 2008). To date most of the research positive psychologists have conducted has been in business coaching. Research into coaching in non-executive and non-business communities has been largely neglected, (Biswas-Diener and Dean, 2007; Green et al, 2006). More experimental research, as well as more group-based research, with objective quantitative outcome measures is needed, (Stober and Grant, 2006; Greif, 2007).

We could find only two validated research papers on group based life coaching outside the business community or single issue support groups, at the time the study took place. Both studies used the 'coach yourself' life coaching group program (LCGP) developed by the researchers. (Grant 2003; Green et al, 2006). Green's initial study measured the effects on two groups, a life coaching group who followed a ten-week program 'coach yourself' (Green, 2004) and a waiting list control group. Green's programme ran for 10 weeks and consisted of a full day workshop followed by nine weekly one hour meetings. The

waiting list group received no intervention during this period and then received the intervention themselves. Green's research focussed on hope theory and goal achievement and is based on the premise that increases in goal achievement would affect well-being. She was also interested in the effect that life coaching would have on depression. This study differed slightly from Green's in that the coaching intervention was a different design and length, and in that the control group met during the intervention period as well.

The current study

The overall efficacy of group and peer coaching and its effect on happiness and general and psychological well-being, was the main aim of the present study. Hope was used as a measure of action and a broad range of measures of well-being were used to assess the general effects of the intervention on well-being. Shane Lopez believes only the best coaches can grasp the in-depth aspects of positive psychology and that applying only popular notions and principles of the discipline, does little to improve peoples' lives (Kaufman & Linley 2007, p90). The concept of this research refutes this notion and aims to show that the tenets of positive psychology, that lie at the heart of the research programme, can be effective in lay hands. Also that when offered to the general population in a coaching workshop model that this is an accessible and informed way in which to examine and improve the quality of peoples' lives.

This study was a response to the lack of research into life coaching. It sought to examine life coaching in a non-business setting and was more interested in the effects of workshops that relied on peer coaching and self reflection, guided by clear exercises designed to facilitate insight, challenges and self learning. Although the group was led by a Life Club trained facilitator, the aim of the study was to measure the effect of the positive intervention more than the expertise of the coaching. Life Clubs were started in 2004 by Nina Grunfeld (www.lifeclubs.co.uk). They help to build social and emotional intelligence, communication and body language skills by developing personal insight, awareness and perspective. They use concepts from coaching, positive psychology, motivational interviewing, acceptance and commitment therapy,

neurolinguistic programming, relationship training and changing limiting beliefs (Grunfeld, 2006; 2006; 2009; 2010).

The aim of the study was to assess group based coaching that was

- Holistic: addressed all areas of life.
- Based on the principles and exercises contained within the model rather than the professionalism of the coach.
- Led by a trained facilitator but the coaching group also relied on peer support.
- Was designed to improve self-knowledge and self-discovery in order that any goals set are intrinsically motivated.
- Designed to challenge, champion and effect positive change.

This study set out to measure the workshops as an overall positive effect. To do this several measures were used to assess some of the main contributing factors of the larger constructs that are understood to be measures of, and contributing factors to happiness and well-being, and to assess the intervention as a combined and integrated package.

Hypothesis

The study hypothesized that participants assigned to the Life Club (coaching) workshops would report significant increases in happiness, subjective well-being, self-efficacy, hope and psychological well-being in comparison to a control group. It was also hypothesized that the experimental coaching group would retain a significant positive effect in these areas three months after the intervention.

Method

Design

This was a quasi-experimental pre-test post-test non-equivalent control group design programme. A series of 2x3 split-plot analyses of variance (ANOVAs) i.e. one for each dependent variable, were carried out with Time (pre-intervention v post-intervention v post intervention to follow-up) as the within participants factor and Group (Experimental v Control) as the between participants factor. The dependent variables were:

happiness, psychological well-being, satisfaction with life, self-efficacy, positive emotion, and hope. The independent variable was a minimum attendance at four Life Club workshops over a six-week period.

Participants

The participants were 40 adults (20-57 years). The majority of participants fell within the 26-35 and 36-45 age ranges (mean age 29). All the participants were recruited from the London area and were self-selecting. No psychological screening of participants was conducted. The participants were assigned to either the Life Coaching Group (experimental group n=23) or to a group who simply met together (control group n=17).

Procedure

The Life Clubs workshops were advertised across a large database and network of organisations. Eight workshops were offered free of charge and advertised as a reward for being part of the research program. All the participants completed a set of pre-intervention (Time 1) self-report measures (as above). The participants were then assigned to either the experimental group or the control group after expressing a preference for attending on either Mondays or Wednesdays. Those that chose Wednesdays were assigned to the control group.

The experimental group (n=23) attended a minimum of four existing Life Club workshops once a week for six weeks, on either a Monday or Wednesday. The control group (n=17) met once a week only on a Wednesday, also for six weeks and simply talked of anything inconsequential. The meetings were unstructured and followed a conversational style. All participants met at the same venue for the same length of time. The group dynamic was slightly different each week because of the choice of workshops, as is the Life Club design. All the participants completed the questionnaires at the end of the six-week intervention period (Time 2) and again three months later (Time 3).

The intervention *(The independent variable)*

The Life Club workshops (the intervention) are designed as a rolling

program that can be joined at any time. For the research program the workshops attended were the advertised program and were also attended by paying public.

The workshops were led by a trained facilitator from Life Clubs and involved both group and peer coaching. Approximately a third of the time was given to group discussion led by the facilitator. This introduced the focus of the workshop and allowed both guidance and sharing. A third of the time was given to peer one to one coaching and the final third of the time was spent on self-reflection.

Measures (Dependent variables)

Participants completed all of the following questionnaires at Time 1, Time 2, and Time 3. Scales were chosen for their reliability and validity.

Generalized Self–Efficacy Scale (GSE) (Schwarzer and Jerusalem, 1995)

A 10 item measure. In samples from 23 nations, Cronbach's alphas ranged from .76 to .90, with the majority in the high .80s.

The Satisfaction With Life Scale (Diener, Emmons, Larsen & Griffin, *1985)*

The SWLS was used to describe a person's global life satisfaction. It is a well-validated measure of subjective satisfaction with life that allows respondents to weight domains of their lives in terms of their own values (Pavot & Diener, 1993).This is a well-validated 5-item instrument. Cronbach alpha coefficients (0.80 to 0.89) and test–retest reliability values (0.54 to 0.83)

Positive and Negative Affect Schedule (PANAS)(Watson, Clark and *Tellegen, 1988)*

A twenty item test, ten items measure positive affect: the extent to which a person feels enthusiastic, active and alert and 10 items measure negative affect: subjective distress and other adverse mood states and negative emotions. It has an Alpha coefficient of .86-90 for the positive affect test and .84-87 for the negative affect test. (Watson et al, 1988)

Orientations to Happiness (Peterson et al, 2005)

A fifteen item test that measures happiness in three ways: engagement or flow, pleasure and meaning. The test can be broken down to give

a separate result for engagement, eudemonic and hedonic aspects to happiness. A five point rating with internal consistencies reported by Peterson et al is said to be satisfactory (pleasure mean = 0.84, flow mean = 0.77 and meaning mean = 0.88, Peterson et al, 2005). This study is interested in the relationships between having a sense of purpose that supports goal congruence and satisfaction with life and happiness.

The Adult Dispositional Hope Scale (GOALS SCALE) (Snyder et al, 1991)

A 12- item measure that measures two aspects of hope; agency and pathway. It is scored with an 8 point scale (where 1=definitely false and 8= definitely true) and is called the Goals Scale when administered to avoid distraction that the term hope can engender (Snyder et al 1997). This study will therefore title this questionnaire as Goals Scale. It consists of four agency items that measure the belief in one's ability to set and achieve goals and four pathway items that measure the ability to imagine and manage the process involved with fulfilling a goal. The last four items are filler questions and are not scored. Hope is the sum of the four pathways and four agency items. This measure is recognised as having good internal reliability. Test retest reliability suggest temporal stability up to an eight week period (Snyder et al, 1991). Alpha co-efficients are also good (Agency = .71-.77 and Pathway = .63-.80)

Psychological Well-Being (Ryff, 1989)

Ryff's six part scale has been demonstrated to relate consistently to a wide variety of well-being and other psychological variables, including life satisfaction, affect balance, depression, morale, happiness, and self-esteem (Ryff, 1989; Ryff & Keyes, 1995). Well-being is a dynamic concept that includes subjective, social, and psychological aspects The Ryff Scales of Psychological Well-Being is a measure that specifically focuses on all areas of psychological well-being. The six sub scales and their alpha values are as follows:

- *Autonomy,* Internal consistency (coefficient alpha) = .83
- *Environmental mastery*, Internal consistency (coefficient alpha) = .86
- *Positive relationships with others*, Internal consistency (coefficient alpha) = .88
- *Purpose in life*, Internal consistency (coefficient alpha) = .88

- *Personal growth*, Internal consistency (coefficient alpha) = .85
- *Self-acceptance*. Internal consistency (coefficient alpha) = .91

These scales are theoretically grounded (Ryff, 1989) and have been validated in numerous studies employing community and nationally representative samples (Ryff & Keyes, 1995). Ryff (1989) found that the co-efficient alphas for the 14-item form ranged from 0.87 to 0.93. For practical purposes this study has chosen to use the nine item test which totals 56 items overall.

Statistical analyses

Prior to analysis, scores on the dependent variables were examined using SPSS Version 11.1 for accuracy of data entry, missing values and fit between their distributions and the assumptions of analyses utilized. To examine differences in the samples scores from Time 1 to Time 2 to Time 3, 3 x 2 repeated measures ANOVAs were conducted on scores for each of the dependent variables. Where the interaction effects of Time and Group were found to be significant, further analyses were conducted to examine between group differences within times, pair wise comparisons of group means at Time 1 and 2, Time 1 and 3, and between Time 2 and 3 were made, using the Bonferroni statistic to control for multiple comparisons. T tests were also carried out on the experimental coaching group over time and for the control group to assess the within-subjects effects. Mauchly's test of sphericity was measured and when significant the analysis used was Greenhouse–Gieser.

Results

The aim of the study was to compare the scores of the experimental group to the control group after the intervention (Time 2) and after a further three months (Time 3). The mean scores for each group (experimental and control) at Times 1, 2 and 3 (pre, post and follow up) were taken from the descriptive statistics used in the repeated measure analysis of the data. These are the results:

Happiness and subjective well-being

Satisfaction with Life

Table1

Means and standard deviations for satisfaction with life

	Experimental Group 1 (n=20)			Control Group 2 (n=11)		
Variable	Time 1	Time 2	Time 3	Time 1	Time 2	Time 3
Satisfaction with Life						
Mean	18.40	21.85	21.50	18.36	19.90	21.01
SD	6.12	6.53	7.3	6.7	6.6	5.7

There was a significant main effect for Time (F2, 58 =10.94 p<.001**). A post hoc analysis, paired sample t-tests using a criterion value for statistical significance set at 0.016, revealed that participants in the experimental group experienced a significant increase in well-being immediately after group sessions ended (t 39 = 4.50, p<0.005) and between pre test and follow up (t 30 = 4.15, p<0.005).

Orientations to happiness

In three parts: 1. Pleasure. 2. Meaning and 3. Engagement. The data for all three parts were analysed separately.

Table 2

Means and standard deviations for orientation to happiness

	Experimental Group 1 (n=20)			Control Group 2 (n=11)		
Variable	Time 1	Time 2	Time 3	Time 1	Time 2	Time 3
Orientation to Happiness: – Total						
Mean	60.95	65.20	65.95	58.18	59.45	61.18
SD	7.5	8.9	10.2	8.6	6.1	6.5
Orientation to Happiness – Pleasure						
Mean	20.35	23.20	22.30	22.36	21.09	20.81
SD	4.1	3.6	4.7	3.9	3.7	4.4
Orientation to Happiness – Meaning						
Mean	22.60	22.65	23.70	18.09	19.81	21.72
SD	3.5	4.6	4.7	5.2	5.3	5.2
Orientation to Happiness-Engagement						
Mean	18.00	19.35	19.95	17.72	18.54	18.63
SD	3.8	4.0	4.3	5.1	3.6	4.4

- The data for Pleasure showed there was a significant interaction effect between Group and Time (F 2,58 = p <.005**). A simple effects analysis revealed two significant comparisons.
- Between pre and post test, the experimental group experienced a significant increase in pleasure, (F 1,29 = 9.97, p<0.005**)
- Between post test and follow up, the experimental group reported a significant increase in pleasure, (F 1,29= 6.72, p<0.05) while the control group decreased slightly.
- The data for Meaning revealed there was a trend.
- The data for Engagement revealed no significant effects

Positive and Negative Affect

Table 3
Means and standard deviations for PANAS

	Experimental Group 1 (n=20)			Control Group 2 (n=11)		
Variable	Time 1	Time 2	Time 3	Time 1	Time 2	Time 3
Positive Affect						
Mean	33.70	38.00	36.10	31.36	28.90	32.54
SD	6.2	7.2	5.9	10.0	12.0	7.8
Negative Effect						
Mean	27.30	23.00	23.1	28.36	25.3	22.27
SD	8.9	9.0	9.0	10.0	9.6	7.9

- *Positive Affect*: Although there was no significant effect for the interaction between Group and Time, When a 2x2 repeated measure analysis was conducted the results for the interaction between Group and Time were significant (F 1,38 = 5.09.p<. 0.05*).
- *Negative Affect:* The main effect for Time was significant (F 2,58 = 9.138 p < .001*). Paired sample t-tests revealed that participants experienced a significant decrease in negative affect
- Between pre and post test (t 22 = 4.479, p< .001)
- Between pre and follow-up (t 19 = 2.481, p< .05)

Hope

Table 4
Means and standard deviations for Hope

	Experimental Group 1 (n=20)			Control Group 2 (n=11)		
Variable	Time 1	Time 2	Time 3	Time 1	Time 2	Time 3
Adult State Hope (Goals Scale)						
Mean	47.05	51.10	49.35	46.45	45.63	49.36
SD	8.6	6.7	8.1	20.2	8.2	9.0
Adult State Hope (Goals Scale)-pathways						
Mean	24.30	26.25	25.54	23.90	24.00	25.7
SD	4.9	4.3	4.6	4.7	4.5	4.6
Adult State Hope (Goals Scale)-Agency						
Mean	22.75	24.85	23.90	22.54	21.63	23.63
SD	4.5	3.9	4.5	4.7	4.7	4.6

- There was a significant interaction between time and group ($F\ 2, 58 = 3.55\ p<0.05$*). A simple effects analysis was carried out on the interaction data. This revealed two significant interactions.
- From post test to follow up, those in the control group reported an increase in hope, while the experimental group decreased slightly.
- Between pre and post test, those in the experimental group experienced a significant increase in Hope, whereas those in the control group experienced a decrease in hope.

Self efficacy

Table 5
Mean scores and standard deviations for *Generalised Self Efficacy*

	Experimental Group 1 (n=20)			Control Group 2 (n=11)		
Variable	Time 1	Time 2	Time 3	Time 1	Time 2	Time 3
Pre test v post test v follow up						
Mean	28.6	31.35	30.7	31.00	30.81	33.00
SD	4.4	4.9	5.0	5.4	4.6	3.7
	Experimental Group 1 (n=23)			Control Group 2 (n=17)		
Variable	Time 1	Time 2	Time 3	Time 1	Time 2	Time 3
Pre test vPost test						
Mean	28.34	30.78		31.17	31.17	
SD	4.7	5.1		4.6	3.8	

- The measure used was the *Generalised Self Efficacy Test* (Schwarzer and Jerusalem, 1995). There was a significant main effect for Time ($F\ 2, 58 = 4.40$ $p<.05$). A post hoc analysis using paired sample t-tests revealed that participants experienced a significant increase in self efficacy immediately after group sessions ended ($t\ 39 = 2.47$, $p<0.05$) and between pre test and follow up
- ($t\ 30 = 2.66$, $p<0.05$].
- There was a strong trend between those in the control and experimental groups over the 3 periods, ($F\ 2,58 = 2.84$, $p = 0.06$ *). When an analysis was done with a 2 x 2 repeated measure (ANOVA) with Group (experimental v control) and Time (pre test, post test,) as factors, the results were significant for an interaction between the groups pre and post test ($F\ 1,38 = 4.98$. $p<.05$).
- The experimental group showed a significant increase in self efficacy after the period of the intervention (Time 2) compared to the control group.

Psychological well-being

Personal Growth

There was a significant main effect for the interaction between Group

and Time (F 2,58 =5.43. p < 05). A simple effects analysis was carried out on the interaction data, which revealed two significant comparisons:

- Between Time 1 and Time 2 those in the experimental group experienced a significant increase in personal growth, (F 91,29 = 6.34, p<0.05*).
- Between Time 1 and Time3 the experimental group also reported a significant increase in personal growth, (F 1,29= 6.91, p<0.05*).

Purpose in life

A significant main effect was found for the interaction between Group and Time (F 2,58 =3.82. p < .05). A simple effects analysis was carried out on the interaction data, which revealed three significant comparisons, those in the experimental group experienced a significant increase in purpose in life:

- Between Time 1 and Time 2 (pre and post test), (F 1,29 = 5.85, p<0.05).
- Between Time 2 and Time 3 (post test and follow up): (F 1,29 = 6.60, p<.05) and Between Time 1 and Time 3 (pre and follow up): (F 1,29) = 6.60, p <05).

Self acceptance

There was an effect for Time. (F 2, 58 =5.51 p<.05). Paired sample t-tests revealed that participants experienced a significant increase in self acceptance

- Between Time 1 and Time 2 (t 38 = 4.09 , p<0.001**) and
- Between Time 1 and Time 3 (t31 = 2.48, p<0.05).
- This main effect was modified by a significant interaction between Group and Time (F 2,58 =3.47. p < .05*). A simple effects analysis was carried out on the interaction data, which revealed one significant comparison.
- Between Time 1 and Time 2 those in the experimental group experienced a significant increase in self acceptance, (F 1,29 = 7.31, p<0.05).

Environmental mastery

There was a significant effect for Time. (F 2, 58 =5.27 p<.05). Paired sample t-tests revealed that participants experienced a significant increase in *Environmental Mastery*:

- Between Time 1 and Time 2 (t 38 = 3.61 , p<0.005**) and
- Between Time 1 and Time 3 (t 31 = 2.88, p<0. 05).
- There was no significant interaction between Group and Time.
- Those in the experimental coaching group increased significantly compared to the control group in

Personal Growth both at the time of the intervention and three months later.
Purpose in Life over all three time comparisons.
Self Acceptance after the intervention.

Autonomy

There were no significant results for *autonomy.*

Positive Relations with Others

There were no significant results for *positive relations with others.*

All Measures comparison

Between Time 1 and Time 2 those in the experimental group experienced a significant increase in effect across all the variables measured, (F 1,28) = 8.87, p<0.006) compared to the control group.

Within-subjects effects

Within subjects effects for the experimental group over time were also analysed. A simple effects analysis was taken, paired contrasts tests in a repeated analysis were conducted for the Experimental Group between Times 1 and 2, and between Times 1 and 3. The significant results for the measures for overall subjective well-being are listed in table 8. The results showed a consistent effect across nearly all of the variables and for all the variables that showed an effect at Time 2 there was also an effect for Time 3. The only exceptions to this were *Self-efficacy* and

Positive Affect which did not sustain the significant effect at Time 3 and *Engagement* (OTH) which had an effect at Time 3 but not at Time 2.

Table 8
Significant repeated measures pair-wise comparisons of effects on the experimental (coaching) group for all variables between Time 1 and 2, and between Time 1 and 3

Variable	Time	Df	F	Sig
Life satisfaction	1and 2	1,19	19.929	.000
	1 and 3	1,19	8.380	.009
Positive affect	1 and 2	1,19	3.857	.008
Negative affect	1 and 2	1,19	16.409	.001
	1 and 3	1,19	6.154	.023
Orientations to happiness				
Pleasure	1and 2	1,19	12.519	.002
	1 and 3	1,19	5.107	.036
Engagement	1and 3	1,19	7.120	.015
Purpose in Life				
PWB	1 and2	1,19	16.924	.001
	1 and 3	1,19	4.948	.038
Self Acceptance				
PWB	1 and 2	1,19	41.592	.000
	1 and 3	1,19	7.363	.014
Personal Growth				
PWB	1 and 2	1,19	7.275	.014
	1 and 3	1,19	4.631	.044
Enviromental Mastery PWB	1 and 2	1,19	6.170	.022
	1 and 3	1,19	7.361	.014
Generalised Self Efficacy	1 and 2	1,19	15.145	.001
	1 and 3	1,19	6.353	.021
Hope-Goals scale	1 and 2	1,19	10.512	.004

T tests

The results for the experimental group were also analysed for within-group effects over time with paired samples t tests. This analysis showed significant results over time for both Time 2 and Time 3 for all the variables except Meaning (OTH), Autonomy (PWB) and Positive Relations with Others PWB).

Control group tests

A similar simple paired analysis was conducted for the control group over the three time periods for all the variables and the results showed only two significant effects. Life Satisfaction improved for the control group at both Time 2 and Time 3 and Environmental Mastery improved at Time 2. All other variables were not significant.

Discussion

This study sought to evaluate the effectiveness of group life coaching delivered as weekly workshops on *happiness* and *subjective well-being*. It also assessed the effect of the coaching on *hope, self-efficacy* and *psychological well-being*. The results showed that the participants who attended the Life Club workshops improved across all the variables in comparison to the control group. The effects across all the variables for the experimental group were greater than the effects for the control group and when analysed for within-subjects effects, the results were significant in all but three sub measures. When all the variables were examined as one total measure for all the aspects and factors under scrutiny, the results showed a strong significant effect.

Increase in aspects that build self knowledge

The results showed that attending the Life Club workshops had the most significant effect on those aspects that focused on a better experience of the self: *personal growth, self acceptance, purpose in life,* and *pleasure*. The participants in the group coaching program also experienced a significant increase in *hope* and showed a marked trend in improved *self-efficacy*. The findings also showed an increase in *satisfaction with life*, a decrease in *negative affect* and an increase in *positive affect*. The most significant effect was for *pleasurable orientation to happiness*.

Effects of coaching on dimensions within psychological well-being

Positive relations with others was not a significant effect and in fact decreased for the experimental group over the whole experimental period. This could be because the emphasis of the workshops was

for self analysis. The experimental group were initially high scorers on this scale which indicates a concern for the welfare of others (Ryff and Singer, 2008) it could be quite understandable that given the opportunity to focus on their own needs this dimension might reduce. However, more research would need to be carried out to back up what is merely speculation.

The very marked lack of effect in *autonomy* for either group was also interesting, and was matched by Green's research. It can perhaps be surmised that group life coaching is not promoting this aspect of well-being that Ryff describes as the 'most western' of all the dimensions of her measure.

Within the psychological well-being questionnaire scores on three dimensions increased significantly: *Self acceptance:* knows and accepts multiple aspects of the self both good and bad, and is a characteristic of self actualisation, optimal functioning, maturity and mental health. *Personal growth:* open to new experiences able to change and realise potential. *Purpose in life:* able to put the former dimension into action and has the ability to see meaning and create a purposeful direction. That these three aspects scored highly compared to the control group is strong evidence that the group based workshops offered effective coaching.

Effects on hope and self efficacy

The combination of improved *self-efficacy*, and general self-development in the categories above in relation to improvements in *dispositional hope* implies a very real change in the ability to set and achieve goals and to imagine and manage the process involved with fulfilling a goal. *Hope* however was not sustained after the initial effect of the workshops. That there was a significant effect on *hope* at Time 2 compared to the control group and that *purpose in life* (see above) was effected significantly indicates that the workshops improved the ability to set goals with an intrinsic purpose and aim, the effects of *purpose in life* were significant across all three time comparisons compared to the control group.

Orientations to happiness

Pleasure was the only aspect of the orientation to happiness measure that

was significant between the two groups however *meaning* and *engagement* showed a trend over time and for *engagement* this was significant. The effect of the coaching workshops to improve both *pleasure* and *positive affect* supported the premise that if the intervention increases *positive affect*, this in itself would facilitate creativity and growth. The design of the workshops was to generate more fun and happiness and increase in this aspect within the happiness measure is completely congruent with the workshop format.

Meaning v purpose in life

It was interesting to note that *meaning* showed little effect when *purpose in life* was significant, the constructs however are entirely different and the results highlighted this. The personal goal orientation of the questions in *purpose in life* (PWB) reflects much more Frankl and Lasch's (1992) concept of meaning in regard to how one perceives life events. The tone of the questions that come under the *meaning* aspect to OTH may appear more dutiful and egocentric to British rather than American participants.

Effects over time

The following variables kept a significant effect over time: *satisfaction with life, negative affect, pleasure* (OTH), purpose in life (PWB), *self acceptance* (PWB), *environmental mastery* (PWB), personal growth, (PWB) and *self efficacy*.

Control group issues

One of the problems this research encountered was the commitment of the participants especially in the control group. Most studies experience a certain level of participant dropout. Those in the experimental group were understandably more committed but of the initial number who responded to advertising (75) only 49 started the research program.

The control group met as a group in order to mitigate the possibility that joining a group regularly would in itself have an effect. The results showed that the control group did experience a significant increase in

Life Satisfaction, Environmental Mastery (PWB) and less *Negative Affect*, they also showed a positive trend in *meaning (OTH)*, *engagement (OTH) and self efficacy*, this mitigated the significance of the interaction between the groups in these variables.

The differences in effect between the two groups is most clearly seen when comparing the significant within-subjects effects results Comparing these results highlights the effects of the coaching intervention and shows that the workshops supported and encouraged self- discovery and pleasure over and above the more general positive effects the control group experienced. The number of participants was smaller than desirable as both groups had less than 25 in number. However, the results showed a consistent effect for the experimental group in comparison to the control group.

The study and positive psychology

Research findings show that the strategies healthy people use to further their own development are in contrast to many of the mainstream approaches employed among mental health professionals (Henry 2006, p.131). Jane Henry has found that the strategies people find most helpful to their personal development are practices and beliefs that encourage finding purpose in value based engagement, future orientation and a positive attitude to life and learning. These strategies were encouraged in the Life Club workshops and are very much in line with the key principles of life-coaching. Positive psychology is validating this marked contrast, starting with the perspective that the person at the centre of the research or examination is already fully functioning and examining what *enhances* and is common to positive functioning. Good coaching works emphatically from this perspective. 'The mission of positive psychology is to develop sound theories of optimal functioning and to find empirically supported ways to improve the lives of ordinary and extraordinary people' (Kaufman, 2006 p.219).

Conclusions

The present study may have benefitted from combining some qualitative research in order to flesh out more detail however it is the whole

package rather than its parts that was under scrutiny. The number of participants was small, however, that there were significant effects despite this, and in comparison to a control group, makes the study worthy of note. The close replication of Green's results is also significant. Green and Grunfeld designed their workshops very differently. Grunfeld has incorporated a wide variety of ideas into the life club format that draws on her own personal experience of what works (Grunfeld, 2006; 2007; 2009; 2010). Green on the other hand emphasises a cognitive psychological and academically informed design. That the results were so similar might imply that the effect of any time spent using coaching strategies that afford learning and development of the self in action will positively affect overall well-being and happiness. It might seem too obvious to say that time spent examining how we are living and being encouraged to become more proactive and cognisant of the choices we are making, is time well spent however one does this.

Quantitative positive psychology research has tended to focus on single interventions. This research has shown how just a short period of coaching, delivered as group coaching workshops, that allowed individuality and variety within the intervention design, can affect a significant number of well-being factors. The significant overall effect across all the measures taken together is evidence that the form of coaching under examination was effective and merits more research.

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Piloting a gratitude intervention in a community mental health team

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Abstract: 'Gratitude is not only the greatest of all virtues, but the parent of all the others' (Cicero). *Gratitude has been incorporated into a number of positive psychology intervention programmes, see for example Seligman's gratitude visit. While its anecdotal benefits have long been known, empirical evidence for the benefits of gratitude, has only been accumulating in the last decade. The authors piloted two gratitude workshops, with a month of gratitude diary keeping, for nine service users attending a community mental health team. Pre and post questionnaire assessment showed a number of positive benefits resulting from the intervention. Participants reported being thankful for more things in their lives, had improved Life Satisfaction, greater environmental mastery, and higher social feelings. All four changes were statistically significant. Separate vignettes provide feedback from the workshop organiser, a service user co-facilitator and a participant. Suggestions are offered for taking this work forward.*

Key words: *gratitude; thankfulness; positive psychology; workshops; CMHT*

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Introduction

There is a long tradition of the importance of gratitude in human relationships, that occurs both historically and cross culturally (Emmons, 2007). There are several definitions of gratitude, which as Emmons points out has been 'depicted as an emotion, a mood, a moral virtue, a habit, a motive, a personal trait, a coping response and even a way of life.' Emmons conceives of gratitude in two stages. First, it is the acknowledgement of goodness in one's life. Second, gratitude is recognising that the source of this goodness lies at least partially outside the self.

The historical tradition concerning gratitude is largely anecdotal. The motivational speaker Jack Canfield in his cassette 'Self-Esteem and Peak Performance,' talks about 'cultivating the attitude of gratitude.' Apart from feeling good by doing this, Jack argues it also makes good 'business sense.' If we have properly thanked an individual, they are more likely to help us out in future. Until relatively recently, there was no empirical evidence to back up assertions like this, so-called 'folk wisdom.' This changed with the publication of the seminal study of Emmons and McCullough (2003).

The Emmons and McCullough (2003) study was important for two main reasons. First, it used randomised controlled trial methodology, which is the 'cornerstone' of evidence based approaches. Second, it showed the powerful effects of gratitude, even following a monitoring only intervention. Emmons and McCullough in fact reported on three studies, two with college students and a third with patients who had neuromuscular disorders. In the first study, 192 college students were randomly allocated to three groups. Group 1 was asked to 'think over the last week...and write down up to five things that you are grateful or thankful for.' A second group recorded 'hassles' and a third 'life events.' After six weeks of monitoring, participants in the gratitude group had better well-being ratings, more positive expectations of the week ahead, had fewer physical symptoms and exercised more. As this study had involved only weekly monitoring, the authors decided to conduct a second study, but this time with daily monitoring. Again 157 college students were randomly assigned to a gratitude group and a hassles group. Instead of a life events group, they added a 'social comparison'

group. In this group participants were asked to 'think about ways that you are better off than others, things you have and they don't.' Again the gratitude group seemed to do best, having higher levels of positive affect and were more likely to have helped someone. The third study used a sample of patients with neuromuscular diseases. They were allocated to the gratitude group or a monitoring only group, where they just completed rating scales over a three week period. The gratitude group, again had higher levels of positive affect, which was also noted by their spouses or significant others, greater optimism, better social connectedness and surprisingly better sleep. The gratitude intervention in these three studies only comprised daily or weekly monitoring, which Emmons and McCullough stated represented a 'rather minimal intervention.'

A recent review of the gratitude field by the first author (Carson, 2010), found 58 studies over the last eight years. Most of these were American, with 31% being experimental studies. Only three papers looked at gratitude and mental health. Two of these were descriptive accounts of how gratitude might be a helpful adjunct to other interventions (Bono and McCullough, 2006; Nelson, 2009). Only one paper was empirically based (Toussaint and Freedman, 2009). These American authors looked at 72 psychotherapy outpatients in a cross-sectional questionnaire based study. They found that gratitude correlated highly with well-being and suggested that gratitude interventions might therefore enhance well-being. As yet, no intervention has been conducted with a mental health population that has focussed only on gratitude. The first author, JC, wondered could the gratitude work developed by Emmons and McCullough (2003), be applied with people experiencing mental health problems?

Method

Nine service users who attended a local Recovery Group (Morgan and Carson, 2009), at a local community mental health teambase, were invited to join the gratitude intervention.

The gratitude intervention

The intervention comprised two 2 hour workshops, a month of monitoring and attendance at a meal. The objectives of the workshops were to:

1. Gain a better understanding of the concept of gratitude.
2. See how the practice of gratitude might impact on each of our lives.
3. Explore the link between gratitude and mental health problems.

All participants were given a free copy of *Thanks: How the New Science of Gratitude Can Make You Happier*, by Professor Robert Emmons, (Emmons, 2007). They were also provided with comprehensive handouts. A week after the second workshop they were taken out for a three course meal at a local restaurant and given a £10 voucher for participating in the project. They were all expected to attend both workshops and to complete a gratitude diary for a month.

Workshop 1

This was facilitated by JC and MM. As we were doing introductions, and unprompted by the facilitators, participants not only introduced themselves but also gave their diagnoses. Three people described themselves as suffering with bipolar disorder, three with psychosis and three as having anxiety and depression. MM described, then asked participants, to complete the Life Thankfulness Review. They were given 10 minutes to finish this. JC then provided a scientific and literary overview of the concept of gratitude. MM then spoke about what gratitude meant for her. Each participant was asked to state what gratitude meant for them. MM then explained about the monthly monitoring and handed out the monthly diaries. All participants were given five 'Thank You' cards and stamps. JC then gave a brief summary

of the course book 'Thanks.' Participants were expected to monitor their gratitude for the month of April. Each day they were expected to write down three things they were thankful for and why? They also had to record who they sent their five 'Thank You' cards to.

Workshop 2

We started this by asking participants to choose what they wanted from the restaurant menu, for the following week. We then asked each of them to feedback on their experience of gratitude from the month of recording. We had also asked them to bring anything with them that reminded them of gratitude. One participant brought along a letter written by her grandson, after the death of his grandfather (her husband). Another spoke of sending one of his 'Thank You' cards to a friend he had not spoken to for many years. This friend had then called him and they renewed their friendship. SC then did a presentation on what gratitude meant for her. She showed the group the gratitude diaries that she had kept for several years. She then did a short presentation on well-being. She had the group take part in some exercises that had been used in positive psychology research, eg. reading the statements used in the famous Nun's study. After this, JC then thanked each participant individually for work they had done. MM asked people to complete the Life Thankfulness Review. The following week the group reconvened for a meal at a local restaurant. Here they were given certificates and a £10 M&S gift voucher. Two weeks later they were sent the study questionnaires. When these had been received and scored, AC provided each participant with an individualised feedback on their results.

Measures

All participants completed a batch of questionnaires before the workshop and two weeks after the meal. The measures were as follows:

1. *The Gratitude Measure*
   This is a six item scale (McCullough et al, 2002). Scores range from 6 to 42, eg. item 4, 'I am grateful to a wide variety of people.' Responses are scored on a 7-point scale from strongly agree to

strongly disagree. This measure is reported to be more of a measure of 'trait' gratitude.

2. *The Ryff Well-Being Scales*
   This is an 84 item scale devised by Professor Carol Ryff (Ryff, 1989). Items are rated on a 6-point scale, again from strongly agree to strongly disagree, unlike the Gratitude Measure, there is no neutral mid-point. The scale has six subscales. These are, Positive Relations with Others (eg. 'maintaining close relationships has been difficult and frustrating for me'), Autonomy (eg. 'sometimes I change the way I act or think to be more like those around me'), Environmental Mastery (eg. 'in general, I feel I am in charge of the situation in which I live'), Personal Growth (eg. 'I am not interested in activities that will expand my horizons'), Purpose in Life (eg. 'I have a sense of direction and purpose in life'), and Self-Acceptance (eg. 'in general I feel confident and positive about myself'). There are 14 items on each subscale and scores range from 14 to 84.

3. *Lambeth Well-Being Indicator*
   We extracted a 21 item scale from the pool of items that make up this scale, which was developed for evaluating community initiatives in Lambeth, by the New Economics Foundation (Lambeth is one of the most deprived urban boroughs in London). The scale covers four domains. Personal Feelings has six items, happiness, life satisfaction, optimism, self-esteem, depression and aspirations. Personal Functioning has five items and looks at autonomy, competence, meaning and purpose, resilience and interest in learning. Social Feelings covers social isolation, sense of belonging, respectful and fair treatment, social progress and social support. Finally, Social Functioning covers caring, altruism, volunteering and social engagement and participation (New Economics Foundation, 2008).

4. *The Life Satisfaction Scale*
   This has five items rated on a 7-point scale, eg. 'I am completely satisfied with my life,' (Pavot and Diener, 2009).

5. *The General Happiness Scale*
   This four item scale was taken from Seligman's book, eg. 'In general I consider myself to be...' 'not a very happy person' (score of 1), to 'a very happy person' (score of 7), (Seligman, 2005).

6. *Life Thankfulness Review.*
   This was given at the start of the first workshop and at the end of the second. Participants were all given a form which they had to complete in the session. It stated, 'When I think about my life at this point in time (today's date), I am grateful and thankful for the following things....' 'Write down as many things as you can think of.' They were given 10 minutes to do this task.

7. *Monthly Diary*
   Each participant was given a diary for the month of April. The instruction at the top of the diary read, 'For each day, write down three things that you are thankful or grateful for that have happened today and why? Try to do this at the end of each day.'

While some of the measures we utilised have extensive information on their reliability and validity, eg. the Gratitude Measure, the Ryff Well-Being Scales and the Life Satisfaction Scale, others were developed more theoretically and had 'culled' items from other established scales, eg. the Lambeth Well-Being Indicator. The Diary and Life Thankfulness Review, were developed just for this study.

Results and vignettes

1. *The Gratitude Measure*
   The average score on the Gratitude Measure at the start of the workshop was 30.56 (range 25-42). After the workshops the mean score was 29.75 (range 23-40). Two participants scored the same on both occasions, three improved and three scored worse. Interestingly 7/9 and 8/9 at pre and post workshops respectively, scored in the bottom 25% on this scale.

2. *Ryff Well-Being Scales*
   Table 1 shows the Ryff Well-Being scores for the nine participants. There were improvements on five subscales, but only one, Environmental Mastery, was significantly different. Taking a criterion of five points or more between pre and post scores, shows there were more improvers on each subscale, with the exception of Personal Growth.

Table 1
Ryff Well-Being Scores Pre and Post Workshops

Subscale	Pre	post	significance	improvers	worse
Positive Relations with Others	63.56	64.11	n.s.	4	2
Autonomy	55.98	60.00	n.s.	5	1
Environmental Mastery	42.11	46.11	P<0.05	5	1
Personal Growth	64.89	64.57	n.s.	1	1
Purpose in Life	51.00	51.89	n.s.	4	1
Self-Acceptance	44.00	49.33	n.s.	5	1

3. *Lambeth Well-Being Indicator*
   Participants improved at post workshop on all four subscales of the Lambeth Well-Being Indicator, though the difference was significant only for Social Feelings. Taking a criterion of three or more to denote improvements or any deterioration, shows that again more service users improved after the workshops.

Table 2
Lambeth Well-Being Indicator Scores Pre and Post Workshops.

Subscale	pre	post	significance	improvers	worse
Personal feelings	18.33	19.00	n.s.	2	0
Personal Functioning	14.22	15.44	n.s.	3	0
Social Feelings	14.44	15.56	P<0.05	2	0
Social Functioning	14.77	17.00	n.s.	4	1

4. *Life Satisfaction Scale*
   The average score before the workshops was 15.22. This had risen to 21.50 after the workshops ($p<0.05$). On this scale 7/9 participants scored higher after the workshops. No one scored lower on the second occasion.

5. *General Happiness Scale*
   The mean score before the workshops was 3.86. This was higher after the workshops at 4.37, though this difference was not statistically significant. Some 6/9 participants scored higher after the workshops, with only one scoring lower.

6. *Life Thankfulness Review*
   At the first workshop participants reported an average of 14.33 items that they were thankful for in their lives. At the end of the second workshop this had risen to 20.44 ($p<0.05$). All participants had higher scores on the second occasion, with the exception of one participant, whose scores went down.

7. *Monthly Diary*
   Seven out of nine participants returned diaries. Of these, three were 100% complete. One of these commented. 'Doing this exercise has helped me develop and maintain a more positive outlook.' Another noted, 'the intractability of depression doesn't necessarily mean that a recognition of gratitude means a lifting of mood.' The third stated, 'I'm not sure how much it helped me. I am already pretty grateful for things that I have, but maybe it deepened that gratitude.' Two returned almost complete diaries, one had 26/30 days completed, the other 22/30. One observed, 'On days when I was feeling negative, the diary helped pick me up a bit.' Two further participants were partial completers. One did 7/30 days and the other 12/30 days. Two participants did not return any diaries. In addition to the diaries, participants had been given five 'Thank You' cards and stamps, with a form to record who they sent these too. The three 100% diary completers, had also filled out this form and sent all five of their 'Thank You' cards. Another three sent 'six', four and three cards each during the monitoring month. Three participants did not complete this exercise. Indeed, one had tried to refuse to

accept the 'Thank You' cards at the start, claiming that recipients of the cards might expect them to do this later on as routine!

Vignette 1: The organiser's prespective. Jerome.

The Trust Member's Council came up with an idea called 'Can Money Buy You Happiness?' They offered to give up to £500 for any proposals from staff or service users that might improve happiness and well-being. I came up with the idea to run a short gratitude intervention for service users, based on research that showed the beneficial aspects of gratitude for well-being. However this was not funded. I was puzzled by this and asked what they had funded in the end. I received no reply to this query, but out of the blue, it was suggested that Tony Coggins would fund my intervention from his Health Promotion budget, at a cost of £380. I asked Margaret to help me facilitate the two workshops and a colleague, Sherry Clark, did some teaching at the second. The intervention ended with a meal at a restaurant, when all the participants received a certificate and a £10 M&S gift voucher. The issue of gratitude is one I believe passionately in, and it's my second personal 'signature strength' on the Petersen and Seligman strengths survey (see www.viastrengths.org). While I believed in the importance of 'cultivating an attitude of gratitude' from the work of Jack Canfield amongst others, this was based purely on anecdote. I was not aware that there was an evidence base, until I read a newspaper article, which cited the Emmons and McCullough study (Ben-Shahar, 2007). It had always struck me that some of our service users with serious mental health problems were unaware of the importance of gratitude. For example, after being successfully rehoused by the council, I mentioned to one woman that I was going to write and thank the Housing Department, something I'd never done before. She told me, 'Would you thank them from me?' In fact experience has taught me that many of our service users are very good at expressing gratitude. Some of our staff on the other hand…. I would be intrigued to run this intervention again but this time to do two sets of workshops with service users and two with groups of staff.

Vignette 2. The facilitator's perspective. Margaret

Never having been a facilitator, always a participant, I was faced with a big challenge and I was extremely nervous. Entering the room with chairs in a circle, I was faced with many familiar faces amongst the participants. I am not sure whether this made it easier for me or not. Not long after starting the gratitude workshop, I was introducing one of the experiential exercises. Jerome stopped me and said 'Margaret, that's not the right exercise!' This could have been very embarrassing, however the participants 'roared' with laughter, which broke the ice, and from then on I was more relaxed.

Later on in the workshop, I shared with the participants many of the things we should all be grateful for. Sunrise, sunset, the stars, everything about Nature, family, friends. The sun setting through my living room, which gives a beautiful glow in the half light at dusk etc.

After the two workshops were over, I received a few 'Thank You' cards, one of which said, 'I am now thankful for things that I've never been thankful for before.' It was then that I realised that my involvement in the gratitude workshop hadn't been in vain.

Since the pilot study, I have sent many 'Thank You' cards to many people. It makes them feel appreciated for what they do for others and I get a warm glow from this. At times I still have to remind myself of all the things I have to be thankful for. I'm sure the workshops have been of great benefit to the participants and I am looking forward to co-facilitating more gratitude workshops.

The participant's perspective. Elizabeth

When I was asked to join the gratitude workshop I was both apprehensive and sceptical, because I had never been involved in such a project before and certainly didn't regard myself as a 'groupie'. However I found it a very positive experience in many ways.

Firstly, because I was involved with a group of people who had all sorts of different mental health problems but were focusing on the subject in hand and I got to know a number

of them quite well, some of whom have subsequently become friends.

Secondly, because it gave me some insight into distinguishing between what I had been brought up to - i.e. polite gratitude ('Thank you for your gift', 'Thank you for having me') and real heartfelt gratitude, where you really recognise and acknowledge the contribution someone else has made to your life, however small, and the importance of saying that to them and not just to yourself. (Though it has to be said that when a friend was looking after me when I had a hip replacement last December, she did say to me 'For goodness' sake stop saying thank you!' - but maybe that was her problem rather than mine!). And I did write my gratitude diary assiduously each day, which made me think, even if it made for pretty boring reading.

And thirdly, because it gave me the opportunity to do some reading on the subject. Robert Emmons, whose book 'Thanks!' we were given to read, provoked a pretty hostile response in me, because of his sanctimonious and judgmental approach. He talks of ingratitude as 'a profound moral failure' and 'an unnatural crime' and cannot understand why the Iraqi football team at the 2004 Summer Olympics did not express deep gratitude to the Americans for liberating their country, but were instead outspoken in their disapproval. Martin Seligman, whose books were not prescribed, I found much more congenial, interesting and informative, if a bit too reliant on quantification (Seligman, 2005).

On the subject of quantification, unlike most other participants, I didn't score significantly higher on the final tests than on the preliminary ones. But nevertheless I gained a great deal from the experience. One cannot necessarily quantify the immeasurable - the infinite variety of the human mind and spirit.

Discussion

As this was a gratitude intervention, the most important measures from the evaluation are those pertaining to the measurement of gratitude. The fundamental question to ask, is did the gratitude intervention lead to improvements in the levels of gratitude of participants? The findings on this were mixed. On the six item Gratitude Measure, there was no change in scores after the study. Looking at the American norms, 8/9 of the study participants still scored in the bottom 25% of the population at the end of the study. While there may of course be cultural differences in the expression of gratitude, this does not explain the lack of change. It seems more likely that the Gratitude Measure is a measure of 'trait' gratitude. It is unlikely that such a short intervention is going to change specific personality traits. In contrast, there were significant improvements on the Life Thankfulness Review measure. At the start of Workshop 1, participants reported being thankful for an average of 14.33 things in their life at that time. At the end of Workshop 2, this had risen to an average of 20.44. Some 8/9 participants improved on this measure. This is a 'state' measure of gratitude and was probably positively influenced by the group experience.

The main feature of the Emmons and McCullough (2003) studies was self-monitoring. They suggested theirs was a 'rather minimal intervention.' Two of our nine participants did not complete the self-monitoring, and only three completed their diaries each day. Completing diaries every day proved difficult for several of our mental health participants. Of the authors, EW and MM, have both completed diaries over this time period, while JC and SC have completed gratitude self-monitoring for a year and longer. In her vignette, EW commented, that while she 'did complete my diary assiduously every day,' she found this to be quite repetitive. Lyubomirsky (2007), recommends weekly gratitude monitoring, which might be more effective if conducted over a longer period.

Toussaint and Freedman (2009), suggested that gratitude interventions might enhance well-being. We found some support for this idea. On the Ryff Well-Being Scales, there were improvements on most subscales, yet the differences were significant only on Environmental Mastery. On the Lambeth Well-Being Scales, there was a significant improvement on Social Feelings. Similarly General Happiness levels

and Life Satisfaction were both better after the intervention, but only the latter was a significant difference.

This is the first study that has evaluated a gratitude intervention with a mental health population. Indeed it is the only published study to date (Carson et al, 2010). It is however only a small pilot study and as such has a number of methodological shortcomings. First, it involved only nine service users. It is really not possible to generalise from this small group to the wider mental health population. Second, participants were chosen by the first author, which may have introduced a selection bias. Third, there was no comparison or control group. Fourth, the study added more elements than 'the rather minimal intervention' of Emmons and McCullough (2003). Participants attended two workshops, received a copy of Professor Emmons' book, were taken out for a meal and received a gift voucher. Fifth, there was no follow-up, so we do not know if the benefits of the intervention lasted. Last, there was no qualitative element to the evaluation. As EW also points out in her vignette, there were probably changes taking place in participants that were not picked up by the quantitative measures used in the study.

Conclusion

This study, though a small pilot study, is the first to use gratitude as an intervention with a group of mental health service users. The results of this study show some promise, with significant improvements in 4/14 possible pre-post intervention comparisons. It is worth conducting a further test of the intervention, probably based on weekly rather than daily gratitude monitoring, and addressing some of the methodological shortcomings of the present study. The approach described in the paper could just as easily be applied to mental health professionals and it would be intriguing to apply it to a staff group as well as service users.

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The Personal Synthesis Programme:
Being positive with people who are HIV positive

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***Abstract**: The Personal Synthesis Programme (PSP) is a comprehensive programme of personal development that addresses universal areas of human life such as emotions, thinking, self-regulation, confidence, coping, motivation, communication, relationships etc. Each of these areas is approached on theoretical, practical, reflective and interpersonal levels. The aim of the programme is to increase the sense of control and self-direction in participants' lives. The programme has been run with HIV+ participants for the last six years. It has consisted of weekly two-hour sessions throughout an academic year. PSP has been evaluated using a triangulation method. The evaluation has shown significant gains in the areas of self-awareness, internal control, emotional control, optimistic outlook, confidence, awareness of others and relationships.*

Key words: 'Personal Synthesis'; 'HIV+'; 'Personal Development Programme'; 'Positive Psychology'

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Introduction

Personal Synthesis Programme (PSP) is a systematic and comprehensive programme of personal development that integrates cognitive, affective, behavioural and social aspects. The programme focuses on developing qualities such as handling emotions, building confidence, making decisions, dealing with anxiety, coping with stress, communicating effectively, forming constructive relationships and so on. It enables individuals without a psychological background to apply findings from psychology and related disciplines to their everyday lives. PSP has been implemented in a number of educational institutions and other organizations (Popovic & Boniwell, 2006), but the focus here will be on running it over the last six years at Positive East, one of the major HIV+ centres in the UK.

It should be clarified at this point that PSP does not directly address HIV related issues (although some of them inevitably emerge in discussions). Neither is its aim the ubiquitous concept of well-being. Such an aim would be either too vague or not universal enough (well-being may mean a different thing for a gay Londoner and a Catholic African immigrant with two children). The purpose of PSP is to empower participants to deal with life challenges on their own and to be more competent in personal matters, which is more likely to be effective than assuming that we know what their problems are and what the best way to manage them is. To put it simply, the aim is to enable participants to be more in charge of their lives, so that they can choose a direction in accord with their own sense of well-being. This is achieved through increasing their skills, understanding and knowledge of various ways they can relate to themselves and the world around them. There is unambiguous evidence that fostering an internal locus of control has positive effects (see, for example, Charlton, 1988) and reflects the non-prescriptive facilitation of optimal functioning advocated by Linley and Joseph (2004).

The content of the program

In accordance with the above aim, rather than starting from the outcomes that are supposed to be produced in participants, the programme

focuses on basic areas of human life, underlying 'building blocks' (such as thinking, feelings, decisions, desires, coping, motivation, behaviour, communication, etc.) that comprise other complex experiences. This has several advantages:

- The ability of individuals to deal with challenges they face is largely based on these underlying components. For example, how somebody will respond to recreational drugs depends on a number of factors such as: openness to new experiences, an ability to distinguish between being daring and reckless, susceptibility to peer pressure, recognizing one's motives, balancing one's feelings, developing self-control, accepting responsibility for oneself, relating to pleasure and one's own body. If these factors are not attended to, there will always be a 'weak link' that would render a direct approach to drug-abuse ineffective.
- Addressing participants' problems directly can be perceived as patronizing and obtrusive. Starting from general topics may be a better way to motivate them to face and deal with their situation in a constructive way.
- Concentrating on the basic areas of human life makes the programme relevant to all participants (from different cultural backgrounds, for example) and yet sufficiently flexible, so that they can adapt it to their personalities and circumstances.
- There are a limited number of these areas, whereas there are an unlimited number of their combinations. Therefore, this approach enables the programme to be comprehensive, despite inevitable time constraints.

Several criteria are used to identify these basic areas:

- *Irreducibility:* the areas included are those that cannot be reduced to other areas of life or their combinations (without losing their essential qualities). For example, each of the factors related to drug-abuse that are mentioned above is a part of the program, but drug-abuse itself is not, because it can be reduced to their combinations. This criterion is important to avoid overlap or repetition.
- *Universality*: each area plays a part in the life of every individual regardless of their culture, beliefs, inclinations or personal qualities,

so they are relevant to everybody. This also means that they are 'timeless', therefore pertinent to any future that may come.

- *Transferability:* the relevant knowledge and skills are not specific, but can be applied in a wide range of situations.
- *Comprehensiveness:* all of the areas should cover the totality of human experience, leaving no gaps. This is vital because they are connected and affect each other.

The topics, or areas, are organised in four categories (four modules):

- *The Personal category* is normally the first module in the programme. This is because the other categories rely on it to some extent. It includes a number of areas that relate to persons themselves, starting with *Self-awareness*. The main focus in this area is on the obstacles to self-awareness (e.g. self-deception) and methods to overcome them. The next one, *Relating to oneself,* addresses self-acceptance and self-rejection (and also guilt and shame), while *Self-evaluation* deals with self-esteem and self-respect. Further on, this category includes areas related to affect (e.g. *Emotions*, *Moods*), cognition (e.g. *Learning*, *Reasoning*) and personal integration (e.g. *Harmonization*).
- *The Being category* incorporates the areas that relate to our life experiences. Some examples are: *Courage* (the purpose of fear and courage, and methods of controlling fear), *Pleasure* (the difference between pleasure and happiness, and what leads to fulfilling pleasures), or *Interest* (dealing with boredom). This category ends with the group of areas that are associated with the perception of one's life situation (including the present, the past and the future).
- *The Doing category* includes the areas that relate to choice and deliberate actions. The first group of topics in this category deals with the issues of meaning, personal freedom and responsibility, and also decision making. Another group (that includes *Strategy*, *Achievement, Coping and Control*) is dedicated to problem solving. The rest is mainly concerned with motivation, goals and effective performance (e.g. *Organization* discusses time management and planning).
- *The Social category* is mainly concerned with relating to others. It depends, to some extent, on the other categories and also overarches them. This category includes areas such as *Belonging* (which is about

being a part of a group) *Awareness of others* (listening, observing, empathy), or *Relationship dynamics* (starting and ending relationships and resolving conflicts with others). The Social category (and the whole program) ends with examining different types of relationship: intrinsic (friendship), instrumental (e.g. professional relationships) and intimate relationships.

At first glance, the number of areas may look overwhelming (64 altogether). No doubt that for all practical purposes it would be much easier to narrow the focus. Indeed, there have been many attempts to reduce personal development to one or a few elements: values (Ward, 1982, p. 135), critical thinking (Ennis, 1993), self-esteem (Nuttall, 1988), wisdom (Reznitskaya & Sternberg, 2004), problem solving (Priestley et al, 1978), or moral behaviour (Pring, 1984). However, there does not seem to be a panacea of personal development that would be the answer to everything, because various areas of life relate to and affect each other (negatively and positively). A comprehensive approach can help participants to deal with many personal and interpersonal issues, some of which may not be foreseeable in advance. The two-dimensional model of all the areas and their categories can be found in Popovic (2005).

The structure of the session

Each of the above areas is approached on three levels: theoretical, practical and reflective. A well structured session contributes to the motivation of facilitators and participants alike. However, the priority remains to engage participants in considering the subjects in relation to their personal experiences, so this structure is fairly flexible.

The theoretical level consists of relevant information about a particular area drawn from psychology and other related disciplines. Pieces of information that have mainly academic value are not included, but only those that can be utilised by participants in their everyday lives. For example, in the area *Emotions*, rather than focusing on the neurophysiological basis or psychological models of emotions, various ways of regulating emotions are examined. Wherever it is feasible, materials present the whole spectrum of possibilities, so that all

participants can find something relevant for themselves (e.g. those who lack self-confidence, as well as those who are overconfident). The materials are also constructed in a non-biased, balanced way to minimize any possible indoctrination. Both, desirable and undesirable aspects of each area are examined (e.g. sincerity and lying in the area of *Communication*). This has several advantages: it enables better awareness and control over participants' own actions and motives, it enables better recognition of the motives and actions of other people, and it preserves participants' autonomy.

The practical level introduces various methods and interventions that can increase the awareness, quality of experience and mastery of an area. A wide range of techniques are included (from relaxation and meditation, to brainstorming and conflict resolution). All of them - and there are over a hundred exercises all together - are designed in such a way that participants can continue using them on their own.

The reflective level: there are some aspects of human life that do not have universal answers. The choice will always depend to some extent on subjective, personal experience. On this level, participants are encouraged to consider some questions relevant to the topic and engage in a reflective activity which can help them to clarify their views and values and integrate their personal experiences.

In addition, the interpersonal level also plays a significant part– participants are encouraged to engage in discussions, share their experiences and learn from each other. In a few occasions this also has led to 'grass root' initiatives such as going to the gym together, or helping each other with temporary accommodation, job hunting or babysitting.

Teaching Methods

The activities sometimes involve the whole group, working in pairs or small groups. A variety of methods are used: presentation, questions, discussion, instruction, exercises and writing. This is necessary because effective programmes need to involve every aspect of the person: perceptive, cognitive, affective and behavioural. Different participants are also inclined towards different ways of learning, so it is easier to engage them if they can find a learning mode that suits them. Furthermore, the sessions need to be adapted to participants'

cognitive and language abilities, so in some cases activities such as games, role playing, telling stories and drawing need to be emphasized over the presentation. Such an approach enables building confidence, sensitivity, openness, concentration and trust, as well as raising self-awareness, self-esteem and awareness of important personal and social issues. Participants are encouraged to be pro-active throughout the session by making suggestions, sharing experiences, expressing doubts and conflicts and receiving help and encouragement from other participants and the presenter in resolving them. This requires a non-judgmental, open and supportive atmosphere. Once the method becomes established, participants usually express a real desire to work in this way.

Implementation with HIV+ participants

The programme is run throughout the whole academic year in the premises of Positive East. The sessions are held weekly and last two hours. Normally, two topics are covered per session. Each module lasts eight weeks totalling thirty three weeks (with one introductory session). This length contributes to achieving sustained personal changes. The participants join the programme on a voluntary basis and receive a certificate at the end of the course, based on their regular attendance. The programme has been run for six consecutive years.

- *Participants' background*. Participants in the first group were mostly African females, but subsequent groups reflected the mix of white gay participants and African men and women, which has had an interesting (and sometimes even amusing) effect on the dynamic of the groups. Different religious orientations are usually found within the same group (Muslim, Catholic, Protestant, Hindu, Atheist). The age varies from early 20s - 60s.
- *Social and economic background*. The majority of participants have been from socially and economically deprived backgrounds, many of them are in receipt of welfare benefits and a significant number have been newly arrived immigrants, asylum seekers or refugees. Besides their health, many participants have been facing other difficulties: housing problems, unemployment, isolation,

immigration problems, drugs issues and homophobically motivated physical attacks. The most important issues for many are a lack of confidence and coping with their present situation.

Abilities and psycho-behavioural profile: language and cognitive abilities varied from individual to individual within a group, from high to very low. Similar differences could be recognized regarding participants' emotional intelligence, social skills and personal awareness. Some of them had learning or emotional-behavioural difficulties. A number of participants have been already in counselling, several were on medications and some have decided to use counselling services in parallel with attending the sessions.

Evaluation and Feedback

Considering that Positive East is a service provider, it was impossible to have a control group. A multiple triangulation approach has been employed, consisting of participants' evaluations (focus groups, written testimonies, a questionnaire); observations (by the facilitator and external observers); and monitoring behavioural changes.

Participants' evaluations

Focus groups: The participants who took part in this type of evaluation process stated that they found the PSP sessions very useful because they made them more aware of their feelings, able to control their emotions better, and be more confident. They also benefited from understanding different cultures and learning not only from the facilitator but from each other too. The participants reported that the PSP has helped them learn how to work in a group, which they could apply elsewhere. Most of all, they enjoyed finding out about themselves and others, how to respond to certain situations and practical activities and exercises.

Evaluation forms

The programme has consistently received a mark of 'excellent' (or equivalent) in evaluation forms completed by participants in compliance with the requirements of the organisation.

Written testimonies by participants

Interpretative Phenomenological Analysis (IPA) was used to analyse 27 testimonies from participants about their experience of the programme. The researchers were interested in individual perspectives, as well as searching for commonalities in the data, which is why IPA was selected. This method has been originally developed and used largely within health psychology, but is utilized widely nowadays in various other areas of psychology (Smith, 1996). IPA is used to explore participants' personal lived experience and how they make sense of it (Smith & Osborn, 2003). The emergent themes were identified from the testimony data, which were then organized into the following super-ordinate themes:

- *Awareness* (of self, situation, others), e.g. 'I believe that this course has really helped me to be aware of my feelings, to listen to my feelings and to others, especially those closest to me…'
- *Control, being in charge of one's life*, e.g. 'My life is in a shambles but with this course I am more able to control temper and pain.'
- *Confidence*, e.g. 'I have the tools to work towards achieving my aims, without making it feel like a strain. I feel more confident.'
- *Coping*, e.g. 'I have learnt new ways of relaxing when I am feeling stressed. I am now able to sleep better because of the exercises I have carried out.'
- *Broadening the mind, new ways of looking at things*, e.g. 'The programme has helped me immensely in terms of opening and broadening my mind. I am more aware of the society and the surroundings that I am living in. Also it has given me confidence, which I need when communicating with others.' 'It is an interactive, friendly way to improve your being and your life. It really makes me see things differently.'
- *Acceptance* (of self, situation, others), e.g. 'Being in the same class with Muslims made me realize that we are not so different'
- *Communicating better, expressing feelings*, e.g. 'It is now much easier for me to tell others how I feel.'
- *Increased optimism*, e.g. 'I am more optimistic about my future.'

Questionnaire

This small scale evaluation study employed a survey design using

a facilitator administered questionnaire. A 21-item questionnaire, designed specifically for the evaluation of this programme to measure self-awareness, satisfaction with life, internal locus of control, emotional control, confidence, optimism and social competence, was completed by participants at the beginning and at the end of the course. The analysis was based on a sample of 58 participants. Comparisons of means at pre- and post-test demonstrated significant gains in optimistic outlook, confidence and emotional control scores. Improvements were also noted in scores for most other items. This is consistent with the results obtained using qualitative methods. However, although these results were encouraging, it is not possible to attribute them solely to the PSP because of the lack of a control group.

Observations

The facilitator's observations have been based on retention, participation, and the group dynamics. Considering the length of the programme, retention has been very encouraging except in two groups that started with relatively small numbers of participants. However, objective factors such as health problems, housing relocations (in the case of immigrants) and re-employment, have had a negative effect on retention. Participation, active involvement and implementation of what was learnt steadily increased throughout the year in all the groups. A greater degree of group cohesion and trust was also noticeable in most cases. Some participants continued contacts outside, and many expressed a desire to do the course again.

- Evaluation by external observers: the programme was evaluated on several occasions by external observers sent by the educational institution that was initially involved in funding the project (Tower Hamlets College). These are relevant extracts and summaries from one such report:
- *Teaching*: 'A very warm, lively, responsive and engaging atmosphere. Good drawing of knowledge of the subject and good use of examples/strategies. Good relationships formed with the group, use of names, full affirmation of individual contributions and good use of humour. Strategies given were useful'.

- *Student response and achievement*: 'Participants engaged well and interested. Newcomers integrated quickly and well'.
- *Summary*: 'Subject and style of delivery entirely appropriate to the group. A positive and informative session, which people clearly enjoyed'.

Behavioural changes

The following tangible behavioural changes commonly occurred during or after the programme: a number of participants (who were able to do so) embarked on voluntary or paid jobs; most of them made some constructive changes regarding their physical health (starting to exercise, reducing or abstaining from smoking, alcohol and recreational drugs consumption); in some cases the use of anti-depressants have been reduced; improved relationships, especially with family members, have also been reported. Some of these changes have been long term, as evidenced by participants who continued using the facilities of the centre after they finished the programme.

Conclusion

Focusing on their personal development rather than their condition seems to be beneficial and welcomed by participants with a HIV positive status. The evidence indicates that addressing basic and universal areas of human life can contribute to the personal development of participants regardless of their age, gender, nationality, cultural background or religion. Evaluation of the programme has shown that significant gains have been achieved in the areas of self-awareness, internal control, emotional control, optimistic outlook, confidence, communication skills, awareness of others and relationships. Also, greater degrees of self-identity and independent thinking, and a better awareness of peer, family and other social issues were observed. However, there was a noticeable difference between those who were implementing theoretical/reflective insights or practical exercises regularly and those who were doing so in an ad-hoc manner. Moreover, since there was no control group, the above findings cannot be taken for granted. In any

case, there is no doubt that the programme heightens the awareness of psychological and personal matters and provides a 'space' for sharing. It also strengthens participants' sense that they can actively affect and control their psychological well-being, rather than feeling victims of their circumstances. As one HIV+ participant commented, 'The programme has helped me to become more positive!'

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The *Recovery Model* or the modelling of a cover-up?

On the creeping privatisation and individualisation of *dis-ease* and *being-unwell-ness*

Christopher Scanlon[1] and John Adlam[2]

***Abstract**: In this article we present a psycho-social, 'group-ish' (Bion, 1961) and philosophically Cynical commentary upon contemporary notions of* recovery, well-being *and* positive psychology. *These are, at times, being cynically deployed to address profoundly damaging processes of social traumatisation that give rise to certain forms of mental dis-ease, which we describe as 'being unwell-ness', and related* psycho-social dis-ease *which is being linked to low productivity, under- or unemployment and low social status, and that we describe as* worklessness *and* worth-lessness. *We state at the outset of the paper that much excellent work is done by statutory, non-statutory and service user led groups and organisations to engage with these problems. However, in our commentary we will suggest how the language and currency of these initiatives are in danger of being hi-jacked and side-tracked by the vested interests of explicit and tacit political and professional agendas of the* in group *at the expense of those whom we seek to help.*

***Key words**: recovery; well-being; work-lessness; worth-lessness; psycho-social; dis-ease; privatisation*

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Introduction

> In a country well-governed, poverty is something to be ashamed of. In a country badly governed, wealth is something to be ashamed of. (Confucius)

The twinned concepts of 'recovery' and 'well-being' in mental health have moved a long way from their roots in the survivor movement to the current position. They have now become well and truly colonised by the mainstream of mental health provision (Rancière, 1991, 2004; Pelletier, 2009a, 2009b), often under the professionalising agenda of 'Positive Psychology'. Many mental healthcare organisations are rolling out a whole raft of generic and specific recovery and 'well-being' projects to enhance the steady process of empowerment and the enabling of service users to take back control and responsibility over their life and their treatment (CSIP et al, 2007). This drive to 'recover' and to 'be-well' is underpinned by the overtly stated intrinsic link with 'social inclusion' and perhaps also with the neo-conservative values of the so-called 'Big Society' (Brooker et al, 2011 in press).

To paraphrase the famous American idiom, our position is that we too 'love motherhood and apple-pie', and in this spirit welcome any and all meaningful attempts to engage those of us who dwell at the edge of our deeply divisive society and to improve the quality of service provision that seeks to address their needs. However, we consider that the 'Positive Psychology' approach to recovery, well-being, and social inclusion is epistemologically flawed and in its application is in danger of becoming politically and professionally over-determined. One hypothesis is that, as a result of the political over-determination of this highly professionalised version of the recovery model, it has become at best psycho-socially de-contextualised and is in danger of becoming positively damaging to the self-esteem of some of those it purports to help. We might even go so far as to suggest that philosophically it is in danger of becoming an approach that colludes with the asocial and anti-social acts of larger scale political failures, which have resulted in widespread social malaise and brought about a recession that is not quite a 'depression', from which the whole of society is struggling to 'recover' and which is in imminent danger of decimating the welfare state in the UK (Cooper & Lousada, 2005; Dartington, 2010).

The survivor movement conceived of recovery (with a small 'r') as a challenge to the oppression of the psychiatric model of diagnosis and of symptom reduction/removal, but the current emphasis on Recovery is increasingly located in 'Clinical and Academic Groupings' that are, once again, being organised and structured around notions of medical diagnosis and rather narrow interpretations of evidence-based health care – nodding in the direction of 'service-user empowerment', whilst simultaneously slashing the provision of services for them. In this sense, we will argue that the recovery approach is in grave danger of becoming a professionally governed fig-leaf to cover-up the political failing and consequent limitations of our chronically under-funded mental health system.

We further suggest that 'recovery' is, in part, being promoted in order to shove the responsibility for 'being-unwellness' [sic] onto the sufferer, so that when they do not recover in proper order (as many do not), this can be seen as their failure rather than ours. 'Recovery and support teams' find themselves addressing only how to recover from the so-called 'positive symptoms' and need not think too long or too hard about how to provide meaningful support for those left with so-called 'negative symptoms', or those who cannot or do not recover and be-well (Cooper & Lousada, 2005; Dartington, 2010).

The language of the recovery approach may well be gentler and apparently more inclusive, but, like all colonising tendencies, it progresses by ensuring that 'the establishment' continues de facto and de jure to define the legitimacy of the complaint, through diagnosis, and to set out the terms on which the 'service user' is to be included (or left out in the cold), depending on their ability or willingness to recover or to be-well, according to the terms and conditions defined by the establishment (Rancière, 1991, 2004: Pelletier, 2009a, 2009b, 2011 in press).

Reclaiming pessimism and a *proper* Cynicism

The philosopher and social commentator Roger Scruton (2010) recently warned against the dangers of false hope and suggested ways in which pessimism, or in our terms a proper philosophical Cynicism (Scanlon and Adlam, 2008, 2011a, 2011b), could and should be elevated

to the status of a virtue in this positively-deluded post-modern world. He suggests that hope 'untempered by the evidence of history' is a danger that threatens, 'not only those who embrace it, but all those within range of their illusions' (Scruton, 2010: 1). In a similar vein Barbara Ehrenreich (2009) challenges what she sees as the over-valued and over-determined discourses of positive thinking and its proponents and argues persuasively that the movement was a chimera, a smoke-and-mirrors magic trick that has 'fooled America and the World'. In taking up these positions both of these writers are arguing against the grain of the dominance of the positive psychology movement, which argues that unhappy individuals could, if they put their mind to it, change and be made happier.

In this article, whilst acknowledging from the outset that there are very many excellent, creative and innovative psycho-social intervention projects being offered under the contested rubrics of 'recovery', well-being and 'social inclusion' initiatives, what we are offering is a necessarily generalised psycho-social critique of some of the problematic political and professional assumptions which underpin these approaches. We will illustrate our critique with reference to three of the many offspring of this movement: the 'recovery approach'; the concept of 'well-being' and its relationship to mental illness; and the 'Improving Access to Psychological Therapies (IAPT)' initiative, each of which purports to present the utilitarian argument for a modern version of happiness (Layard, 2003, 2006).

We will try to understand why approaches such as these might, at best, have limited impact, particularly on the more complex and severe mental health and social problems that we have discussed in greater detail elsewhere (Adlam and Scanlon, 2005; Scanlon and Adlam, 2008, 2009, 2011a in press, 2011c in press). We root our explorations in psycho-social and psychodynamic hypotheses about how these limitations can be understood as a systemic failure to recognise and give due respect to the fact that, at any given time, there will always be some of us that are only able to take up their membership of the social group by standing in opposition to it or at its edge. In analysing the processes and mechanisms of Recovery, well-being and social inclusion/exclusion in these ways, our focus is also on the dynamics of the welfare state and the systems of care which stand in intimate relationship to this refusal to join in.

We construe the psycho-social problems emerging from these dynamics to be expressions of institutionalised forms of reciprocal violence that are played out between us and them in a world where it seems to be desirable and normative for the rich to get richer and the poor to get poorer. We consider that these dynamics are so entrenched that it is no longer clinically relevant who started it or who is doing what to whom. In particular we are interested in the psychodynamics of splitting phenomena within individuals, teams, organisations as well as the wider social systems which serve inadvertently to 'cover up' and exacerbate the underpinning psycho-social and socio-economic conditions whilst simultaneously striving to promote Recovery, Well-being and Social Inclusion.

Improving Access to Psychological Therapies for work-lessness and worth-lessness

> Everyone in our society has a right to make choices about how they live their lives and contribute to the communities in which they live. Unfortunately, for many people who suffer from depression and anxiety disorders, these opportunities are often limited … As a society, we cannot allow this situation to continue – it is a tragic waste of the lives and potential of the individuals and families … It is also expensive to the taxpayer and businesses which must bear the costs of inadequate NHS treatment, loss of employee productivity and benefit payments to long-term sufferers. (DH, 2007: 2)

These were the words with which Patricia Hewitt, then Secretary of State for Health, announced the introduction of the IAPT programme 'to promote social inclusion and improve economic productivity' (DH, 2007: 5). Cognitive Behavioural Therapy (CBT) was to be rolled out across the nation, at significant cost to the taxpayer, as a panacea for the treatment of the unemployed and the relatively unproductive, despite the very limited or biased claims for its effectiveness or efficacy noted respectively by Lynch et al (2010) and Cuijpers et al (2010). The clear implication of this policy is that under-employment and worklessness – or worth-lessness (Adlam et al, 2010) – is related to the failure of individuals' cognitive functions or their failure to act, as compared with

the free market-embracing 'lifestyle choices' of the so-called 'decent, hard working family' so beloved of our contemporary political ruling classes.

We note what is superficially the paradox that the most socially excluded, least 'productive' section of the population, explicitly targeted by the then Labour government in its policy statement, are those for whom the IAPT clinical programme is least suited. To glimpse who we might be speaking of here, we note that the IAPT programme discovered reasonably quickly that 'one size does not fit all' and other brief intervention models such as Dynamic Interpersonal Therapy (DIT) are now starting to be offered alongside more explicitly cognitive treatments (Lemma et al, 2010; Gelman et al, 2010), although there is also anecdotal evidence that DIT has a fraction of the monies made available to the CBT practitioners to enable workers to be trained in this modality.

Although this initiative might provide some evidence of efficacy and effectiveness (Clark et al, 2009), these findings need to be contextualised in ways which mirror the relative success and failure of other high-profile social inclusion initiatives such as Sure Start, which was set up to reach out to disadvantaged children and families. The evaluation of Sure Start was that it was found to be helpful for those who were able to avail themselves of it; however, not only did it fail to reach its intended target of those families who were living closer to the edge, but at times it was positively deleterious to have Sure Start in their neighbourhood (Rutter, 2006; Belsky et al, 2007). Unlike Sure Start's espoused and intended aim to reach out to those most in need, IAPT has clearly stated criteria that actively excludes the more complex patients and so denies them the possibility of improving their access to psychological therapies, at least through its portal. What both of these initiatives have in common is that, by happenstance or design, they end up excluding or denying services to those who are, or experience themselves to be, too complex (Gelman et al, 2010).

Elsewhere (Scanlon and Adlam, 2008, 2011a, 2011b) we have explored the long history of the vilification and violent exclusion of the homeless and workless, which has its origins at least as far back as the Enclosure land reforms of the late Middle Ages and which has been legislatively enshrined in the Poor Laws, the Vagrancy Acts, especially that of 1714, the laws on intentional homelessness and other similar

measures: all the way from Karl Marx's observation that an unlicensed beggar could be executed as an enemy of the common weal if he was caught three times, through to the current Coalition government's proposals to enforce a 'three strikes and you're out' rule upon benefit claimants who are held to have intentionally refused work. Arguably not much has changed, except that the aim and focus of the retaliation for the terrible offence of having no work has moved away from the body of the offender and towards his mind (and his pocket) (Foucault, 1977).

Slavoj Zizek (1997) argues that societally we hold contradictory conceptualisations about unemployment and welfare benefits: we understand that unemployment is a function of economic and socio-political processes both locally and globally, but we also respond to it as if to a personal, essentially moral failure. In this way a public, social dis-ease has been privatised and personalised as individual psychopathology or disease, and so by a socio-political sleight of hand the individual, not the state, is responsible for the consequences and sequelae of the undoubtedly depressing failures of our social and political infrastructures (Dorling, 2010; Dartington, 2010; Fisher, 2009). This in turn provides justification for the granting of professional license to positive psychologists to be deployed against what is construed as the real enemy of the common weal – the faulty cognitions and behaviours of depressed and failing individuals. It also provides a political justification for 'Personalised' direct payments and individualised budgets (Department of Health, 2006, 2007, 2010) that service users can use to 'shop around' for the best value (brief) psychological treatments which are increasingly only 'on sale' from government approved 'positive psychology' and 'well-being' practitioners. We do this at the same time as offering redundancy to benefits and housing support workers – as was the case in one Community Mental Health Team to which one of us consults (Adlam et al, 2010).

Positive psychology: Spinning the evidence?

The workless, then, are not to worry, they must be happy: and in their happiness and well-being, to realise that what is missing in their lives is a chance to 'get on their bikes' or 'on the bus' (as one government MP recently suggests), and seek the sort of 'Positive Psychological'

interventions that will help them find gainful employment. But if they are unfortunate enough to be driven 'mad' by the lack of work, the insufficiency of these personalised budgets or the lack of affordable social housing and find themselves in need of respite, this too should not be a source of concern because, in an almost Orwellian double-speak, we are *positively* reframing and renaming those stigmatising and distressing psychiatric hospitals as 'well-being villages' and fully integrating them into a *Community* which is no longer afraid or judgmental about those who find themselves in these distressing states of 'being-unwell-ness' [sic]. Our observation is that these processes of renaming, *reframing, personalisation* and *recovery,* are increasingly being used to cover-up the underlying socio-economic factors which are the root cause of this very real psycho-social dis-ease, the economic short-falls in properly funding our welfare services, whilst simultaneously re-locating *the problem* into individuals' cognitive, behavioural or moral failing and then treating it as if it were *over there.* This gives the illusion that 'being-unwellness' is being taken seriously, and that it will be solved in such a way as mysteriously to improve our economic and socio-political circumstance through greater productivity.

Despite this re-branding of what we would see as a dubious pursuit of a questionable Utopia through 'Positive Psychology', the idea itself is not new. Indeed, one of the founding fathers of academic and clinical psychology, B.F. Skinner (1946), described exactly such a behaviourally-engineered Utopia in his rather unselfconsciously named novel 'Walden II'; a book that bears comparison with Aldous Huxley's dystopian 'Brave New World' (1932), in which human beings are 'ordered' according to specifications produced by the official polic(y)ing [sic] of a self-defined intellectual elite.

The authors of the papers in this Special Issue describe a range of group-based interventions aimed at recovery and well-being and several make specific reference to an 'extensive' literature on positive psychology, happiness, well-being and recovery. However, as Ehrenreich (2009) argues, the claim that this literature is evidence-based often seems to mean that tautological evidence has been produced by research protocols designed by positive psychologists, to measure concepts defined by positive psychologists, and excluding projects not administered by positive psychologists. Ehrenreich proposes that this movement can be seen as an ideologically driven 'professionalising'

project, on a scale so large that the sheer volume of publications of papers has produced what Cuipjers et al (2010) describe as a publication bias. This bias gives an impression of efficacy and effectiveness (to which this Special Edition might be unintentionally contributing) which is not borne out by more careful meta-analyses (Lynch et al, 2009). This literature also rests upon the assumptions that lack of evidence for other approaches must equate to evidence of lack and that 'evidence-based practice' rooted in quasi-experimental design must always take precedence over other more qualitative 'practice-based evidence': even though it would be obvious to most of us that if health and social care services were limited to proof-based interventions, the scope of most of our work in mental health, social care and community justice settings would be very limited indeed.

On the fear and loathing of the 'negative': Splitting in groups, organisations and society

> Things fall apart, the centre cannot hold
> Mere anarchy is loosed upon the world …
> The best lack all conviction, while the worst
> Are full of passionate intensity …
> W.B. Yeats, *The Second Coming* (1919)

Ehrenreich (2009) argues that one of the obvious and perhaps deliberately manufactured problems with the notion of a 'positive psychology' is that it implies, if not actually states, that there must be a negative psychology with which it is implicitly and explicitly contrasted and to which it is opposed. For example, she cites Martin Seligman, one of the leading proponents of positive psychology, who launches vociferous attacks upon those of us who are seen as promoting irrational beliefs about victimhood; '[I]n general when things go wrong we have a culture which supports the belief that this was done to you by some larger force, as opposed to, you brought it on yourself by your character or your decisions' (Seligman cited in Ehrenreich, 2009:169). This is a position which seemingly wilfully disregards the overwhelming evidence that it is the prevailing social conditions giving rise to childhood adversity, relative poverty and social inequality which

both cause and exacerbate the wide range of health and social problems that have been the focus of this paper (see Jordan, 1996; Gilligan, 1996; Felitti et al, 1998; Young, 1999; Scourfield and Drakeford, 2002; Charlesworth et al, 2004; Declerk, 2006; UNICEF, 2007; Joseph Rowntree Foundation, 2007; Zizek, 2008; Wilkinson and Pickett, 2009; World Health Organisation, 2009; Dorling, 2010; Hutton, 2010 inter alia). We join with Ehrenreich (2009) in suggesting that the currency of this version of 'positive psychology' is to 'privatise' suffering and distress by making the individual personally responsible for their own ill-health and related work-lessness, rather than, as we would suggest, more publicly to debate the causes and continuance of the systematic, societal and global violence that has excluded 'them' from the common-wealth. Viewed from this perspective, the limitations of any approach which sets out to increase personal responsibility and choice, through seeking to correct faulty cognitions and maladaptive schema in these ways, are in serious danger of becoming politically de-contextualised: an unrealisable Utopian social-inclusion model without a realistic 'socio-political model' for understanding the phenomena being treated.

These differences quickly become polarised into right/left, free-will/determinism, chicken and egg conversations which could be stated as: to what extent does the individual construct the group, and to what extent does the group construct the individual mind? This inconclusive question is often discussed as if it were simply a rational problem of agreeing a set of treatment ideologies (Scheid, 1994). However, we believe that these questions are far deeper and have far-reaching consequences for the psycho-social and socio-economic welfare of all citizens of the world. In our view the questions arising from these controversial debates tap into a deep psycho-social fault line at the heart of the human psyche and the structures and the culture of the organisations and communities that we construct. It is an inevitable and insoluble problem based on the problem that T.S. Eliot (1943) described, that 'Humankind cannot bear too much reality'. For instance, we suggest that it is almost impossible for most of us really to think and to feel ourselves in an authentic relationship with the fact that at the time of writing this paper tens of thousands of children in Uganda are in danger of starvation, while in the UK and America two of the biggest threats to young people's health are diabetes and obesity – the very definition of a psycho-socially caused health problem that has come

to be referred to as diabesity (Kaufman, 2005); or with the knowledge that our unthinking 'consumption' of our planet's resources is leading inexorably towards ecological catastrophes that will profoundly damage the health and welfare of future generations.

Whether it be third-world starvation, first world greed or more local forms of psycho-social dis-ease and being-unwellness, deeply problematic splitting processes emerge that we might describe as a kind of societal 'bipolar affective disorder'. The imagined more 'negative' aspect of the split is manifest by those who, in Yeats' terms, might be construed as 'lacking conviction' and who are experienced (and experience themselves) as more depressed. An imagined more 'positive' aspect of the split is manifest by those who become 'filled with passionate intensity', a position which we might interpret as a reaction-formation, a manic defence against having to face up to the unbearable socio-political realities outlined above. As is the case with 'bipolar affective disorder' in the personal and interpersonal domain, we are clear that both extremes are psychotic exaggerations that are distortions of a more elusive 'reality' which none of us can claim fully to know.

Conclusion

It was the American critic Art Buchwald who said 'If you attack the establishment long enough and hard enough, they will make you a member of it' and so, by extension, dependent upon it. The recovery movement did not last long before this fate befell it and in this paper we have attempted to discuss some of the psycho-social and socio-political factors which have contributed to this colonisation. Brooker et al (2011, in press) question the helpfulness of the term recovery in its current, 'colonised' form and prefer to describe their journey as one of discovery and of the emergence of a new self and a new set of possibilities. This is perhaps to discover a new self in the same way in which the old world explorers 'discovered' the continents of the new world. The colonisers' assumption was that there was no civilisation there to be 'discovered': only savagery and disorder. There was no concept of a collaboration or synthesis: a bringing together of the old and the new. Only the imposition of a new order could confer sense or culture where none

previously was held to exist. Our view might be that there is much to be valued in apparent 'savagery and disorder' if we have eyes to see and ears to hear and the willingness to look and listen.

Our view is that these two models coincide around the same question that underpins the modern American myth – 'anybody can be somebody' – rather than the under-appreciated fact that everybody already is somebody. On the surface of it the discussion is about how best to provide help for people to recover from mental disorder and traumatic experience associated with social exclusion and unhappiness. We are grateful for the opportunity to join in the debate in this 'Special Issue' of *Groupwork* because, as group analysts, we consider that this genuinely group-ish problem is rooted in our shared incapacity to think together about the socio-economic anarchy that we loosed upon the world.

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