APPLIED POSITIVE PSYCHOLOGY

integrated positive practice

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PREPARING FOR THE JOURNEY

Do not go where the path may lead,
go instead where there is no path
and leave a trail.
Ralph Waldo Emerson

LEARNING OBJECTIVES – AT THE END OF THE CHAPTER YOU WILL BE ABLE TO…

- Take a multidimensional approach to wellbeing
- Use our LIFE model to guide your efforts to promote wellbeing
- Understand and respond to pertinent criticisms of PP
- Conceptualise PP as a form of praxis, and as an applied psychological discipline
- Articulate a motto encapsulating the 'point' of PP
- Engage in integrated positive practice!

LIST OF TOPICS…

- Multidimensionality
- Wilber's Integral Framework
- The LIFE model
- Layering/stratification
- Bronfenbrenner's experimental ecology
- Critiques of PP
- Praxis and applied disciplines
- The mental health–illness circumplex
- PP 2.0/second-wave PP
- Facilitation not prescription

In this first chapter, we are going to lay the groundwork for the book. The metaphor that springs most readily to mind is that of preparing for a journey. We can think of this journey in two respects. First, we are referring to the journey that you as readers will be taking through the book. Together, over these eight chapters, we will be charting a course through the latest empirical and theoretical terrain in PP. Collectively, of course, we shall travel together. However, there will be ample time and opportunities for you to take individual detours, to explore some of the many tangential paths we shall spy along the way, or to rest awhile in a particularly interesting location and explore it in more depth. The second meaning of this hopefully not-too-strained journey metaphor concerns the ongoing adventure of PP itself. Of course, since boldly striking forth into new – or at least underexplored and underappreciated – territory, PP has successfully covered a good deal of ground, attracting an ever-increasing number of interested people along the way. However, given the speed with which PP has raced forward, the time is right to pause and gather our bearings. There is much to be gained from catching a breath and looking around, taking stock of where we have come from and where we are now. Most importantly, we need to consider where we should go from here.

Persisting with this metaphor, our preparation for this journey – your own through the book, and that of PP itself – will focus on two key items that will be helpful on our travels: a map and a motto. In the first part of the chapter, we will articulate a conceptual map of the territory that might be relevant to PP, the terrain that we can explore on our journey. Broadly speaking, this map – i.e., our LIFE model – covers the various 'dimensions' of the person. By elucidating these dimensions, this model will enable us to take a comprehensive approach to wellbeing. This is not the only possible map one could use; nonetheless, you will hopefully be persuaded of its merits and will find it useful. Nor can our map be regarded as complete; it can and *should be* subject to critique and improvement, including by you, our reader. Nevertheless, we hope that it will contain, in Koestler's (1964, p. 22) poetic words, a 'shadowy pattern of truth'. The second part of the chapter will then articulate a motto that will guide us on our journey. This motto is a response to the searching question of what PP is actually *for*. Our answer is that the point of PP is '*to make life better*'. This motto will give purpose to our journey by helping us understand *why* we are travelling and to what end. Equipped with this map and motto, we will then be ready to set off on our adventures!

PRACTICE ESSAY QUESTIONS . . .

- Critically evaluate the LIFE model as a multidimensional approach to wellbeing.
- What relationship does APP have to other applied disciplines such as clinical psychology?

A map to guide us

> A map is not the territory it represents, but if correct, it has a similar structure to the territory, which accounts for its usefulness.
> Alfred Korzybski

In this first part, we shall articulate a map of the person; more specifically, a *multidimensional* map. This means we are suggesting that people comprise multiple dimensions, all of which need to be appreciated in order to arrive at a comprehensive understanding of the person. This multidimensional conceptualisation of the person, then, inevitably and automatically facilitates – indeed necessitates – a multidimensional appreciation of wellbeing; logically, the two go hand-in-hand. Once we appreciate the various dimensions of the person, we can try to promote wellbeing by targeting *all* these different dimensions. So, what map will we be using? Various multidimensional models of the person, and hence of wellbeing, are possible candidates.

One influential model is offered by the World Health Organisation (WHO). Their definition of health – formulated in 1948 and unchanged since – is 'a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity'. This recognises three main dimensions to the person and their health/wellbeing: physical, mental and social. This same triad is also evident in Engel's (1977) biopsychosocial model of health. In contrast to the prevailing reductive biomedical approach within medicine, Engel sought a more comprehensive understanding of health and illness, one incorporating 'the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness' (p. 132). More closely related to PP, Jahoda (1958) also formulated a biopsychosocial model, in her case pertaining to 'positive mental health' (the prefix 'positive' reveals her as a key influence on the PP movement). These models have influenced contemporary conceptualisations of health and wellbeing.[1] Pollard and Davidson (2001, p. 10) define wellbeing as a 'state of successful performance throughout the life course integrating physical, cognitive and social-emotional function'. This definition also has three dimensions, albeit different ones from those identified by the WHO and Engel, which suggests there is room for debate over what dimensions a multidimensional model should contain. Thus, the LIFE model in this book – detailed below – is by no means the only possible one. However, we feel this may be more comprehensive and useful than the WHO and Engel models, as we explain next.

[1] It is worth clarifying here the distinction between health and wellbeing. As de Chavez et al. (2005) elucidate, some definitions position health as a component of the broader notion of wellbeing; conversely, other conceptualisations make health the more encompassing concept; still other models use the terms synonymously. However, there is growing preference for taking wellbeing as the broader term, and using health to refer specifically to the physical dimensions of wellbeing, which is the way we shall use the terms.

The Layered Integrated Framework Example (LIFE) model

The multidimensional model of the person – and hence of wellbeing – which underpins this book is derived from the Integral Framework, developed by the influential American philosopher Ken Wilber (1995, 2000). We shall briefly elucidate Wilber's framework, before explaining below (in the subsection entitled Layering) how we have adapted it to create our own LIFE model. Wilber's framework is described as an ontological 'map' elucidating 'the basic dimensions of an individual' (Esbjörn-Hargens, 2006, p. 83). What is striking about his framework is the innovative way in which it identifies *four* dimensions, in contrast to the three biopsychosocial dimensions of the WHO, Engel and Jahoda models, described above. These dimensions are produced through the intersection of two binaries that are in themselves common. However, when these binaries are juxtaposed, this creates a framework that is novel and unexpected, and yet also logically appealing and parsimonious.

RESEARCH AND PRACTICE CASE STUDIES . . .

Ken Wilber is one of the most influential philosophers of recent times, and an iconoclastic thinker. In 1968 he dropped out of his graduate studies in biochemistry, and, while working as a dishwasher to pay the bills, immersed himself in spiritual literature, and by 1973 had finished his ground-breaking manuscript, *The Spectrum of Consciousness*. A prolific career followed, including a complete hiatus for four years to care for his terminally ill wife. Wilber is regarded with suspicion in some academic quarters as a 'transpersonal' philosopher. However, this characterisation is misleading – his work attempts to formulate a grand overarching framework incorporating all understanding about existence, including, but most certainly not limited to, transpersonal theories and ideas around spirituality.

The first binary is the ***mind–body dichotomy***. The interaction between subjective mind and objective body is one of the most intractable issues in the history of thought (Shear, 1998). Indeed, such are the complexities of this issue, it has been labelled the 'hard problem' of philosophy (Chalmers, 2004). A range of perspectives on this have developed over the centuries (Moravia, 1995). Materialistic monism (or reductive/eliminative materialism) grants primacy to the physical body, with subjective mind seen as an illusion or epiphenomenon, as articulated by prominent contemporary philosophers such as Daniel Dennett (1990). Conversely, transcendental monism views mind as the fundamental reality,

with material substance essentially a mental construct or creation. Advocates of this view range from idealist philosophers like Schopenhauer (1969 (1819)) to modern quantum physicists (Goswami, 1990). Finally, dualistic perspectives acknowledge the reality of both material body and subjective mind, with various theories taking different positions on the nature of their interaction. This position is perhaps most commonly associated with the influential philosopher René Descartes (2008 (1641)), who thought that the pineal gland in the centre of the brain was the seat of mind–matter interaction. More recently, Chalmers' (1995) dual-aspect theory proposes that the fundamental 'reality' underlying both mind and body is information; this information is then both manifested physically (as the body/brain) and experienced subjectively (as the mind).

REFLECTION . . .

What is your take on the mind–body debate? What do you think is the relationship between the mind and the body/brain? Does the brain 'cause' the mind? Can the mind impact upon the brain? Perhaps matter is an illusion, a figment of mind? Such questions have perplexed philosophers for centuries. Where do you stand?

One such dualistic perspective underlies the dominant paradigm in contemporary consciousness studies, the neural correlates of consciousness (NCC) approach (Fell, 2004). This is based on the premise of 'psychophysical isomorphism', i.e., the view that states of mind are accompanied by analogous neurophysical states. At this early point in our understanding of the brain, this paradigm aims only to chart the neurophysiological correlates of cognitive functions and mental states; our knowledge is not sufficiently advanced to ascertain directional causality (whether the brain 'causes' the mind, or vice versa) or resolve the ontological mind–body problem (i.e., *how* NCCs are connected to conscious states). These unresolved issues are goals for a future research programme, as outlined by Chalmers (2004, p. 1): 'The task of the science of consciousness . . . is to systematically integrate two key classes of data into a scientific framework: third person data, or data about brain experiences, and first person data, or data about subjective experiences.' Nevertheless, the NCC approach certainly does acknowledge the binary reality of subjective mind and objective body/brain. This binary, then, is one of the two dichotomies that form Wilber's Integral Framework.

The second binary is the ***individual–collective dichotomy***. This reflects the notion that there are two fundamental 'modes of existence', which Bakan (1966) identified as 'agency' and 'communion'. On one hand, people exist as discrete individuals. Thus, agency refers to the way people differentiate themselves from

others and develop autonomy as free agents. On the other hand, people are also inevitably and inextricably 'nestled in systems of cultural and social networks' (Wilber, 2005, p. 256). (Even in cases of extreme isolation, social relationships were still necessary to bring the individual into existence.) As such, communion concerns the way people are situated within collective networks that sustain their being, whether physically, emotionally or cognitively. The study of these different modes of being has traditionally been fairly segmented within academia, with agency generally more the province of biology and psychology, and communion claimed by various forms of social theory, such as politics or sociology (Giddens & Dallmayr, 1982). However, more recently, theorists have acknowledged the difficulty of studying these two modes in isolation and recognised the need to explore the complex interactions between them. As such, the term 'psychosocial', which actually has a long and distinguished history (Halliday, 1948), is now increasingly prominent across academic fields, from psychology to epidemiology (Martikainen et al., 2002). This psychosocial binary, then, is the second dichotomy that forms Wilber's Integral Framework.

The innovation offered by Wilber's framework is that it juxtaposes these two binaries, creating a 2 × 2 matrix of four quadrants, which we shall refer to as *domains*, as shown in Figure 1. Beginning with the top left of the schematic, we have the subjective-individual quadrant. This is the domain of the mind, an umbrella term encompassing general subjective experience, including conscious thoughts, feelings and sensations (as well as unconscious subjective dynamics). The top right objective-individual quadrant is the domain of the body and the brain, i.e., all aspects of physiological functioning and behaviour. The lower left is the subjective-collective (or 'intersubjective') quadrant. This is the domain of relationships, and the way these produce a common hermeneutic (i.e., interpretative or sense-making) worldspace, including shared meanings and values. We can refer to this domain

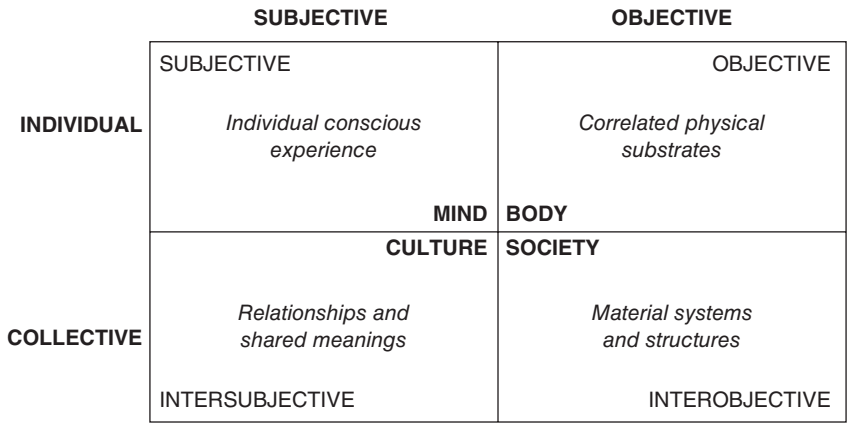

Figure 1 Schematic diagram of the four quadrants, adapted from Wilber (1995)

as that of culture, as in 'the culture' of a group of people. Finally, the lower right objective-collective (or 'interobjective') quadrant is the domain of society. This encompasses the material and structural aspects of social networks, such as the physical instantiations of communities (e.g., housing infrastructure), or socio-economic processes.

Wilber's framework has begun to be utilised in academia as a way of conceptualising how to promote wellbeing in an integrated, multidimensional way. Hanlon et al. (2010, p. 307) have used it in public health to understand the 'maze of interconnected problems' which impact upon wellbeing. They offer a hypothetical case study, the gist of which is as follows. A person is depressed due to unemployment. From the perspective of the individual-subjective quadrant, their depression can be viewed in terms of distress, understood with cognitive theories of mental illness, and addressed through therapy. From the perspective of the individual-objective quadrant, their depression can be seen in terms of brain dysfunction, understood through neurochemical theories, and addressed through medication. From the perspective of the subjective-collective quadrant, their depression can be considered in terms of cultural meanings around unemployment, understood through theories of social constructionism, and addressed by challenging societal norms. From the perspective of the objective-collective quadrant, their depression can be approached in terms of socio-economic factors that underlie unemployment, understood through economic theories, and addressed with political efforts towards a fairer society. Hanlon et al. argue that all these 'key dimensions of human experience need to be considered, harmonized and acted on as a whole' to fully address mental health issues (2010, p. 311).

REFLECTION . . .

What do you consider to be more important or instrumental in shaping your own wellbeing – your psychological qualities, your physiology, your relationships or your place in society?

Wilber's framework is a powerful tool for conceptualising and approaching wellbeing. However, within PP, while Ken Wilber is spoken of respectfully by many scholars (Walsh, 2001), so far his framework has not yet been harnessed as an overarching model to guide our understanding and our endeavours to promote wellbeing. Currently though, this book makes the case that this framework can indeed help us develop a comprehensive approach to wellbeing. One of the strengths of his framework is that it is 'content free': rather than proposing theories in a given area, it allows scholars to situate extant theories and research from the area under study according to the four-quadrant framework (Esbjörn-Hargens, 2006).

Moreover, we can appreciate the importance of considering theories/concepts from *all* the domains, and examining how they might interrelate. Such considerations form the substance of the book as a whole, and will be explored in depth throughout the chapters. However, we can briefly consider the domains in turn to get a flavour of the concepts relating to wellbeing that can be situated within each, and hence within our own adaptation of this framework, the LIFE model.

The subjective domain is the location for the wealth of constructs directly pertaining to mental health and illness. Here, wellbeing can be conceptualised either positively as the presence of desiderata, such as pleasure, or negatively as the absence of mental illness. The desiderata include the triad of elements that Seligman (2002) suggests comprises the well-lived life. First, the pleasurable life, as reflected in constructs like subjective wellbeing (SWB). Second, the engaged life, which encompasses notions like flow (Csikszentmihalyi, 1990). Third, the meaningful life, as reflected in Ryff's (1989) model of psychological wellbeing (PWB). (Of course, situating these constructs in this domain does not mean they are unconnected to the other domains. Ryff's PWB model includes relationships, which pertain to the intersubjective domain. Indeed, the *point* about the domains is that they are interlinked.) This domain also includes the panoply of desirable psychological qualities embraced by PP, from emotional intelligence (Salovey & Mayer, 1989) to hope (Snyder, 2000). In addition, recent theorising suggests that the remit of PP does not only cover these positive constructs, but extends to 'negative' constructs, such as sadness (Wong, 2011) and depression (Sin & Lyubomirsky, 2009), which we can also situate here. In a way, as the most 'psychological' of the domains, this is the root domain. PP is first and foremost a psychological discipline, pertaining to the mind. The other domains are only relevant to PP to the extent that they impinge upon the mind, e.g., affect a person's subjective sense of wellbeing. Nevertheless, it is helpful to explore the other domains to gain a comprehensive understanding of the range of factors that influence wellbeing.

The objective domain concerns the physiological functioning and behaviour of the body and the brain. First, this quadrant encompasses everything relating to physical health. Larson (1999) has identified numerous models of health, including the WHO model (noted above); the medical model, which defines health as the 'absence of disease and disability' (p. 124); the wellness model, concerned with 'progress towards higher levels of functioning' (p. 129); and the environmental model, pertaining to successful adaptation to one's milieu. These models can all be situated in this domain. Located here too are the diverse health behaviours which impact upon physical wellbeing, like exercise (Hefferon & Mutrie, 2012), and risk behaviours that detract from health, like alcohol use (Farrell et al., 2001). Second this domain includes efforts towards understanding the

physiological aspects of states of wellbeing, as per the mind–body connection introduced above. This includes analysis of biological substrates of pleasure, e.g., neuroendocrine biomarkers (Ryff et al., 2006). Similarly, embracing the NCC paradigm, a positive neuroscience research programme has begun exploring the 'neural correlates of wellbeing' (Urry et al., 2004). For instance, trait asymmetric activation of the prefrontal cortex is linked to greater levels of positive affect (Davidson, 2000). More generally, this whole domain can be situated within the broader arena of positive health (Seligman, 2008).

The intersubjective domain covers relationships and the shared culture (e.g., values and meanings) that these generate. One useful overarching construct pertaining to this domain is social capital. This refers to the 'sum total of the resources, actual or virtual, that accrue to an individual (or a group) by virtue of being enmeshed in a durable network of more or less institutionalized relationships of mutual acquaintance and recognition' (Bourdieu, 1986, p. 248). Social capital is an elastic construct which encompasses all types of relationships of relevance to PP. These range from bonds within the home, addressed by specialities like positive relationship science (Fincham & Beach, 2010) and family-centred positive psychology (Sheridan et al., 2004), to relations in the workplace or the classroom, as covered by PP sub-disciplines such as positive organisational scholarship (Cameron et al., 2003) and positive education (Seligman et al., 2009). This domain captures the manifold ways in which relationships are vital to wellbeing, from offering social support (Kawachi & Berkman, 2001) to being sources of self-esteem (Symister & Friend, 2003). The domain also covers the emergent forms of culture generated by relationships. This includes the way cultural systems can generate values and worldviews that can be conducive to wellbeing, like religion (Koenig, 2009), or detrimental, like materialism (van Boven, 2005). Intersubjective concerns also include cultural norms – in relation to phenomena like gender (Lomas, 2013) – that influence behaviour and consequently affect wellbeing.

Finally, the interobjective domain refers to the structural aspects of society: the impersonal processes, institutions and environments which provide the scaffolding for people's lives. These structures range from the material conditions of the built environment to macro-economic forces that influence employment rates. This domain thus encompasses the work of diverse theorists, across different fields, exploring the way these structures impact upon wellbeing. Economists have embraced SWB as an alternative to Gross Domestic Product as a barometer of societal progress (Layard, 2005), and have analysed the impact of various structural factors on SWB, including employment (Lucas et al., 2004) and income (Easterlin, 1995). Other relevant factors include indices used by the United Nations (UN) (2013) to calculate the 'human development index', namely living standards, health outcomes and education provision. Alternatively, the

World Bank has explored the impact of the quality of governance on wellbeing (Kaufmann et al., 2009). Interobjective structural considerations also include the quality of the built and natural environment (e.g., freedom from air pollution), whether at a local community level (Burke et al., 2009) or a wider national or even global level (Thompson et al., 2013).

So, we have outlined the four domains of our map, which will be used to help structure the book, as set out in the Introduction. We will focus in turn on the mind (Chapter 2), the body/brain (Chapter 3), and culture and society (Chapter 4), before using these domains collectively to explore lifespan development (Chapter 5), occupations and organisations (Chapter 6), religion and spirituality (Chapter 7) and becoming PP practitioners (Chapter 8). Thus, we can see how a multidimensional approach provides the architecture for a comprehensive approach to wellbeing, involving the application of PPIs across all four domains. However, before we move on to presenting the other element in our preparation for the journey – namely our motto – our map is not quite complete. It is not simply that map has four different domains; each domain can itself be stratified into a number of levels, as the next section outlines. By taking into account these different levels, our APP approach becomes even more comprehensive. That is, we can devise and apply interventions and activities that are targeted not only towards the various specific domains, but towards different levels within each domain.

Layering

So far we have introduced Wilber's Integral Framework. Now we shall explain how we have adapted his original framework to produce our own Layered Integrated Framework Example (LIFE) model (see also Lomas et al., forthcoming). Essentially, we can introduce further nuance and subtlety to our understanding of wellbeing by viewing each domain as being layered or stratified, thus producing our LIFE adaptation. That is, rather than just conceptualising each domain as an undifferentiated whole, we can develop a more sophisticated understanding by delineating different strands within them. There are potentially many possible ways of 'carving up' the domains, and our approach is by no means the only viable option. (Indeed, Wilber himself identifies different strata within his own model, although his stratification is more a historical-developmental perspective concerning the emergence of particular qualities in human development.) This is why we have named our own adaptation as the Layered Integrated Framework *Example* – our model is just one example of how such layering might be done, and indeed of a multidimensional model more generally. Nevertheless, we hope the particular layering strategy pursued here will prove convincing and helpful. Essentially, our approach is to view each domain as comprising various levels. These can be arranged in order of scale, such that each level encompasses or supersedes the level 'below' it, as shown in

Figure 2.[2] This concept of layering can be explained in more detail by considering the domains in turn.

We will first consider the subjective domain, since, as suggested above, from a PP perspective this is the *root* domain. We can readily identify at least four different phenomenological strata: embodied sensations, emotions, cognitions

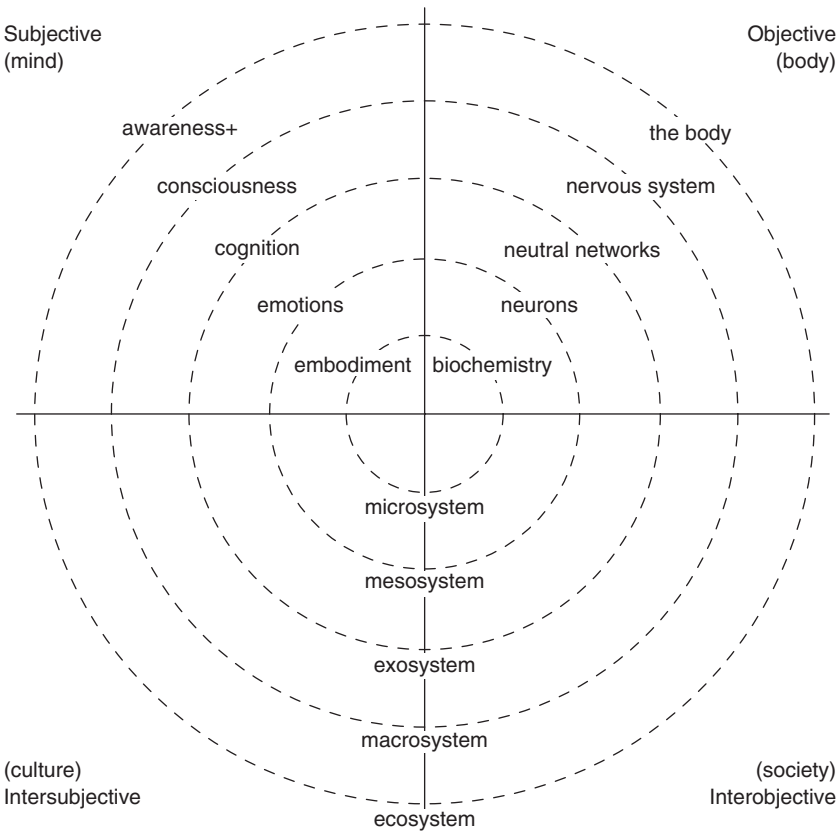

Figure 2 The Layered Integrated Framework Example (LIFE) model

[2] In considering the figure, it is worth emphasising that levels that are located on the same concentric circle are not 'equivalent' in any way. For example, the second inner ring features emotions, neurons and mesosystems. These are not functional counterparts; each domain was stratified on its own terms, and these three were placed on the second tier simply because they happened to be the second term in the sequence for that domain. Moreover, there is nothing magical about there being five layers in each domain; as emphasised above, our approach to stratification is just one possible way of layering these domains. It would be perfectly possible and legitimate to stratify each domain with fewer levels, or indeed a greater number of more fine-grained levels.

and conscious awareness. Furthermore, these strata can arguably be viewed as proceeding from 'lower' to 'higher', for two reasons. First, in phylogenetic terms (i.e., the development of the species), we can perhaps see these strata emerging in this sequence: embodied sensations are thought to have emerged much earlier in our evolutionary progression than discursive (i.e., linguistic) cognitions (MacLean, 1990). Secondly, and similarly, this emergent sequence would also apply to ontogenetic development (i.e., the growth of the person), since infants experience sensations before they acquire emotions, followed still later by more complex cognitions (Piaget, 1971). We have also added a more contentious fifth stratum, labelled tentatively as 'awareness+'. This level reflects the work of theorists who propose that conscious awareness can be superseded by yet more advanced phenomenological capacities and higher states of consciousness (Josipovic, 2010), as explained at the end of Chapter 2 and in more detail in Chapter 7.

In PP, our understanding of the role these subjective levels play in enhancing or hindering wellbeing is growing rapidly. Moreover, the field is replete with a cornucopia of PPIs to promote wellbeing at the various levels. First, PP is increasingly attuned to the complex intersections between embodiment and wellbeing (Hefferon, 2013), and various body awareness therapies have arisen that focus on these connections (Gard, 2005). Moving 'up' levels, the importance of positive emotions to PP can hardly be overstated, with a focus on constructs like happiness being almost the core defining feature of the field. In terms of APP, we see an ever-expanding list of PPIs to promote desirable emotions, from compassion (Neff & Germer, 2013) to gratitude (Emmons & McCullough, 2003). At the cognitive level, the relevance of discursive thoughts to wellbeing has long been understood (Beck et al., 1979). Such understanding has generated cognitively-focused PPIs, such as narrative restructuring exercises (Pennebaker & Seagal, 1999). Of course, the various levels are not hermetically sealed, but commingle and interact, as evidenced by constructs bridging emotion and cognition, like emotional intelligence (Mayer & Salovey, 1997) and its associated interventions (Nelis et al., 2009). Finally, the levels of consciousness and even awareness+ are very well catered-for by the phenomenal proliferation of constructs and interventions related to the Buddhist-derived notion of mindfulness (Kabat-Zinn, 2003).

Turning now to the objective domain, here we can arrange the levels into a *holarchy*, i.e., a hierarchy in which each level encompasses the level beneath it (see the box below for the origin of this word). Biochemical molecules and atoms (e.g., sodium ions) are components of neurons; neurons combine to create neural networks; such networks are part of the larger nervous system; and the nervous system is but one element of the whole body. (We can of course identify other viable holarchies, perhaps involving more gradations or highlighting other elements.) In terms of PP, we can examine how each of these levels influences wellbeing, and moreover, design interventions to act on each level. At a biochemical level,

mental illness can be understood in terms of the activity of neurotransmitters like serotonin, as in the monoamine deficiency model of depression (Schildkraut, 1965). Interventions at this level aim to alter biochemical 'imbalances', as with selective serotonin reuptake inhibitor (SSRI) treatments (Ferguson, 2001). Such biochemical interventions are at present the sole province of medical disciplines like psychiatry, used in treating mental illness. However, research has demonstrated the positive impact on wellbeing of psychoactive drugs such as psilocybin (Griffiths et al., 2006) and MDMA (Adamson & Metzner, 1988). It is conceivable that medical practitioners will in future harness such substances to proactively promote wellbeing (Sessa, 2007), as discussed in Chapter 3.

REFLECTION . . .

The term *holarchy* originated with the Hungarian intellectual Arthur Koestler (1978). To explain this, we need to introduce another neologism coined by Koestler: the *holon*. Koestler proposed the word *holon*, derived etymologically from the words 'whole' and 'part', to reflect the idea that everything in existence is simultaneously a whole and a part. For example, a person is a whole being, yet is part of a family; a family is a whole unit, yet is nevertheless part of a community, and so on. So, each element in the system, such as the family, is a holon – both a whole unit (relative to the level beneath it, i.e., the individual), and a constituent part (relative to the level above it, i.e., the community). As such, a holarchy refers to this arrangement in which holons are embedded within larger holons, which are in turn themselves nested within still larger holons. In terms of our stratification of the objective domain, and indeed of the intersubjective and interobjective domains (see below), the concept of a holarchy is more appropriate than that of a hierarchy. The latter embeds notions of top–down rule, where higher levels dominate and control their subservient inferior levels. In contrast, in a holarchical arrangement, the relationship between the levels is more complex: each level is somewhat autonomous, and causal influences can proceed up the chain as well as down. What do you think of the holarchy concept?

Moving up the holarchy, we can explore the impact of neural networks on wellbeing. These networks refer to the way mental activities are produced by the interaction of areas distributed throughout the brain (Fell et al., 2010). Relevant methods of analysis include electroencephalography (EEG), which gauges the synchronisation of neural populations (Basar et al., 2001). EEG analysis connects wellbeing to particular patterns of neural activity, such as greater left-sided activation of the brain (Rickard & Vella-Brodrick, 2013). Moreover, from an APP perspective, these beneficial activation patterns can be promoted by interventions

such as neurofeedback (Hammond, 2005). Neurofeedback activities can be situated within a larger framework of biofeedback, which can affect the nervous system generally, thus reaching a more encompassing holarchical level. Here, Kleen and Reitsma (2011) combined Heart Rate Variability (HRV) biofeedback training (lower HRV is associated with outcomes like anxiety) with mindfulness to good effect. Stepping up to the whole body, PP has tended to overlook its relevance to wellbeing, as reflected in Seligman's (2008) remark that PP needed to evolve beyond being a 'neck-up' focused discipline. However, work has begun to incorporate the body more into PP, exploring the complex intersections between physical health/illness and constructs like SWB and PWB (Hefferon, 2013). From an APP perspective, there is a panoply of PPIs that work with the body to promote wellbeing, from exercise (Hefferon & Mutrie, 2012) to creating meaning with the body through dance therapy (Puig et al., 2006).

Having outlined our stratification of the subjective and objective domains, we now turn to the two collective domains. As with the objective domain, we can again conceptualise these as being stratified holarchically. For this stratification, we will use Bronfenbrenner's (1977) influential experimental ecology model, which identified six socio-cultural levels, ordered according to scale from the micro to the macro. This model can be used for both domains, as it straddles the two quadrants. That is, one can analyse all levels of his model from either an intersubjective perspective (e.g., shared values) or an interobjective perspective (e.g., structural aspects of that level). We shall consider these levels in turn, from smallest to largest. However, we shall omit the 'smallest' level of his model, since this is not relevant to the intersubjective or interobjective domains; in Bronfenbrenner's original model, the first level is the person themselves (e.g., their cognitive processes). However, in our adapted version, this first level has been massively expanded, becoming in effect the entire subjective and objective domains. (The LIFE model also omits the sixth of Bronfenbrenner's levels, namely the chronosystem, which pertains to change over time. However, consideration of the chronosystem in effect constitutes the entire fifth chapter of this book, which focuses on lifespan development.) As such, in terms of the intersubjective and interobjective domains, we begin the stratification at the second tier of Bronfenbrenner's model, namely the microsystem. As with the other domains, we shall again highlight examples of PP constructs and practices that pertain to each level.

The microsystem refers to the immediate social setting of the person, e.g., their family or workplace. To reinforce the point about Bronfenbrenner's model straddling both domains, we can approach these settings from either an intersubjective (e.g., a family's shared values) or an interobjective (e.g., their material circumstances) perspective. In PP, the importance of the microsystem is recognised in studies highlighting the powerful association between relationships and wellbeing (Phillips et al., 2008). In APP terms, PPIs delivered at a microsystem level

include the use of PP activities in couples therapy (Kauffman & Silberman, 2009). The next level is the broader network of the mesosystem, which refers to interrelationships among different microsystems. Meso-level PPIs may involve working with clients across diverse settings, such as helping students in school *and* supporting them outside school (Sheridan et al., 2004). Indeed, Prilleltensky et al. (2001, p. 151) argue that 'clinical and community interventions are inseparable' (as reflected in the provision of an MSc in Clinical and Community Psychology at our own institution). A larger scale still is the exosystem, which refers to structures that 'encompass the immediate settings', such as the wider community in which the various microsystems are situated (Bronfenbrenner, 1977, p. 515). Community factors, both intersubjective (e.g., social capital) and interobjective (e.g., provision of social services), have a large impact upon wellbeing (Burke et al., 2009). We can promote wellbeing at the exosystem level through community interventions, like the Well London Project, which works with local communities in terms of health promotion and community development (Phillips et al., 2012).

REFLECTION . . .

What do you think of Bronfenbrenner's (1977) experimental ecology, and the way we have deployed it in our LIFE model? Do you think this is a helpful way of conceptualising our socio-cultural world? Can you think of other possible ways of stratifying the intersubjective and interobjective domains?

The most expansive of Bronfenbrenner's (1977, p. 515) levels is the macrosystem, i.e., 'overarching institutional patterns . . . such as the economic, social, educational, legal, and political systems', of which the other levels are 'concrete manifestations'. Analysis of the impact of the macrosystem on wellbeing focuses on economic and political factors, like quality of governance (Kaufmann et al., 1999), with recognition that wellbeing depends upon 'effective social and political institutions' (Duncan, 2010, p. 165). In terms of APP, we can consider interventions at a policy level, promoting wellbeing by making regulatory frameworks more conducive to this end. Indeed, UN-commissioned analyses of global levels of SWB have led to structural macro-policy recommendations (Helliwell et al., 2013). Finally, we shall take the liberty of adding another level to Bronfenbrenner's original model, namely the global eco-system. The biosphere encompasses all the other systems, since it is the physical matrix that supports their very existence. From a PP perspective, this means extending our concern with wellbeing to *environmental* wellbeing, since existentially, our wellbeing is ultimately dependent upon the health

of the planet (Smith et al., 2013). This dependence is recognised in recent efforts to take ecological variables into account, such as societal sustainability, when calculating macro-level wellbeing, as in the New Economics Foundation's (NEF) (2013) Happy Planet Index. In terms of APP, as ecological wellbeing depends to some extent on human behaviour, we can devise PPIs that might impact positively on the environment, intervening at any of the levels of Bronfenbrenner's model to influence people in the direction of more sustainable behaviours (Hopper & Nielsen, 1991).

Our motto

So, we have constructed a detailed map of the terrain that APP can be concerned with, and highlighted some of the ways in which we can promote wellbeing across the various domains and levels – these will, of course, be examined in detail throughout the book. As such, we are almost ready to begin our journey! However, before we set off, it will help to avail ourselves of a motto that can help us understand *why* we are travelling, and lend purpose to our mission. To this end, we have constructed a purposeful teleological statement to guide us. This motto was devised in response to us interrogating at length the issue of what PP is actually *for*. Our answer is that the point of PP is *to make life better*. Although this motto initially comes across as plain, even banal, we believe that a number of important concepts are embedded within it that collectively make it a powerful statement of intent. Moreover, the motto also serves as an answer to some trenchant criticisms that have been levelled against PP in recent years (e.g., Lazarus, 2003). In some ways, such critics are the best friends of the PP movement, as they shine a clinical light on its weak points and unacknowledged biases. Responding thoughtfully to such critiques, as this motto seeks to, can only help to strengthen PP.

REFLECTION . . .

What do you see as the 'point' of PP, and what might your own motto be? Whatever phrase you choose as your motto, what are the meanings and nuances embedded within it?

The first component of our guiding statement is the verb 'to make'. This serves to reinforce the idea of PP as a form of praxis, and to designate PP primarily as an applied discipline. As outlined in the introduction, this designation helps address the issue of the *identity* of PP, and whether it even needs to exist *per se* as a going

concern (since the movement has arguably gone some way towards fulfilling its original mission, i.e., redressing the negative bias within psychology). Moreover, the word 'praxis' incorporates various other meanings which further help to conceptualise the nature of PP. First, praxis can be defined as 'practical action informed by theory' (Foster, 1986, p. 96). This definition reinforces the notion that PP seeks to promote wellbeing in empirically-validated and theoretically-justified ways, which differentiates it from generic self-help movements. A second key meaning embedded in the term concerns the relationship between the PP practitioner and their participant/client. In the social sciences, praxis has its most committed advocates among politically-minded scholars committed to 'action research' (Kemmis & McTaggart, 1982). In this paradigm, also called participatory research, collaborative inquiry and emancipatory research, researchers and researched *collaborate* in effecting real-world changes. Thus, praxis suggests a non-coercive, non-hierarchical partnership between practitioner and client. So, PP is ideally facilitative rather than prescriptive – encouraging people to determine their own goals and helping them achieve these, rather than paternalistically telling people how to be.

If PP is indeed an applied discipline, we must ask, who is it for and in what circumstances? What differentiates PP from other applied disciplines, like clinical psychology, which are also undoubtedly concerned with improving wellbeing? Until recently, one answer would be that clinical psychology alleviates negative mental states, while PP aims to promote positive states. However, that distinction might not hold any longer. On one hand, some clinical psychologists have argued that their discipline should also focus on positive mental health (Wood & Tarrier, 2010). On the other hand, PP is also beginning to engage with what could be considered to be difficult and challenging states (e.g., finding meaning in suffering). More fundamentally, some theorists have even questioned the validity of labelling particular emotions or outcomes as either 'positive' or 'negative' (Lazarus, 2003), as discussed further below. Another possible answer could be that PP is defined by the use of specific practices, such as gratitude tasks. However, that definition is not especially useful either. To illustrate this, consider mindfulness, a form of meditation that has been embraced by psychology and medicine (as discussed in Chapter 2). Does this count as a PPI? The answer would have to be no, at least not exclusively. In so far as mindfulness has been used in treating physical illness, it can be seen as a medical intervention (Kabat-Zinn et al., 1987). In so far as it has been adapted for mental health disorders, it constitutes a clinical psychology intervention (Teasdale et al., 2000). In so far as it has been harnessed in psychotherapy, it qualifies as a psychotherapeutic tool (Germer et al., 2005). Given the range of uses of mindfulness, not to mention its Buddhist roots, it would be hubristic to 'claim it' as a PPI.

The range of contexts in which mindfulness has been used, however, might offer one possible way of delineating a specific territory for APP, namely that, generally speaking, APP can be defined as the use of wellbeing practices with a *non-clinical*

population.[3] For instance, mindfulness has been used in non-clinical settings to promote wellbeing (Smith et al., 1995); in this case, it would qualify as a PPI. In presenting this tentative definition, it is worth saying that the authors engaged in ongoing debate about its merits. We wondered, what about the use of PP in treating mental health problems? We felt this definition would not preclude PPIs being used for this (Sin & Lyubomirsky, 2009); the question is how one conceptualises such problems and categorises people suffering from them. The issue of when 'negative' mental states become classified as clinical disorders is much debated (Flett et al., 1997). We can certainly recognise that there are times when a person is deemed to be experiencing dysphoria, but this is not treated as a clinical issue, either by health professionals or by the person themselves. For instance, a sufferer may ascribe their depression to a legitimate sense of existential anomie, rather than view it as a psychiatric disorder (Szasz, 1960). In such cases, people may have historically tried psychotherapy; now, others may engage with a PP practitioner. APP would thus include interactions that were like 'therapy for people who don't want therapy'. There remains the grey area of interventions that originated in PP – e.g., gratitude exercises – being used in clinical settings. By our rationale, in such circumstances, these would simply be clinical psychology interventions (clinical psychology would thereby expand its own boundaries, taking in exercises that actively promote 'positive' thoughts/emotions).

REFLECTION . . .

Who do you think PP is for, and under what circumstances? What do you think of our designation of PP as the use of wellbeing practices with a *non-clinical* population? Do you agree that, even with such a designation, PP might still be used in treating mental health problems? The ideas in this chapter are just suggestions – you may construe the nature and role of PP differently. How would you demarcate the 'territory' for PP? Do we even *need* to specify a territory in this way? Reflect on your opinions.

[3] This delineation overlaps to some extent with the field of coaching psychology as defined by Grant (2006, p. 12): 'The systematic application of behavioural science to the enhancement of life experience, work performance and well-being for individuals, groups and organisations who do not have clinically significant mental health issues.' However, following Biswas-Diener (2009), we reserve the term 'coaching' for interactions involving a one-to-one 'professional relationship' between a coach and client – akin to psychotherapy, except helping 'functioning people perform even better' (p. 546). Our vision for PP is much broader than this, including, but certainly not limited to, such interactions – as elucidated in this book. As such, we could view coaching as a subset of PP (though those in coaching psychology may not agree!), as discussed in Chapter 6.

At this point, given that we are suggesting that PP might be used in ameliorating mental health issues, it is worth updating a common PP metaphor: the mental illness–health continuum. A founding image used in articulating a role for PP was that whereas fields like clinical psychology just aimed to bring people from '–5' (i.e., mental illness) to '0' (i.e., absence of mental illness), PP could take people up to '+5' (i.e., positive mental health). This image of a single continuum from illness to health implies that PP is only relevant once people reach this metaphorical '0', i.e., are free from mental health problems. However, we reject this implication, as PP may be useful in helping treat mental illness, e.g., as an adjunctive intervention (Sin & Lyubomirsky, 2009), as argued above. More fundamentally, we also disagree that mental illness and health are mutually exclusive, that one can only flourish if free from mental illness. A fascinating study suggested that a small minority of people score highly on measures of depression and flourishing *simultaneously* (Keyes, 2002). Indeed, there has long been a cultural association between mental illness and certain aspects of flourishing, especially creativity (Kaufman, 2001). We contend, then, that the continuum metaphor might be better configured as a circumplex, as shown in Figure 3. Here, mental illness ('–5' to '0') and mental health ('0' to '+5') are represented as separate orthogonal dimensions. An individual might be judged to be at a particular point on *both* dimensions – suffering with mental health issues to some extent *and* also flourishing to some extent – thus locating them somewhere in the two-dimensional space of the model. And, wherever they are 'located', we argue that PP can play a role in making their life better.

The second component of our guiding teleological statement is the noun 'life', which nicely reflects the LIFE acronym we have chosen for our multidimensional model of the person. The choice of this word as the target of PP serves to drastically widen the scope of the discipline. In many ways, this expansion is *already*

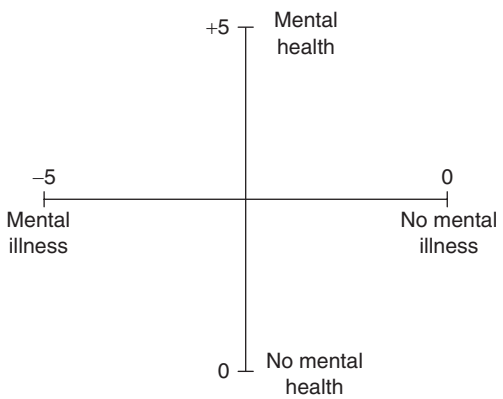

Figure 3 The mental illness–health circumplex

taking place within PP – this motto simply recognises and conceptualises this. We might consider this 'widening' in three respects: going beyond the mind, beyond the individual and beyond the species. Here the LIFE model really helps to clarify matters, since our vision for the enlarged scope of PP encompasses all domains and levels of the model. First, PP is beginning to go beyond the mind by incorporating the whole body, both in terms of embodiment (the first level of the subjective domain) and physiology (the whole objective domain) (Hefferon, 2013). Second, PP is starting to go beyond the individual by considering their socio-cultural context, as reflected in the entire intersubjective and interobjective domains of the model. Finally, PP is even starting to go beyond humankind by taking into account the wellbeing of the environment, as represented by the addition of the eco-system level. Thus, by seeking to make 'life' better, we are not aiming to simply improve the mind, or even just make the individual better, but to improve all aspects of life: individual functioning (both subjective and objective), social contexts at all levels of Bronfenbrenner's model (in both intersubjective and interobjective terms) and finally the biosphere that actually sustains life.

Expanding our focus in this way helps answer various criticisms of PP. First, going beyond the mind to incorporate the body addresses a historical lack of attention to the corporeal in PP (Hefferon, 2013). Second, going beyond the individual to consider social contexts answers one of the most pernicious critiques levelled against PP – its tendency towards an individualistic conceptualisation of wellbeing. From a critical perspective, PP is accused of promulgating a culturally-specific version of the good life, drawing upon a North American tradition of individualism in which happiness is seen as a private concern, achieved through self-determined choices (Becker & Marecek, 2008). While some attention is paid to social contexts in PP – indeed, institutions are one of the 'three pillars' of personal fulfilment (Peterson, 2006a) – analysis of these is largely restricted to what Bellah et al. (1996, p. xxv) call 'social in the narrow sense', i.e., limited to local settings. For instance, it is recognised that positive family relationships contribute to SWB (Reis & Gable, 2003). However, there has been little critical analysis of the way political, cultural and socio-economic factors impinge upon wellbeing, or of structural factors that might affect a person's ability to flourish, such as educational and economic opportunities (Prilleltensky & Prilleltensky, 2005). These are important issues, which we discuss in depth in Chapter 4 (and will generally seek to be cognizant of throughout the book). As such, by articulating a stratified multidimensional model of wellbeing, we can begin to redress such critiques.

The third component of our guiding teleological statement is the adjective 'better'. This is chosen as being deliberately ambiguous and polysemantic. Dictionary definitions attribute a range of meanings to the term, including more useful, satisfactory, effective and desirable, and greater in excellence or quality. Thus, although the word is value-laden – seeking positive change – it does not ascribe a particular form to these improvements. Most notably, it avoids

positioning 'happiness' as the goal of PP. This is important for various reasons. First, eschewing the word 'happy' as a goal helps neutralise the prominent criticism of PP as being 'happyology' (Peterson, 2006a). As Peterson laments, this has led to PP being linked to the 'ubiquitous smiley face' in media coverage of the field. There are various dangers inherent in this depiction of PP. There is a risk of PP being viewed as just another self-help movement based around positive thinking. This lends the impression that PP is simply old wine in new bottles, rehashing the tropes of previous movements centred on the power of positive thoughts (Becker & Marecek, 2008), such as the 'New Thought' trend associated with Phineas Quimby (2007 (1846–1865)). More perniciously, an undue emphasis on happiness has generated accusations that PP promotes a 'tyranny of positive thinking' (Held, 2004, p. 12), making happiness normative to the extent that failure to experience positivity is viewed almost as a moral failing (Ehrenreich, 2009).

Avoiding the term 'happy', however, is not just about distancing PP from antecedent ideologies, thus hoping for a better critical reception. Rather, it reflects a growing appreciation in PP of the nuances of emotions. PP has sometimes been guilty of promulgating a simplistic Manichean dichotomy, where positive emotions are associated with happiness and are therefore unreservedly good, while negative emotions are coterminous with unhappiness and thereby unreservedly bad (Lazarus, 2003). However, a more nuanced treatment of emotions is emerging, a trend labelled the 'second-wave' of PP (Held, 2004), or 'positive psychology 2.0' (Wong, 2011). Positive emotions/qualities can have maladaptive outcomes, e.g., optimism is linked to under-appreciation of risk (Peterson & Vaidya, 2003). Conversely, dysphorias may actually serve to promote wellbeing, e.g., anxiety can alert us to threats. Indeed, Lazarus (2003) questions the very possibility of classifying emotions as positive or negative, as many emotions are co-valenced, with their impact contextually determined. For example, love can be either agony or ecstasy, depending on whether it is reciprocated. At a deeper philosophical level, there is an inherently dialectical relationship between positive and negative emotions, which are by definition conceptually co-dependent (Ryff & Singer, 2003). Just as 'up' only exists if 'down' is recognised, 'positive' only has meaning if 'negative' also exists. Trying to eradicate the 'negative' is thus as nonsensical as trying to abolish 'down'. Thus, Resnick et al. (2001) urge us to avoid polarising psychology into good and bad, but to appreciate the complexities of the good life.

REFLECTION . . .

Think about the complexities of your own emotions. In what circumstances might emotions normally deemed 'positive' inhibit flourishing, or 'negative' emotions actually be conducive to wellbeing?

Thus, the vagueness of the word 'better' means these complexities are recognised. Moreover, it is an admission that our understanding of how to inculcate and promote the good life is always incomplete and provisional. Finally, reflecting the point about expanding the scope of PP, using 'better' prevents an undue individualistic focus on private emotional states, and extends our focus to improving social conditions – for we cannot speak of making social contexts 'happier', only making them 'better' so that they may be more conducive to happiness. That said, we do need some way of assessing what 'better' means in the context of PP. This judgement lies primarily with the people who are the subject of PPIs, i.e., their assessment of whether their life has been made better. Crucially, the person themself will determine the basis on which they make this assessment. This autonomy mirrors current measures of life satisfaction (e.g. 'Are you happy with your life?') which represent a 'global assessment of a person's quality of life *according to a person's chosen criteria*' (Shin & Johnson, 1978, p. 477, our italics). Moreover, this autonomy reflects the idea, raised above in relation to praxis, that PP should be facilitative, not prescriptive. The person themself determines what 'better' consists of, and whether this has indeed been achieved.

So, we have constructed our map, and articulated our motto. One final issue remains: the name we give to our endeavours! In recent years, a profusion of positive disciplines has emerged, including positive education (Seligman et al., 2009), positive psychotherapy (Seligman et al., 2006), positive health (Seligman, 2008) and positive sociology (Stebbins, 2009). While these disciplines are often treated as subsets of PP, the broader terms positive social science (Seligman, 1999) and even positive science (Sheldon, 2011) have been used to encompass these approaches. However, a better overarching label might be Integrated Positive Practice. The word 'integrated' encapsulates the multidimensional nature of wellbeing, and is a key term in our LIFE acronym. The phrase 'positive practice' is useful, since by eschewing the word 'psychology' it is able to embrace all the various positive disciplines as an overarching conceptual term. The word 'practice' also overlaps conceptually with the term 'praxis' and thus serves to emphasise the applied nature of the discipline. At the same time, we can still recognise PP (i.e., psychology) as being the root of the varied positive disciplines: whether we are engaging in positive neuroscience or positive sociology, ultimately, the fundamental test of our interventions – at whatever level of scale – is whether people subjectively *feel better* about their lives as a result. Thus, the critical outcome will always be a subjective assessment of improvement (hence our assertion above about the subjective domain being the root quadrant). That being said, we hope the phrase Integrated Positive Practice will help lift our visions to new horizons and empower us to approach and engage with wellbeing in a comprehensive and multidimensional way. And so. . . the journey begins!

SUMMARY – THIS CHAPTER HAS…

- Articulated the desirability of taking a multidimensional approach to wellbeing
- Introduced Ken Wilber's Integral Framework and Bronfenbrenner's experimental ecology
- Presented our own multidimensional LIFE model as the conceptual map for this book
- Articulated a motto for PP, namely *to make life better*
- Used this motto to identify PP as a form of praxis, and as an applied psychology discipline
- Used this motto to expand the focus of PP beyond the mind and beyond the individual
- Used this motto to take a more nuanced approach to conceptualising emotions

QUIZ…

1 In what year did the WHO formulate its definition of health?
2 What is the dominant mind–body paradigm within consciousness studies?
3 Who identified agency and communion as being the two fundamental modes of being?
4 Which domain pertains to relationships, the intersubjective or interobjective?
5 Who coined the terms 'holon' and 'holarchy'?
6 What level did our LIFE model add to Bronfenbrenner's original experimental ecology?
7 Who said 'The philosophers have only interpreted the world, in various ways. The point, however, is to change it'?
8 In the social sciences, what is another name for 'action research'? (3 possible answers)
9 In order of increasing scale, which level comes after 'micro' in Bronfenbrenner's ecology?
10 Who was the originator of the 'New Thought' movement?

RESOURCES AND SUGGESTIONS…

- You can find more information about Ken Wilber at www.kenwilber.com, and more on the Integral Framework generally at www.integralinstitute.org.
- In terms of the frameworks outlined in this chapter, you may not be persuaded by Wilber and Bronfenbrenner's models, or by our adaptation of these in the form of our LIFE model. That's OK! Other multidimensional frameworks exist, like Layder's (1993) research map, which you could use instead. In terms of the use of conceptual maps in academia generally, *Visualizing Social Science Research: Maps, Methods, & Meaning*, by Wheeldon and Ahlberg (2011), is well worth a read.