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WELLFOCUS PPT: Modifying Positive Psychotherapy for Psychosis

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Abstract

Positive psychotherapy (PPT) is an established psychological intervention initially validated with people experiencing symptoms of depression. PPT is a positive psychology intervention, an academic discipline which has developed somewhat separately from psychotherapy and focuses on amplifying wellbeing rather than ameliorating deficit. The processes targeted in PPT (e.g. strengths, forgiveness, gratitude, savouring) are not emphasised in traditional psychotherapy approaches to psychosis. The goal in modifying PPT is to develop a new clinical approach to helping people experiencing psychosis. An evidence-based theoretical framework was therefore used to modify 14-session standard PPT into a manualised intervention, called WELLFOCUS PPT, which aims to improve wellbeing for people with psychosis. Informed by a systematic review and qualitative research, modification was undertaken in four stages: qualitative study, expert consultation, manualisation and stake-holder review. The resulting WELLFOCUS PPT is a theory-based 11-session manualised group therapy.

Keywords: Positive psychotherapy; positive psychology; manualised complex intervention; psychosis; wellbeing.

Introduction

Positive Psychotherapy (PPT) is an established psychological therapy that focuses on strengths and positive experiences in order to promote wellbeing (a 'good life'). In contrast to some traditional psychotherapies, PPT is strengths-focused rather than problem-focused. PPT does attend to problems, such as negative memories, but in doing so encourages people to focus on strengths and positive aspects of experience. It attempts to undo problems by building on positives that may be related to specific symptoms, e.g. in order to overcome pessimism and hopelessness, optimism is reinforced. PPT exercises focus on mindfully savouring enjoyable experiences; recording good things; gratitude, forgiveness, identifying and using character strengths, either alone or with others; and focusing on positives in otherwise negative events or memories (Rashid, 2013; Rashid & Seligman, 2013).

PPT was initially validated with people experiencing moderate to severe depressive symptoms. It was based on the assumption that optimal treatment not only targets faulty cognitions, unresolved and suppressed emotions and troubled relationships, but also involves "directly and primarily building positive emotions, character strengths, and meaning" (p. 775) (Seligman, Rashid, & Parks, 2006). It is one of a family of 'positive interventions', which are designed to promote wellbeing rather than ameliorate deficit. A meta-analysis of 51 studies of positive interventions demonstrated significantly improved wellbeing and decreased depressive symptoms for people with depression (Sin & Lyubomirsky, 2009). A more recent meta-analysis of 39 randomised studies from positive psychology (the academic discipline of development and evaluation of positive interventions) involving 6,139 participants concluded that positive psychology interventions can be effective in enhancing subjective and psychological wellbeing and reducing depressive symptoms (Bolier et al., 2013). More specifically, randomised controlled trials (RCTs) comparing PPT with no treatment show decreased depressive symptoms in students (Lü, Wang, & Liu, 2013; Parks-Sheiner, 2009; Rashid & Anjum, 2008;

Seligman et al., 2006) and other non-clinical, community samples (Schueller & Parks, 2012; Seligman et al., 2006; Seligman, Steen, Park, & Peterson, 2005).

The standard PPT intervention manual (Rashid & Seligman, in press) describes how to provide PPT to non-clinical (6-sessions) and clinical (14-sessions) samples. However, PPT is now being integrated within other interventions (Cromer, 2013) and used with other client groups, e.g. a small sample of smokers found benefits from PPT in combination with smoking cessation counselling and nicotine patch treatment (Kahler et al., 2014). Brain injury rehabilitation is another area which may benefit from modified PPT (Bertisch, Rath, Long, Ashman, & Rashid, 2014; Evans, 2011). PPT has also been adapted for suicidal inpatients (Huffman et al., 2014) and for physical health conditions (Celano, Beale, Moore, Wexler, & Huffman, 2013; DuBois et al., 2012; Huffman et al., 2011). More generally, positive interventions are being adapted for various populations, e.g. people with developmental disabilities (Feldman, Condillac, Tough, Hunt, & Griffiths, 2002). For a summary of studies using the PPT protocol, see Rashid (2014).

Wellbeing research has not been widely integrated within traditional treatment protocols for people with more severe mental health problems (Slade, 2010), and so a further area that may benefit from modification is psychosis. The NICE guidelines for psychosis and schizophrenia in adults [CG178, published February 2014] recommends CBT and family therapy, and emphasises the importance of carers, friends and family for recovery. The emphasis in policy and clinical guidelines on recovery, resilience, self-management and hopefulness require new approaches to supporting people with psychosis, as these have not been the main focus of existing psychotherapies.

Within PPT for psychosis, an uncontrolled feasibility study of 16 people with schizophrenia evaluated a ‘positive living’ intervention modified from 6-session PPT (Meyer, Johnson, Parks, Iwanski, & Penn, 2012). The intervention was shown to be feasible and increased participants’ wellbeing, savouring, hope, self-esteem, and personal recovery. By

contrast, the current study – called WELLFOCUS – constitutes the first full modification of PPT for psychosis. This full adaptation is analogous to the development of standard cognitive behavioural therapy (CBT) to CBT for psychosis (CBTp), and addresses some overlapping issues, including the efficacy of developing meaningful relationships. WELLFOCUS is consistent with 'third wave' approaches, like acceptance and commitment therapy (ACT) and mindfulness-based cognitive therapy (MBCT), in emphasising strengths, values, and de-emphasising thought-challenging (Longmore & Worrell, 2007). Furthermore, it connects to an evolving understanding of wellbeing in psychosis (Schrank, Riches, Coggins, Tylee, & Slade, 2013) and the importance of a positive identity for recovery (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011).

WELLFOCUS PPT employs a theoretical framework and significant service user feedback and review (Reese, Slone, & Miserocchi, 2013; Tompkins, Swift, & Callahan, 2013) to modify 14-session standard PPT into a manualised intervention for people with psychosis. The scientific framework for WELLFOCUS is the Medical Research Council (MRC) Framework for Evaluating Complex Health Interventions (Craig et al., 2008). The three phases of this framework involved establishing the theory, developing a model and intervention manual, and testing the intervention in an exploratory trial. The first phase of this framework has been achieved in previous work, which is summarised below. The present study focuses on the development of the model and manual.

WELLFOCUS PPT theory was established through a previous systematic review and qualitative study. The systematic review reported a narrative synthesis of interventions targeting wellbeing in psychosis, and identified 28 controlled trials using 20 measures of wellbeing (Schrank, Bird, et al., 2013). The content of these measures informed the development of a static framework of wellbeing in psychosis with four concentric dimensions. These dimensions were categorised as *non-observable* (e.g. meaning or purpose in life), *observable* (e.g. physical health), *proximal* (e.g. relationships), *distal* (e.g. access to services) and a distinct self-defined

dimension of wellbeing. This static framework of wellbeing for people with psychosis offers an evidence-based conceptual structure of wellbeing which provides an empirical basis for organising wellbeing research in psychosis and for understanding influences on wellbeing.

A qualitative study with mental health service users with psychosis (n=23) in England was undertaken to identify processes involved in experiencing and modifying wellbeing (Schrank, Riches, Bird, et al., 2013). This developed a dynamic framework of wellbeing, describing how improved wellbeing can be characterised as a transition towards an enhanced sense of self. Consistent with the earlier static framework, the four levels of influence were identified (non-observable, observable, proximal, distal) which influence the transition to enhanced sense of self. Seven key indicators of an enhanced sense of self for people with psychosis were good feelings, symptom relief, connectedness, hope, self-worth, empowerment, and meaning. These key elements of the dynamic framework are shown in Figure 1.

Insert Figure 1

The aim of the current study is to build on this previous work and modify standard PPT for use in psychosis. The two objectives are to (1) develop a manual for WELLFOCUS PPT, by modifying 14-session standard PPT on the basis of the theory generated from the systematic review and the dynamic framework, and (2) develop an explicit and testable model which identifies the mediating processes and proximal and distal outcomes arising from WELLFOCUS PPT. A manual is needed to allow formal evaluation, to make explicit the clinical change processes, and to provide a resource for disseminating the intervention.

Method

Design

Development of the WELLFOCUS model comprised four stages. Stage 1 involved semi-structured interviews with staff (psychotherapists and care coordinators) and service users (patients with psychosis) to identify candidate modifications to standard PPT. Stage 2 involved consultation with expert therapists to refine the recommendations from Stage 1 and identify target areas of WELLFOCUS PPT. Stage 3 involved development of a manual and model using unpublished guidelines for developing manuals (REMINDE – see www.equator-network.org/resource-centre/library-of-health-research-reporting/reporting-guidelines-under-development). Stage 4 involved review by clinicians and service users of the WELLFOCUS PPT manual.

Participants

Participants in Stage 1 (Interviews) were service users with a diagnosis of psychosis and staff with experience working with people with psychosis. Service user interview data was collected at the same interview used in the earlier qualitative study (Schrank, Riches, Bird, et al., 2013). All service user participants were adult outpatients with a clinical diagnosis of psychosis. They were relatively stable and able to live independently. Both staff and service users were recruited from mental health services in South London. Participants in Stage 2 (Consultation) were a convenience sample of collaborators with relevant expertise. Stage 3 (Manualisation) did not involve participants outside the research team. Stage 4 (Review) participants were trial therapists, service users, and service user researchers.

Procedure

Stage 1 (Interviews)

Semi-structured interviews employed a topic guide which summarised standard PPT exercises (Rashid, 2008) and sought feedback and suggestions for modification. Service users and staff

were asked identical questions. Table 1 provides an overview of the key components of 14-session standard PPT:

Insert Table 1

Stage 2 (Consultation)

The standard PPT manual (Rashid & Seligman, in press) and Stage 1 data analysis were presented to experts in a one-day meeting. Experts (n=12) comprised five trial therapists, four health service researchers, one standard PPT specialist, and two experts in providing wellbeing interventions to the general population. These experts were chosen to give a range of perspectives from clinical and positive psychology backgrounds. Solutions to identified challenges and modifications to standard PPT exercises were proposed and consensus was reached on adaptations to standard PPT.

Stage 3 (Manualisation)

Manualisation followed REMINDE guidelines, which identify four parts of a complex intervention manual: introduction, evidence base, intervention manual, and implementation manual. Each part of the REMINDE guidelines has items and descriptors to aid reporting. The key steps when developing the WELLFOCUS manual were as follows: developing a generic session structure, number and content of sessions, therapist style, session-specific hand-outs and other session tools. The manual was written by the WELLFOCUS research team based on the WELLFOCUS Theory and Stages 1 and 2 of the present study.

Stage 4 (Review)

Trial therapists reviewed iterative WELLFOCUS manual drafts. The final draft manual was reviewed by service users not involved in Stage 1, and final refinements were made.

Theory and Analysis

Stage 1 interviews were audiotaped, transcribed, and analysed using the qualitative data analysis software package Nvivo9. Data were coded using predefined categories of Challenges or Proposed modifications, for both generic issues (applicable to any psychological intervention or applicable across several PPT exercises) and PPT exercise-specific issues. This resulted in four pre-specified clusters of data: generic challenges; proposed generic modifications; PPT exercise-specific challenges; and proposed exercise-specific modifications. Within each cluster, data were then organised into emergent themes, with issues and solutions being matched where possible. The analysis was repeatedly discussed amongst the researchers (BS, SR, MS) and adapted according to consensus. The analysis produced a data set presented to the experts at Stage 2, in order to obtain external validation for the recommendations. The WELLFOCUS model was developed using data from Stage 1 interviews and the Stage 2 expert consultation, as well as the systematic review and dynamic framework. An iterative inductive process was employed, with researchers (BS, SR, MS) immersing themselves in the data and repeatedly discussing model components and their implications until consensus was reached within the research team.

Results

Stage 1 (Interviews)

A total of 23 service users with a clinical diagnosis of psychosis (mean age: 44.6 years (SD 9.3), 35% female, 15 (65%) with a diagnosis of schizophrenia) and 14 staff (mean age: 36.5 years (SD 10.3), 71% female, mean length of relevant experience: 11.6 years (SD 12.4)) were interviewed. Four generic themes emerged as challenges: *attitudes*, *illness*, *engagement* and *interaction*. These four themes are different types of challenges that the interviewees felt may impact the utility of the intervention. This is outlined in Table 2.

Insert Table 2

Thematic analysis also identified PPT exercise-specific challenges and proposed solutions. Participants felt that Satisficing vs. Maximising and Altruism would be challenging and possibly unsuitable for service users with psychosis and were hence removed from WELLFOCUS PPT. Identified issues and proposed solutions for all other sessions are outlined in Table 3.

Insert Table 3

Sessions were organised into three clusters, according to the perceived degree of challenge for people with psychosis: 'easiest' (Savouring, Three Good Things), 'intermediate' (Character Strengths; Signature Strengths, Signature Strengths of Others, Positive Communication) and 'most challenging' (Good vs. Bad Memories, Gratitude, Forgiveness, Hope, Optimism & Posttraumatic Growth).

Stage 2 (Consultation)

The experts discussed the Stage 1 analysis and produced general and exercise-specific recommendations for WELLFOCUS PPT. The four Stage 1 themes of *attitudes*, *illness*, *engagement* and *interaction* were used to guide general recommendations (indicated below) and Stage 1 exercise-specific challenges and proposed solutions were used to guide the exercise-specific recommendations. A therapy title, WELLFOCUS PPT, and sub-heading, Positive Psychotherapy for Psychosis, were agreed, with an emphasis on aiming to improve wellbeing.

Informed by the generic theme of *illness*, session and exercise titles were modified to optimise clarity and accommodate psychosis-specific challenges, e.g. Orientation to PPT, Positive Communication, and Hope, Optimism & Posttraumatic Growth were relabelled, in the

latter case to avoid invoking the relationship between psychosis and trauma (Beards et al., 2013; Kilcommons & Morrison, 2005). Positive Communication (Active Constructive Responding) was relabelled as Positive Responding.

The experts devised a Celebration session where group members should be congratulated and awarded a certificate. This retained the integrative elements of The Full Life from standard PPT but increased focus on individual accomplishment, with a personal letter from therapists, which group members could choose to read aloud, or ask therapists to read aloud, to facilitate *engagement*.

Homework was integrated with the main session exercise and relabelled as an Ongoing Exercise, to address *engagement*. The experts decided Ongoing Exercises for Sessions 1-10 should begin in session, with planning and encouragement for group members to continue in their own time. Session 11 would reprise an earlier Ongoing Exercise. Ongoing Exercises would be incentivised with gifts (e.g. Good Things Boxes), a WELLFOCUS Journal, between-session phone calls, and by including a previous session recap, all to facilitate *engagement*.

Exercises would be supported with clear, concise worksheets in lay language, to facilitate *engagement*, with colourful illustrations, to address *illness*. Writing exercises were deemed important and retained but literacy was de-emphasised by including options such as drawing, coloured pens/pencils, and greeting cards, rather than letters for those with reading/writing difficulties, to address *illness*.

The experts agreed that exercises should be personal, experiential, and interactive, to address *illness* and *engagement*. Small things should be valued and meaningfulness conveyed at every level, including facilitating the development of a meaningful narrative for each group member, therapist self-disclosure, therapist involvement in exercises, as well as appropriate choices of refreshments, venue and music, to facilitate *engagement* and *interaction*. Savouring of food and drink was included but with therapists asked to be mindful of negative symptoms and provide eating and drinking choices, to address *attitudes* and *illness*.

Three Good Things was reconceptualised as Good Things to reduce the burden of identifying three things, with Good Things Boxes and the WELLFOCUS Journal used to allow flexibility when recording good things. Challenges identifying good things were addressed with group support and recapping previous good things, to facilitate *interaction*.

Personal strengths sessions were included but the experts agreed that the Values in Action Inventory of Strengths from standard PPT was too long and should be replaced by large pictures that display Character Strengths, to address *illness*. The experts agreed that a single personal strength should be identified, to address *illness*. Family involvement in Signature Strengths of Others was minimised and the Family Strengths Tree and family gathering exercises were eliminated. Family involvement was broadened to include friends or staff, to facilitate *engagement*. Therapists referred to 'significant other or person' instead of family, to facilitate *interaction*.

Forgiveness was spread across two sessions, to address *attitudes*, and psycho-educational hand-outs were used, to address *illness*. Experts agreed that forgiveness should be conceptualised by using recent examples of someone who has 'let you down', thus reducing the likelihood that group members consider childhood trauma (Varese et al., 2012), to address *attitudes*. Good vs. Bad Memories was removed. The experts agreed its focus on bad memories and distress could accentuate negative appraisals. Instead it was combined with Gratitude, as in standard PPT, but also in One Door Closes Another Door Opens and Forgiveness.

Experts agreed with the three Stage 1 clusters (i.e. easiest, intermediate, and most challenging PPT exercises) but decided that sessions should culminate in positive themes. Therefore, Forgiveness preceded Gratitude, with One Door Closes Another Door Opens in between. Mid-therapy feedback was eliminated to facilitate *engagement* and continuation.

Stage 3. Manualisation

To meet the need for a manual outlined earlier (evaluation, change processes, dissemination of the intervention), four key target areas of the WELLFOCUS model were identified from the systematic review, dynamic framework and Stages 1-2 findings: increasing positive experiences, amplifying strengths, fostering positive relationships, and creating a more meaningful self-narrative. These components are intended to lead to improved wellbeing, defined as an enhanced sense of self, according to the dynamic framework of wellbeing (Schrank, Riches, Bird, et al., 2013). A draft manual was produced by researchers (SR, BS, MS). Based on the initial session clustering from Stage 1 (i.e. easiest, intermediate, and most challenging exercises) and Stage 2 modifications, a sequencing of WELLFOCUS PPT sessions was finalised. This is shown in Table 4.

Insert Table 4

The Introduction of the manual discussed the model and the intervention, with generic advice for therapists. WELLFOCUS PPT would be delivered by two therapists who would follow the WELLFOCUS PPT manual. Therapist self-disclosure was encouraged and prompted in all sessions. Therapists would participate in exercises, to facilitate *interaction*.

Group members would not be prohibited from sharing distressing, unpleasant, or negative states and experiences; any 'negative' statements from group members would be validated, to address *illness*, but negative experiences would not become central to sessions. Instead therapists would establish a link between the negative experience and one or more target areas of WELLFOCUS PPT, all to address *attitudes*. For example, if a group member would describe having been bullied at school but had also identified their strength as humour and playfulness, then the therapist could bring their attention to how they had been able to use humour to manage the situation. Therapists would be instructed to model and support positive

responding, be accessible, support change, and encourage experiential learning, to facilitate *engagement* and *interaction*.

WELLFOCUS PPT would be provided regardless of current symptom severity and was designed for both community and inpatient settings. However, it was suggested to offer WELLFOCUS PPT only to those who were cognitively able to follow the content, as determined by the relevant clinician.

Sessions would follow a generic structure: 90 minutes sessions, with 5 minutes savouring music at the beginning and end, and a 10 minute mid-session break with refreshments, to facilitate *engagement*. The overarching emphasis on continuity between sessions led to individual sessions beginning with a welcome, recap and warm-up exercise, to facilitate *engagement*, before introducing the main Ongoing Exercise. The more theory-laden content of standard PPT was shifted towards greater experiential tasks, with warm-ups and role-plays, to address *illness*. The WELLFOCUS manual contained session-by-session guidance, example scripts, and therapist tips for all sessions. WELLFOCUS PPT used additional supporting materials, including the WELLFOCUS Journal, session hand-outs, strengths pictures, Good Things Boxes, and WELLFOCUS PPT music. The journal included pages for all sessions, which summarised the content, rationale, and Ongoing Exercise of each session, used accessible language and colour-coding for the session to which they apply. At each session, WELLFOCUS group members would receive worksheets which fasten in the WELLFOCUS Journal, all to address *illness* and facilitate *engagement*. WELLFOCUS PPT music was selected by researchers (BS, SR) in collaboration with musicians. The 11 tracks were all instrumental to optimise savouring and chosen to correspond in pitch, pace and ambience to session topics, in order to facilitate *engagement*, according to the views of BS, SR, and the musicians consulted.

Stage 4. Review

Nine WELLFOCUS therapists reviewed the draft manual and suggested minor modifications to warm-up exercises and WELLFOCUS PPT components. One expert, who had experience providing wellbeing interventions to the general population, reviewed the hand-outs. Six service users and service user researchers from the Service User Advisory Group reviewed the draft manual and identified four key issues (*attitudes*, *illness*, *behaviour change*, and *confidentiality*) and further modifications. Their review is summarised in Table 5.

Insert Table 5

Following these revisions, the WELLFOCUS PPT manual was finalised by SR, BS, MS.

Discussion

Strengths and Limitations

There are various challenges when modifying psychological interventions for psychosis, and similar issues have arisen in modifying standard cognitive behavioral therapy for use with people experiencing psychosis. A previous modification of standard PPT for psychosis was based on 6-session standard PPT, and evaluated in an uncontrolled study in a single specialist psychotherapy service (Meyer et al., 2012), thus limiting generalisability. These limitations and challenges were addressed in the present study in the following ways: WELLFOCUS PPT modifies the larger 14-session PPT intervention; it is based on an established scientific framework (Craig et al., 2008), a systematic review and qualitative work, an explicit and testable model, and was developed in a diverse ethnic and cultural context. The resulting intervention is intended for use in community mental health services. It integrates theoretical developments with expert opinion as well as the input of individuals with lived experience of psychosis.

Modifications from standard PPT to WELLFOCUS PPT were based on Stages 1-4 (qualitative study, expert consultation, manualisation, stake-holder review). Independent of Stage 1 data, Stage 4 themes overlapped with Stage 1 themes by highlighting *attitudes* and *illness*, an outcome which lends further support to Stage 1 findings. In addition, Stage 4 broadened the scope of modifications for WELLFOCUS PPT by including distal concerns, with themes of *confidentiality* and *behaviour change*. The latter concern highlights that interventions need to support skills that can be used beyond the clinic (Bellg et al., 2004). WELLFOCUS PPT targets continuity and relapse prevention throughout.

WELLFOCUS PPT aims to promote general clarity in the delivery of the intervention. Special attention has been given to creating an environment that facilitates positive social interactions. In terms of goals and ambitions, WELLFOCUS PPT places emphasis on valuing the small things in life and on accessing what is meaningful for people; but it also recognises the need to be realistic in order to counter any risk that the exercises appear contrived or unable to accommodate negative experiences. Furthermore, all exercises have been modified to avoid trauma, address attention difficulties, difficult life events and family situations, thus optimising the likelihood that group members have a positive experience.

Implications and Future Research

The four key target areas of the WELLFOCUS model are increasing positive experiences, amplifying strengths, fostering positive relationships, and creating a more meaningful self-narrative. These components are intended to lead to improved wellbeing, defined as an enhanced sense of self, according to the dynamic framework of wellbeing. Based on the experience in developing WELLFOCUS PPT, we speculate that mediating processes might include the content of the sessions (e.g. the use of positive interventions such as forgiveness), therapist factors (e.g. the use of positive self-disclosure) and group factors (e.g. giving and receiving feedback about strengths). A future pilot RCT (ISRCTN04199273) (Schrank et al., 2014) will

include post-therapy interviews and focus groups with participants and therapists to evaluate the presence and impact of these candidate mediators. Given the nature of PPT, therapist self-disclosure focused on positive aspects of therapists' lives, which functioned to model Positive Responding and aimed to reduce the 'them and us' distinction. The WELLFOCUS manual encouraged therapist self-disclosure of positive things, e.g. a good thing that has happened that day or a personal character strength. For clinicians, self-disclosure is more frequently considered in relation to risk of boundary violation rather than being a positive opportunity to facilitate change. This softening of the clinician role to include sometimes being less role-based – and perhaps more 'real' (Gelso et al., 2005) – mirrors the change being asked of group participants, whose problems of course remain but are being invited to develop an identity as a person in recovery who can self-identify and use strengths (Davidson, Bellamy, Guy, & Miller, 2012).

Future modifications of WELLFOCUS might consider different types of therapists (e.g. coaches, not clinicians, as group facilitators) and modification into individual psychotherapy, potentially with separate versions for inpatients and outpatients. The WELLFOCUS manual will be further refined based on the outcomes of the pilot RCT.

Conclusion

WELLFOCUS used an evidence-based theoretical framework to modify 14-session standard PPT into WELLFOCUS PPT. Building on a systematic review of wellbeing in psychosis and qualitative research examining how people with psychosis understand their own wellbeing, this study developed a new manualised group psychotherapy to improve wellbeing in people with psychosis, using four stages of research (qualitative study, expert consultation, manualisation, stake-holder review). The outcome of this process was a briefer intervention that included modifications specifically tailored to address common challenges experienced by people living with psychosis.

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Table 1. Standard 14-session PPT

Session	Content	Homework
1. Orientation to PPT	Group guidelines, importance of homework, presenting problems are discussed	Positive Introduction (a story of when you were 'at your best')
2. Character Strengths	Identify (up to 5) character strengths using the Values in Action (VIA) Classification of Character Strengths questionnaire, possibly with family/friends	Blessing Journal (identify three good things each night)
3. Signature Strengths	Identify signature strengths	Signature Strength Action Plan
4 Good vs. Bad Memories	Memories and cognitive reappraisal are discussed	Writing Memories (focusing on bad memories and distress)
5. Forgiveness	Transforming forgiveness into positive emotions	Forgiveness Letter (not necessarily delivered)
6. Gratitude	Enduring thankfulness, good/bad memories are discussed	Gratitude Letter and Visit
7. Mid-Session Feedback	Recap Signature Strengths Action Plan, Forgiveness, Gratitude. Discussion of progress	None
8. Satisficing vs. Maximising	Discuss settling for "good enough" rather than exploring almost all possible options	Plan areas that could benefit from satisficing
9. Hope, Optimism & Posttraumatic Growth	Consider unexpected/unintended positives. Optimism, hope, and new opportunities are discussed. Growth from trauma is explored	One Door Closes One Door Opens
10. Positive Communication	Active Constructive Responding is discussed	Active Constructive Responding
11. Signature Strengths of Others	Character strengths of family are discussed	Family Strengths Tree
12. Savouring	Take time to notice various elements of an experience. Savouring techniques are discussed	Planned Savouring Activity
13. Altruism	Giving the gift of time to help others is discussed	Gift of Time
14. The Full Life	Integration of positive emotions, engagement, positive relationships, meaning and accomplishment. Discuss ways to sustain positive changes	None

Table 2. Service user and staff generic views on standard PPT

Theme	Challenges	Proposed Modifications
Attitudes	Positive approach may be rejected as "unrealistic"	Make it realistic, validate negative feelings
Illness	Concentration/motivation may impact on exercises	Use clear language; avoid theory, abstraction, didactic style; emphasise structure, flexibility; adapt tasks, use small concrete steps, assess group needs, tailor sessions to individuals
Engagement	Exercises may feel meaningless, negative memories of homework, lack of social/financial opportunities	Explain rationale/session-by-session outline, focus on meaningful life/values, identify realistic, personal goals, e.g. small tasks, gradually introduce/increase feedback, plan exercises in session, support and be aware of negative memories ("Don't call it homework"), use reminder phone calls/text messages, award certificates, afternoon sessions, breaks with refreshments, provide information to take away
Interaction	Difficulties with social contact, disclosure, self-confidence, group comparison, dominant group members, lack of interest in other people	Warm-up exercises; foster mutual acceptance/equality, trusting environment, honest interest in others; therapist self-disclosure/humour to normalise experiences/integrate group

Table 3. Challenges and solutions identified in Stage 1 (interviews)

Standard PPT session	Challenges	Proposed Modifications
1. Orientation	No specific challenges	No specific modifications proposed
2. Character Strengths	Difficulties identifying strengths; strengths may be disputed; others may abuse one's strengths; strengths discussion is embarrassing; VIA questionnaire is too long; identification of three good things every night is too much; literacy issues; too formulaic or repetitive; difficult to remember as a daily task	Empower/assist group members: everyone has strengths; everyone is valued; encourage group support for identifying strengths ("other people can often see strengths that we can't"); 'Three Good Things' should be a separate session; emphasis on small good things; recording at flexible times; allow alternatives for writing (e.g. drawing, painting, collecting keepsakes); normalise experience of no good things on some days
3. Signature Strengths	Difficulties identifying activities; unrealistic ideas; anxiety about lack of skills, abilities, or performance; unachieved goals may lead to negative feelings ("feeling like a failure")	Focus on realistic goals; have alternative, back-up goals; encourage teaching of strengths to others (including therapists); discuss strengths with others outside the therapy; in-session

		planning, follow up and recording of achievements
4. Good vs. Bad Memories	Difficulties identifying good memories; focus on bad memories (unhappy childhood, trauma) and distress may accentuate negative appraisal; memory problems; belief that good memories are not deserved	Establish values and goals to stimulate memories; focus on recent memories; normalise positive and negative memories; emphasise self-kindness, help notice positive feelings (“good memories make you smile”)
5. Forgiveness	May “unlock” anger, trauma, shame, and depression; feeling vulnerable or disempowered (“an invitation to be harmed again”); not ready to forgive; some events are ‘unforgivable’; different interpretations of concept of forgiveness; difficult to achieve in short intervention	Avoid talking about trauma; construe as feeling “let down by someone”; acknowledge forgiveness is a personal process that takes time; consider reasons for forgiveness; begin with small examples; therapist self-disclosure; emphasise connotations like “lifting a burden”, “making peace”, “putting anger and bitterness behind you”, “moving on”, becoming a “better, stronger person”; be realistic: not all need be forgiven; those you forgive need not stay friends; consider forgiving oneself instead of/in addition to others
6. Gratitude	Difficulties identifying people or events; increased awareness of lack of positives; triggers negative thoughts or envy; disproportionate gratitude: being overly grateful for small things may be disempowering ("I'm always the one who is helped"); distribution of gratitude letter may be inappropriate; literacy difficulties; uncommon to express gratitude in some cultures	Discuss people who deserve recognition; discuss appropriate level of gratitude; contextualise gratitude: emphasise reciprocal (“give and take”) interactions; warm-up exercise to build up to writing a letter; discuss feelings of letter recipients, who should see letter, appropriate time to send; alternatives to letter, e.g. greeting card, making something, verbal thanks, writing letter to oneself
7. Feedback	No specific challenges	No specific modifications proposed
9. Hope, Optimism & Posttraumatic Growth	Content may be distressing; evoke negative memories, disappointments, embarrassments, or serious ongoing problems (e.g. abuse, bereavement, harmful relationships); not everything has a positive side; might feel patronising, belittling, denying the problem, superficially positive	Avoid reactivating trauma: focus on recent “disappointments”, frame as "learning from your mistakes"; begin with small examples; be realistic: some events might have little positive outcome; normalise negativity in experience; consider lessons learned and how to implement them in the future
10. Positive Communication	Avoidance or fear of social situations; feel unconnected to people or groups; feeling inferior; difficult to transfer to real life situations; psychotic misinterpretation of interpersonal communication, e.g. suspicion; takes too long to learn	Discuss valuing relationships and social interactions; discuss concerns over social settings; normalise social anxiety and negative experiences; use group to practice; therapist acts as role model; encourage small, meaningful interactions.

11. Signature Strengths of Others	Difficulty finding meaningful tasks or others to collaborate with; no family or difficult family relationships, feel uncomfortable socialising; difficult to meet up with group members outside group; bored by long activities.	Let group relationships and activities develop naturally; role-play in pairs; encourage small, accessible tasks; balance and alternate group pairings, encourage family participation but normalising relationship difficulties, identifying mediator to discuss family problems, nominate several possible family members or friends for involvement
12. Savouring	Difficulty concentrating, feeling positive emotions or "letting go"; not valuing anything; negative feelings; frightened of good feelings; enjoyment "cannot be learned", everyone enjoys things differently; "pleasure" suggests superficial fun: may be harmful, e.g. substance abuse; food sensitivity, weight issues, eating disorders	Discuss and normalise enjoyment and values; let participants experiment; emphasis small pleasurable things (e.g. cup of tea, crossword); be conscious of participants with weight issues or eating disorders and pleasurable but harmful activities: avoid word "pleasure"
14. The Full Life	No specific challenges	No specific modifications proposed

Table 4. WELLFOCUS PPT sessions

Session	Ongoing Exercise	Content	Target area(s)
1. Welcome to WELLFOCUS PPT	Positive Introduction	Group guidelines, rationale, positive responding	Positive experiences,· strengths
2. Savouring	Planned savouring activity	Mindful eating, drinking and listening exercises	Positive experiences
3. Good Things	Identify good things	Identify recent good things using the Good Things Box	Positive experiences
4. Identifying a Personal Strength	Identify a character strength	Identify one character strength using strengths pictures	Strengths
5. Using Personal Strengths	Strength Activity	Plan and carry out an activity using your strength	Strengths
6. Using Strengths Together	Strength Activity with Significant Other	Plan and carry out activity that uses strengths of both individuals	Strengths, positive relationships
7. Forgiveness 1	A Sea of Forgiveness	Focus on letting go of a grudge	Positive relationships, meaningful self-narrative
8. Forgiveness 2	Forgiveness letter	Identify a person to forgive and write them a letter	Positive relationships, meaningful self-narrative
9. One Door Closes	One Door Closes Another	Identify positive conclusions from negative experiences	Meaningful self-narrative

Another Door Opens	Door Opens		
10. Gratitude	Writing a gratitude letter	Identifying a person you have never properly thanked and write them a letter	Positive relationships
11. Celebration	Positive responding	Celebrate achievements	Positive experiences

Table 5. Service user advisory group feedback on WELLFOCUS PPT

Theme	Challenges	Modifications
Attitudes	Positivity may appear inauthentic/patronising: "it can be hard to think that there might be light at the end of the tunnel"	Emphasise being genuine and realistic
Illness	Problems/symptoms may feel unacknowledged	Emphasise that negatives are not being ignored
Behaviour change	Relapse in psychosis must be acknowledged: "benefits may last only as long as the therapy"	Ongoing Exercises encourage behaviour change; recaps/Celebration session encourage continuation of exercises; journal/worksheets given to group members to keep
Confidentiality	Concerns for confidentiality in group setting	Confidentiality highlighted in WELLFOCUS manual; example script given for Session 1

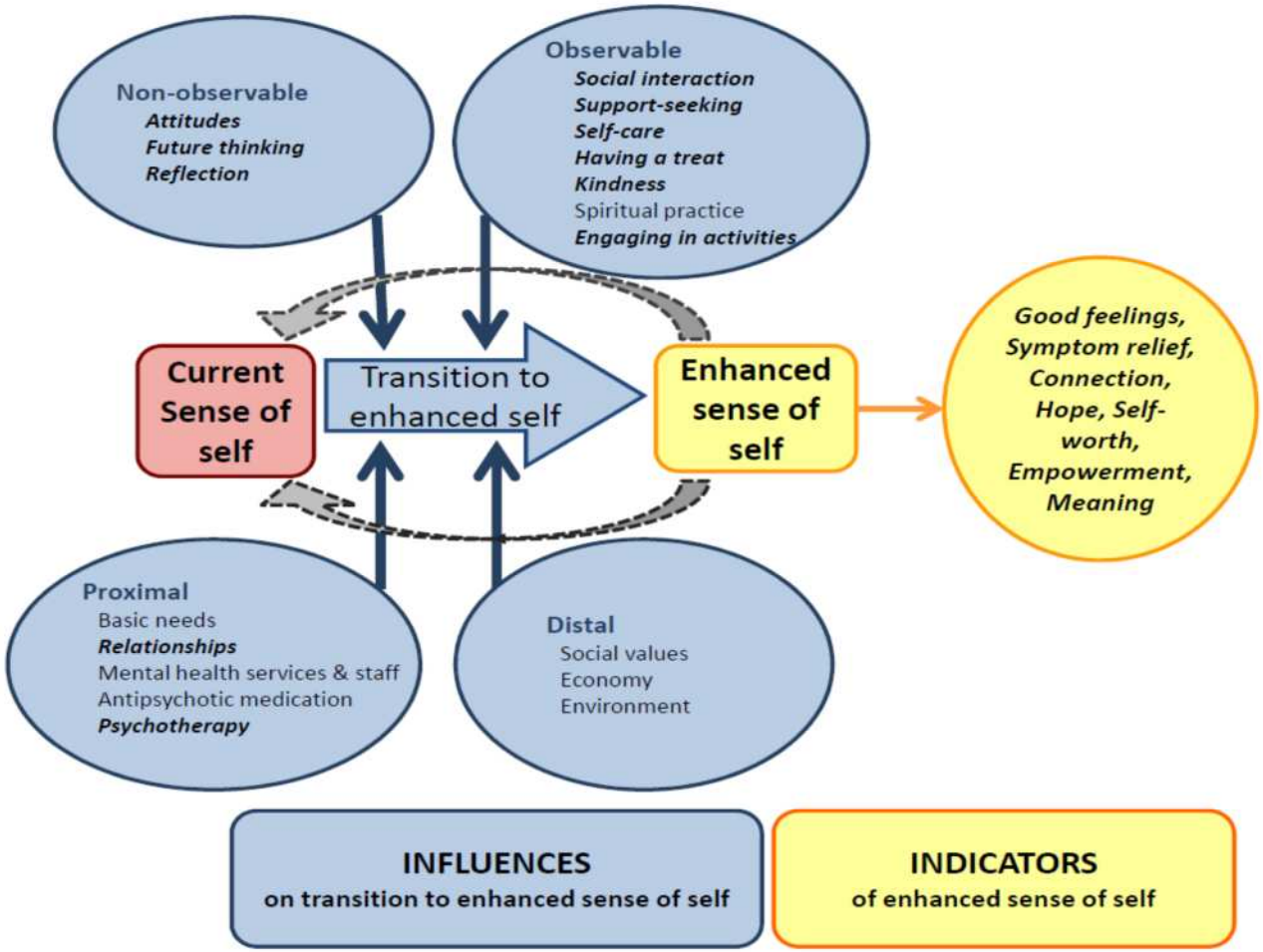

Figure 1: Section from Dynamic framework of wellbeing