

## Document Version

Peer reviewed version

Citation for published version (APA):

Valiente, C., Espinosa, R., Contreras, A., Trucharte, A., Caballero, R., Peinado, V. & Perdigón, A. (2021). A multicomponent positive psychology group intervention for people with severe psychiatric conditions; a randomized clinical trial. *Psychiatric Rehabilitation Journal*. <https://doi.org/10.1037/prj0000509>.

### Citing this paper:

Please note that where the full-text provided on Comillas' Research Portal is the Author Accepted Manuscript or Post-Print version this may differ from the final Published version. If citing, it is advised that you check and use the publisher's definitive version for pagination, volume/issue, and date of publication details. And where the final published version is provided on the Research Portal, if citing you are again advised to check the publisher's website for any subsequent corrections.

General rights:

Copyright and moral rights for the publications made accessible in the Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognize and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the Research Portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the Research Portal

### Take down policy

If you believe that this document breaches copyright please contact Comillas providing details, and we will remove access to the work immediately and investigate your claim.

Cultivating well-being beyond symptomatology in a sample of people with severe psychiatric conditions; the feasibility, acceptability and possible benefits of a group intervention

Carmen Valiente<sup>a</sup>, Regina Espinosa<sup>b</sup>, Alba Contreras<sup>a</sup>, Almudena Trucharte<sup>a</sup>, Rocío Caballero<sup>a</sup>, Vanesa Peinado<sup>a</sup>

<sup>a</sup> Department of Clinical Psychology, School of Psychology, Complutense University. Madrid, Spain.

<sup>b</sup> Department of Psychology, School of Education and Health, Camilo José Cela University. Madrid, Spain.

## **Abstract**

The process of recovery from serious mental health problems can be improved by promoting wellness. Moving away from the traditional focus of symptom reduction and stability, third-generation perspectives promote non-judgmental acceptance of problems as well as the development of a person's well-being and strengths. The aim of this study is to provide data on the feasibility, acceptability and effectiveness of a manualised group intervention protocol to improve well-being in clients with severe psychiatric conditions. Results showed that the protocol was feasible and highly acceptable for participants, showing high attendance and adherence rates as well as high satisfaction. On completion of group therapy, participants reported a significant improvement in self-acceptance and significant decreases in interpersonal sensitivity and depression. The results of this pilot study indicate that positive psychology group therapy may be a powerful complementary strategy in mental health promotion among people with severe psychiatric conditions. Though the validity of the study is limited by the lack of a comparison group, the present study will allow for the optimisation of trial processes and inform the evaluation strategy for a future definitive randomised control trial.

**Key words:** positive psychology, third-generation psychotherapy, well-being, self-acceptance, severe psychiatric conditions.

## **Introduction**

Well-being is possible even within the context of a life conditioned by severe psychiatric conditions. Bergsma, Have, Veenhoven, & Graaf (2011) found that having a mental disorder does not rule out happiness, since nearly 70% of people diagnosed with a mental disorder reported having often felt happy in the previous weeks. According to the state of complete mental health model, high levels of well-being can coexist with a mental illness (Keyes, 2007). In the same vein, Vázquez and Hervás (2008) have argued that mental health and mental illness are two separate dimensions that should be considered and evaluated separately.

According to Westerhof & Keyes (2010), mental illness and mental health are two distinct but interrelated dimensions. For instance, mental health is an important predictor of the mental disorders course. In a three-year longitudinal study, Bergsma et al (2011) found that people who reported happy moods more frequently, were less likely to have a mental disorder during follow-up. The literature review by Emsley, Chiliza, Asma & Lehloenya (2011) found that, together with early response to treatment and severity of initial symptoms, subjective well-being was the most significant predictor of remission in schizophrenia. Schennach-Wolff et al. (2010) stressed the importance of early improvement in well-being, given that it had a significant predictive value of symptom response and remission during inpatient psychiatric treatment. Likewise, there is some evidence pointing to a close relationship between subjective well-being and medication adherence in schizophrenia (Naber, Karow & Lambert, 2005).

Seligman (2011) pondered which 'elements' free people would choose for their own good and identified five central features of well-being: positive emotion, engagement (being in the flow), relationships, meaning (purpose in life), and accomplishment (PERMA). It is interesting to note that the concept of recovery in

mental health overlaps with the conceptualisation of well-being (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). In a systematic review by Slade et al. (2012), five key recovery processes were identified: connectedness, hope and optimism about the future, positive identity, meaning in life and empowerment (CHIME). It is not surprising that this overlapping occurs because people, whether they have a mental disorder or not, almost always long for a better life.

Recovery from mental illness can be improved if interventions target the person's well-being and their strengths (Fava & Tomba, 2009). Despite encouraging data and the fact that psychological therapies for schizophrenia have been introduced into the main recommended treatment guidelines, there is still room for clinical improvement (Laws, Darlington, Kondel, McKenna & Jauhar, 2018). The need for a more positive psychiatry, capable of both increasing the well-being and treating the suffering associated with severe psychiatric conditions, has begun to be vindicated. (Jeste, Palmer & Saks, 2017). In general, psychological interventions for schizophrenia have a small treatment effect on well-being outcomes, although effects improve somewhat when aspects related to well-being are a primary objective of the intervention (Valiente, Espinosa, Trucharte, Nieto & Martínez-Prado, 2019a). Recovery from schizophrenia spectrum disorders requires specific and appropriate interventions (Slade, 2010). However, standard interventions for people with severe psychiatric conditions, with a strong focus on stabilising the clinical picture, do not always address the key processes of subjective recovery.

Some innovative psychological interventions have an expanded view of therapeutic outcomes, aiming not only for symptom control and stability but also for human flourishing and positive change (Kashdan, & Ciarrochi, 2013). Interventions based on Positive Psychology (PPI), mindfulness-based approaches and Acceptance and

Commitment Therapies (ACT) are relatively novel for schizophrenia and are being used more increasingly to promote recovery (Slade, 2010; Shonin, Van Gordon & Griffiths, 2014; Khoury, Lecomte, Gaudiano & Paquina, 2013, respectively). They have complementary aims, as PPI focuses on improving well-being and optimal functioning (Duckworth, Steen & Seligman, 2005), mindfulness approaches promote distancing oneself from distorted mental processes, which facilitates regulation through non-reactive observance (Shonin et al, 2014), and the ACT emphasises non-critical acceptance of difficult mental events and encourages behaviour consistent with a person's personal values (Hayes, Strosahl & Wilson, 2012). Mindfulness-based approaches and ACT may also have synergistic effects with PPI, facilitating experiences of positive emotions. For instance, there is some evidence to suggest that mindfulness-based approaches can open the door to greater awareness, which can increase the effects of positive psychological interventions (e.g. Ivtzan et al., 2016; Geschwind, Peeters, Drukker, Van Os & Wichers, 2011; Gu, Strauss, Bond & Cavanagh, 2015). Likewise, the ACT's emphasis on acceptance can reduce reactivity to stress, allowing the individual to focus on actions and experiences that he/she values, which would likely be associated with positive emotions (Bohlmeijer, Lamers and Fledderus, 2015).

In relation to the efficacy of PPI, two meta-analyses in predominantly non-clinical samples have shown significant effects on well-being and depression (Bolier, et al., 2013; Sin & Lyubomirsky, 2009). A third meta-analysis by Chakhssi, Kraiss, Sommers-Spijkerman & Bohlmeijer (2018) has shown the potential of PPIs to improve well-being and to reduce distress in populations with clinical disorders. PPIs appear viable and acceptable to the user, as evidenced by high adherence and satisfaction (Huffman et al., 2014; Lopez-Gomez, Chaves, Hervas, & Vazquez, 2017). Unquestionably, the recovery of people with any type of severe psychiatric conditions requires increasing their positive emotions and/or personal strengths (Slade, 2010).

Given the complexity of their clinical picture, it is essential that therapeutic tasks are pleasant and manageable, which seems to be the case with PPI exercises that are perceived as pleasant (Kahler et al., 2014) and easy to complete (Huffman et al., 2014). PPI for psychosis appears to be a promising intervention, although supporting evidence is scarce. In a pilot and pioneering study, Meyer, Johnson, Parks, Iwanski & Penn (2012) found that a positive group psychology intervention significantly improved the levels of well-being, self-esteem, and optimism of participants with schizophrenia. In a single centre randomised controlled trial, Schrank et al. (2016) have also shown the efficacy of an IPP group; reducing psychotic and depressive symptoms, and improving levels of hope, self-esteem, and sense of coherence in people with psychosis. Moreover, in a recent pilot study in a clinical sample with paranoid tendencies, Valiente et al. (2019b) found a significant improvement in self-esteem and a significant decrease in paranoid ideation and anxiety.

Both mindfulness approaches as well as some ACT strategies seek to change the function of mental events and the individual's relationship to them (A-Tjak et al., 2015) and seem well-suited for people with severe psychiatric conditions. An increasing number of mindfulness interventions are being used with people with schizophrenia spectrum disorders (Khoury et al., 2013). Despite initial skepticism, it has been found that people with current distressing psychosis are very well equipped to participate in and benefit from mindfulness practice (Chadwick, Taylor & Abba, 2005; Chadwick, Hughes, Russell, Russell & Dagnan, 2009). Some studies have found that mindfulness interventions are somewhat more effective in treating negative symptoms (Khoury, et al., 2013). However, no matter what the symptoms are, Chadwick (2019) has argued that mindfulness is a fundamental core humanising therapeutic process that enhances acceptance both in psychotic experience and the self. Cramer, Lauche, Haller, Langhorst

& Dobos (2016) concluded in their meta-analysis that interventions based on mindfulness and acceptance are recommended as an additional treatment for patients with psychosis.

In recent decades, ACTs have also proliferated to help a variety of people with clinical problems develop psychological flexibility and get more engaged in actions consistent with their personal values (Hayes, Luoma, Bond, Masuda & Lillis, 2006). A meta-analysis by Powers, Maarten y Emmelkamp (2009) has indicated that ACT outperformed control conditions for several problem domains across target problems and outcome domains after treatment and at follow-up. More specifically, in a pilot study of a group intervention for people with psychosis, Johns et al. (2016) found that ACT was feasible and acceptable and led to clinical improvements. In a recent systematic review of randomised controlled trials in psychotic disorders, it was shown that ACT was an effective intervention in depression, anxiety, and hallucinations (Yıldız, 2019). Vaessen et al. (2019) has shown using an ecological momentary intervention approach that participants with early psychosis find ACT useful and applicable to diverse contexts of their everyday life. ACT approaches appear to be adequate to help people with severe psychiatric conditions to recover, as their effectiveness has generally been observed to be somewhat greater with more serious problems (Hayes et al., 2006)

The primary aim of this study was to determine the feasibility and acceptability of delivering a group intervention based on third-generation therapies to improve well-being as a complement rather than a replacement to traditional interventions for severe psychiatric conditions. The second aim was to conduct a preliminary evaluation of potential clinical effects on well-being, satisfaction with life, experiential avoidance and symptoms, to inform future development and randomised controlled evaluation with



this population. Regarding the effect of the intervention, we hypothesise that the group intervention will be feasible and acceptable for participants with a severe psychiatric condition and that it will produce improvements in the different dimensions of well-being, satisfaction with life and experiential avoidance, and will not have adverse effects in their symptoms.

## **Method**

A pre-post design was used to test the acceptability, feasibility and potential benefits of a group intervention that aims to enhance well-being.

### **Participants**

Participants were referred to the study by a Non-Profit Organization (NPO) that provides ambulatory services for people with severe psychiatric conditions. All participants were screened and referred to the group intervention by their key therapist if they met the inclusion criteria. Participants were eligible to participate if they were aged 18–65 years and had a minimum of motivation and commitment to participate in group therapy aiming well-being. At the discretion of the main therapist, participants were excluded if they had: 1) limited cognitive resources or serious formal thinking disorder and/or 2) a current diagnosis of substance dependence or a severe personality disorder that could interfere with benefiting from a psychotherapy group.

During 2018 and at the beginning of 2019, 4 therapy groups were conducted at the NPO centre. A total of 30 participants were referred and consented to take part in the study. However, there were 2 dropouts and 7 participants did not complete the post-treatment evaluation (See figure 1). Participants that completed pre and post evaluation did not differ from these 9 participants that were referred but did not attend the group on age, gender, education, employment or screening characteristics ( $p$  values all  $> .01$ ) (see table 1).

Insert figure 1

## Measures

### **Feasibility and Acceptability.**

*Protocol adherence form.* At the end of each session, group therapists filled out a 10-item inventory designed for the study in which they jointly assessed the fulfilment of the objectives in each of the sessions (e.g. explanation of the key concepts of the session, or completion of the target exercises of the session). Each group objective was rated on a 4- Likert scale (0 = “not done”; 1 = “partially done”; 2 = “fully completed”; 3 = “not applicable”). A total score was obtained by averaging all ratings, where higher scores meant higher adherence, varying from 0 (no adherence) to 20 (high adherence).

*Attendance and exercise engagement form.* At the end of each session, group therapists filled out an inventory designed for the current study in which they jointly assessed the participant’s attendance (0 = “absence”; 1 = “attendance”), his/her engagement in exercises in the session (0 = “not done”; 1 = “exercise fully completed”) and his/her engagement in exercises out of the session (0 = “not done”; 1 = “exercise fully completed”). A total attendance score is obtained by summing the number of sessions that all participants have attended, where higher scores mean higher attendance, varying from 0 (no attendance) to 11 (complete attendance). Two total exercise engagement scores are obtained (i.e. in-session and out of the session) by summing the number of exercises completed by all participants, where higher scores mean higher exercise engagement, varying from 0 (no exercise engagement) to 11 (greatest exercise engagement).

Participants’ satisfaction was measured by the **Client Satisfaction Questionnaire (CSQ-8, Larsen, Attkisson, Hargreaves, & Nguyen, 1979)**. The CSQ-8 is an 8-item measure that assessed general satisfaction with the group and employed a

4- Likert scale. Two open-ended questions were added to identify what participants liked most about the group and suggestions for changes.

**Clinical and well-being measures.**

Psychological symptoms were measured by the **Symptom Checklist 90-Revised (SCL-90-R; Derogatis, 2002)**. The SCL-90R is a 90-item self-report symptom inventory rated on a 5-point scale of distress from 0 (not at all) to 4 (a lot). The SCL-90R consists of nine primary symptom dimensions: somatisation, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. In our study, the internal consistency for each of the subscales were Cronbach's  $\alpha = 0.87$ ,  $\alpha = 0.88$ ,  $\alpha = 0.76$ ,  $\alpha = 0.89$ ,  $\alpha = 0.85$ ,  $\alpha = 0.90$ ,  $\alpha = 0.84$ ,  $\alpha = 0.81$ ,  $\alpha = 0.90$ , respectively, and, severity index Cronbach's  $\alpha = 0.97$ .

Experiential avoidance was measured by the **Acceptance and Action Questionnaire-II (AAQ-II; Bond et al., 2011)**. The AAQ-II is a 10-item revision of the original 9-item AAQ that assesses the level of tolerance to distressing mental events such as body sensations, thoughts or emotions (e.g. "I'm afraid of my feelings"). Each item is rated on a 7-point Likert scale ranging from 1 (never true) to 7 (always true). These ratings are summed up to obtain a total score. High scores indicate greater experiential avoidance and psychological inflexibility. In our study the internal consistency for this subscale was adequate ( $\alpha = 0.80$ ).

Eudaimonic well-being was measured by the **Scales of Psychological Well-Being (SPWB; Ryff & Keyes, 1995)**. The SPWB is a 54-item questionnaire that has 6 sub-dimensions with 9 items each and with scores ranging from 9 to 54 in each sub-dimension. Each item is rated using a 6-point Likert scale. These sub-dimensions are; autonomy, environmental mastery, personal growth, positive relationships with others, purpose in life and self-acceptance. Due to the initial low internal consistency found for

SPWB subscales in this study and given that low reliability diminishes the chance of significant findings (Hunter & Schmidt, 1990), items that lower the final Cronbach's  $\alpha$  for each subscale were eliminated. Other studies with samples of severe psychiatric conditions have found low internal consistency for the SPWB subscales (e.g. Browne et al., 2017). The final internal consistency after dropping items that lower the Cronbach's  $\alpha$  were; 0.68 for autonomy, 0.74 for environmental mastery, 0.81 for personal growth, 0.75 for positive relationships with others, 0.80 for purpose in life and 0.64 for self-acceptance.

Hedonic well-being was measured by **Satisfaction with life Scale (SWLS; Diener, Emmons, Larsen, & Griffin, 1985)**. The SWLS is a 5-item scale measuring a person's global level of satisfaction with their life, using a 7-point Likert scale. Higher scores indicated higher levels of satisfaction with one's life and the minimum score is 0 and the maximum possible score is 35. A sample question is: 'In most ways my life is close to my ideal'. In our study, the SWLS showed good internal reliability (Cronbach's  $\alpha = 0.83$ ).

Well-being was also measured on a weekly basis by the **Warwick-Edinburgh Mental Well-being Scale (WEMWBS; Tennant et al., 2007)**. The WEMWBS is a 14-item measure of positive well-being which frames well-being as a multi-dimensional construct. The WEMWBS uses a 5-point Likert scale. The overall score is the sum of all items, varying from 14 (indicating low well-being) to 70 (indicating high well-being). The overall scale has proven feasible, reliable, and sensitive to change in people with various mental health problems. In our study, the WEMWBS showed good internal reliability (Cronbach's  $\alpha = 0.96$ ).

## **Procedure**

Ethical approval for the study was obtained from the Deontological Commission

in the Faculty of Psychology at UCM and permission to carry out the study was obtained for the board of the NPO participating in this study. The research was conducted in compliance with the Declaration of Helsinki (Puri, Suresh, Gogtay, Thatte, 2009). All participants were informed about the study and the group intervention and signed a written informed consent before entering the study. After signing the informed consent, participants were assessed at baseline. The assessments were carried out by self-report measures and were completed with the help of a trained research assistant, who was not involved in the delivery of the group therapy. At the beginning of each group session, participants filled out an anonymous weekly assessment of well-being. There was an additional post-treatment evaluation after the completion of the last group session.

### **Intervention.**

The construction of the manual was informed by a previous pilot study carried out on people with paranoid tendencies (see Valiente et al., 2019b). Based on this previous experience, a series of steps were taken to create a new protocol that would adjust to the characteristics of severe psychiatric conditions. Six 2-hour adaptation meetings were carried out with the professionals from the specialised centres; therapy sessions were viewed and adapted one by one. In general, the adaptations involved: 1) reducing the number of exercises and metaphors; 2) simplifying the exercises and introducing elements that could facilitate the understanding of the concepts (e.g. pictograms); 3) introducing measures to increase the participant's adherence to the intervention (e.g. Cloth bracelets were created as a stimulus control intervention to cue positivity and as a reminder of homework assignments; 4) positive reinforcing strategies to increase motivation were introduced to promote the assignment completion in and

out of the group session; and 5) for those that could need extra help to understand or complete the assignments, additional support sessions were introduced.

The general aim of the intervention was to improve well-being, without denying the existence of the negative aspects, but focusing on generating positivity and actions congruent with what is important for the person. Group program was organised in three modules: 1) emotions; 2) self-acceptance; and 3) values and purpose in life (see Valiente et al., 2019b). The protocol was based on the broaden-and-build-theory (Fredrickson, 2001) and thus, the group began with hedonic well-being content and moved towards eudaimonic well-being. In the design of the intervention, the problems and contents associated with severe psychiatric conditions in the process of recovery were taken into account. However, the target processes of this intervention were not the symptoms, but rather positive experiences and positive relationships with oneself and others, the use of personal strengths and the identification of values and life purposes. Based on previous PPI experiences with people with schizophrenia (Slade, Brownell, Rashid and Schrank, 2016), we have incorporated into the protocol an emphasis on promoting positive emotions, gratitude, forgiveness and fostering personal strengths. We also integrated strategies to encourage positive self-care behaviour from compassion-focused therapy (Gilbert, 2010). In addition, concepts that are worked in ACT for psychosis are addressed (Morris, Johns & Oliver, 2013), with a focus on components such as acceptance and the establishment of goals congruent with the person's values.

All sessions had a very similar structure; although the first and last sessions had some specific components (see Valiente et al., 2019b). In session one, there was a particular emphasis on the discussion of norms and goals in the intervention, and on getting to know each other. Conversely, in session eleven, the focus was on the overview of the experiences shared in the group, celebrating and ending the group.

During the sessions, non-carbonated drinks and dried fruits were made available to create a positive emotional environment and for the savouring exercises.

All groups were conducted by two psychologists with clinical experience in people with severe psychiatric conditions and expertise conducting psychotherapy groups. A number of measures were taken to ensure adequate skill acquisition and skill maintenance. First, all group therapists were provided with 2-day (8 hours) specific training of the intervention protocol and exercises. Second, all group therapists in this study received regular one-hour sessions of bimonthly supervision where they were provided with guidelines and support. The objective of the supervision was to maintain a positive and empathic therapeutic attitude and a focus on well-being, to clarify the principles and nature of the exercises and to answer any doubts regarding the progress of the group. Third, all of the groups followed the same adapted protocol, which includes 11 weekly group sessions of 90 minutes each. The group therapists were provided with a Therapist's Handbook and a PowerPoint agenda to encourage treatment fidelity and participant's in-session attention. And forth, group leaders met prior to each group session to plan the session and exercises as described in the Therapist's Handbook. They also met after the session to discuss the group progress and filled out the Protocol adherence and Attendance and exercise engagement forms.

A number of measures were used to ensure understanding, participation and learning during intervention. First, self-disclosure of all participants and therapists was encouraged during sessions. Whenever possible after the activities (e.g. videos or exercises), the therapist opened up a space of time to share ideas or feelings generated and then introduced key concepts according to what had been said. Second, the group therapist encouraged experiential learning throughout the group using videos and demonstrative exercises (e.g. Chinese traps were used to teach the concept of

acceptance) and providing therapist modelling both in the session exercises and when discussing homework. Third, each participant was provided with a booklet with information sheets and description of exercises in session, and a set of colour-coded cards where they could do their homework exercises. Fourth, each participant was also given a *positive box* to keep the homework cards, and other things with a positive connotation (e.g. a photograph, a movie ticket, a leaf gathered during a nice walk) that brings a good memory or a pleasant emotion. Thus, the box can serve as a cue of positive experiences and savouring. Fifth, therapists were encouraged to avoid adopting an expert role or authoritarian postures. The importance of establishing horizontal relationships within the group was also emphasised (e.g. sessions were conducted in a circle and therapists were recommended to do, and briefly share, all group exercises). And finally, all participants had a referral psychologist whom they could work with on their symptoms and negative emotions - should they arise. When issues out of the group agenda arose in group, they were validated and the participant was recommended to discuss them with the key psychotherapist after the group session.

### **Data analysis**

Feasibility and acceptability of the group intervention were assessed by descriptive statistics of adherence and satisfaction with the group intervention. The analysis of participant's satisfaction combined quantitative results with results from a qualitative satisfaction to search for recommendations for specific changes to the intervention modules and delivery strategy. Exploratory outcome analysis involved Repeated Measures *t*-Tests to assess changes between pre-post evaluations of well-being, self-esteem and symptoms. In addition, within-subject effect sizes were calculated by Cohen's *d* (Cohen, 1988).

### **Results**



Demographic and screening characteristics of all participants as well as the differences between those who completed pre and post evaluations (n=21) and those that did not complete pre and/or post evaluations (n=9) are shown in Table 1. There were no differences in demographic and screening characteristics between them. All participants were on psychotropic medications and received conventional psychiatric follow-up while attending the group.

Insert table 1

### **Feasibility**

The group engaged two therapists which, including the 90-minute duration of the group across the 11 weeks (16.5-hours), preparation time before group (5.5-hours), bimonthly supervision (5-hours) and filling out the evaluation forms (2.5-hours), required approximately 29.5 hours of staff time. This was perceived as feasible in the discussions held with the centre management. Given that 30 users of the service accessed the 4 groups with two therapists each, the group intervention would account for the equivalent to approximately 7.8 staff hours for each of the participants in the course of three months. Moreover, the centre did not have to purchase further resources to run the groups. Most importantly, the group therapists reported feeling very motivated and energised with the training, supervision and the implementation of the group.

Adherence to the protocol (i.e. fulfilment of the session's objectives) as rated by group therapists was high. The mean adherence score for all sessions and for all groups was 19.45 (SD = 0.41; ranging 11-20). The total dropout rate was 30% (n=9) in this study. Of the nine participants who could not be included in the analysis, two withdrew their consent and left the study before the start of the intervention. Five of the remaining

seven participants could not be included in the analysis because they did not complete the post-evaluation and the remaining two, although they had a post-evaluation, attended only one session. Dropouts was related to medical (n = 4) or occupational (n = 3) reasons.

Participants' adherence in terms of attendance and engagement with exercises was also high. Of the 21 participants with pre and post evaluations, 6 (28.6%) had attended all sessions, 14 (66.7%) attended between 6 to 10 sessions and 1 (4.8%) attended only 5 group sessions. Of the seven participants not included in the final analyses, 4 (57.2%) had attended between 1 and 3 sessions, 2 (28.6%) between 5 and 6 sessions, and 1 (14.3%) attended 7 sessions. The mean attendance for the 28 participants that remained in the study was 8.04 (SD= 3.17; ranging 1-11), while it was 9.52 (SD= 1.60; ranging 5-11) for the 21 participants with pre and post evaluations.

In relation to exercise engagement in session, 85.7% of the participants engaged in at least 9 exercises out of a maximum of 11. The mean exercise engagement was 9.52 (SD= 1.72, ranging 5-11). In relation to homework engagement, 42.9% of the participants engaged in at least 7 exercises out of a maximum of 9. The mean homework engagement was 4.85 (SD= 3.03, ranging 0-9).

### **Acceptability**

The total mean satisfaction rating was 28.47 (SD = 2.38; range: 24-32, n = 21), indicating high satisfaction. Mean ratings were > 3.5 for all items except one which was 3 ("To what extent has our program covered your needs?"). User feedback indicated some key strengths of the intervention: a) the establishment of horizontal and warm relationships (e.g. "What I liked most was the atmosphere created, the communication and diversity of the group."); b) the didactics used (e.g. "I loved the use of metaphors and brainstorming about the different issues"); and c) the positivity shift (e.g. "I liked

the savouring and resilience sessions”). In general, the participants pointed out that they liked the content, the interpersonal dynamics and the exercises dealt in the group. Most participants reported that they would not change anything about the group, but a few of the participants pointed out that they would have liked more time and simpler explanations.

### **Analyses of clinical and well-being outcomes**

Mean scores at pre and post-treatment for the eudaimonic and hedonic well-being, symptoms and experiential avoidance are presented in Table 2. Student's *t* tests of repeated measures indicated a significant improvement over time in the SPWB subscale of self-acceptance (see table 2). Although, most of the well-being measures showed improvement at post treatment compared to baseline, these improvements were not significant in SPWB subscales (autonomy, environmental mastery, personal growth, and positive relationships with others) or in satisfaction with life. As shown in table 2, within-subject effect sizes of significant improvements were from small to medium.

Insert table 2

In addition, as shown in figure 2, there seems to be a slight tendency to improve the intersessions well-being ratings of participants during the course of the intervention, as measured by the WEMWBS, especially among participants with higher attendance.

Insert figure 2

Finally, student's *t* tests from repeated measures analyses also showed a statistically significant improvement over time in symptoms, as measured by the SLC-90-R, with declines in interpersonal sensitivity and depression. Also, these reductions were almost significant in anxiety and obsessions-compulsions sub-scales, and in severity scores, between the two-time points of evaluation (see Table 2). However, there

was no statistically significant decline in the severity of rest of SCL-90-R sub-scales or in experiential avoidance levels after treatment. As shown in table 2, within-subject effect sizes of significant improvements were from small to medium.

## **Discussion**

The main goal of this study was to determine the feasibility and acceptability of delivering a third-generation group intervention to improve well-being for people with severe psychiatric conditions. Overall, it appears that this group intervention can be implemented successfully as a complimentary intervention to psychotherapy in a clinical setting for people with severe psychiatric conditions. The implementation demonstrated that the intervention was low-cost and used procedures that were easy to apply and implement by staff. In fact, mean adherence to the protocol by the therapist was very high. It should be noted that, according to the informal evaluations made by the staff, therapists enjoyed the training and the supervision and were energised by the experience. However, some of the therapists reported that they would have liked to have had more time to review some of the content and exercises for some of the lower functioning participants.

The dropout rate in this study was comparable to other intervention trials in patients with psychosis (Wahlbeck, Tuunainen, Ahokas, & Leucht, 2001). The group protocol can be considered feasible because of the good attendance rates and the amount of exercises during the session performed by participants. Although non-adherence (Barkhof, Meijer, de Sonnevile, Linszen, & de Haan, 2012) and avoidance of mental health services (Shrivastava, Johnston, & Bureau, 2012) is a prominent problem in populations with severe psychiatric conditions, the current study found good adherence figures that may at least in part be due to the appealing aspects of the aim of the group (i.e. well-being). These results are consistent with previous studies that reported high

attendance and compliance for positive psychology interventions in clinical samples (Huffman et al., 2014; Lopez-Gomez, et al., 2017) and for people with schizophrenia (Meyer et al., 2012). However, the level of engagement with the homework outside the session was lower than in-session exercises and efforts should be made to improve it. In the positive education arena, it has been argued that positive interventions make more of a difference when there is “Live it” (targeting to staff well-being), “Teach it” (referring to the positive intervention in itself) and “Embed it” (targeting practices to promote well-being in the community) (Seligman, Rashid & Parks, 2006; Norrish, Williams, O’Connor & Robinson, 2013). It is possible that more benefit and better adherence could be achieved if the intervention is contextualised in an atmosphere that reinforces and strengthens a positive attitude in all institutional dynamics.

The level of satisfaction with the group intervention was also very high with most participants experiencing the group to be useful and beneficial with very positive ratings and comments from participants. Lopez-Gomez et al. (2017) have found comparable levels of client satisfaction with positive psychological interventions in severe clinical samples, although they indicated that the level of acceptability was not conditioned by the severity of symptoms. Like the therapists had also indicated, some participants pointed out that it would have been beneficial to have longer therapy time.

Preliminary investigation of changes in well-being dimensions, satisfaction with life, experiential avoidance and symptoms were conducted. At the end of the group, participants only reported a significant increase in the self-acceptance dimension of well-being. Such improvements may be associated with participants feeling better about themselves in spite of their limitations, which is a fundamental element for positive psychological functioning and associated to central symptoms such as paranoia (Murphy, Bentall, Freeman, O’Rourke & Hutton, 2018). Likewise, in psychotic samples,

other pioneer positive psychotherapy group interventions have found a significant improvement in similar outcomes such as self-esteem (Schrank et al., 2016) and self-efficacy (Goldberg et al., 2013). Similarly, changes in the well-being dimension of self-acceptance after a positive psychology group intervention have been reported in a clinical sample with severe depression (Chaves, Lopez-Gomez, Hervas & Vazquez, 2017). Contrary to this finding and to our expectation that the intervention would increase psychological flexibility, there was no significant pre-post effect on experiential avoidance. So, while participants were helped to accept themselves more, there was no significant improvement in their overall experiential tolerance.

The lack of significant improvement in other SPWB subscales could be associated with the sample characteristics, as it is important to note that participants in this study were people with severe mental conditions and most of them with a long psychiatric history. Many were also heavily medicated and with a high degree of chronification. Therefore, these findings of improvement, although not in all areas of welfare, are not negligible and represent progress in improving their complicated lives. Moreover, as it is portrayed in figure 2, participant's intersessions score in well-being seemed to improve as the intervention progressed. It should be noted that although participant's mean in all sessions was lower on the WEMWBS than that of the General Spanish population (Castellvi et al., 2014), the scores improved as sessions were completed.

Nevertheless, there was no significant difference in life satisfaction before and after the intervention. In this regard, there is some evidence that indicates that life satisfaction tends to be stable over time unless life circumstances change considerably (Fujita & Diener, 2001; Steger & Kashdan, 2007). It is important to note that people with severe psychiatric conditions suffer multiple social and personal disadvantages that

make it difficult to achieve the usual life goals that could promote a substantial change in one's life.

Participants in the study also reported a significant decrease in depression and interpersonal sensitivity while there were no adverse effects on other symptoms after the group intervention. Reductions in depression have also been shown in other positive psychology group interventions for people with psychotic symptoms (Schrank et al., 2016). In addition, this finding is in line with a recent meta-analysis that has emphasised the potential of positive psychological interventions not only to improve well-being, but also to reduce distress in populations with clinical disorders (Chakhssi et al., 2018). Although there were no significant reductions in paranoid ideation, participants reported a significant decrease in interpersonal sensitivity at the end of the group. Interpersonal sensitivity is a personality feature that has been related to suspiciousness after victimisation experiences and is closely connected to paranoia (Masillo et al., 2019). Interpersonal sensitivity reduction has clear implications for interpersonal functioning and social isolation, which have been shown to be a risk factor for onset of psychotic disorders (Gayer-Anderson & Morgan, 2013) and have many other negative health consequences (Campagne, 2019).

There are a number of limitations that are associated with the current study. First, the pre-post design does not allow making inferences about the efficacy of the group intervention. However, the primary purpose of the study was to assess feasibility and acceptability of the intervention in participants with SMI and so, it is considered that this design is justified. Secondly, the sample was small. Although it is important to note that this is only a pilot study and it is challenging to get large samples of SMI given the usual abandonment rates (Villeneuve, Potvin, Lesage & Nicole, 2010). Therefore, it is important that future studies include a larger sample with a comparison group to

determine the efficacy of this intervention. Third, our outcome measures were self-reported and it is therefore possible that the results are biased by demand effects or social desirability. Finally, the current study does not provide information about how long these changes were maintained and thus, future studies should address the duration of the effects of these types of interventions.

### **Final summary**

In conclusion, we found that this group intervention was feasible and helpful for people with severe psychiatric conditions in specialised health centres. These groups were well received by the therapist and participants and were rated as highly satisfactory. Overall, it appears that the group intervention had limited, but relevant clinical benefits for participants with severe psychiatric conditions. Since, reducing excessive sensitivity and distress as well as improving self-acceptance may contribute to reduced vulnerability and increased resilience in people with these conditions. However, the study was preliminary and uncontrolled, and there is a need to perform randomised controlled clinical trials of this intervention. Moreover, our findings provide preliminary data supporting the implementation of group interventions that aim at well-being, instead of reduction of symptoms, in people with severe psychiatric conditions. These results are in line with advocates of positive psychiatry such as Jeste et al (2017) which state that interventions aimed at positive processes can make important contributions. It is also in line with recent evidence that indicates that the current emphasis on symptomatic remission is not enough and that an emphasis on real life functioning is necessary (Oorschot et al., 2012)



## **Acknowledgements**

This research was supported by grants from the Spanish Ministry of Science and Innovation (PSI2016-74987-P).

We are grateful to the participants that were willing to complete the measures on repeated occasions. We thank professional in CRPS for their input in the construction of the therapist manual and their involvement in the project. We are very grateful to the Fundación Manantial that supported and welcomed our research. The authors thank James L. O’Grady for proofreading the article.

## References

- A-Tjak, J. G. L., Davis, M. L., Morina, N., Powers, M. B., Smits, J. A. J., and Emmelkamp, P. M. G. (2015). A meta-analysis of the efficacy of acceptance and commitment therapy for clinically relevant mental and physical health problems. *Psychother. Psychosom*, *84*, 30–36
- Barkhof, E., Meijer, C. J., de Sonnevile, L. M., Linszen, D. H., & de Haan, L. (2012). Interventions to improve adherence to antipsychotic medication in patients with schizophrenia—a review of the past decade. *European psychiatry*, *27*(1), 9-18.
- Bergsma, A., Have, M. T., Veenhoven, R., & Graaf, R. D. (2011). Most people with mental disorders are happy: A 3-year follow-up in the Dutch general population. *The Journal of Positive Psychology*, *6*(4), 253-259.
- Bohlmeijer, E. T., Lamers, S. M. A., & Fledderus, M. (2015). Flourishing in people with depressive symptomatology increases with Acceptance and Commitment Therapy. Post-hoc analyses of a randomized controlled trial. *Behaviour Research and Therapy*, *65*, 101–106.
- Bolier, L., Haverman, M., Westerhof, G. J., Riper, H., Smit, F., & Bohlmeijer, E. (2013). Positive psychology interventions: a meta-analysis of randomized controlled studies. *BMC public health*, *13*(1), 119-139.
- Bond, F. W., Hayes, S. C., Baer, R. A., Carpenter, K. M., Guenole, N., Orcutt, H. K., Waltz, T., & Zettle, R. D. (2011). Preliminary Psychometric Properties of the Acceptance and Action Questionnaire-II: A revised measure of psychological inflexibility and experiential avoidance. *Behavior Therapy*, *42*, 676–688
- Browne, J., Penn, D. L., Meyer-Kalos, P. S., Mueser, K. T., Estroff, S. E., Brunette, M. F. & Robinson, D. G. (2017). Psychological well-being and mental health recovery in the NIMH RAISE early treatment program. *Schizophrenia research*, *185*, 167-172.

- Campagne, D. M. (2019). Stress and Perceived Social Isolation (loneliness). *Archives of gerontology and geriatrics*, 82, 192-199.
- Castellví, P., Forero, C. G., Codony, M., Vilagut, G., Brugulat, P., Medina, A., ... & Ferrer, M. (2014). The Spanish version of the Warwick-Edinburgh Mental Well-Being Scale (WEMWBS) is valid for use in the general population. *Quality of Life Research*, 23(3), 857-868.
- Chadwick, P., Taylor, K. N., & Abba, N. (2005). Mindfulness groups for people with psychosis. *Behavioural and Cognitive Psychotherapy*, 33(3), 351-359.
- Chadwick, P., Hughes, S., Russell, D., Russell, I., & Dagnan, D. (2009). Mindfulness groups for distressing voices and paranoia: a replication and randomized feasibility trial. *Behavioural and Cognitive Psychotherapy*, 37(4), 403-412.
- Chadwick, P. (2019). Mindfulness for psychosis: a humanising therapeutic process. *Current opinion in psychology*.
- Chakhssi, F., Kraiss, J. T., Sommers-Spijkerman, M., & Bohlmeijer, E. T. (2018). The effect of positive psychology interventions on well-being and distress in clinical samples with psychiatric or somatic disorders: a systematic review and meta-analysis. *BMC psychiatry*, 18(1), 211-228.
- Chaves, C., Lopez-Gomez, I., Hervas, G., & Vazquez, C. (2017). A comparative study on the efficacy of a positive psychology intervention and a cognitive behavioral therapy for clinical depression. *Cognitive Therapy and Research*, 41(3), 417-433.
- Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences* (2nd ed.). New York: Academic Press.
- Cramer, H., Lauche, R., Haller, H., Langhorst, J., & Dobos, G. (2016). Mindfulness-and acceptance-based interventions for psychosis: a systematic review and meta-

- analysis. *Global advances in health and medicine*, 5(1), 30-43.
- Derogatis, L.R. (2002). SCL-90-R: *Cuestionario de 90 síntomas*. Madrid, Spain: TEA Ediciones.
- Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of personality assessment*, 49(1), 71–75.
- Emmons, R. A., & McCullough, M. E. (2003). Counting blessings versus burdens: An experimental investigation of gratitude and subjective well-being in daily life. *Journal of Personality and Social Psychology*, 84(2), 377–389.
- Emsley, R., Chiliza, B., Asmal, L., & Lehloenya, K. (2011). The concepts of remission and recovery in schizophrenia. *Current Opinion in Psychiatry*, 24(2), 114-121.
- Fava, G. A., & Tomba, E. (2009). Increasing psychological well-being and resilience by psychotherapeutic methods. *Journal of personality*, 77(6), 1903-1934.
- Fredrickson, B. L. (2001). The role of positive emotions in positive psychology: The broaden-and-build theory of positive emotions. *American psychologist*, 56(3), 218-229.
- Freeman, D., Garety, P., Bebbington, P., Smith, B., Rollinson, R., Fowler, D., . . . Dunn, G. (2005). Psychological investigation of the structure of paranoia in a non-clinical population. *British Journal of Psychiatry*, 186(5), 427-435.
- Fujita, F., & Diener, E. (2005). Life satisfaction set-point: Stability and change. *Journal of personality and social psychology*, 88(1), 158-164.
- Gayer-Anderson, C., & Morgan, C. (2013). Social networks, support and early psychosis: a systematic review. *Epidemiology and psychiatric sciences*, 22(2), 131-146.
- Geschwind, N., Peeters, F., Drukker, M., van Os, J., Wichers, M., 2011. Mindfulness training increases momentary positive emotions and reward experience in adults

- vulnerable to depression: a randomized controlled trial. *J. Consult. Clin. Psychol.*, 79 (5), 618.
- Gilbert, P. (2010). An Introduction to Compassion Focused Therapy in Cognitive Behavior Therapy. *International Journal of Cognitive Therapy*, 3(2), 97–112.
- Goldberg RW, Dickerson F, Lucksted A, Brown CH, Weber E, Tenhula WN, et al. (2013). Living well: an intervention to improve self-management of medical illness for individuals with serious mental illness. *Psychiatr Serv.* 64(1):51–7.
- Gu, J., Strauss, C., Bond, R., Cavanagh, K., (2015). How do mindfulness-based cognitive therapy and mindfulness-based stress reduction improve mental health and wellbeing? A systematic review and meta-analysis of mediation studies. *Clin. Psychol. Rev.* 37, 1–12.
- Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour research and therapy*, 44(1), 1-25.
- Hayes, S. C., Strosahl, K. D., & Wilson, K. G. (2012). *Acceptance and commitment therapy: The process and practice of mindful change (2nd ed.)*. New York: Guilford Press.
- Huffman, J. C., DuBois, C. M., Healy, B. C., Boehm, J. K., Kashdan, T. B., Celano, C. M. & Lyubomirsky, S. (2014). Feasibility and utility of positive psychology exercises for suicidal inpatients. *General hospital psychiatry*, 36(1), 88-94.
- Hunter, J. E., & Schmidt, F. L. (1990). *Methods of meta-analysis. Correcting error and bias in research findings*. Newbury Park: Sage Publications.
- Ivtzan, I., Young, T., Martman, J., Jeffrey, A., Lomas, T., Hart, R., & Eiroa-Orosa, F. J. (2016). Integrating mindfulness into positive psychology: A randomised controlled trial of an online positive mindfulness program. *Mindfulness*, 7(6), 1396-1407.

- Jeste, D. V., Palmer, B.W., & Saks, E. R. (2017). Why We Need Positive Psychiatry for Schizophrenia and Other Psychotic Disorders. *Schizophrenia Bulletin*, 43(2), 227-229.
- Johns, L.C., Cannon, M., Singleton, N., Murray, R.M., Farrell, M., Brugha, T., Meltzer, H. (2004). Prevalence and correlates of self-reported psychotic symptoms in the British population. *British Journal of Psychiatry*, 185(4), 298-305.
- Johns, L.C., Oliver, J.E., Khondoker, M., Byrne, M., Jolley, S., Wykes, T. & Morris E.M.J. (2016) The feasibility and acceptability of a brief Acceptance and Commitment Therapy (ACT) group intervention for people with psychosis: The ‘ACT for life’ study. *Journal of behavior therapy & experimental psychiatry*, 50, 257-263.
- Johnson, D.P., Penn, D.L., Fredrickson, B.L., Kring, A.M., Meyer, P.S., Catalino, L.I., & Brantley, M. (2011). A pilot study of loving-kindness meditation for the negative symptoms of schizophrenia. *Schizophrenia research*, 129(2-3), 137–140.
- Kahler, C. W., Spillane, N. S., Day, A., Clerkin, E. M., Parks, A., Leventhal, A. M., & Brown, R. A. (2014). Positive psychotherapy for smoking cessation: Treatment development, feasibility, and preliminary results. *Journal of Positive Psychology*, 9(1), 19-29.
- Kashdan, T. B., & Ciarrochi, J. V. (Eds.). (2013). *Mindfulness, acceptance, and positive psychology: The seven foundations of well-being*. New Harbinger Publications.
- Keyes, C. L. (2007). Promoting and protecting mental health as flourishing: A complementary strategy for improving national mental health. *American psychologist*, 62(2), 95-108.
- Keyes, C. L., Dhingra, S. S., & Simoes, E. J. (2010). Change in level of positive mental health as a predictor of future risk of mental illness. *American journal of public health*, 100 (12), 2366-2371.

- Khoury, B., Lecomte, T., Gaudiano, B. A., & Paquin, K. (2013). Mindfulness interventions for psychosis: a meta-analysis. *Schizophrenia research*, *150*(1), 176-184.
- Larsen, D. L., Attkisson, C. C., Hargreaves, W. A., & Nguyen, T. D. (1979). Assessment of client/patient satisfaction: development of a general scale. *Evaluation and program planning*, *2*(3), 197-207.
- Laws, K. R., Darlington, N., Kondel, T. K., McKenna, P. J., & Jauhar, S. (2018). Cognitive Behavioural Therapy for schizophrenia-outcomes for functioning, distress and quality of life: a meta-analysis. *BMC psychology*, *6*(1), 32.
- Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445-452.
- Lopez-Gomez, I., Chaves, C., Hervas, G., & Vazquez, C. (2017). Comparing the acceptability of a positive psychology intervention versus a cognitive behavioural therapy for clinical depression. *Clinical psychology & psychotherapy*, *24*(5), 1029-1039.
- Masillo, A., Valmaggia, L. R., Saba, R., Brandizzi, M., Lo Cascio, N., Telesforo, L., ... & Girardi, P. (2019). Interpersonal sensitivity, bullying victimization and paranoid ideation among help-seeking adolescents and young adults. *Early intervention in psychiatry*, *13*(1), 57-63.
- Meyer, P. S., Johnson, D. P., Parks, A., Iwanski, C., & Penn, D. L. (2012). Positive living: A pilot study of group positive psychotherapy for people with schizophrenia. *The Journal of Positive Psychology*, *7*(3), 239-248.
- Morris, E. M. J., Johns, L. C., & Oliver, J. E. (2013). *Acceptance and Commitment Therapy and Mindfulness for Psychosis*. John Wiley & Sons Inc.

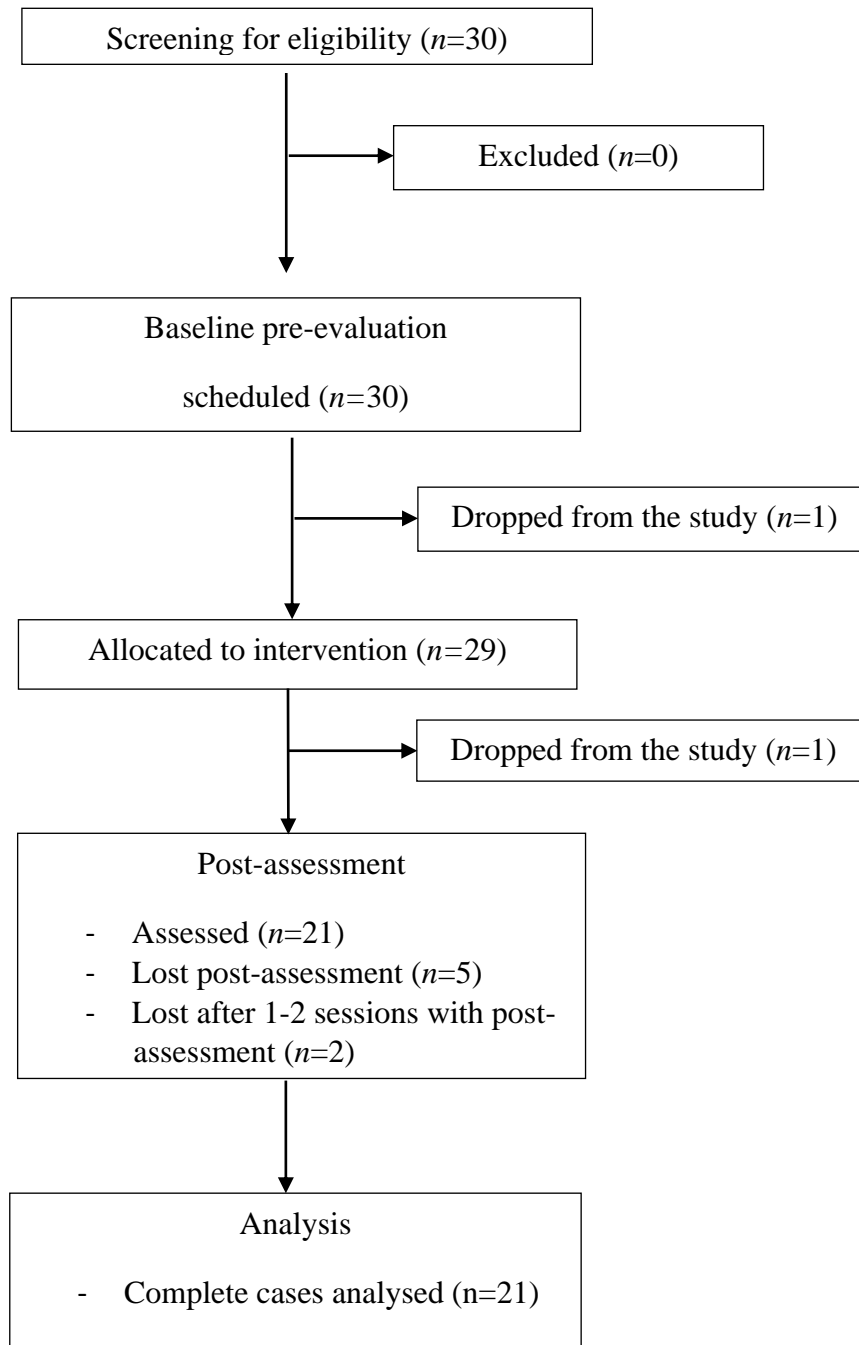
- Murphy, P., Bentall, R. P., Freeman, D., O'Rourke, S., & Hutton, P. (2018). The paranoia as defence model of persecutory delusions: a systematic review and meta-analysis. *The Lancet Psychiatry*, *5*(11), 913-929.
- Naber, D., Karow, A., & Lambert, M. (2005). Subjective well-being under neuroleptic treatment and its relevance for compliance. *Acta Psychiatrica Scandinavica*, *111*, 29-34.
- Norrish, J., Williams, P., O'Connor, M., & Robinson, J. (2013). An applied framework for positive education. *International Journal of Wellbeing*, *3*, 147–161.
- Oorschot, M., Lataster, T., Thewissen, V., Lardinois, M., Van Os, J., Delespaul, P. A. E. G., & Myin-Germeys, I. (2012). Symptomatic remission in psychosis and real-life functioning. *The British Journal of Psychiatry*, *201*(3), 215-220.
- Puri KS, Suresh KR, Gogtay NJ, Thatte UM (2009) Declaration of Helsinki, 2008: implications for stakeholders in research. *J Postgrad Med* *55*, 131–134.
- Ryff, C. D., & Keyes, C. L. M. (1995). The structure of psychological well-being revisited. *Journal of personality and social psychology*, *69*(4), 719–727.
- Schrank, B., Brownell, T., Jakaite, Z., Larkin, C., Pesola, F., Riches, S., Tylee, A., & Slade, M. (2016). Evaluation of a positive psychotherapy group intervention for people with psychosis: pilot randomized controlled trial, *Epidemiology and Psychiatric Sciences*, *25*(3), 235-246.
- Schennach-Wolff, R., Jager, M., Obermeier, M., Schmauss, M., Laux, G., Pfeiffer, H., Naber, D., Schmidt, L.G., Gaebel, W., Klosterkötter, J., Heuser, I., Kühn, K.U., Lemke, M.R., Rütger, E., Klingberg, S., Gastpar, M., Seemüller, F., Möller, H.J., & Riedel, M. (2010). Quality of life and subjective well-being in schizophrenia and schizophrenia spectrum disorders: valid predictors of symptomatic response and remission? *World J Biol Psychiatry*, *11*, 729–738.



- Seligman, M. E., Rashid, T., & Parks, A. C. (2006). Positive psychotherapy. *American psychologist*, *61*(8), 774–788.
- Seligman, M. E. (2011). *Flourish*. New York, NY: Simon & Schuster.
- Shrivastava, A., Johnston, M., & Bureau, Y. (2012). Stigma of mental illness-1: Clinical reflections. *Mens sana monographs*, *10*(1), 70.
- Shonin, E., Van Gordon, W., & Griffiths, M.D. (2014). Do mindfulness-based therapies have a role in the treatment of psychosis? *Aust NZ J Psychiatry* *48*(2), 124–127.
- Sin, N. L., & Lyubomirsky, S. (2009). Enhancing well-being and alleviating depressive symptoms with positive psychology interventions: A practice-friendly meta-analysis. *Journal of clinical psychology*, *65*(5), 467–487.
- Slade, M. (2010). Mental illness and well-being: The central importance of positive psychology and recovery approaches. *BMC health services research*, *10*(1), 26-40.
- Slade, M., Leamy, M., Bacon, F., Janosik, M., Le Boutillier, C., Williams, J., & Bird, V. (2012). International differences in understanding recovery: systematic review. *Epidemiology and Psychiatric Sciences*, *21*(4), 353-364.
- Slade, M., Brownell, T., Rashid, T., & Schrank, B. (2016). *Positive psychotherapy for psychosis: a clinician's guide and manual*. Routledge.
- Steger, M. F., & Kashdan, T. B. (2007). Stability and specificity of meaning in life and life satisfaction over one year. *Journal of Happiness Studies*, *8*(2), 161-179.
- Tennant, R., Hiller, L., Fishwick, R., Platt, S., Joseph, S., Weich, S., Stewart-Brown, S. (2007). The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation. *Health and Quality of Life Outcomes*, *5*(1), 63-76.

- Vaessen, T., Steinhart, H., Batink, T., Klippel, A., Van Nierop, M., Reininghaus, U., & Myin-Germeys, I. (2019). ACT in daily life in early psychosis: an ecological momentary intervention approach. *Psychosis*, 1–12
- Valiente, C., Espinosa, R., Contreras, A., Trucharte, A., Duque, A., Nieto, J., ... & Chaves, C. (2019b). Cultivating well-being beyond symptomatology in a clinical sample with paranoid tendencies; the feasibility, acceptability and possible benefit of a group intervention. *The Journal of Positive Psychology*, 1-12.
- Valiente, C., Espinosa, R., Trucharte, A., Nieto, J. & Martínez-Prado, L. (2019a) The challenge of wellbeing and quality of life: a meta-analysis of psychological interventions in schizophrenia. *Schizophrenia research*, 208, 16–24.
- Vázquez, C., & Hervás, G. (2008). *Psicología positiva aplicada*. Bilbao: Desclée de Brouwer.
- Villeneuve, K., Potvin, S., Lesage, A., & Nicole, L. (2010). Meta-analysis of rates of drop-out from psychosocial treatment among persons with schizophrenia spectrum disorder. *Schizophrenia Research*, 121(1-3), 266-270.
- Wahlbeck, K., Tuunainen, A., Ahokas, A., & Leucht, S. (2001). Dropout rates in randomised antipsychotic drug trials. *Psychopharmacology*, 155(3), 230-23
- Westerhof, G. J., & Keyes, C. L. (2010). Mental illness and mental health: The two continua model across the lifespan. *Journal of adult development*, 17(2), 110-119.
- Yıldız, E. (2019). The effects of acceptance and commitment therapy in psychosis treatment: A systematic review of randomized controlled trials. *Perspectives in psychiatric care*, 1-19.

**Figure 1.** Participant flow diagram



**Table 1.***Demographic and clinical characteristics of group participants*

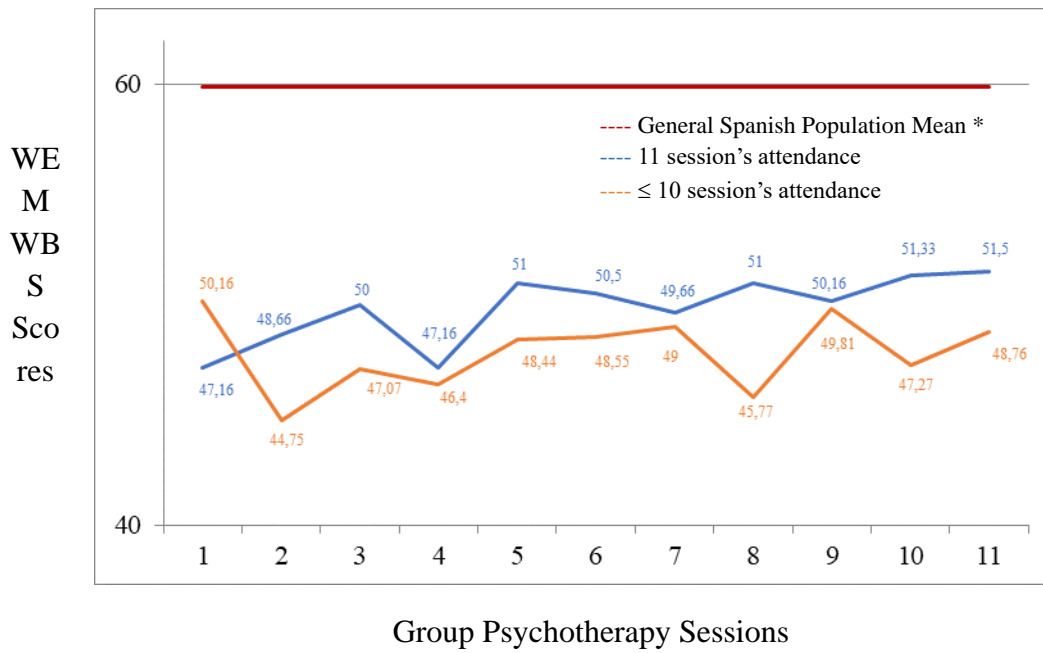
	All (N=30)	Included (n=21)	Non-included (n=9)	<i>U</i> / <i>X</i> <sup>2</sup> ( <i>df</i> )	<i>p</i>
<i>Demographic characteristics</i>					
Age in years, mean (SD)	46.37 (7.81)	46.4 (7.82)	46.2 (8.27)	87.5	0.55
Sex: Women, n (%)	21 (70)	14 (66.6)	7 (77.7)	0.37 (1)	0.44
Single status, n (%)	19 (63.3)	12 (57.1)	7 (77.7)	4.60 (4)	0.33
Education, n (%)					0.68
Secondary School	15 (50)	10 (47.61)	5 (55.5)	0.77 (2)	
College Education	6 (20)	5 (23.8)	1 (11.1)		
Unemployed, n (%)	27 (90)	18 (85.7)	9 (100)	0.49 (1)	0.67
<i>Clinical characteristics</i>					
Diagnosis, n (%)					
Schizophrenia	18 (60)	13 (61.9)	5 (55.5)		
Depressive disorders	6 (20)	3 (14.2)	3 (33.3)		
Anxiety disorders	1 (3.3)	1 (4.76)	0	1.61 (3)	0.65
Personality disorders	4 (13.3)	3 (14.2)	1 (11.1)		
Others	1 (3.3)	1 (4.76)	0		
Medication, Yes, n (%)					
Benzodiazepines	19 (63.3)	14 (66.6)	5 (55.5)	0.57 (1)	0.36
Hypnotics (No benzo)	5 (16.7)	2 (9.52)	3 (33.3)	0.86 (1)	0.12
Antipsychotics	25 (83.3)	18 (85.7)	7 (77.7)	0.84 (1)	0.65
Anti-depressants	11 (36.7)	9 (42.8)	2 (9.52)	1.36 (1)	0.22
Stabilizers mood	10 (33.3)	5 (23.8)	5 (55.5)	2.56 (1)	0.12
First symptom, n (%)					
Childhood	0	0	0		
Adolescence	6 (20)	3 (14.2)	3 (33.3)	1.54 (2)	0.46
Adulthood	21 (70)	16 (76.1)	5 (55.5)		
Other therapy-frequency, n (%)					
1 hour per week	5 (16.7)	2 (9.52)	3 (33.3)		
1 hour each 2 weeks	6 (20)	5 (23.8)	1 (11.1)	4.31 (4)	0.36
1 hour per month	10 (33.3)	8 (38)	2 (9.52)		
Less	5 (16.7)	3 (14.2)	2 (9.52)		
No therapy	2 (6.7)	2 (9.52)	0		

**Table 2.***Means and standard deviations before and after the group*

Measures, means (SDs)	Pre-treatment	Post-treatment	Student's <i>t</i> ( <i>df</i> )	<i>p</i>	<i>d</i>
SPWB (Well-being);					
Autonomy	21.1 (4.03)	20.8 (4.33)	.27 (20)	.78	.06
Environmental mastery	19.5 (5.27)	21 (4.89)	-1.61 (20)	.12	.35
Personal growth	18.3 (5.86)	18.5 (4.84)	-.18 (20)	.85	.04
Positive relationships with others	18.3 (3.81)	19.1 (2.20)	-1.12 (20)	.27	.24
Purpose in life	18.3 (5.59)	18.4 (4.90)	-.16 (20)	.87	.03
Self-acceptance	27.8 (6.01)	30.2 (4.75)	-2.81 (20)	.01*	.61
SWLS (Satisfaction with life)	20.5 (7.25)	20.3 (7.03)	.18 (20)	.85	.03
AAQ-II (Experiential avoidance)	43.7 (10.7)	41.8 (10.6)	.84 (20)	.40	.18
SCL-90-R (Symptoms);					
Somatisation	1.04 (.78)	.88 (.71)	1.47 (20)	.15	.32
Obsessions-compulsions	1.59 (.85)	1.35 (.82)	1.88 (20)	.07	.40
Interpersonal sensitivity	1.50 (.75)	1.12 (.67)	2.72 (20)	.01*	.57
Depression	1.56 (.81)	1.24 (.79)	2.90 (20)	.009**	.64
Anxiety	1.10 (.71)	.90 (.67)	1.93 (20)	.06	.40
Hostility	.56 (.57)	.55 (.81)	.11 (20)	.90	.02
Phobic anxiety	.91 (.68)	.93 (.84)	-.12 (20)	.91	.03
Paranoid ideation	1.30 (.83)	1.23 (.89)	.44 (20)	.67	.10
Psychoticism	1.11 (.85)	.90 (.80)	1.31 (20)	.20	.28
Severity index	1.22 (.61)	1.04 (.60)	1.75 (20)	.09	.38

*Note.* SPWB: Scales of Psychological Well-Being; SWLS: Satisfaction with life scale; SCL-90-R: Symptom Checklist 90-Revised; AAQ-II: Acceptance and Action Questionnaire-II. \* $p < .05$ ; \*\* $p < .01$ .

**Figure 2.** Inter-sessions well-being changes across time (N= 21)



*Note.* WEMWBS: Warwick-Edinburgh Mental Well-being Scale; \* Mean and SD for General Spanish Population was 59.9 (7.8) (Castellví et al., 2014).