June 2024

Learning and Using Positive Psychology as an Intervention for Clients: Examining Changes in Mental Health Clinician's Complete Mental Health

Frances Coolman
University of South Florida

Learning and Using Positive Psychology as an Intervention for Clients:

Examining Changes in Mental Health Clinician's Complete Mental Health

by

Frances Coolman

A thesis submitted in partial fulfillment
of the requirements for the degree of
Education Specialist
Department of Educational and Psychological Studies
College of Education
University of South Florida

Major Professor: Shannon Suldo, Ph.D.
John Ferron, Ph.D.
Evan Dart, Ph.D.

Date of Approval:
May 20, 2024

Keywords: Mental health clinicians, dual factor model, positive psychology

Acknowledgments

There are many people I am grateful for when it comes to the completion of this thesis. Too many to name individually without adding at least five additional pages and causing me to redo my table of contents, yet again. But I will start with thanking my parents, Bradley and Shindok, for instilling and fostering an undying love of learning in me and encouraging me to continue asking "but why" questions my whole life - even if it was annoying when I was younger, and they could never make it through children's books. Thank you to my sisters (Audrey, Emily, Gloria, and Nancy) for always loving and supporting me. And my brothers (Arland, Eli, and Isaiah), though I am not sure they know about this thesis. I love them dearly and cannot leave them out. Thank you to Josh, for offering to learn SAS multiple times when I was frustrated with my statistics, even though he has absolutely no statistical training at all. Thank you to my friends for genuinely caring about my thesis process and pretending to fully understand it. Thank you to my cohort for allowing me to vent and answering my technical questions so I did not have to go find the answers on my own. Thank you to Dr. Shannon Suldo, for supporting me constantly, providing timely feedback, and being a wonderful mentor and friend through my graduate studies, I truly would not be here without her. Thank you to Dr. John Ferron, for letting me stalk his office hours to fix my SAS code, interpret my results, and support me consistently through this study. Thank you to Dr. Evan Dart for being a part of my committee and my STARS mentor. Thank you to Camryn Legra, who worked on this study with me. I would not be here without her. Thank you to anyone who reads this thesis, even if you only skip to the discussion section. I would not blame you one bit. I am running out of room, so I will end my acknowledgements here. It has been a journey, but I am so unbelievably thankful for these noted people and many more in the completion of this thesis.

Table of Contents

List of Tables iv

Abstract v

Chapter I: Introduction 1
- Context and Background 1
- Statement of the Problem 4
- Purpose and Research Questions 4
- Significance: Conceptual and Theoretical Framework 7
  - Dual-Factor Model 7
- Defining Key Terms 8
  - Positive Psychology 8
  - Positive Psychology Interventions (PPI) 9
  - Dual-Factor Model of Mental Health 9
  - Subjective Well-Being 9
  - Psychopathology and Mental Illness 10
  - Community Mental Health Care 10
  - Mental Health Clinicians 10
- Delimitations 11
- Limitations 11

Chapter II: Review of the Literature 13
- Positive Psychology Overview 13
  - Subjective Well-Being 14
  - Positive Psychology Interventions 15
- Mental Health Clinicians 21
  - Types of Credentials of Mental Health Clinicians 21
  - Clinicians Adopting New Interventions 22
  - Mental Health Clinician's Well-Being 24
- Youth Mental Health Care 26
- The Positive Psychology through Happiness (PPH) Assessment and HAPPINESS 27
  - Curriculum 27
    - Intervention content. 27
    - Professional development. 29
    - Initial use. 30
- Summary 31

Chapter III: Method 32
- Setting 32

Participants 32
Ethical Considerations 34
Preliminary Study of the Intervention 35
Procedures 35
Materials and Measures 37
PPH Assessment and HAPPINESS Curriculum 37
Fidelity of Use of PPH Assessment and HAPPINESS Curriculum 38
Quantitative Measures of Clinician Outcomes 38
SWLS 39
Flourishing Scale 39
PANAS 40
PSS-10 41
Data Analysis 41

Chapter IV: Results 43
Preliminary Analyses 43
Creation of composite scores 43
Missing data analysis and treatment 44
Attrition analysis 44
Descriptive statistics 46
Research Question 1 48
Research Question 2 50
Life satisfaction 51
Flourishing 51
Positive affect 52
Negative affect 52
Perceived stress 53
Research Question 3 54

Chapter V: Discussion 60
Summary and Explanation of Findings 62
Research Question 1 62
Research Question 2 63
Research Question 3 66
Contributions to the Literature 67
Implications for Practice 68
Limitations 69
Future Directions 71
Summary 73

References 74

Appendix A: Participant Consent Form 84

Appendix B: Positive Psychology Exit Interview Protocol 87

Appendix C: Satisfaction With Life Scale 88

Appendix D: Flourishing Scale 89

Appendix E: Positive and Negative Affect Scale 90

Appendix F: Perceived Stress Scale 91

Appendix G: Self-Report of Fidelity of Use of PPH Assessment and HAPPINESS Curriculum 92

Appendix H: IRB Approval 93

List of Tables

Table 1 Mental Health Classification within the Dual-Factor Model 8

Table 2 Internal Reliability for Baseline and Post Measures 43

Table 3 Clinicians' Scores on Baseline Measures of Mental Health 46

Table 4 Descriptive Statistics: Pre-Mental Health Measures 46

Table 5 Descriptive Statistics: Post-Mental Health Measures 47

Table 6 Changes in Interventionists' Complete Mental Health 49

Table 7 Life Satisfaction (SWLS) Scores Across Time, Tests of Within- and Between-Subjects Effects 51

Table 8 Flourishing Scale (FS) Scores Across Time, Tests of Within- and Between-Subjects Effects 52

Table 9 Positive and Negative Affect (PANAS) Scores Across Time, Tests of Within- and Between-Subjects Effects 53

Table 10 Perceived Stress Scale (PSS) Scores Across Time, Tests of Within- and Between-Subjects Effects 53

Table 11 Total Exposure of Variable and Number of Youth Clients for Interventionists 56

Table 12 Correlation between Exposure to Intervention and Mental Health Gain Scores of Clinicians 57

Abstract

Traditionally, mental health was viewed as the absence of illness or disorders, but over time it has increasingly become viewed as also holding the presence of positive factors (Keyes, 2003; Ryff & Singer, 1998; Suldo & Shaffer, 2008). The switch from only focusing on negative factors to incorporating positive factors as well brought more traction to the growing field of positive psychology, defined as "the scientific study of positive experiences and positive individual traits, and the institutions that facilitate their development" (Duckworth, Steen, & Seligman, 2005, p. 630). Inclusion of both positive indicators of wellness combined with negative indicators of illness brought about the dual-factor model of mental health (Greenspoon & Saklofske, 2001). A social services organization in the southeastern U.S. that employs mental health clinicians who serve children, adolescents, and their families, created a positive psychology-based intervention called "Positive Psychology through Happiness" (PPH). The PPH was evaluated by researchers in the USF College of Education in a pilot study (2021-22) and subsequent randomized control trial (RCT; 2022-23) to inform the evidence-base for future use agency-wide. In the pilot, three participants who used the PPH regularly took part in exit interviews to describe their experiences. In addition to perceiving benefits for clients, clinicians reported feeling an increase in their own well-being, simply from using the positive psychology intervention with their clients and aspects of positive psychology in their own lives. The purpose of the current study was to examine intervention impact on clinician well-being more systematically among the clinicians who took part in the RCT addressing impact of PPH on youth client mental health outcomes. In the larger RCT, 89 clinicians consented and took

baseline measure of complete mental health, using self-report indicators of complete mental health: subjective well-being (i.e., satisfaction with life, flourishing, positive and negative affect) and distress (i.e., perceived stress). After baseline, they were randomized to intervention group (n = 45); clinicians immediately trained in PPH and asked to use it with up to their next 10 youth clients) or control group (n = 44) continue business-as-usual interventions and techniques). Of those 89 clinicians, 44 also completed posttest measures of complete mental health (n = 19 in intervention group*;* n = 25 in control group). Results of a repeated measures ANOVA indicated that, among the intervention group, there was a significant increase in satisfaction with life over time (p = .005, d = .37), as well as small decreases in negative affect (p = .008, d = .25), and perceived stress (p = .04, d = .19). The gains in life satisfaction and decreases in negative affect and perceived stress mirror findings from the pilot suggesting improvements in clinician wellness. The other measures of wellness (PA and FS) did not change significantly over time. Analyses that included a control group did not yield any statistically significant interactions between group and time, suggesting the trends for improved mental health observed among the intervention group were not unique (i.e., associated with group assignment). Further analyses of the intervention group indicated that amount of use of the PPI in sessions (i.e., "exposure" to the PPI) did not have statistically significant association with change on any indicator of complete mental health. This study indicates that there might be possible benefits of using a positive psychology-based intervention with clients for mental health clinicians' satisfaction with life, as well as decreases in negative affect and perceived stress. Implications for future research and practice are discussed.

Chapter I: Introduction

Context and Background

Overtime, mental health has changed from being viewed as only the lack of illness or a disorder, to being looked at as a complete state of being, which includes the presence of positive factors that include life satisfaction, self-acceptance, and social contribution (Keyes, 2003; Ryff & Singer, 1998; Suldo & Doll, 2021; Suldo & Shaffer, 2008). This focus on positive experiences and positive individual traits, as well as the institutions that help facilitate this development, is known as positive psychology (Duckworth et al., 2005). Seligman and Csikszentmihalyi devoted a special issue of the *American Psychologist* to positive psychology in January 2000, pointing out that psychology had its focus on negative events (i.e., depression, racism, violence, etc.) and hardly anything to say about positive aspects such as character strengths, virtues, and the various conditions that could lead to higher levels of happiness or civic engagement. This opened what is known as the positive psychology movement (Gable & Haidt, 2005).

Positive psychology specifically looks at the conditions and processes that contribute to flourishing or optimal functioning in people, institutions, and groups (Gable & Haidt, 2005). The focus is on well-being and optimal functioning through building on strengths and not simply attempting to correct weaknesses, as the this does not automatically allow for lives to be filled with meaning and purpose. While alleviating negative symptoms might not bring about meaning and purpose, it is possible that the fostering of positive emotions and building character could alleviate suffering and undo some of its root causes (Duckworth et al., 2005). The pairing of positive indicators of wellness mixed with the traditional negative indicators of illness to

completely measure mental health is known as the dual-factor model of mental health (Suldo & Doll, 2021; Suldo & Shaffer, 2008).

Through this movement, positive psychology interventions (PPI) became increasingly popular to use in treating mental health among clients referred for therapy as well as individuals without psychopathology who were merely seeking to improve their emotional well-being. Thinking about the dual-factor model, PPIs were logically developed due to the recognition that well-being and psychopathology are two independent constructs (Carr et al., 2021). PPIs can be broadly defined as interventions grounded in the science of positive emotions, with the main goal of increasing well-being, not just reducing symptoms (Schueller et al., 2014). Tejada-Gallardo and colleagues (2020) conducted a meta-analysis of studies evaluating PPIs used in schools with adolescents and found a significant small effect size for subjective well-being, psychological well-being, and changes on depression symptoms, with the effects on psychological well-being and depression being observed to remain significant overtime. Carr and colleagues (2021) used the broad definition of PPIs to conduct a meta-analysis looking at 347 studies with an average age of 36.75 years old, inclusive of child and adult samples. They found at post-test that PPIs had statistically significant small to medium effects on anxiety, stress, quality of life, strengths, well-being, and depression (Carr et al., 2021). Taken together, this meta-analytic work shows that PPIs are impactful and beneficial to children, adolescents, and adults.

Mental health clinicians, counselors, and psychologists engage in a risky but also rewarding career path. Through their work with clients, they are often exposed to trauma and can be impacted by the negative and painful consequences that accompany it, known as vicarious traumatization, which can impact not only the professional at work and in their personal lives, but also the professional's relationship with their clients (Harrison & Westood, 2009). These

mental health professionals are susceptible to negative impacts with their professional lives which can weaken their therapeutic effectiveness (Richards et al., 2010). Working as a mental health clinician can be emotionally demanding as well as challenging, and without attending to their own functioning and overall wellness, they can be at risk of developing problems with their professional competence as well as high levels of burnout (Dreison et al., 2018; Elman & Forrest, 2007). Those who serve in the field of mental health therapy and counseling have important jobs, but this work does not come without risk to one's own well-being and the need to protect or enhance it to help their clients achieve the best outcomes, as counselors who are well are more likely to help clients (Lawson & Myers, 2011).

As positive psychology interventions gain traction and popularity, it is not uncommon for their methods to be used not only in research, but also in clinical care. Sin and Lyubomirsky (2009) conducted a meta-analysis of the effectiveness of PPIs on enhancing well-being and alleviating depressive symptoms specifically within clinical practice. Results of this meta-analysis with 49 studies indicated that well-being was significantly enhanced, and depressive symptoms were effectively treated, both with a medium-sized effect (Sin & Lyubomirsky, 2009). In 2021, van Agteren and colleagues found through a systematic review and meta-analysis of psychological interventions aimed at improving mental wellbeing that multi-component PPIs and mindfulness-based interventions had the greatest efficacy when used with clinical and non-clinical populations. This shows how PPIs can be useful not only with general populations in instances of typically functioning adults who volunteer to take part in research studies, but also in clinical care when it comes to increasing well-being and alleviating negative symptoms. In comparison to other psychological interventions such as cognitive behavioral therapy (CBT) or

acceptance and commitment therapy (ACT), PPIs had the greatest impacts of improving mental wellbeing of those in the general population (van Agteren et al., 2021).

Statement of Problem

A growing body of research shows that PPIs can be beneficial to youth in the school setting, as well as a treatment for adults in a variety of different settings. As positive psychology continues to gain popularity, more and more use of these types of interventions are used to foster complete mental health, from a dual-factor model standpoint (i.e., increasing positive symptoms as well as decreasing negative symptoms; Suldo & Doll, 2021). Mental health clinicians are impacted by the taxing, yet rewarding work they partake in with their clients. It is important for these clinicians to have high, as compared to low, levels of personal well-being, in order for them to serve their clients as best as possible. The well-being of mental health professionals is one of high importance, as these individual's work to support others' overall well-being, and are shown to help increase client's wellness when they are well themselves (Lawson & Myers, 2011). While various interventions have been advanced for clinician use to increase their well-being such as deliberate self-care measures, meditation, and mindfulness (Posluns & Gall, 2020; Richards et al., 2010; Simionato et al., 2019), it may be useful and efficient if they could increase their well-being through exposure to positive psychology, from learning about and implementing these strategies with their clients and possibly using some of these strategies themselves.

Purpose and Research Questions

Senior leadership within a social services organization aspired to train its workforce of mental health clinicians in a positive psychology approach to clinical assessment and intervention in order to further increase their clients' subjective well-being. Lead clinicians within the agency manualized this approach, termed the Positive Psychology through Happiness

(PPH) Assessment and HAPPINESS Curriculum, and contracted researchers within the USF College of Education to pilot, refine, and evaluate this new intervention in a 2-year study (2021-23). In the pilot of clinician acceptability and utility (Suldo et al., 2023), analysis of exit interviews with participants suggested that clinicians perceived increases in their subjective well-being, simply from learning the PPH, using it with their clients, and using some of the positive psychology strategies in their own personal lives (Suldo et al., 2023). Prior research suggests that mental health clinicians with higher levels of well-being and overall wellness are able to better help their clients, as their well-being constitutes a vulnerability to sound service provision (Simionato et al., 2019). Posluns and Gall's (2019) literature review supported the need for mental health clinicians to take care of themselves, as practitioner burnout and lower levels of well-being can reduce the level of therapeutic care they provide, impacting overall therapeutic effectiveness. The program evaluation of the PPH (2021-23) involved random assignment of clinicians to an intervention group (training in and use of PPH) or control group (continue with using existing interventions as usual). As clinician's might not have had any previous exposure to positive psychology, simply being trained in PPH and learning about positive psychology could allow for changes in their own complete mental health, for instance if they apply positive psychology assessment and intervention strategies to themselves. The primary outcomes of this evaluation involve change in client outcomes, indicators of well-being and psychopathology, and client acceptability. The current study focuses on secondary effects of the PPH on clinician well-being and compares the end-of-study complete mental health of the clinicians in the intervention group to that of the clinicians in the control group. Any changes in clinicians in the intervention groups' complete mental health were also examined from their pre and post measurements. The

purpose of the current study was to measure and analyze clinicians' personal well-being to answer the following research questions:

1) Among clinicians in the intervention group who were trained in a positive psychology intervention intended for use with their clients, do they experience significant changes in personal mental health as indicated levels of:
    a. Satisfaction with life
    b. Flourishing
    c. Positive affect
    d. Negative affect
    e. Perceived stress?
2) Are end-of-year or changes in personal mental health among clinicians who were trained in a positive psychology intervention significantly different from end-of-year changes in mental health among peer clinicians assigned to continue using business-as-usual interventions during the same time period, with respect to levels of
    a. Satisfaction with life
    b. Flourishing
    c. Positive affect
    d. Negative affect
    e. Perceived stress?
3) To what extent do clinicians randomly assigned to complete training in the positive psychology-based intervention use it in subsequent months, and is there a variation in how much it is used and changes in subjective well-being?

Significance: Conceptual and Theoretical Framework

Dual-Factor Model

With the shift from focusing on a deficit-based model of mental health to including an individual's well-being, this complete picture of mental health brought about what is known as the dual-factor model (Greenspoon & Saklofske, 2001; Suldo & Doll, 2021). This model emphasizes how mental health is reflected not only in measures of psychopathology, but also in indictors of subjective well-being. When examined with youth, the presence of well-being does not necessarily mean the absence of psychopathology, though there is some correlation (Suldo & Doll, 2021). The interaction of the two domains (psychopathology and subjective well-being) creates four different quadrants of mental health level, depicted in Table 1. These four quadrants include: 1) both low psychopathology and low mental health (*Vulnerable*), 2) both high psychopathology and high mental health (*Symptomatic but content*), 3) both high psychopathology and low mental health (*Troubled*), or 4) both low psychopathology and high mental health (*Complete mental health*) (Suldo & Doll, 2021; Suldo & Shaffer, 2008). When examining mental health clinicians' subjective well-being, it is important to keep their complete mental health in mind. While there are multiple studies examining the dual-factor model with youth (Suldo & Doll, 2021), there have been fewer published applications done with adults. In an exception, Fraken and colleagues (2018) examined the dual continua model of well-being and psychology with 472 adults (M age = 44.4 year's) who completed two self-report measures, one measuring well-being (Mental Health Continuum Short Form; Keyes, 2005) and one measuring psychopathology (The Outcome Questionnaire; Lambert et al., 2004). This study was done specifically to validate the Mental Health Continuum Short Form and the dual continua model of well-being/psychopathology within an adult mental health setting. The researchers found

support for the four aforementioned groups, "suggesting that the dual continua model is widely applicable in mental health care" (Fraken et al, 2018, p. 2198). The current study examines clinician's complete mental health, by assessing their subjective well-being and perceived stress (an aspect of psychopathology) adding to the dual-factor model in terms of adults, and not students.

Table 1
Mental Health Classification within the Dual-Factor Model

Levels of Psychopathology	Levels of Subjective Well-Being	
	Average to High	Low
Elevated	Symptomatic but content	Troubled
Low	Complete mental health	Vulnerable

Note: model drawn from Suldo and Shaffer (2008)

Defining Key Terms

Positive Psychology

"Positive psychology is the study of conditions and processes that contribute to the flourishing or optimal functioning of people, groups, and institutions" (Gable & Haidt, 2005, p. 104). Positive psychology is the scientific study of human strengths and virtues, what makes life worth living, and what creates well-being amongst people. The aim of positive psychology is to not only focus on fixing what is wrong, but also to build the best qualities in life. This addresses positive subjective experience through well-being, satisfaction, flow, joy, happiness, optimism, hope, and faith (Seligman, 2002).

Positive Psychology Interventions (PPI)

PPIs emerged with the positive psychology movement as the development and evaluation of interventions that aimed to enhance well-being (i.e., setting valued goals, imagining one's best self, using signature strengths, savoring past or present pleasures, being grateful for positive experiences, developing optimism, etc.). In sum, PPIs are both treatment methods as well as intentional activities that aim to cultivate positive cognitions, behaviors, or feelings (van Agteren et al., 2021). Using a broad definition, PPIs are evidence-based interventions that have a primary goal of increasing one's wellbeing and were developed within the field of psychology (Carr et al., 2021). In the current study, the PPI being examined (PPH) is not evidence-based yet, as it is a new intervention, but was created off principles of previous evidence-based PPIs.

Dual-Factor Model of Mental Health

The dual-factor model of mental health is the complete state of being, consisting of the presence of positive factors, wellness, as well as the absence of mental illness or disorder, not simply one or the other (Suldo & Shaffer, 2008) as depicted in Table 1.

Subjective Well-Being

Subjective well-being has been fundamentally defined as the combination of emotional and cognitive constructs (i.e., life satisfaction) and the frequency to which one experiences positive and/or negative emotions (Diener et al., 2009). Life satisfaction is one of the key aspects of subjective well-being. The constitutive definition of life satisfaction by Diener et al. (1985) reflects a cognitive judgment of one's perceived quality of life. Flourishing refers to when one experiences positive emotions and functioning most of the time and is another positive indicator of mental health (Gable & Haidt, 2005).

Psychopathology and Mental Illness

Mental illness is defined by the National Institute of Mental Health as a mental, behavioral, or emotional disorder that can vary in impact from no impairment to mild, moderate, or even severe (2022). One indicator of distress tied to mental illness is the impact of perceived stress, or how objectively stressful events can be determined by one's own perceptions of how stressful they are (Cohen et al., 1983). Historically, psychological research and practice have typically ignored positive functioning and well-being, focusing only on the treatment of mental illness (Chakhssi et al., 2018).

Community Mental Health Care

Thornicroft and colleagues (2016) define community mental health care as care that is encompassing of a population approach that views patients in socio-economic context that is individual and also population-based prevention allowing open access to team-based services and is cost-effective. Community mental health care from this definition not only focuses on one's deficits and disabilities, but also on one's strengths and capabilities through the community, including service to youth and families.

Mental Health Clinicians

Mental health service providers can include a wide variety of credentialed professionals, referred to sometimes interchangeably as psychologists, counselors, therapists, and clinicians. In this study, the term *mental health clinicians* refers to at a minimum masters-level health care professionals, trained to evaluate one's mental health and use therapeutic techniques based on specific training programs. Their goal is to work with clients in order to reduce symptoms and help them find better ways of thinking, feeling, and living (NAMI, 2020).

Delimitations

This study involves secondary analysis of data from a randomized control trial with willing mental health clinicians at the community agency. All of these clinicians work in a southeast state and are employed by the agency within various regions. Half of these clinicians were randomly assigned to learn and implement the Positive Psychology through Happiness assessment and HAPPINESS curriculum starting in August 2022, while the other half did not have access to this new intervention until August 2023. Baseline data on all participants subjective well-being was recorded initially during the summer of 2022, before the randomization had occurred, and again during the summer of 2023, after the randomized control trial period ended. Aggregated data compares self-report outcomes from the control and intervention group. Further details regarding the measures, scales, and methodology to collect this data will be discussed in later chapters. Findings of this study generalize only to clinicians at this one agency.

Limitations

A limitation to this study is the variation of fidelity of implementation of the new intervention by clinicians randomized to the intervention condition; for unknown reasons perhaps related to acceptability, clinicians differ in the extent to that they adopted and employed this positive psychology intervention. Clinicians are required to use this new intervention as one of their tools with clients, but not as their only tool, which created varying degrees of usage between clinicians. For instance, some clinicians in the intervention group might only use it minimally, < 10% of a session, while others might use the entire program, ~100% of a session. Clinicians may also have varying amounts of buy-in to the positive psychology intervention, which may have impacted their thoughts around its efficacy and overall usage, which then might

be a factor that impacted the levels of changes we saw in clinician's subjective well-being. Other life factors when post data are collected may have interfered with subjective well-being data being collected. Clinicians who are in the control group might have experience with positive psychology from previous training and education, which could impact their outcomes on the subjective well-being measures. The larger program evaluation (randomized control trial) was not specifically initially designed to look at changes in clinicians; instead, the focus was on student outcomes. This researcher's interest in clinician outcomes was a preliminary byproduct of clinician experiences noticed from data collected during the pilot year. Clinicians are not learning this intervention to implement in their own lives, simply it was learnt to use with their clients and this researcher looked to see if this exposure and association had any changes on these clinician's own complete mental health (subjective well-being and perceived stress).

Chapter II: Review of the Literature

In order to better understand positive psychology interventions (PPIs) and possible changes in mental health clinicians' outcomes from learning about and utilizing this approach, topics such as PPIs, mental health clinician's well-being, and various treatments mental health clinicians use are further explored in this chapter. A brief review of PPIs is included to set the stage as to why clinicians are using this modern intervention approach that is based in positive psychology. Next, mental health outcomes including subjective well-being are explored further in depth, specifically that of mental health clinicians and why this is important. Looking at adults' mental health, previous research done with the dual-factor model is described. The current practices of mental health clinicians were also examined, to try and better understand mental health clinicians' well-being.

Positive Psychology Overview

Positive psychology focuses on promoting well-being and an individual's ability to thrive, despite possible mental illnesses, such as anxiety or depression. Positive psychology is the scientific study of positive experiences and individual's positive traits, and the institutions that facilitate their development (Duckworth et al., 2005). Not only does research in the field of positive psychology study individuals and their environments, it also examines groups and institutions as a whole, looking at how they flourish or have optimal functioning (Gable & Haidt, 2005). This focus of study developed from a realization that research tended to concentrate on damage and disorder and not the aspects of what make life worth living.

Seligman (2002) noted that the word "happy" is scientifically unmanageable. Therefore, positive psychology was split into three more manageable domains: 1) the pleasant life, 2) the engaged life, and 3) the meaningful life. The *pleasant life* is concerned with positive emotions from the past (i.e., contentment, satisfaction), present (i.e., somatic pleasure, immediate and momentary sensory delights), and future (i.e., optimism, hope, faith). This domain maximizes positive emotions and minimizes negative emotions as well as pain. The *engaged life* uses an individual's positive traits, including character strengths and one's unique talents. One's deployment of individual positive strengths and talents creates the engaged life because this leads to overall more engagement, absorption, and flow. The *meaningful life*, which is the last domain, entails belonging to and serving positive institutions that enable the best in human nature. Some of these include strong families, strong communities, and democracy. It is believed that positive traits and emotions flourish their best in the environment of positive institutions (Gable & Haidt, 2005). Since meaning derives from belonging to and serving something larger than oneself, a meaningful life comes from serving something larger than oneself. These three domains make up different avenues to the term "happiness", each in its own respectable way (Seligman 2002; Gable & Haidt, 2005).

Subjective Well-Being

The use of positive psychology has created access for individuals to learn tools to increase their lives in these three domains, with the goal of increasing happiness, commonly operationalized as subjective well-being (Diener et al., 2009; Greenspoon & Saklofske, 2001). Subjective well-being and life satisfaction are ways for one to indicate how they feel about their life; past, present, and/or future. "A person who has high subjective well-being experiences frequent positive emotions, infrequent negative emotion, and an overall judgement of high

satisfaction with his or her life on the whole" (Suldo et al., 2014, p. 20). Subjective well-being is important to the current study, as the compilation of indicators used to fully assess the clinicians' outcomes will create an overall picture of their subjective well-being as part of their complete mental health.

The components of well-being broken down include "the presence of positive emotion, the absence of negative emotion, and a cognitive judgment of satisfaction and fulfillment" (Duckworth et al., 2005, p. 636). It is important to keep in mind that this is all of subjective importance, which is how these well-being measures have been created. One of the most widely used well-being measures of life satisfaction among adults is the Satisfaction with Life Scale (SWLS; Diener 1985; Appendix C). The SWLS is a self-report measure that highly correlates (*r*'s about 0.8) with other well-being measures such as the Subjective Happiness Scale and the Fordyce Happiness Measure (1988). Common measures of affective experiences in adults include the Positive and Negative Affect Scale (PANAS; Watson et al., 1988; Appendix E). The PANAS is a self-report measure that is a valid and reliable tool for gauging positive and negative affect (Merz et al., 2013). As well-being is typically subjective, self-report scales are especially appropriate, as individuals are able to evaluate their own experiences (Duckworth et al., 2005). Subjective well-being- reflected in level of life satisfaction and frequency of positive and negative affect (i.e., self-report judgements of one's well-being) were used to measure clinicians' outcomes in the current study.

Positive Psychology Interventions

There is a growing literature surrounding positive psychology interventions (PPI) applied in a variety of settings, with multiple of age groups, and for diverse purposes ranging from prevention and promotion to treatment (Carr et al., 2021; Chakhssi et al., 2018; Furchtlehner et

al., 2020; van Ageteren et al., 2021). Given the focus of this thesis, this section of the literature review will focus primarily on the impact of PPIs on subjective well-being *in adults* and use of PPIs in *clinical counseling settings*. Even though the current study is derived from a RCT examining change in youth clients' subjective well-being, this study aims to examine how the use of a positive psychology-based intervention changes subjective well-being outcomes for the clinician being trained in and implementing them.

Carr et al. (2021) conducted a systematic review and meta-analysis around the effectiveness of PPIs. Positive psychology interventions are generally considered interventions that are designed to increase well-being through building pleasure, engagement, meaning, and positive emotions (Duckworth et al., 2005). This review broadly defined PPIs and included studies that described randomized control trials (RCTs), cluster RCTs, or other randomization pairings that evaluated PPIs by having an intervention that aimed at increasing well-being consistent with positive psychology theory. A few examples of PPI activities would be setting valued goals, using signature strengths, developing optimism, savoring past or present experiences, strengthening relationships, etc. (Carr et al., 2021). PPIs encompass a wide array of things, making it difficult to provide a precise definition. For the purpose of the current study, a broad inclusive definition of positive psychology interventions was used. This definition is "evidence-based interventions which have the primary aim of increasing wellbeing (not just reducing symptoms), that have been developed within any field of psychology" (Carr et al., 2021, p. 749).

The systematic review and meta-analysis by Carr and colleagues (2021) looked only at PPIs that were evaluated in quantitative studies, using RCT designs, that included outcome measures of well-being or strengths through pathways of positive psychology. The end result

yielded 336 papers with 347 studies with an average age of participant being 36.75 years old (*SD* = 21.16). At post-test, Carr et al. (2021) reported a statistically significant small to medium effect of PPI on anxiety (g = −0.62), stress (g = −0.58), QoL (g = 0.48), strengths (g = 0.46), wellbeing (g = 0.39), and depression (g = −0.39), with this same small to medium effect size staying consistent at the three months follow-up, though this did not stay true at the seven-month follow-up. Implications of these findings point towards the applicability of PPIs as a useful tool for prevention in non-clinical populations and as a treatment strategy for those in clinical populations with various levels of psychopathology, all around showing usefulness of PPIs on those they are aiming to treat (Carr et al., 2021). van Agteren and colleagues (2021) published another systematic review and meta-analysis looking at psychological interventions aimed to improve mental well-being in both clinical and non-clinical populations. This large meta-analysis and systematic review used studies that had PPI usage in workforces, schools, the general community, and clinical settings, all offered in a variety of formats and intensities. With a total of 419 RCT examined (*n* = 53,299) it was found that mental well-being can be significantly improved consistently with multi-component (i.e., use more than one activity or exercise) PPIs and mindfulness-based interventions, with singular PPIs also proving to be moderately effective (but less so than multicomponent intervention). These results support the use of higher-intensity, multi-component PPI programs compared to singular activities and exercises (van Agteren et al., 2021). This is promising for the current study, as PPH involves many components of positive psychology.

As the current study is examining how being trained in a PPI might influence mental health clinicians' well-being at their place of work, the next systematic review by Cameron and Caza (2004) is relevant in that it looked specifically at PPI studies in organizational contexts of

working adults. These contexts are places such as working in healthcare, teachers, IT, agencies, etc., examining if employee well-being and performance were enhanced with PPI usage. It was shown that positive psychology applied to a workplace leads to benefits for both the individual and workplace as a whole, aiming for individual and organizational flourishing (Cameron & Caza, 2004). Meyers and colleagues (2013) identified 15 articles with 1540 participants total that covered a range of interventions such as, but not limited to, programs that enhance resilience, gratitude, and/or provide solution-focused coaching. The goal of this systematic review was to summarize the findings of PPI studies specifically within organizational contexts, which is pertinent to the current study as the knowledge and practice of PPIs could residually increase clinicians' own well-being and potentially that of the organization as a whole following agency-wide adoption of a promising PPI. Of note, employees with higher levels of subjective well-being are less likely to leave their organization, have enhanced levels of creativity, and facilitate the building of cognitive, social, and physical resources (Meyers et al., 2013).

Donaldson and colleagues (2019) examined PPIs implemented at work, finding 22 studies (N=6207) that revealed PPIs had a small to moderate effect on desirable and undesirable work outcomes. They found that through use of PPIs at work there was an improvement in job well-being, personal well-being, engagement, workplace trust, prosocial behavior and a reduction in job stress, all of which are important in a functioning work environment (Donaldson et al., 2019). These meta-analyses found that implementing PPIs in the work context did consistently enhance the well-being of employees, and therefore have an impact on the organizational context (Donaldson et al., 2019; Meyers et al., 2013). Thus, there is evidence that positive psychology interventions may support increases for well-being on an individual level as well as an organizational level (Carr et al., 2021; Donaldson et al., 2019; Meyers et al., 2013).

This is promising for the current study which anticipates increases in clinician's individual levels of well-being, which could eventually promote workplace well-being.

PPIs are also being used specifically in clinical practices. D'raven and Pasha-Zaidi (2014) examined the use of positive psychology with counseling practitioners, stating that

> Positive psychology shares many of the same goals as those found in counseling psychology and focuses on the prevention of mental illness, the promotion of positive mental health, and the treatment of distress by strengthening what is good and generating positive emotions to help clients attain grater levels of functioning (p. 384).

The PPIs reviewed in this article focused on ones that are low-cost and quick to generate results by building positive emotions and experiences for clients in both clinical and nonclinical settings. D'raven and Pasha-Zaidi (2014) found that a number of these PPIs (e.g., acts of kindness, writing about positive experiences, gratitude, goal setting, character strengths, and savoring) used by clinicians helped their clients increase levels of happiness. Thus, this review highlighted the importance of using PPIs within counseling settings. Both positive psychology and counseling traditions focus on positive aspects of human development and functioning with the target of wellness as the goal for their intervention, highlighting how the use of PPIs in counseling psychology can be beneficial for the positive psychology field (D'raven & Pasha-Zaidi, 2014). Considering how these clinicians may use positive psychology in their practice, this assertion from D'raven and Pasha-Zaidi is important to note: "counseling practitioners who incorporate PPIs into their practice can themselves benefit from the new, yet old, science of well-being and expand their range of counseling skills and techniques for greater professional flexibility" (p. 397, 2014).

A meta-analysis conducted by Sin and Lyubomirsky (2009) examined PPIs in the context of clinical practice and its enhancement of well-being, as well as alleviation of depressive symptoms, aligning then with outcomes that are salient in a dual-factor model. Through the examination of 51 PPIs with 4,266 individuals, Sin and Lyubomrisky (2009) concluded that PPIs are significant in enhancing well-being as well as decreasing depressive symptoms through therapy, intervention, or activity that was primarily aimed at increasing positive feelings, behaviors or cognitions. Regarding implications for counselors using PPIs in their practice, practitioners have the unique skills and knowledge to facilitate individual growth, in both clinical and research settings, with various populations, which makes counselors ideal to implement PPIs in both clinical and research settings (D'raven & Pasha-Zaidi, 2014; Furchtlehner et al., 2020). This supports the notion that clinicians in the current study can effectively adopt and implement a PPI framework compared to their traditional methods.

More recently, Chakhssi and colleagues (2018) conducted a systematic review and meta-analysis on the effect of PPI on well-being and distress in clinical samples, specifically within a clinical setting for adults. They explored how PPIs impact well-being, depression, anxiety and stress in clinical samples with psychiatric or somatic disorders. A total of 30 studies were included, with 1864 patients (*M* age = 47.8 years old, *SD* = 11.5) with somatic or psychiatric disorders (e.g., cancer, chronic pain, depressive disorder, anxiety disorders, etc.). In comparison to control groups, this analysis and review found that PPIs have a small but significant effect on well-being and depression both at post-intervention and follow-up, with moderate significant effect sizes for anxiety at post-intervention and follow-up and stress effect sizes insignificant (Chakhssi et al., 2018). This study is important because it looks at a population who historically has lower well-being compared to the general population. It relates to the current study as those

individuals who might be receiving positive psychology treatment from the clinicians may have psychiatric disorders.

In an example of the utility of PPIs as compared to traditional treatments, researchers have examined outcomes of clients with depression treated with positive psychotherapy (Rashid & Seligman, 2018) in comparison to cognitive-behavioral therapy (Furchtlehner et al., 2020). Positive psychotherapy includes strengths and resource-based, rather than problem-focused, therapeutic approaches that are broadly based on positive psychology principles. This RCT found that depressive symptoms and common psychological distress were reduced further by those in the positive psychotherapy group, indicating that positive psychotherapy is particularly effective in alleviating depressive symptoms (Furchtlehner et al., 2020). In van Ageteren and colleagues (2021) systematic review and meta-analysis, similar results were found. PPIs demonstrated the greatest efficacy in both clinical and non-clinical populations, even greater than cognitive behavioral therapy-based and acceptance and commitment therapy-based interventions (van Ageteren et al., 2021).

Mental Health Clinicians

Types of Credentials of Mental Health Clinicians

There are a variety of different types of mental health professionals with various degrees that serve within the mental health field. Their job titles and specialties can vary by state. They can work in a variety of settings, such as general hospitals and psychiatric facilities, and outpatient facilities (i.e., community mental health clinics, schools, and private practices.) Psychologists generally hold a doctoral degree in clinical, counseling, or education-based psychology. School psychologists can have either a doctoral or Educational Specialist (Ed.S.) degree or equivalent (i.e., master's degree plus additional specialty training). Mental health

counselors, clinicians, and therapists include masters-level health care professionals with degrees in a mental health related field such as psychology, counseling psychology, and marriage or family therapy. Clinical social workers with a master's degree in social work can also serve as mental health professionals. Regardless of degree or job title, each individual must obtain the appropriate licensure and credentials required by their state (NAMI, 2023).

According to the Florida Board of Clinical Social Work, Marriage & Family Therapy and Mental Health Counseling, in order to be licensed as a Mental Health Counselor in Florida, one must have: the appropriate transcript showing the minimum of an earned master's degree from an institutionally accredited program in the appropriate field, two years of post-master's supervised experience with a qualified supervisor, license verification, completed the appropriate courses (i.e., laws & rules, HIV/AIDS, and domestic violence), and passed the National Clinical Mental Health Counseling Examination (2023). At this agency, all clinicians have at least a master's level degree and hold the appropriate credentials to be a mental health counselor. The majority of them work in school-based programs that the agency partners with, though they are not a school-based organization (2023).

Clinicians Adopting New Interventions

Mental health professionals serve youth and families with various treatments and interventions, yet these professionals' attitudes toward organizational change have not been well studied (Aarons, 2004). While there is a small amount of research surrounding mental health professionals adopting specific interventions, Aarons (2004) is the only study this author found about attitudes of clinicians involved in disseminating and implementing evidence-based practices as a whole, within their organizations. Aarons (2004) assessed 332 clinical and case management service providers and 51 program managers who provided mental health services to

children, adolescents, and their families. Aarons found that there are four different dimensions to be examined when introducing a new intervention to existing clinicians: 1) willingness to adopt a new practice if required, 2) willingness to adopt a new practice given their intuitive appeal, 3) general openness toward new or innovative practices, and 4) perceived divergence of usual practice with academically developed or research-based practices (Aarons, 2004).

Building off of Aarons' (2004) study, Frank and colleagues (2020) completed a systematic review of therapist training approaches as a whole. Specifically, this review examined different training models, as a lack of effective therapist training is a major barrier to evidence-based delivery. The 76 studies used for this review found that there are still barriers to therapists implementing new and adopting new evidence-based interventions, but workshops in combination with consultation are most successful approach to increasing self-reported evidence-based intervention use (Frank et al., 2020). Perhaps due to some or all of the four dimensions Aarons (2004) noted, introducing a new intervention to clinicians might simply be a continuous barrier when it comes to clinician's adopting new interventions in their practice.

This literature is relevant to the current study, as the expressed intent of agency leadership is that all the clinicians will be required to adopt the new positive psychology intervention (PPH) at one point or another. PPH is not an evidence-based intervention at this time, which may create further difficulties with clinicians adopting the new practice and therefore impacting the clinicians' own outcomes. Clinicians at the agency might not have a positive perception or high adherence to PPH, which might lower their positive psychology usage through PPH. While the preliminary study from the pilot year yielded positive opinions from these three clinicians (Suldo et al., 2023), the RCT to be accessed for the current study permitted for data to be collected on the clinician's subjective well-being to explore for

quantitative changes after adopting this positive psychology-based intervention, but not their attitudes and opinions on PPH, which may have interfered with the outcomes of the current study if they were unwilling or unopen to this new service.

Mental Health Clinician's Well-Being

There is a paucity of research on mental health professionals' well-being, which it surprising to this author as they are responsible for the well-being of others. For the purpose of this literature review, mental health clinicians refer to those who provide counseling services to individuals, youth and/or adults. In the studies discussed next, these may be referred to as psychotherapists, mental health counselors, mental health clinicians, or mental health professionals. The bulk of the literature available focuses on push towards mental health professionals need to practice self-care, as this is potentially important to avoid burnout and improve their well-being, which also benefits those that they serve (Simionato et al., 2019).

According to the American Counseling Association (2005), these professionals have a responsibility to do no harm, benefit those they serve, and pursue excellence within their profession. As mental health professionals are especially vulnerable to lower levels of well-being due to trauma exposure and burnout from their demanding roles, it is imperative their well-being be prioritized to help those they are trained to help, since impaired counselors are more likely to cause harm to their clients and well counselors are more likely to help their clients become well (Lawson & Myers, 2011; Richards, Campenni, & Muse-Burke, 2010; Simionato et al., 2019). Schwartz and colleagues (2020) addressed the even more prevalent need for supporting clinician's mental health and well-being post COVID-19 pandemic, explaining how the pandemic has exacerbated already high levels of burnout and emotional/mental health repercussions from the COVID-19 pandemic. Unique challenges have been brought about from

the changes through the pandemic, proving how long-term, proactive individual, organizational, and societal infrastructures for clinician mental health support are at an all-time high (Schwartz, 2020).

Richards and colleagues (2010) examined self-care and well-being among mental health professionals, specifically looking at mediating effects of self-awareness and mindfulness. As has been established earlier in literature, mental health professionals' use of and views on importance of self-care activities have been found to be significantly associated with their well-being (Posluns & Gall, 2020). One aspect of self-care that positively impacts well-being is mindfulness. Mindfulness indirectly influences the relationship between self-care importance and well-being, which then promotes well-being for mental health professionals (Richards et al., 2010). Simionato and colleagues (2019) examined how to increase well-being which helps with professional competence for psychotherapists, noting the importance of self-care and professional development. Citing the APA Code of Ethics, the principles of Beneficence and Nonmalificence encourages that these psychotherapists engage in work to increase their well-being that will additionally increase their clinical work and professional functioning.

Dattilio's (2015) review of relevant literature found a tendency for clinicians to neglect their own mental health, even though they serve in a field that promotes overall health and well-being of those with whom they work. Empirical studies report the need that mental health professionals have for their own well-being, yet often they do not seek support for it. Dattilio (2015) noted various self-care strategies, some of which have elements from positive psychology such as flourishing and strengthening positive emotionality and character strengths. The specific mention of positive psychology is particularly relevant to the current study as it suggests that the

use of positive psychology could be beneficial in increasing mental health professionals' well-being, though currently lacks the research to support this notion (Dattilio, 2015).

Youth Mental Health Care

Not new to the Covid-19 pandemic, but exacerbated by it, youth mental health outcomes have progressively worsened with more than 50% impacted by mental disorders by the age of 25, (Copeland et al., 2011; McGorry et al., 2022; Rosen et al., 2021). With this knowledge, it is imperative we work towards a system of youth mental health care that is developmentally and culturally appropriate as well as effective, highlighting how services should be community-based, non-judgmental, and non-stigmatizing with friends and families included gravitating around the community (McGorry et al., 2022). When it comes to mental illness in youth, prevention is important, which may be achieved through enhancing protective factors such as having a structured routine and more time in nature (Rosen et al., 2021).

PPIs can also be used as preventative treatment, especially as highlighted in Tejada-Gallardo and colleagues (2020) systematic review and meta-analysis of multicomponent PPI for adolescents in schools. Looking at well-being and psychological distress symptoms in adolescents, Tejada-Gallardo and colleagues' meta-analysis of nine articles with a total of 4898 participants ranging from 10 to 18 year's old (M=13.27, SD=1.85) indicated that school-based multicomponent PPI enhanced subjective and psychological well-being and reduced symptoms of depression but not anxiety. These multicomponent PPIs can increase mental health of adolescents in the short and long term (Tejada-Gallardo et al., 2020). While there are a variety of settings available for youth mental health care, educational settings offer opportunity to promote well-being, as schools can be recognized as community-based populations (McGorry et al., 2022). Other settings where youth mental health care can be provided include community

education or school, school and university mental health services, digital platforms and telehealth, primary care, home-based care, community treatment, residential service, volunteer programs, and inpatient services (McGorry et al., 2022).

The Positive Psychology through Happiness (PPH) Assessment and HAPPINESS *Curriculum*

The PPH Assessment and HAPPINESS Curriculum examined in the current study is a recently advanced PPI developed for use by community mental health clinicians serving youth and adults, including youth in schools who present with mental health problems. A year-long pilot study conducted to advance, refine, and gauge acceptability of this curriculum was conducted in 2021-22, with six clinicians enrolled as research participants.

Intervention content. The PPH Assessment and HAPPINESS Curriculum is an intervention manual and assessment created by the agency to be currently used by their clinicians and in the future made available to the public, currently copywrite pending. Due to the pending copywrite, this author is unable to attach the manual and assessment to this document but provides a summary explanation of each. The PPH Assessment contains a weekly and monthly check-in. One or the other is to be utilized at the beginning of each session a clinician has with a client. At the initial assessment, clients are given 'The PPH Assessment – Monthly' for their baseline and then again completed once a month to assess changes. This assessment asks a Strength Question, (i.e., List something positive about yourself or something you are good at) and Enjoyment Questions (i.e., On a scale of 1-10, with 10 being the highest, how happy are you?, Think of all the things you do in your daily life and complete this sentence: I am most happy when I am _____, How many hours last week did you spend enjoying (identified activity)?, What could you do to increase the amount of time you're able to dedicate to _____?)

and then presents seven items (i.e., I feel satisfied with my life as a whole, I feel good about myself as a person, I feel good about my physical health, I feel good about my mental health, I feel good about my relationships with others, I feel good about my education, and I feel good about my job) that clients rate from 1=strongly disagree to 5=strongly agree. When clients meet with their clinician the weeks between the monthly sessions, they are given 'The PPH Assessment – Weekly' that only asks the Strength and Enjoyment Questions from the monthly assessment.

This new approach that the agency is taking with the PPH Assessment and HAPPINESS Curriculum (described next) is rooted in positive psychology theory as it focuses on strengths and positive subjective experiences through well-being, joy, and happiness (Seligman, 2002) instead of only attempting to fix what is wrong. The PPH Assessments ask questions about the client's subjective well-being and use of intentional activity that makes them feel happy. PPIs are treatment methods as well as intentional activities aimed to cultivate positive cognitions, behaviors, or feelings (van Agteren et al., 2021), which is the focus of the PPH Assessment through using the HAPPINESS Curriculum.

The HAPPINESS Curriculum consists of nine different sections, corresponding to each letter of HAPPINESS (i.e., H = Understanding Happiness, A = Assessing Where I Am Now, P = Producing Positive Thoughts and Actions, P = Practicing My Daily Habits, I = Investigating a New Way of Doing Things, N = Navigating the Bumps in the Road, E = Examining My Successes, S = Spreading My Strengths, S = Savoring My Success). The purpose of this intervention is to help each client understand their individual happiness (subjective well-being) and create goals and steps to work towards being happier, all under a positive psychology framework. The intervention is manualized and developed to be used in order of the

HAPPINESS steps, allowing for some steps to have more time spent on them but moving through from H to the last S. For each letter there are three different types of lesson tools that clinicians can choose to use during a session called ACTS. ACTS stands for Activities (suggested exercises to do with client in session or to prescribe the client do outside of the session), Cognitive Copy (worksheets designed for clients to work on in session), Talking Points (questions used to guide discussion), and Simple Changes (brief worksheets to be done weekly around simple changes to reach happiness goal).

The HAPPINESS Curriculum is based in positive psychology using aspects of signature strengths (Gable & Haidt, 2005), developing optimism for the future, and savoring (van Agteren et al., 2021). No matter how much they ultimately use or do not use the HAPPINESS Curriculum with their clients, the intervention group received the trainings on how to use it and was exposed to positive psychology as a clinical tool. Most of the clinicians in this study work with students in schools through their community partnership with schools. Previous research has shown increases in student outcomes and well-being when using a positive psychology intervention (Tejada-Gallardo et. al, 2020).

Professional development. In the pilot of the intervention (2021-22), six clinicians were trained in PPH Assessment and HAPPINESS Curriculum during two separate three-hour trainings. All but one clinician completed both trainings. After each training, clinicians filled out a Qualtrics survey that allowed for the researchers to receive feedback on the trainings (Suldo et al., 2023). There was a pre and post knowledge quiz administered to assess their understanding of the training and intervention, with all clinicians needing a minimum of 80% to pass. The five clinicians who took the post knowledge quiz scored an 85% or higher (Suldo et al., 2023). Clinicians were trained to use the PPH assessment each session, and the HAPPINESS curriculum

materials as much as appropriate during sessions. In these live trainings, clinicians learn they have some autonomy over the extent that they choose to use the PPH Assessment and HAPPINESS Curriculum in conjunction with their other interventions and tools (Suldo et al., 2023).

Initial use. After completing an initial professional development to learn the intervention, three of the six clinicians ultimately used PPH in 137 sessions with 28 clients. Only three clinicians participated fully in the pilot year due to one clinician leaving the agency and the other two being unresponsive to attempts to include them in the program evaluation after receiving the training (Suldo et al., 2023). Feedback from the three participating clinicians allowed for USF and personnel at the agency to create iterations to the program and trainings in order to prepare for a subsequent RCT (July 2022 – August 2023). When examining the average acceptability of each step on the HAPPINESS Curriculum, all nine steps received a rating of at least 4 on 5-point likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). A few examples of items asked in this acceptability measure include: The PPH was able to meet the client's needs, The PPH was helpful for the client, and The client was receptive to the PPH approach (Suldo et al., 2023At the end of the pilot year, each of the three clinicians participated in an exit interview to gather their thoughts on using positive psychology as an intervention and their perceptions of positive psychology as it influenced their personal and professional lives. Through a preliminary analysis of these interviews, it was noted that these pilot clinicians felt a personal impact in their lives from employing a positive psychology intervention with their clients (Suldo et al., 2023). A review of consolidated responses from these interviews indicated that: "all clinicians found use of positive psychology as a clinical tool as beneficial with their clients, all clinicians took principles of positive psychology and applied use to their personal

lives, and all clinicians plan to use positive psychology in some capacity in their future career and with their future clients" (p. 33, Suldo et al., 2023). The full report is available upon request.

Summary

The use of PPIs shows benefits to students, youth, and adults that have taken part in them either as a clinical support or promotion activity (Chakhssi et al., 2018; Furchtlehner et al., 2020; Tejada-Gallardo et. al, 2020; van Agteren et al., 2021). Support for higher levels of well-being and complete mental health (Suldo & Doll, 2021) are supported through the research and use of PPIs. Through the pilot year of PPH and HAPPINESS, a program grounded in positive psychology, the clinicians who completed the training and used the intervention verbally reported personal benefits from using this intervention with their clients and in their own lives (Suldo et al., 2023). Previous research shows a need for mental health clinicians and counselors to increase their own well-being, as they typically neglect it despite being in a field that promotes mental health (Dattilio, 2015). This literature suggests that it is possible mental health clinicians might personally benefit from being trained in and implementing a positive psychology-based intervention instead of using traditional methods during their counseling sessions with clients. Thus, the purpose of the current study was to examine changes in clinician's complete mental health based on their usage of an advancing PPI created and currently used by the agency.

Chapter III: Method

The current study investigates the changes in mental health clinicians' complete mental health (subjective well-being and psychopathology indicators) associated with use of a positive psychology intervention with their clients. A quantitative approach was used to compare randomly assigned control group clinicians and intervention group clinicians' baseline (pre-training) and post intervention scores on various well-being measures. This chapter describes the participants, the procedures used to collect the data, and details on the measures used. This chapter also overviews the statistical analyses used.

Setting

The partner social services organization has particular expertise in child welfare services but also serves communities through early childhood services, counseling and other mental health services, community partnership schools, and mentoring. This agency provides services to clients throughout the state of Florida. The participants in the current study work in various regions and settings across Florida, mainly in partner schools and a few community centers. Leadership at the agency supported the initiative for a positive psychology-based intervention and strongly encouraged clinicians to participate in the randomized control trial (RCT). The trainings and check-ins for the current study were all done virtually with the clinicians. After the conclusion of the larger program evaluation and current study, all clinicians at the agency may be trained in this newly developed intervention pending evidence of promise.

Participants

Participants in the current study were clinicians from the agency who agreed to participate in a program evaluation of a new intervention- the Positive Psychology through Happiness (PPH) Assessment and HAPPINESS curriculum. All participants in the current study work with either counseling and other mental health services or the community partnership schools and hold at minimum a master's level degree and training allowing them to provide these services.

A total of 89 clinicians agreed to participate in a RCT connected to a program evaluation the agency hired the University of South Florida (USF) to conduct, making this a convenience sample. Participants were enrolled in two cohorts: Cohort 1 (summer/fall 2022) and Cohort 2 (winter/spring 2023). There were no demographics collected on the clinicians besides which region they work in, which was used to randomize the sample. In order to participate in this study, clinicians must have had their own caseload of clients and be a licensed mental health clinician. Further, they had to review and sign a consent form (see Appendix A) in which they agreed to share their data on self-report measures. Consenting clinicians were randomized to two groups: intervention (learn and use the PPH now) and control (business as usual; learn and use the PPH after the study has concluded). The clients who worked with the intervention group of clinicians received the positive psychology intervention to some degree and those clients who worked with the control group clinicians did not receive any of the positive psychology intervention, since these clinicians were not exposed to this intervention until all the data was collected.

As a reminder, the current study focused on clinician mental health is a sub study of a larger program evaluation focused on change in youth outcomes; the current study is not

examining an intervention for the clinicians themselves to receive, but instead be trained in and use with their youth client. Of the 89 clinicians who enrolled in the study, 44 fully participated by filling out both the pre and post measures. Of these 44 participants, 19 had been randomly assigned to the intervention group and the remaining 25 were in the control group. There were 45 other clinicians who consented to take part in the study but did not complete the post measures (n = 26 intervention group; n = 19 control group). Of those 45, 28 left the agency during the study, 6 withdrew from the study, 6 moved to a supervisor or other position that did not see clients during the study year, and 4 did not respond to multiple requests to take the pre or post measures for unknown reasons. Attrition analyses conducted to examine if there were differences in baseline mental health scores for those who completed the study and those who did are reported in Chapter 4.

Ethical Considerations

Each clinician that agreed to fill out self-report measures of subjective well-being and perceived stress (an indicator of psychopathology) had previously signed a consent form that explained that all of their data would be kept confidential for each individual, and only shared with their work organization in aggregated form (see Appendix A). These consent forms emphasized that their participation in filling out self-report measures surrounding complete mental health was completely voluntary. It is important to note that since the agency created this positive psychology intervention and plans to adopt it as a tool for all their mental health clinicians, they are likely to ultimately request that all clinicians learn and use this new intervention (PPH Assessment and HAPPINESS curriculum). However, participation in research including providing information on their own complete mental health measures was completely voluntary. Confidentiality was ensured by holding the data on a secure and password protected

file that only USF had access to through Box for data storage. All data shared with the agency was de-identified through aggregation.

Preliminary Study of the Intervention

During the pilot year of the program evaluation (December 2021-June 2022), six mental health clinicians from the agency were recruited and consented to pilot the PPH Assessment and HAPPINESS Curriculum. Feedback from three of these clinicians allowed for USF and the agency to create iterations to the program and trainings in order to prepare for the subsequent RCT year (July 2022 – August 2023). The author of this thesis conducted exit interviews with the three clinicians in summer 2022 (see interview protocol in Appendix B). Learning that the pilot clinicians felt a personal impact in their lives from employing a positive psychology intervention with their clients led this author to be interested in quantitative complete mental health changes that could possibly occur from learning about and utilizing a positive psychology-based intervention with clients. The full interim report on the pilot year is available upon request.

Procedures

Initial informational sessions regarding the RCT were held on July 13th and July 18th, 2022 (Cohort 1) and December 1st, 2022 (Cohort 2). All clinicians who attended a meeting were sent a consent form via DocuSign that was reviewed and further explained during these initial informational sessions. After clinicians learned about the upcoming RCT and what was required of them, they were able to fill out the consent form. Later during the informational session, pretraining/baseline measures were taken of the consented clinicians to learn about their current levels of complete mental health. Clinicians were then sent a Qualtrics link containing the various complete mental health measures (described later in this chapter). For Cohort 1, at the

end of July 2022, all clinicians who signed a consent form were randomly assigned to either the intervention or control group. This same process was repeated for Cohort 2 in December of 2022. As aforementioned, clinicians assigned to the intervention group were asked to administer the intervention to clients and were not receiving it for themselves. Clinicians assigned to be in the intervention group attended three two-hour trainings to learn about the positive psychology-based intervention (PPH Assessment and HAPPINESS Curriculum) created by the community agency. A knowledge test was administered after the trainings, with each clinician needing an 80% or higher to begin administering the PPH Assessment and HAPPINESS Curriculum. They then utilized this intervention with incoming clients for the 2022-2023 school year as much or as little as they saw professionally fit.

After the school year and data collection for the RCT were over, all consented clinicians (both control and interventionist groups) were invited to fill out the same Qualtrics link from earlier that collects their measures on complete mental health described below. Administration of post-test measures took place from May 4th, 2023, to June 20th, 2023. To re-orient clinicians to the measures, USF invited clinicians participating in the RCT (in either group: intervention or control) to take part in a brief, virtual meeting to review progress with the study, including to celebrate their participation and wrap up study activities. These meetings were held on May 4th, May 10th, and May 15th, 2023. Those clinicians in attendance were administered the post-test measures during this wrap-up meeting. Anyone who was unable to attend one of the final meetings was sent an email (first attempt May 18th, 2023) directing them to fill out the post-test measures; another email was sent on May 31st to the group of clinicians for whom post-test measures had still not been completed. After that, individual emails were sent to each clinician who had not filled out post-test measures in an attempt to gather this data. The post-test measures

survey was exactly the same as the pre-test. At the start of the online survey, respondents were asked to provide their first name, last initial, and date of birth, in order to provide USF study staff to link pre and post-test responses to each other. Personnel at the community agency communicated with the research team about reasons for some clinicians' non-response by indicating which of the 89 clinicians had left the agency, transitioned role, etc.

Materials and Measures

PPH Assessment and HAPPINESS Curriculum

The PPH Assessment and HAPPINESS Curriculum is an intervention manual and assessment created by the community agency to be currently used by their clinicians' and in the future made available to the public, currently copywrite pending. The PPH Assessment and HAPPINESS Curriculum is described in detail near the end of Chapter 2. In sum, the purpose of this intervention and manual is to help each client understand their individual happiness (subjective well-being) and create goals and steps to work towards being happier, all under a positive psychology framework. Clinicians were trained in using the manualized intervention and the materials with it through completion of initial professional development (PD). The initial PD underscores that the PPH Assessment and HAPPINESS Curriculum is intended to be integrated with other clinical practices (e.g., cognitive-behavioral therapy, motivational interviewing, trauma-informed care) pending the client's individual needs and treatment plan. Thus, clinicians have autonomy over the extent that they chose to use the intervention in conjunction with their other interventions and tools. No matter how much they used or did not use the PPH Assessment and HAPPINESS Curriculum, the intervention group received the trainings on how to use it and were exposed to positive psychology as a clinical tool. Most of the clinicians in this study work with students in schools through their community partnership with

schools. Previous research has shown increases in student outcomes and well-being when using a positive psychology intervention (Tejada-Gallardo et al., 2020).

Fidelity of Use of PPH Assessment and HAPPINESS Curriculum

After each session that a clinician completed with a client identified as a participant in the larger evaluation of the PPH, the clinician was asked to fill out a self-report of their use of the PPH Assessment and Happiness Curriculum during that session (Appendix G). This self-report survey was created to monitor usage of the intervention within each condition, by each clinician (presumably only those assigned to the intervention group), and within each session. One question asked was "Approximately how much of this session did you use the PPH Assessment and HAPPINESS Curriculum?" with answers ranging from none (0%) to nearly all (close to 100% of session content). This data collected was used to calculate the number of times and average amount of time in a session that a clinician in the intervention group used the PPH Assessment and HAPPINESS Curriculum during the RCT year. To ensure that this data was collected, approximately once a week a graduate research assistant sent an individualized email to each clinician in the interventionist group. The email contained a summary list of the clinician's clients enrolled in the study, a reminder to complete the self-report fidelity of use form after each session with a client on the list, and an opportunity for the clinician to ask any questions regarding the fidelity measure.

Quantitative Measures of Clinician Outcomes

Subjective well-being was measured through participants' self-report on the Satisfaction with Life Scale (see Appendix C; SWLS; Diener et al., 1985), the Flourishing Scale (see Appendix D; Diener et al., 2009), and the Positive and Negative Affect Schedule (see Appendix E; PANAS; Watson et al., 1988). In line with a dual-factor model of mental health in which

mental health is assessed using positive and negative indicators of mental health, emotional distress was measured using the Perceived Stress Scales (see Appendix F; PSS; Cohen et al., 1983). All of these measures have been used to assess an individual's complete mental health and were used pre randomization/training of the interventionist vs. control implementation group and again at the end of the RCT year (summer 2023).

SWLS

The SWLS consists of 5 items rated on a 7-point response format. This self-report measure is intended to assess one's overall life satisfaction, which is sometimes referred to as global satisfaction, and has been extensively used as a subjective measure of quality of life (Pavot & Diener, 1993). SWLS scores range from 5-35. The scores represent a range of satisfaction with life: 5-9 represents extremely dissatisfied, 10-14 represents dissatisfied, 15-19 represents slightly dissatisfied, 20-24 represents slightly satisfied, 25-29 represents satisfied, and 30-35 represents extremely satisfied (Diener et al., 1985). One's perception of life satisfaction is known to represent the cognitive component of subjective well-being, or the scientific measurement of happiness (Diener et al., 1985). The validity of the SWLS has been demonstrated with a wide range of ages. Good internal reliability has been consistently demonstrated with observed coefficient alphas for the scale ranging typically between .79 and .89 (Taber, 2018). Reported test-retest reliabilities have varied from .84 to .54 from a 1-month interval across a 4-year interval (Pavot & Diener, 1993). Discriminant validity of this measure has been established through consistent observations of negative relations with clinical measures of distress, while convergent validity is evident in moderate-to-strong correlations with other measures of well-being and positive affect (Pavot & Diener, 1993).

Flourishing Scale

The Flourishing Scale is an 8-item self-report measure on a 7-point scale that assess core aspects of social-psychological functioning and prosperity through relatedness, self-acceptance, competence, social relationships, and capability of activities that someone finds important (Diener et al., 2010). Diener et al. (2010) showed the Flourishing Scale to have good psychometric properties when completed by college student populations across six universities (n = 689), with high internal (.87), and temporal reliabilities (.71), and high convergence with other well-being scales including the SWLS (r = .62, n = 680, p<.001). Reliability analysis showed good internal consistency (alpha = .83) for the flourishing scale composite in a sample of 9,646 participants with ages from 19 to 111 (M = 44.21, SD = 16.40) through a longitudinal study tracking the well-being of a nationally representative sample of New Zealanders (Hone et al., 2014). The Flourishing Scale gives a single score that ranges between 8 and 56 with higher scores representing higher levels of well-being, strengths, and resources (Diener et al., 2010).

PANAS

The PANAS is made up of 20-items rated a 5-point scale. The self-report scale measures frequency of positive and negative affect, which can provide indices of the affective component of subjective well-being. Ten questions measure positive affect (PA) and 10 questions measure negative affect (NA). PA scores range from 10-50 with higher scores representing higher levels of positive affect and NA scores also range from 10-50 with lower scores representing lower levels of negative affect (Watson et al., 1988). Both PA and NA represent largely independent constructs that range from low to high levels of emotional experience (Merz et al., 2013). Watson and colleagues (1988) found the alpha reliabilities of the PANAS PA and NA scales were .86 and .87, respectively. The correlation between the PA and NA scales was found to be -

.09 (Watson et al., 1988). The PANAS has been found to have excellent convergent and discriminant correlations with much lengthier measure of the underlying mood factors; making it a reliable, valid, and efficient means for measuring positive and negative affect dimensions of mood (Watson et al., 1988).

PSS-10

The PSS-10 is a 10-item self-report measure. Using a 5-point scale, respondents indicate the degree to which one perceives aspects of their life as uncontrollable, unpredictable, and overloading. Individual scores on the PSS-10 range from 0-40, with higher scores indicating higher perceived stress. Items 4, 5, 7, and 8 are reverse scored then all items are summed to make a composite score. (Appendix F) Scores from 0-13 would be considered low stress, scores from 14-26 would be considered moderate stress, and scores from 27-40 would be considered high perceived stress (Cohen et al., 1983). Roberti and colleagues (2011) found the Cronbach's alpha reliability coefficients through a sample of 285 undergraduate college students across three public universities in the southeast United States with a median age of 21 years old (M = 23.8, SD = 79). The reliability coefficients are as follows: PSS10 Total Score (10 items; .89), Perceived Helplessness factor (6 items; .85), and Perceived Self-Efficacy (4 items; .82). The interscale correlation between Perceived Helplessness and Perceived Self-Efficacy was .65, which indicates a large overlap (Roberti et al., 2011). It was indicated that the PSS-10 is a reliable and valid self-report measure of perceived stress, with convergent validity supported (Roberti et al., 2011).

Data Analysis

To begin data analysis, preliminary analyses were completed to check for missing data and look for any outliers. Next, this researcher checked for assumptions with the repeated

measures to ensure that the factors are independent of each other. To examine the first question focused on if there are any changes in interventionists pre and post test scores, a repeated measures ANOVA was used to see if the mean scores went up as a whole and on each individual scale and yielded an interaction and main effect by group. In order to address the research question regarding differences between the clinicians who were trained in and implemented the positive psychology intervention and those who continued on with business as usual, gain scores were calculated for both clinicians in the treatment and control group and a mixed-model ANOVA was conducted.

To examine if there were differences for those in the interventionist group who used PPH more or less, data were reviewed from clinician self-report of how much they used PPH in each session. On the fidelity of use form, clinicians recorded if their use was none – 0%, some – up to 25%, about half – up to 50%, more than half – up to 75%, or almost all of the session – about 100%. Exposure scores were created by multiplying the average amount of positive psychology-based intervention usage in each session with the number of times the interventionist used the positive psychology-based intervention. Exposure scores and their creation are noted in chapter four with Table 11. For this continuous exposure variable was then correlated with the interventionist groups gain scores (calculated by subtracting the pre score from the post score), to see if there were any changes in outcomes for those who used the positive psychology-based intervention more than others. These procedures allowed for the researcher to examine if there are any changes within each individual group being examined, across the individual scales and the construct of complete mental health as a whole, and the interventionist group due to amount of PPH usage.

Chapter IV: Results

This chapter describes the quantitative results conducted from the analyses to answer the three research questions. Each research question is separated with its analysis and results. This chapter briefly describes the results of analyses in relation to the hypotheses.

Preliminary Analyses

Creation of Composite Scores

For each scale used, a composite score was created. The SWLS (Appendix C) contains 5 items that are summed in order create a composite score; for this measure no items are reverse scored. The FS (Appendix D) contains 8 items that are summed in order to create a composite score; for this measure no items are reverse scored. The PANAS (Appendix E) contains two composite scores, one for negative affect and one for positive affect. Positive affect is calculated by summing items 1, 3, 5, 9, 10, 12, 14, 16, 17, and 19. Negative affect is calculated by summing items 2, 4, 6, 7, 8, 11, 13, 15, 18, and 20. The PSS (Appendix F) contains 10 items. Items 4, 5, 7, and 8 are reverse scored then all items are summed to make a composite score. Table 2 shows the reliability of the composite scores that were used for the current study.

Table 2
Internal Reliability for Baseline and Post Measure

	Baseline	Post Measure
	Cronbach's Alpha	Cronbach's Alpha
SWLS	0.86	0.91
FS	0.82	0.89
PANAS: PA	0.87	0.87
PANAS: NA	0.66	0.81
PSS	0.69	0.82

Note. PA = positive affect, NA = negative affect

Missing Data Analysis and Treatment

While a total of 89 clinicians signed the consent form to participate in the full study regarding PPH evaluation, which includes the current sub study looking at changes in their complete mental health scores, only 44 clinicians filled out both the pre and post complete mental health measures (51.6% missing post mental health measures). This was due to both missing data, as well as high attrition from both the study and the community agency as a whole. Of the 89 who signed consent forms, five clinicians never filled out any pre or post measures (1 was in the intervention group, and 4 in the control group). Of the remaining 84, 44 ultimately assigned to the interventionist group filled out the premeasures, and 40 assigned to the control group filled out the premeasures. At post, 19 assigned to the intervention group filled out the post measures (43.2% retention in the study), and 25 assigned to the control group filled out the post measures (62.5% retention in the study). In total, there were 19 clinicians in the intervention group who filled out both pre and post mental health measures, and 25 clinicians in the control group who filled out both pre and post mental health measures. In analyses of change in mental health, this study used listwise deletion of data. If a participant did not have any data at the post time point, they were effectively removed from the sample after completion of the attrition analyses. Given the simplicity of the design (i.e., pre-post only, vs. pre and multiple follow-up points), the researcher chose to only retain participants with data at both time points, since those who did not fill out the post measures did not have *any* personal mental health data available for use to enable comparisons between groups or overtime.

Attrition Analysis

An attrition analysis was conducted to measure if there was a significant difference in baseline/pre mental health scores for those who completed the study and those who did not. This

comparison data was completed through a series of independent t-test, comparing the baseline scores of the 44 clinicians who completed the study (i.e., "study group") to the baseline scores of those 40 who did not provide post data but did have baseline data (i.e., "attrition group"). While there was a total of 89 clinicians who had consented for the study, only 84 filled out the baseline measures. Of the 40 participants without post data, 19 left the agency during the study period (13 intervention, 6 control), 4 remained clinicians at the agency but withdrew from study participation (2 intervention, 2 control), 13 transitioned to a different position at the agency such as supervisor or intake coordinator (9 intervention, 4 control), and 4 remained clinicians at the agency but were unresponsive to requests to complete post-test measures for unknown reasons (1 intervention, 3 control). As reported in Table 1, there was not a significant difference between the study group and the attrition group on the measures of life satisfaction (SWLS), flourishing (FS), and negative affect (NA). Though there was not a significant difference for the SWLS, a trend in the data was identified in which the study group started with a higher life satisfaction score (M = 24.68, SD = 6.08) compared to the attrition group (M = 21.93, SD = 6.96), $t(82)$ = -1.94, p =.056. There was a significant difference for stress (scores on the Perceived Stress measure), showing that the 44 who completed the study started with a lower stress score (M = 26.95, SD = 4.57) than those who were lost to attrition for various reasons (M = 29.88, SD = 6.97), $t(82)$ = 2.27, p <.05. There was also a significant difference in the positive affect (PA) between the two groups. The 44 who stayed in the study had higher baseline positive affect (M = 35.77, SD = 6.75) compared to the attrition group, (M = 31.15, SD = 7.68), $t(82)$ = -2.94, p <.05. In sum, clinicians who did not fill out post measures for any reason started the study with a higher perceived stress score, lower levels of positive affect, and somewhat lower life satisfaction scores, but reported levels of flourishing and negative affect that were similar to

those of clinicians who remaining in the study throughout the year. Table 3 shows full results of the independent samples t-tests.

Table 3
Clinicians' Scores on Baseline Measures of Mental Health

Variable	*t*	df	*p*	Study Group (*n* = 44) *M*	*SD*	Attrition Group (*n* = 40) *M*	*SD*
SWLS	-1.94	82	0.056	24.68	6.08	21.93	6.96
FS	-0.53	82	0.60	41.32	4.30	40.75	5.48
PA	-2.94	82	0.004*	35.77	6.74	31.15	7.68
NA	1.33	82	0.19	19.05	4.40	20.93	8.19
PSS	2.27	82	0.026*	26.95	4.57	29.88	6.97

Note. *$p < .05$

Descriptive Statistics

The results that follow are restricted to analyses conducted with the study group (i.e., participants with complete data at pre and post). Table 4 displays the descriptive statistics for the complete mental health measures (SWLS, FS, PANAS, PSS) taken before any exposure to positive psychology for both the intervention group and the control group, and before either group was randomly assigned. The post measure descriptive statistics are displayed in Table 5, after interventionists had received the positive psychology-based intervention training and used the intervention as much or little as they saw professionally fit.

Table 4
Descriptive Statistics: Pre-Mental Health Measures

	Intervention Group (*n* = 19)				Control Group (*n* = 25)			
Measure	Mean	SD	Skewness	Kurtosis	Mean	SD	Skewness	Kurtosis
SWLS	24.95	5.90	-0.335	-1.230	24.48	6.32	-0.762	0.430
FS	47.47	5.22	-0.539	0.249	47.64	4.62	-0.804	0.452
PA	36.05	7.95	-0.466	-0.176	35.56	5.85	0.010	-0.862
NA	18.63	3.95	0.222	-0.137	19.36	4.77	0.268	-1.165
PSS	25.63	4.36	-0.705	-0.298	28.00	4.46	0.033	-1.118

Table 5
Descriptive Statistics: Post-Mental Health Measures

	Intervention Group (n = 19)				Control Group (n = 25)			
Measure	Mean	SD	Skewness	Kurtosis	Mean	SD	Skewness	Kurtosis
SWLS	27.11	4.40	4.396	-0.956	25.96	6.77	-1.532	1.819
FS	48.26	6.31	-1.086	1.075	47.52	5.99	-0.843	0.299
PA	34.58	7.66	-0.783	1.644	36.44	6.37	0.199	-1.102
NA	17.32	5.23	0.980	0.678	16.12	4.62	0.412	-1.116
PSS	25.16	4.48	-0.199	-1.027	24.92	5.77	0.387	-1.229

A comparison of values in Table 4 and Table 5 shows the differences across the rows for the baselines for each measure between the intervention and the control groups. A comparison of values in Table 4 and Table 5 shows the outcome scores for each interventionist and affords comparisons between the two groups across the rows. For the SWLS, scores 20-24 represent slightly satisfied and 25-29 represent satisfied (Diener et al., 1985). Both the intervention and control group increased within the satisfied range, with a higher increase for the intervention group (M = 24.95 to M = 27.11) than for the control group (M = 24.48 to M = 25.96). For the FS, scores range between 8 and 56 with higher scores representing higher levels of well-being, strengths, and resources (Diener et al., 2010). Scores for the FS stayed relatively stable for both groups, with a small increase for the intervention group (M = 47.47 to M = 48.26) and a slight decrease for the control group (M = 47.64 to M = 47.52). The PANAS is split into PA or positive affect, and NA or negative affect. Both are represented with scores from 10-50, where a higher score on the PA shows more positive affect and lower score on the NA shows lower NA (Watson et al., 1988). PA for the intervention group dropped slightly (M = 36.05 to M = 34.58) and increased slightly for the control group (M = 35.56 to M = 36.44). NA had a small decrease for the intervention group (M = 18.63 to M = 17.32) and a larger decrease for the control group (M = 19.36 to M = 16.12), showing negative affect lowering over the course of the study. PSS

scores range from 0 to 40, with higher scores indicating higher perceived stress. Scores of 14-26 indicate moderate stress and scores of 27-40 indicate high perceived stress (Cohen et al., 1983). The control group started with higher levels of perceived stress within the high stress range (M = 28.00) and ended with a bigger decrease in perceived stress into the moderate stress range (M = 24.92). The intervention group had little change in perceived stress throughout the study, starting at a lower point than the control group (M = 25.63) and ending around the same (M = 25.16), both of which were within the moderate stress range. At baseline, the two groups had similar mean scores on the SWLS, FS, PA, and NA. For unknown reasons participants in the control group started with a higher score on the PSS.

Research Question 1

Among clinicians in the intervention group who were trained in a positive psychology intervention intended for use with their clients, do they experience significant changes in personal mental health as indicated as levels of

a. Satisfaction with life
b. Flourishing
c. Positive affect
d. Negative affect
e. Perceived stress?

Research question one aimed to determine whether mental health clinicians who were assigned to the intervention group, to administer the intervention, experienced any significant changes in their complete mental health after participating in professional development on the positive psychology-based intervention (i.e., two three-hour trainings on the PPH) and then deciding to use it as they saw fit with their clients at their own professional discretion. This research question

examined if the use and exposure of a positive psychology-based intervention could residually impact their own complete mental health.

A repeated measures ANOVA was conducted to examine changes in personal mental health in the intervention group from their pre scores to post scores. Through a series of repeated measures ANOVA analyses (one per dependent variable: SWLS, FS, PANAS, PSS, from time one to time two) using data from the intervention group only tested change in mental health scores. All scales subtracted time one scores from time two scores to see the gains between the two points in time. Results are shown in Table 6, including p-values and effect sizes (Cohen's d). Effect sizes were calculated using the gain scores (or the difference score from subtracting time one from time two) and divided by the standard deviation from the scores at time one.

Table 6
Changes in Interventionists' Complete Mental Health

		Group Differences from Pre- to Post-Intervention Interventionists (n = 19)	
	Gain Scores	*p*	*d*
SWLS	2.158	.005*	0.37
FS	0.789	.53	0.15
PA	-1.473	.76	0.11
NA	-1.316	.008*	0.25
PSS	-0.474	.04*	0.19

Note. *p< .05

As indicated in Table 6, there was a significant change in the interventionists' complete mental health on three of the five scales: SWLS, NA, and PSS. Cohen (1988) interpreted effect sizes as small (d = .20), medium (d = .50), and large (d = .80). The SWLS showed a 2.158 increase (p = .005, d = 0.37) with a small to medium effect size, this showed an overall increase in life satisfaction. Prior studies that used the SWLS to evaluate the effects of an intervention intended to increase adults' subjective well-being through gratitude or stress management found

a comparable increase in SWLS scores over time, for instance from about 22.1 to 23.7 (Cunha et al., 2019) and 22.8 to 26.4 (Berkland et al., 2017), respectively. When looking at NA from the PANAS in the current study, there was a 1.316 decrease over time ($p = .008$, $d = 0.25$), with a small effect size, this shows that negative affect went down over time. This change in PANAS-NA is smaller than the magnitude of the change observed in the aforementioned gratitude intervention study, where NA reduced from 23.5 to 20.0 (Cunha et al., 2019). In the current study, perceived stress (PSS) decreased by 0.474 ($p = .04$, $d = 0.19$) showing a small effect of lower stress throughout the study. Prior studies that used the PSS to evaluate the effects of interventions intended to decrease adults' stress through mindfulness found larger reductions in PSS total scores over time, for instance from about 30.2 to 25.1 (Deckro et al., 2002) and 24.6 to 14.6 (Querstret et al., 2018). In the current study, neither the FS nor PA showed a significant change over time for the interventionist group.

Research Question 2

Are end-of-year of changes in personal mental health among clinicians who were trained in a positive psychology intervention significantly different from end-of-year changes in mental health among peer clinicians assigned to continue using business-as-usual interventions during the same time period with respect to levels of

a. Satisfaction with life
b. Flourishing
c. Positive affect
d. Negative affect
e. Perceived stress?

Research question two looked at the time and group interaction to see if there were any significantly different changes in complete mental health between the group assigned to intervention and the control business-as-usual group.

A mixed model ANOVA through repeated measures within the ANOVA was used to answer this question. A mixed model ANOVA assumes that scores for each condition are normally distributed, sphericity of the covariance matrix, and equal error variances. Each table includes the results of the ANOVA as it relates to the five areas that were measured.

Life Satisfaction

Table 7 shows results from the SWLS, where only the time effect is statistically significant ($p < .05$) which was reported within question one. There was no significant interaction between time and the clinician group and there is no significant effect with the between-subjects of the clinician group, suggesting that clinicians across both groups tended to begin and increase in life satisfaction similarly over time, rather than positive change being particularly unique to the intervention group. There was not a significant difference between the groups of clinicians.

Table 7
Life Satisfaction (SWLS) Scores Across Time, Tests of Within- and Between-Subjects Effects

Variable	*F*	*p*
Life Satisfaction		
Time	8.69	.005*
Clinician Group	0.22	.64
Time x Clinician Group	0.31	.58

Note. *$p < .05$

Flourishing

Table 8 shows results from the FS. There were no significant interactions found between time and the clinician group and the between-subjects of the clinician group. This means that

there was no difference over time for either group, there was also no difference between the clinician groups (interventionists and control) on these measures, and when considering both time and the different clinician groups together, scores stayed consistent regardless of the time or the group the clinician was in.

Table 8

Flourishing Scale (FS) Scores Across Time, Tests of Within- and Between-Subjects Effects

Variable	*F*	*p*
Flourishing		
Time	0.22	.64
Clinician Group	0.04	.85
Time x Clinician Group	0.40	.53

Note. **p* < .05

Positive Affect

Table 9 shows the results from the PANAS. As discussed during research question one, there was no significant change of Positive Affect over time for the intervention group. There were no significant interactions between time and the clinician group in regard to Positive Affect as well, implying that neither the difference in clinician groups nor the change over time were significant, and when considering them together there was not an effect on each other.

Negative Affect

Table 9 shows results from the PANAS, where only the time effect for Negative Affect is statistically significant ($p < .05$), which was discussed within research question one. There is not a significant interaction between time and the clinician group and there is no significant effect with the between-subjects of the clinician group for Negative Affect, indicating the aforementioned reduction in negative affect was not unique to the intervention group.

Table 9
Positive and Negative Affect (PANAS) Scores Across Time, Tests of Within- and Between-Subjects Effects

Variable	*F*	*p*
Positive Affect		
Time	0.09	.76
Clinician Group	0.14	.71
Table 9 *Continued*		
Time x Clinician Group	1.47	.23
Negative Affect		
Time	7.68	.008*
Clinician Group	0.04	.84
Time x Clinician Group	1.37	.25

Note. *$p < .05$

Perceived Stress

Table 10 shows results from the PSS, where only the time effect is statistically significant ($p < .05$) as discussed within research question one. There is no significant interaction between time and the clinician group and there is no significant effect with the between-subjects of the clinician group with perceived stress. This means the change overtime was not unique to which group the clinician was in.

Table 10
Perceived Stress Scale (PSS) Scores Across Time, Tests of Within- and Between-Subjects Effects

Variable	*F*	*p*
Perceived Stress		
Time	4.28	.04*
Clinician Group	0.80	.38
Time x Clinician Group	2.24	.14

Note. *$p < .05$

Taken together, this set of analyses indicated that there were no significant interactions between time and the clinician group, as well as no significant effects with the between-subjects of the clinician groups for any of the measures (SWLS, FS, PANAS, PSS). This means there were no significantly different end-of-year changes in personal mental health among clinicians

who used the positive psychology-based intervention as compared to those clinicians who continued with business-as-usual during this same time period.

Research Question 3

> To what extent do clinicians randomly assigned to complete training in the positive psychology-based intervention use it in subsequent months, and is there a variation in how much it is used and changes in complete mental health?

Research question three examined if there were any significant differences in the changes of a clinician's complete mental health in relation to how much or little they used the positive psychology-based intervention, which would show their total exposure to the intervention used.

A total exposure variable was created for each of the 19 clinicians who were assigned to the intervention condition and completed both the pre and post measures of mental health. The total exposure variable was created by examining the average of each interventionist's fidelity usage of the positive psychology-based intervention, and multiplied then by the number of times that they used it (i.e., completed a fidelity measure after a session with a client in the study). For each session, fidelity of use of the PPH was reported by percentage shown in Appendix G: none (0%), some (up to 25% of session content), about half (about 50% of session content), most (about 75% of session content), and nearly all (close to 100% of session content). A report of "none" was assigned a score of 0. A report of "some" was assigned a score of .25, A report of "about half" was assigned a score of .5. A report of "most" was assigned a score of .75. A report of "nearly all" was assigned a score of 1.

Table 11 shows the average of the amount of PPH usage per session. The column with "Amount" presents the number of sessions for which a clinician completed the fidelity measure (a whole number). The column labeled "Usage" presents the average percentage reported in the

fidelity measure (sum of all use percentage values, divided by the number of entries). The "Total exposure" score for each interventionist clinician is the product of the usage and amount, or a total of all the usage [sum of each score assigned to the percentage reported by the interventionist]). Total exposure scores of 0 represents a clinician in the interventionist group who received the training to administer the positive psychology-based intervention (PPH), but either chose not to use it with their clients *or* did not report the fidelity of usage. To fully depict amount of clinician variability in treatment of youth clients with PPH, Table 11 also presents the number of youth clients each interventionist enrolled in the positive psychology-based intervention within the RCT (i.e., collected baseline data for at the start of treatment), and also the number of youth clients the interventionist completed during the study (i.e., collected post data for by the conclusion of the RCT). Lack of use of PPH with clients may be associated with minimal opportunities due to low enrollment of clients in the study. Indeed, in this study the correlation between Total Exposure and number of youth clients who completed the study was .91 (see Table 12). For clinicians with multiple enrolled clients, it is unknown why failure to complete the fidelity measure occurred given regular reminders from study staff and the agency to report fidelity of use with enrolled clients. However, for two clinician participants (ID numbers 112 and 172) who enrolled and collected post-treatment data from numerous youth clients in the RCT, no fidelity measures were completed; their fidelity data is conceptualized as missing rather than a "0" score because they completed treatment with several youth participants they enrolled in the study.

Difference scores were then created by subtracting pre-intervention measure scores from post-intervention measure scores on each of the five scales (SWLS, FS, PA, NA, and PSS) which allowed a correlation to be calculated with the total exposure and difference scores. Table 12

shows the mean, standard deviation, and correlations between the total exposure variable, usage, amount, clients enrolled, clients completed and gain scores across the different mental health measures. As aforementioned, Clinician 111 and Clinician 172 did not report any usage data but both enrolled and completed multiple clients in the study. They were excluded from correlational analysis of clinician outcomes and total exposure, amount, or usage, and retained for correlational analysis of clinician outcomes with clients enrolled and completed. This is reflected in Table 12 when the *N* changes between 17 and 19.

Table 11

Total Exposure Variable and Number of Youth Clients for Interventionists

Clinician ID	Amount	Usage	Total Exposure	Youth Clients Enrolled in RCT	Youth Clients Completed in RCT
108	12	0.73	8.75	6	4
109	18	0.43	7.25	5	3
111	2	0	0	3	1
112	.	.	.	10	10
113	6	0.21	1.25	9	1
116	0	0	0	1	0
117	12	0.5	6	6	2
142	2	0.5	1	1	1
146	2	0.25	0.5	4	4
147	1	0.25	0.25	8	3
155	76	0.28	21.5	12	7
165	36	0.49	17.75	9	6
167	49	0.46	22.5	10	7
169	0	0	0	0	0
171	0	0	0	0	0
172	.	.	.	7	6
174	40	0.28	11.5	6	5
177	0	0	0	2	0
183	0	0	0	0	0

Note. "." = missing data.

Table 12

Correlation between Exposure to Intervention and Mental Health Gain Scores of Clinicians

Variable	*N*	*M*	*SD*	TotExp	Usage	Amount	CliEn	CliCom	DiffSWLS	DiffFS	DiffPA	DiffNA
TotExp	17	5.78	7.97	1.000								
Usage	17	0.26	0.23	0.556	1.000							
Amount	17	15.06	22.19	0.945*	0.391	1.000						
CliEn	19	5.21	3.85	0.770*	0.548*	0.761*	1.000					
CliCom	19	3.16	3.00	0.905*	0.624*	0.864*	0.822*	1.000				
DiffSWLS	19	2.16	4.48	-0.280	-0.415 ^{t}	-0.296	-0.560*	-0.659*	1.000			
DiffFS	19	1.65	3.94	0.316	0.146	0.231	-0.069	-0.275	0.534*	1.000		
DiffPA	19	-1.47	7.87	0.316	0.374	0.253	0.185	0.126	0.259	0.318	1.000	
DiffNA	19	-1.32	5.88	0.094	-0.061	0.021	-0.021	0.088	0.209	0.295	0.425^{t}	1.000
DiffPSS	19	-0.47	4.03	-0.370	-0.239	-0.337	-0.258	-0.236	0.032	-0.003	0.120	0.331

Note. *$p < .05$, $^{t}p < .10$; TotExp = Total Exposure (amount x usage), CliEn = number of clients enrolled in RCT, CliCom = number of clients completed in RCT, DiffSWLS = gains in SWLS from pre to post, DiffFS = gains in FS from pre to post, DiffPA = gains in PA from pre to post, DiffNA = gains in NA from pre to post; DiffPSS = gains in PSS from pre to post.

A correlation of gain scores with PPH use was conducted by examining the five scales of complete mental health with various indicators of clinician engagement with an opportunity to use the PPH intervention. The primary emphasis for this research question is on total exposure (n = 17 due to missing fidelity of use data from 2 clinicians with high client enrollment); however, this researcher also included in Table 12 associations with other potential indicators for engagement for full reporting. With regard to associations between total exposure to PPH and clinician mental health, there were no significant correlations (p <.05) between gains in SWLS, FS, PA, NA, and PSS and total exposure to the positive psychology-based intervention. Since there were no statistically significant correlations, any interpretations of magnitude from this portion of the study may be non-generalizable. To fully explore trends in the data within this underpowered study, Cohen's (1992) guidelines were used to understand the strength/magnitude of correlations as small (r = .1), medium (r = .3), and large (r = .5) for this specific sample. Three associations reached the threshold for medium in magnitude. Specifically, the correlation between clinicians' total exposure to the positive psychology intervention and change in personal levels of perceived stress was negative, with a medium magnitude and non-significant p-value (r = 0.370, p = .144). This suggests that as exposure to the positive psychology-based intervention increased, levels of perceived stress reported by clinicians tended to decrease for this sample. It was also found that as total exposure to PPH increased, personal flourishing and positive affect also tended to increase with a medium magnitude correlation but a non-significant p-value (r = 0.316, p = .216 for flourishing; *3*. In sum, there were no statistically significant findings between total exposure to PPH and any indicator of complete mental health for research question three, in part due to lack of power associated with a small sample size (N = 17). Trends in the data include medium-sized associations between greater total use of PPH and improvements in three

indicators of mental health (perceived stress, positive affect, and flourishing), supporting the value of future studies with larger samples of clinicians to further explore the reliability of these trends.

Chapter V: Discussion

Positive psychology interventions (PPI) have been used in various settings, with diverse groups of different ages, for reasons ranging from prevention to treatment (Carr et al., 2024; Carr et al., 2021; Chakhssi et al., 2018; Furchtlehner et al., 2020; van Ageteren et al., 2021). A mega-analysis comprised of meta-analyses conducted in 2024 by Carr and colleagues gathered information from 198 meta-analyses broadly defining PPI as interventions that have the goal of well-being enhancement, which are achieved through pathways consistent with positive psychology theory even if the interventions were not developed in the contemporary positive psychology movement. It was concluded that the use of PPIs in psychological practice has an extensive evidence base to support their overall effectiveness on client mental health, including indicators of well-being, depression, anxiety, strengths, stress, and quality of life (Carr et al., 2024). "Positive Psychology through Happiness" (PPH) is a new positive psychology-based intervention developed for use in community mental health care that was refined and evaluated by researchers in the USF College of Education between 2021 – 2023. During the initial use of the PPH by clinician participants in a pilot study (2021-22), three participants who were trained in and regularly used PPH described their experiences during exit interviews (Suldo et al., 2023). Through these exit interviews, clinicians reported experiencing an increase in their own well-being from learning about and using the positive psychology-based intervention (PPH).

Mental health clinicians, referred to as clinicians for short, engage in work that is emotionally demanding and challenging, making them susceptible to negative impacts in their professional lives including high levels of burnout (Dreison et al., 2018; Richards et al., 2010).

Burnout impacts clinicians' general well-being, which in turn impacts client engagement and benefits from therapy (Luther et al., 2017; Yang & Hayes, 2020). The need to protect or enhance clinicians' own mental health is important to help their clients achieve the best outcomes, as clinicians with higher well-being are more likely to help their clients and less likely to experience burnout (Lawson & Myers, 2011; Luther et al., 2017; Yang & Hayes, 2020). In other words, clinicians' highly demanding jobs impact their own well-being, which then impacts the potential positive outcomes of their clients.

As positive psychology and PPIs gain popularity, the literature shows that the use of these interventions can increase positive symptoms and decrease negative symptoms in those receiving the interventions (Carr et al., 2024), which is the basis for fostering complete mental health from the standpoint of the dual-factor model (Suldo & Doll, 2021). For mental health professionals to provide high levels of care to help their clients, it is important for these professionals to also take care of their own well-being (Lawson & Myers, 2011; Yang & Hayes; 2020). Interventions that have been used for clinicians to advance their own well-being include engaging in therapy themselves or deliberate self-care measures (Posluns & Gall, 2020; Yang & Hayes 2020), which can be time consuming and take effort from the clinicians to do often on their own time outside of work. From the pilot year of the PPH evaluation, three clinicians reported positive impacts of learning and using a positive psychology-based intervention with their clients during exit interviews (Suldo et al., 2023).

This study investigated whether learning and using a positive psychology-based intervention (PPH) in the workplace had any impact on clinicians' complete mental health over time, compared to those who did not use positive psychology, and in conjunction with how much or little they were exposed to the PPH during their treatment of youth clients. As part of a larger

program evaluation and RCT, two cohorts of clinicians in the current study took baseline measurements of their mental health before being randomized into the intervention or control group. The intervention group learned and was instructed to utilize PPH as they saw professionally fit, whereas the control group was instructed to continue to provide services as usual and did not receive access to the PPH training or intervention materials. At the end of the RCT, 7 to 10 months later, these clinicians took the same measures to see if there were changes in their complete mental health.

Summary and Explanation of Findings

Research Question 1

The first aim of this study examined whether clinicians in the intervention group who used a positive psychology intervention with their clients experienced significant changes in personal mental health as indicated by levels of wellness (satisfaction with life, flourishing, positive affect) and distress (negative affect, perceived stress). In order to study this question, data was analyzed from 19 clinicians who had been randomly assigned to the intervention group and completed both baseline (before randomization) and posttest (end of year) measures of mental health, specifically the SWLS, FS, PANAS, and PSS. Posttest measures were administered after the interventionists had been fully trained in the PPH, and asked to use the positive psychology intervention with youth clients during treatment, with integration into clinical care at their own professional discretion. A repeated measures ANOVA was then conducted to look at changes between the pre and posttest scores, producing five different measures of complete mental health.

Using Cohen's (1988) guidelines for interpreting effect sizes, there were three significant ($p < .05$) measures that showed changes over time. Specifically, satisfaction with life (SWLS),

negative affect (NA), and perceived stress (PSS) had small to medium sized effects. Between the pre and post-test assessment points, clinicians' satisfaction with life increased (d = 0.37), and negative affect (d = 0.25) and perceived stress (d = 0.19) decreased. Neither flourishing (FS) or positive affect (PA) showed a significant change over time. In the pilot study of PPH, exit interviews yielded that learning and utilizing PPH allowed for them to see benefits in their own personal lives (Suldo et al., 2023). Mental health professionals are vulnerable to lower levels of well-being due to the work they engage in (Simionato et al., 2019) and often neglect their own mental health (Dattilio, 2015). PPIs have been proven effective in terms of well-being, depression, anxiety, strengths, stress, and quality of life when used with various populations as a form of treatment for their clients (Carr et al., 2024), but continue to lack any research around impacts they might have on the clinicians learning and administering them aside from the current study. Findings around the clients changes are generally consistent with experiences reported by different participants in the pilot study (Suldo et al., 2023), supporting the notion that mental health clinicians may experience improvements in mental health throughout the year (increase in their satisfaction with life, and decrease their negative affect and perceived stress) that included professional learning and use of a positive psychology-based intervention, the PPH, with their clients. No significant changes in flourishing might be explained by relatively high starting scores (M = 47.47) in this sample, as the range is 8 to 56 (Diener et al., 2010). A study by Hone and colleagues (2014) found an average of 44.21 with 9,646 participants.

Research Question 2

The second aim of this study was to examine whether or not the business-as-usual control or intervention group had significantly different changes during the same time period, with respect to levels of satisfaction with life, flourishing, positive affect, negative affect, or perceived

stress. It was found that there were no significant differences between the two groups, suggesting that both groups of clinicians had the same level of changes over time. The aforementioned increases in satisfaction with life and decreases in negative affect and perceived stress experienced by the intervention group (as reported for research question one), does not appear unique to the intervention group. The control group was found to have similar changes over the same time period.

One reason that there might not be significant differences between the control and intervention groups may be because the control group did not have added duties that the interventionist group did with regard to participating in the study. The control group started with 40 clinician participants and ended with 25 (62.5% retention), while the intervention group started with 44 clinician participants and ended with 19 (43.2% retention). Added tasks such as (1) completing the initial training in the PPH, (2) receiving check-ins from the PPH trainer who encouraged them to attend weekly office hours to discuss use of PPH after the initial training was completed, and (3) receiving email reminders from study staff to (a) administer outcome mental health measures form youth clients at the start of treatment and again at the end of treatment or the school year [enroll and complete youth clients], and (b) complete fidelity measures reporting use of PPH for each youth client in the study, might have added to the overall stress and workload that the intervention group had to manage. Among the business-as-usual control group, the only study-related tasks involved part 3a as described for the intervention group, essentially receiving reminders to enroll their youth clients in the study by administering outcomes measure health measures at the start of treatment and then end of treatment or the school year. With an already high attrition rate amongst mental health clinicians, between 30-60% possibly due to stress from the job (Beidas et al., 2016), engaging in additional tasks from being a part of the

interventionist group associated with learning, using, and reporting on use of a new intervention could have reduced the potential to increase further in indicators of well-being and decrease further in indicators of psychopathology. Future research might thus consider using an active control group assigned to learn and use a different new intervention.

Existing literature available relevant to clinicians' own mental health suggests that clinicians often neglect their own mental health despite the importance of tending to it, in order to help better their clients (Dattillio, 2015; Simionato et al., 2019). Research on self-care practices are the most prevalent when it comes to working to increase well-being in mental health professionals (Posluns & Gall, 2020; Richards et al., 2010). In the current study, neither the control or intervention group had any PPIs or self-care strategies administered to try and increase their own well-being or decrease their stress.

The similar changes on mental health indicators seen between the intervention and control group could be due to the time of year that they took the pre and post measures, or other extraneous variables in the clinicians' lives during that time. As a majority of the clinicians in the study worked in school-based settings, taking post measures at the end of the academic year when school is ending and clinician's might be preparing for summer break could have impacted their mental health scores. All clinicians in the study could have been terminating care at the post time point (due to the end of the school year and thus access to the client) and reflecting on clients' treatment gains and therapeutic success, impacting both the intervention and control groups' complete mental health. It is also notable that clinicians in the control group who continued using business-as-usual interventions were using evidence-based interventions with their clients due to agency requirements. Use of evidence-based interventions can be related to positive experiences for clinicians (Adams et al., 2019).

Research Question 3

The third aim of this study was to examine if clinicians randomly assigned to the positive psychology-based intervention (PPH) experienced changes in their complete mental health based on how much they used it. The current study of 17 clinicians with complete data on personal mental health and PPH usage identified associations that were not statistically significant but of medium strength in magnitude. In particular, findings included medium strength correlations between total exposure to PPH and increases in clinician flourishing (r = .32) and positive affect (r = .32), as well as decreases in perceived stress (r = -.37). In other words, the more that these interventionists used PPH, trends in the data suggested that flourishing and positive affect increased and perceived stress decreased, as evidenced by medium strength correlations (r > .30).

In examining the dataset that led to these results revealed that there was a wide variation in use of PPH, which might have impacted the results in unanticipated ways. Five of the clinicians did not appear to engage in PPH at all, and two more clinicians did not report any instances of use in session despite having enrolled several youth clients in the study. The remaining 12 clinicians had a range of 1 to 76 recorded instances of using PPH with their youth clients. This shows a wide range of implementation of the new intervention the 19 clinicians all learned at the beginning of the study.

Frank and colleagues (2020) systematic review of therapist training approaches identified barriers to adopting new evidence-based interventions and found that introducing a new intervention to clinicians might be a continuous barrier when it comes to clinicians adopting new interventions. Willingness to adopt a new practice if required, willingness to adopt a new practice given its intuitive appeal, general openness toward a new or innovative practice, and perceived divergence of usual practice with academically developed or research-based practices

are four dimensions that have been examined when introducing a new intervention to existing clients (Aarons, 2004). These factors might have impacted the intervention group's willingness to adopt PPH into their current practice or not, as they were allowed to use it as they saw professionally fit.

Contributions to the Literature

This research study contributes to the literature in several different ways. To the researcher's knowledge, this is the first study that has examined mental health clinician's complete mental health using the SWLS, FS, PANAS, and PSS, and looked at possible impacts of using a positive psychology intervention with clients on the treating clinician's own mental health. The results of this study that exclude the control group suggest there might be positive changes in clinicians' complete mental health associated with learning and using a positive psychology-based intervention with their clients. This would be beneficial to the field, as many mental health clinician's neglect their own well-being (Dattilio, 2015) and higher well-being in mental health professionals is important to their job of helping clients (Lawson & Myers, 2011; Yang & Hayes; 2020). However, the pre- to post-treatment changes observed in the intervention group were not significantly different from changes observed in a business-as-usual control group, which precludes this researcher from attributing change in clinician mental health to their unique experiences with the PPH. Further, this study was underpowered to detect potentially significant relationships between improvements in clinician mental health and use of the PPH.

Although unrelated to the primary research questions, preliminary analyses involving examination of clinician attrition from the study yielded interesting findings. Specifically, this study included an attrition analysis to determine if there were differences in the combined sample (intervention and control) of mental health clinicians who completed the study and stayed

working as a clinician in the agency (n = 44), compared to the 40 clinicians who did not complete post-test personal mental health measures because they left the agency (19/40; 47.5%), changed job roles (13/40; 32.5%), withdrew from the study (4/40; 10%), or did not respond to requests to participate at post for unknown reasons (4/40; 10%). The results found that those who stayed employed as clinicians at the community agency and completed the study started with lower levels of perceived stress and higher levels of positive affect. This suggests that clinicians potentially most likely to persist in a mental health provider role at the same agency throughout the year may be more likely to report relatively low stress and high positive affect from the start, whether those who leave the agency, clinician role, or study may be more likely to begin the project with elevated stress and lower positive affect. To this researcher's knowledge, this is the first study that has examined an attrition analysis looking at complete mental health with multiple positive and negative indicators. Previous research has examined burnout and financial stressors in terms of clinician turnover (Beidas et al., 2016), but not in terms of mental health as the attrition analysis that was conducted for the current study did.

Implications for Practice

The first finding from this study that I would like to address for implications for practice is the high attrition rate, which was 51.6% and not uncommon for this field (Adams et al., 2019; Beidas et al., 2016). An attrition analysis was run with the baseline measures of the participants who started but never completed the study on the five indicators of complete mental health. This study found significant differences between the clinicians who stayed working as clinicians at the agency, and those that left the agency or the study. Clinicians who did not finish the study for various reasons started with higher levels of perceived stress compared to clinicians who did finish the study and stayed at the agency. Clinicians who stayed through the study and at the

agency also started with higher levels of positive affect compared to those who did not complete the study. This attrition analysis shed light on the possibility that those who have higher perceived stress and lower positive affect might be more prone to leaving a community mental health organization, the clinician role, or leaving a study. Monitoring and taking steps to increase positive affect or decrease perceived stress might help retain mental health clinicians.

Another implication for practice is that there could be some benefit for mental health clinicians to learning and using positive psychology-based interventions with their clients. In this study, PPH interventionists experienced a significant increase in satisfaction with life and a decrease in negative affect and perceived stress (although so did their colleagues who provided services as usual). There was a small increase in flourishing found with this sample of interventionists, though not statistically significant. There is a need for clinicians to increase their well-being, as this helps them serve their clients better (Lawson & Myers, 2011; Richards et al., 2010; Simionato et al., 2019). For this sample, more exposure to the positive psychology-based intervention (PPH), was correlated with increases in personal flourishing and positive affect, and reductions in perceived stress, at a medium strength association. More research with larger samples and more statistical power is needed to determine if community mental health providers in other samples experience similar changes with the use of PPIs as they work with their clients.

Limitations

There are several limitations to this study. Due to high attrition and mobility within the participating agency, there was high attrition in the current study as well, which was not anticipated by the research team. The study enrolled 89 clinician participants (84 of whom completed premeasures) but ended with 44 who filled out both the pre and post measures

required for analysis, yielding an attrition rate of 51.6% for this study that spanned the course of a single school year. However, the level of attrition appears comparable with other studies in community mental health. Specifically, Adams and colleagues (2019) examined therapist financial strain and turnover and reported a turnover rate of 39% throughout the duration of their 1-year study. This is consistent with other studies that have found rates between 30% and 60% for clinician or therapist turnover (Beidas et al., 2016), which is consistent with the loss of participation of 52% of clinicians in the current study.

This level of attrition reduced the overall sample size and thus the power to detect an effect when one existed. Sample size was further reduced in analyses of relationships between usage and changes in mental health, as the study team uncovered missing fidelity reports. This missing data further impacted the power of the correlation analyzes, and limited opportunities for even sizeable findings to be statistically significant and generalizable. Finally, this study controlled for intervention group but not many other variables that could impact clinician mental health outcomes; other life factors could have contributed to any changes that were measured in the clinician's mental health, including but not limited to the time of year they took the pre and post measures (fall or winter till end of spring or early summer), fatigue associated with the demand of learning a new in and other life stressors or positive factors.

Another limitation specific to the intervention group is the considerable variability in clinician usage of PPH after training. Some trained clinicians reported no use, whereas others reported frequent use in numerous sessions with multiple clients. The heterogeneity of usage and lack of real-time fidelity monitoring limits potential conclusions about typical clinician experiences in the intervention group.

Future Directions

The current study examined how using a positive psychology-based intervention (PPH) might be related to mental health clinician's own mental health. PPH is theoretically grounded in positive psychology but is undergoing studies to discover if it is effective for increasing youth clients' subjective well-being, which would contribute to its consideration as an evidence-based treatment or not. Future research should continue to examine PPH and how it might impact clients with whom it is used. Future research should also examine if PPIs that are already evidence-based have an impact on mental health clinician's complete mental health when they are used with high fidelity and more overall exposure. More research on possible effects from PPIs or exposure to positive psychology using the SWLS, FS, PANAS, and PSS for mental health clinicians should be conducted to understand how these scales change with this population.

Additionally, more qualitative studies around impacts of PPI and perceived changes in complete mental health with clinicians could allow for more information to be known for this field. Future studies could also examine the outcome associated with mental health clinicians' intentionally applying PPIs to themselves (vs. facilitating such application to their clients' lives), to see if intentional personal use increases their well-being or decreases levels of psychopathology. This would be a new area of research, as current research trends around self-care for mental health clinicians to help their overall well-being. Self-care strategies according to Dattilio (2015) are defined as strategies used to manage or reduce their stress and live a healthier lifestyle. This differs from PPIs, as PPIs are broadly defined as interventions used to enhance well-being (Carr et al., 2024), and many studies look at this as clinicians enhancing the

well-being of others (Carr et al., 2024; Chakhssi et al., 2018; Furchtlehner et al., 2020; van Ageteren et al., 2021) whereas self-care strategies are used on oneself (Dattilio, 2015).

With a paucity of research around mental health clinicians adopting new interventions, further qualitative research around clinicians' experiences when learning and using new interventions would be beneficial to understanding barriers and what might further support clinicians to use new interventions with their clients, specifically PPIs. Interviews conducted with clinicians to learn more about why they did or did not use the positive psychology-based intervention could benefit future research and studies to engage clinicians in the adoption of new interventions. Using Aaron's (2004) four dimensions to guide interviews could allow for researchers to better understand clinicians' willingness to adopt a new intervention. It could also be beneficial to look at the number of years a clinician has been seeing clients and how this impacts their willingness to adopt new practices. This would not only be useful for the adoption of PPIs in practice, but other interventions that organizations might want their clinicians to utilize too.

Future research on attrition rates and reasons for leaving community mental health organizations should be conducted. The current study found that clinicians who left the agency or left the study started with lower scores of positive affect and higher levels of perceived stress. Future studies should examine other factors that might be related to attrition, as well as what potential factors could help with retention in a community mental health organization. Current research focuses on financial stressors, overworking, and burnout as high contributing factors to clinician turnover (Beidas et al., 2016; Luther et al., 2017), and further research that examines if use of PPIs can lower burnout for clinicians would be useful. Future studies addressing how to

help lower attrition rates would be beneficial to community mental health organizations and the populations that they serve.

Summary

Findings from this study indicate that there could be a connection between attrition rates in a community mental health organizations and higher levels of perceived stress as well as lower levels of positive affect from clinicians who leave the clinician role at a particular agency in a year period. Additionally, this study examined if learning and using a positive psychology-based intervention (PPH) to use as seen professionally fit with their clients would impact their own complete mental health (reduce psychopathology and/or increase subjective well-being). Clinicians who learned and had the option to use PPH experienced increases in satisfaction with life, as well as decreases in negative affect and decreases in perceived stress. These changes were not unique to the clinicians who learned and used PPH, but instead statistically similar to experiences of peer clinicians randomly assigned to the business-as-usual control that involved fewer work-place demands associated with learning, using, and reporting experiences with a new intervention. For the clinicians who did use PPH, more exposure to the positive psychology-based intervention was correlated with medium size but not statistically significant increases in flourishing and positive affect and decreases in perceived stress. This research begins to examine how using PPIs might impact mental health clinicians' own complete mental health. Further research should be conducted with mental health clinicians using PPIs in their therapeutic work with their clients as well as in personal applications, and how each is associated with changes in their complete mental health.

References

Aarons, G. A. (2004). Mental health provider attitudes toward adoption of evidence-based practice: The evidence-based practice attitude scale (EBPAS). *Mental Health Services Research, 6*(2), 61-74.

Adams, D. R., Williams, N. J., Becker-Haimes, E. M., Skriner, L., Shaffer, L., DeWitt, K., Neimark, G., Jones, D. T., & Beidas, R. S. (2019). Therapist financial strain and turnover: Interactions with system-level implementation of evidence-based practices. Administration and Policy in Mental Health and Mental Health Services Research, 46(6), 713–723. https://doi.org/10.1007/s10488-019-00949-8

Bearse, J. L., McMinn, M. R., Seegobin, W., & Free, K. (2013). Barriers to psychologists seeking mental health care. *Professional Psychology: Research and Practice, 44*(3), 150-157.

Beidas, R.S., Marcus, S., Wolk, C.B. *et al.* (2016). A prospective examination of clinician and supervisor turnover within the Context of implementation of evidence-based practices in a publicly-funded mental health system. *Administration and Policy Mental Health 43*, 640–649. https://doi.org/10.1007/s10488-015-0673-6

Berkland, B. E., Werneburg, B. L., Jenkins, S. M., Friend, J. L., Clark, M. M., Rosedahl, J. K., Limburg, P. J., Riley, B. A., Lecy, D. R., & Sood, A. (2017). A Worksite Wellness Intervention: Improving Happiness, Life Satisfaction, and Gratitude in Health Care Workers. *Mayo Clinic proceedings. Innovations, quality & outcomes*, *1*(3), 203–210. https://doi.org/10.1016/j.mayocpiqo.2017.09.002

Cameron, K. S., & Caza, A. (2004). Introduction: Contributions to the discipline of positive organizational scholarship. *American Behavioral Scientist,47*, 731–739.

Carr, A., Cullen, K., Keeney, C., Canning, C., Mooney, O., Chinseallaigh, E., & O'Dowd, A. (2021). Effectiveness of positive psychology interventions: A systematic review and meta-analysis. *The Journal of Positive Psychology, 16*(6), 749-769. Doi:10.1080/17439760.2020.1818807

Carr, A., Finneran, L., Boyd, C., Shirey, C., Canning, C., Stafford, O., … Burke, T. (2024). The evidence-base for positive psychology interventions: a mega-analysis of meta-analyses. *The Journal of Positive Psychology*, *19*(2), 191–205. https://doi.org/10.1080/17439760.2023.2168564

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), 1–17. https://doi.org/10.1186/s12888-018-1739-2.

Cohen J. (1988). *Statistical Power Analysis for the Behavioral Sciences*. New York, NY: Routledge Academic

Cohen, J. (1992). Statistical Power Analysis. Current Directions in Psychological Science, 1(3), 98-101. https://doi.org/10.1111/1467-8721.ep10768783

Cohen, S., Kamarck, T., & Mermelstein, R. (1983) A global measure of perceived stress. *Journal of Health and Social Behavior, 24,* 385–396.

Copeland, W., Shanahan, L., Costello, E. J., & Angold, A. (2011). Cumulative prevalence of psychiatric disorders by young adulthood: A prospective cohort analysis from the great smokey mountains study. *Journal of the Academy of Child and Adolescent Psychiatry, 50*(30), 252-261. Doi:10.1016/j.jaac.2010.12.014

Cunha, L. F., Pellanda L. C., & Reppold, C. T. (2019). Positive psychology and gratitude interventions: A randomized clinical trial. *Frontiers in Psychology, 10,*(584), 1-9, doi:10.3389/fpsyg.2019.00584

D'Raven, L. L. & Pasha-Zaidi, N. (2014). Positive psychology interventions: A review for counselling practitioners. *Canadian Journal of Counselling and Psychotherapy, 48*(4), 383-408.

Dattilio, F. M. (2015). The self-care of psychologists and mental health professionals: A review and practitioner guide. *Australian Psychological Study, 50,* 393-399. Doi:10.1111/ap.12157

Deckro, G. R., Ballinger, K. M., Hoyt, M., Wilcher, M., Dusek, J., Myers, P., et al. (2002). The evaluation of a mind/body intervention to reduce psychological distress and perceived stress in college students. *Journal of American College Health, 50*, 281e287. http://dx.doi.org/10.1080/ 07448480209603446.

Diener, E., Emmons, R. A., Larsen, R. J., & Griffin, S. (1985). The satisfaction with life scale. *Journal of Personality Assessment, 49*, 71–75.

Diener, E., Wirtz, D., Tov, W., Kim-Prieto, C., Choi, D., Oishi, S., & Biswas-Diener, R. (2009). New measures of well-being: Flourishing and positive and negative feelings. *Social Indicators Research*, *39*, 247-266.

Diener, E., Wirtz, D., Tov, W., Kim-Prieto, C., Choi, D. W., Oishi, S., et al. (2010). New well-being measures: Short scales to assess flourishing and positive and negative feelings. *Social Indicators Research, 97*(2), 143–156. doi:10.1007/s11205-009-9493-y

Donaldson S. I., Lee, J. Y., & Donaldson, S. I. (2019). Evaluating positive psychology interventions at work: A systematic review and meta-analysis. *International Journal of Applied Positive Psychology, 4,*113-134. Doi:10.1007/s41042-019-00021-8

Dreison, K. C., Luther, L., Bonfils, K. A., Sliter, M. T., McGrew, J. H., & Salyers, M. P. (2018). Job burnout in mental health providers: A meta-analysis of 35 years of intervention research. *Journal of Occupational Health Psychology, 23*(1), 18–30. https://doi.org/10.1037/ocp0000047

Duckworth, A. L., Steen, T. A., & Seligman, M. E. P. (2005). Positive psychology in clinical practice. *Annual Review of Clinical Psychology*, *1*, 629-651. Doi:10:1146/annurev.clinpsy.1.102803.144154.

Elman, N. S., & Forrest, L. (2007). From trainee impairment to professional competence problems: Seeking new terminology that facilitates effective action. *Professional Psychology: Research and Practice, 38*(5), 501–509. https://doi.org/10.1037/0735-7028.38.5.501

Florida Board of Clinical Social Workers, M. & F. T. M. H. C. (n.d.). *Licensed mental health counselor*. Florida Board of. Retrieved April 2023, from https://floridasmentalhealthprofessions.gov/licensing/licensed-mental-health-counselor/

Fordyce, M. W. (1988). A review of research on the happiness measures: A sixty second index of happiness and mental health. Social Indicators Research, 20, 355-381. http://dx.doi.org/10.1007/BF00302333

Fraken, K., Lamers, S., Ten Klooster, P. M., Bohlmeijer, E. T., & Westerhof, G. J. (2018). Validation of the mental health continuum-short form and the dual continua model of well-being and psychopathology in adult mental health setting. Journal of Clinical Psychology, 74(12), 2187-2202. Doi:10.1002/jclp.22659

Frank, H. E., Becker-Haimes, E. M., & Kendall, P. C. (2020). Therapist training in evidence-based interventions for mental health: A systematic review of training approaches and outcomes. *Clinical Psychology, 27*(3), 1-30. Doi:10.1111/cpsp.12330

Furchtlehner, L. M., Schuster, R., & Laireiter, A. (2020). A comparative study of the efficacy of group positive psychotherapy and group cognitive behavioral therapy in the treatment of depressive disorders: A randomized controlled trial. *The Journal of Positive Psychology, 15*(6), 832-845. Doi:10.1080/17439760.2019.1663250

Gable, S. L. & Haidt, J. (2005). What (and why) is positive psychology? *Review of General Psychology, 9(*2), 103-110.

Greenspoon, P. J., & Saklofske, D. H. (2001). Toward an integration of subjective well-being and psychopathology. *Social Indicators Research, 54*, 81–108.

Harrison, R. L. & Westwood, M. J. (2009) Preventing vicarious traumatization of mental health therapists: Identifying protective factors. *Psychotherapy: Theory, Research, Practice, Training, 46*(2), 203-219. Doi:10.1037/a0016081

Hone, L., Jarden, A., & Schofield, G. (2014). Psychometric properties of the flourishing scale in a new Zealand sample. *Social Indicators Research, 119*, 1031-1045. Doi:10.1007/s11205-013-0501-x

Keyes C. L. M. (2005). Mental illness and/or mental health? Investigating axioms of the complete state model of health. *Journal of Consulting and Clinical Psychology*, 73, 539–548. 10.1037/0022-006X.73.3.539

Keyes, C. L. M. (2006). Mental health in adolescence: Is America's youth flourishing? *American Journal of Orthopsychiatry, 76*, 395–402.

Lambert, M. J., Gregersen, A. T., & Burlingame, G. M. (2004). The Outcome Questionnaire-45. In M. E. Maruish (Ed.), *The use of psychological testing for treatment planning and outcomes assessment: Instruments for adults* (pp. 191–234). Lawrence Erlbaum Associates Publishers.

Lawson, G. & Myers, J. E. (2011). Wellness, professional quality of life, and career-sustaining behaviors: What keeps us well? *Journal of Counseling and Development, 89*(2), 163-171. Doi:10.1002/j.1556-6678.2011.tb00074

Luther, L., Gearhart, T., Fukui, S., Morse, G., Rollins, A. L., & Salyers, M. P. (2017). Working overtime in community mental health: Associations with clinician burnout and perceived quality of care. *Psychiatric Rehabilitation Journal*, 40(2), 252–259. https://doi.org/10.1037/prj0000234

McGorry, P. D., Mei, C., Chanen, A., Hodges, C., Alvarez-Jimenez, M., & Killackey, E. (2022). Designing and scaling up integrated youth mental health care. *World Psychiatry, 21*(1), 61-76. Doi:10.1002/wps.20938

Merz, E. L., Malcarne, V. L., Roesch, S. C., Ko, C. M., Emerson, M., Roma, V. G., & Sadler, G. R. (2013). Psychometric proppertives of Positive and Negative Affect Schedule (PANAS) original and short forms in an African American community sample. *Journal of Affective Disorders, 151*(3), 942-949.

Meyers, M. C., van Woerkom, M., & Bakker, A. B. (2013). The added value of the positive: A literature review of positive psychology interventions in organizations. *European Journal of Work and Organizational Psychology, 22*(5), 618-632. Doi:10.1080/1359432X.2012.694689

National Alliance on Mental Illness. (April, 2020). *Types of Mental Health Professionals.* *https://www.nami.org/About-Mental-Illness/Treatments/Types-of-Mental-Health-Professionals*

Pavot, W. & Diener, E. (1993). The affective and cognitive context of self-reported measures of subjective well-being. *Social Indicators Researchers, 28*, 1-20. Doi:10.1007/bf01086714

Posluns, K. & Gall, T. L. (2020). Dear mental health practitioners, take care of yourselves: A literature review of self-care. *International Journal for the Advancement of Counselling, 42*, 1-20. Doi:10.1007/s10447-019-09382-w

Querstret, D., Cropley, M., & Fife-Schaw, C. (2018). The effects of an online mindfulness intervention on perceived stress, depression and anxiety in a non-clinical sample: A randomised waitlist control trial. *Mindfulness, 9*, 1825–1836. Doi:10.1007/s12671-081-0925

Richards, K. C., Campenni, C. E., & Muse-Burke, J. L. (2010). Self-care and well-being in mental health professionals: The mediating effects of self-awareness and mindfulness. *Journal of Mental Health Counseling, 32*(3), 247-264.

Roberti, J. W., Harrington, L. N., & Storch, E. A. (2011). Further psychometric support for the 10-item version of the perceived stress scale. *Journal of College Counseling, 9*(2), 135-147. doi:10.1002/j.2161-1882.2006.tb00100.x

Rosen, M. L., Rodman, A. M., Kasparek, S. W., Mayes, M., Freeman, M. M., Lengua, L. J., Meltzoff, A. N., & McLaughlin, K. A. (2021). Promoting youth mental health during the COVID-19 pandemic: A longitudinal study. *PLoS ONE, 16*(8). doi: 10.1371/journal.pone.0255294

Ryff, C. D., & Singer, B. (1998). The contours of positive human health. *Psychological Inquiry, 9*, 1–28.

Schueller, S. M., Kashdan, T. B., & Parks, A. C. (2014). Synthesizing positive psychological interventions: Suggestions for conducting and interpreting meta-analyses. *International Journal of Wellbeing*, 4(1), 91–98.

Schwartz, R., Sinskey, J. L., Uma, A., & Margolis, R. D. (2020). Addressing postpandemic clinician mental health: A narrative review and conceptual framework. *Annals of Internal Medicine, 173*(12), 981-988. Doi:10.7326/M20-4199

Seligman, M.E.P. (2002). Authentic Happiness: Using the New Positive Psychology to Realize Your Potential for Lasting Fulfillment. New York: Free Press

Seligman, M. E. P. (2002). Positive psychology, positive prevention, and positive therapy. In C. R. Snyder & S. J. Lopez (Eds.), *Handbook of positive psychology* (pp. 3–12). New York: Oxford University Press.

Simionato, G., Simpson, S., & Reid, C. (2019). Burnout as an ethical issue in psychotherapy. *Psychotherapy, 56,*(4), 460-482. Doi:10.1037/pst0000261

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*(26). Doi:10.1186/1472-6963-10-26

Suldo, S. M., Coolman, F., & Legra, C. (2023). *Interim Report (Year 1 Activities): Program Evaluation of the Positive Psychology through Happiness (PPH) Assessment and HAPPINESS Curriculum*. University of South Florida, School Mental Health Collaborative (SMHC): Research, Training, and Technical Assistance Center. (Report available upon request)

Suldo, M. S., & Doll, B. (2021). Conceptualizing youth mental health through a dual-factor model. In P. J. Lazarus, S. Suldo, & B. Doll (Eds.) *Fostering the emotional well-being of our youth: A school-based approach.* Oxford Academic.

Suldo, S. M., Savage, J. A., & Mercer, S. H. (2014). Increasing middle school students' life satisfaction: Efficacy of a Positive Psychology Group Intervention. *Journal of Happiness Studies, 15*, 19-42. Doi:10.1007/s10902-013-9414-2

Suldo, S. M., & Shaffer, E. J. (2008). Looking beyond psychopathology: A dual-factor model of mental health in youth. *School Psychology Review, 37*(1), 32-68. Doi:10.1080/02796015.2008.12087908

Taber, K.S. (2018). The use of cronbach's alpha when developed and reporting research instruments in the science education. *Research in Science Education, 48,* 1273-1296. Doi:10.1007/s11165-016-9602-2

Tejada-Gallardo, C., Blasco-Belled, A., Torrelles-Nadal, C., & Alsinet, C. (2020). Effects of school-based multicomponent positive psychology interventions on well-being and distress in adolescents: a systematic review and meta-analysis. *Journal of Youth and Adolescence*, *49*(10), 1943-1960.

Thornicroft, G., Deb, T., & Henderson, C. (2016). Community mental health care worldwide: Current status and further developments. *World Psychiatry, 15*(3), 276-286. Doi:10.1002/wps.20349

Types of mental health professionals. NAMI. (n.d.). Retrieved April 2023, from https://www.nami.org/About-Mental-Illness/Treatments/Types-of-Mental-Health-Professionals

U.S. Department of Health and Human Services. (n.d.). *Mental illness*. National Institute of Mental Health. Retrieved December 2022, from https://www.nimh.nih.gov/health/statistics/mental-illness

Van Agteren, J., Iasiello, M., Lo, L., Bartholomaeus, J., Kopsaftis, Z., Carey, M., et al. (2021). A systematic review and meta-analysis of psychological interventions to improve mental wellbeing. *Nature Human Behaviour*, *5*, 631–652. doi: 10.1038/s41562-021-01093-w

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS Scales. *Journal of Personality and Social Psychology, 54*(6), 1063–1070.

Appendix A: Participant Consent Form

UNIVERSITY OF SOUTH FLORIDA
USF RESEARCH & INNOVATION

Dear [redacted]

This letter tells you about a project, "Evaluation of the PPH Assessment and HAPPINESS Curriculum." The project/study is supported by [redacted] in collaboration with researchers from the University of South Florida (USF). The goal of the project is to evaluate the newly developed program. The program was developed to use principles from positive psychology and related approaches to monitor and increase happiness within clients, instead of traditional counseling services that focus on negative cycles.

- ✓ Who We Are: The team is led by Dr. Shannon Suldo and her graduate student assistant, Frances Coolman. Dr. Suldo and Ms. Coolman are from the School Psychology Program within the USF College of Education. We are doing the study in partnership with [redacted] and clinicians affiliated with [redacted]
- ✓ Why We Are Requesting Your Participation: We are doing this study to evaluate a new program created by [redacted]–Positive Psychology through Happiness (PPH) Assessment, and a clinical intervention framework with procedures and activities that align with the acronym HAPPINESS. Findings from the evaluation will inform how well the program works to improve client outcomes and treatment satisfaction. Findings will also inform the extent to which program materials are used in sessions. Clinician perspectives of the usefulness of the program and trainings to learn it will permit continued refinement of materials. You are being asked to take part because you are affiliated with [redacted] work with clients for whom the program is appropriate for use.
- ✓ Why You Should Participate: We need to know more about the impact of promising programs to help clients develop skills to increase emotional well-being (happiness) and overall mental health. To address this need, we are evaluating the PPH Assessment and HAPPINESS Curriculum. We anticipate that clinicians will develop proficiency with the PPH Assessment and HAPPINESS Curriculum through trainings provided by [redacted] Please note that you will not receive extra compensation for time spent in study activities. You may receive some professional time off and/or public recognition for participation in the program evaluation.
- ✓ What Your Participation Requires: In this evaluation, clinicians will be randomly assigned to either the *intervention* or *control* group for the 2022-2023 school year.

  Data collection. All clinicians- those in the *intervention* and *control* group- will be asked to collect confidential mental health outcomes measures for youth clients before and after treatment, and anonymous client satisfaction with services data after treatment. All clinicians will also be asked to provide confidential ratings of their personal well-being (life satisfaction, affect, stress) on two occasions—before random assignment to group, and at the end of the 2022-2023 academic year. These ratings will be aggregated across groups to determine if using the PPH Assessment and Happiness Curriculum impacts clinician wellness.

  Intervention group. Clinicians in the *intervention* group will be asked to complete the initial training in, and then use, the PPH Assessment and HAPPINESS Curriculum. During these activities, you will complete brief surveys to provide feedback on training and program activities, and report fidelity of implementation (FOI) with the PPH Assessment and HAPPINESS Curriculum delivery. After conclusion of a treatment plan that used the PPH Assessment and HAPPINESS Curriculum, you may be asked to take part in a confidential exit interview with USF study staff about your experiences with the program. Regarding the *initial training,* [redacted] will host a series of workshops to help clinicians develop expertise in positive psychology, stages of change theory, and the PPH Assessment and HAPPINESS Curriculum in particular. Clinicians will receive the intervention manual *HAPPINESS Curriculum* and accompanying worksheets to become familiar with throughout the training. Readiness to implement the program will be ensured through growth on knowledge tests before and after training, and performance on activities during the training. Individualized training sessions will be held as needed until proficiency in knowledge and skills is demonstrated. All clinicians using the PPH Assessment and HAPPINESS Curriculum will receive *ongoing support during program implementation* from [redacted] team members to ensure the program is used as intended during sessions with clients. This ongoing professional learning will consist of (a) monthly group case consultation, and (b) periodic coaching meetings ("office hours"), all held remotely via Zoom. Feedback, duration, and focus of case consultation and coaching meetings will be individualized based on clinician needs.

  Control group. Clinicians who were randomly assigned to the control group will receive the refined initial training and program materials during the 2023-2024 school year, to enable all [redacted] clinicians to learn and use the PPH Assessment and HAPPINESS Curriculum with their clients.

Learning and providing the PPH Assessment and HAPPINESS Curriculum are not considered study activities, since using the program to assess and increase happiness is part of the [redacted] clinician's professional role. The study activities entail data collection activities (e.g., collection of client outcome and satisfaction data; clinician ratings of training and program acceptability, and use of the PPH Assessment and HAPPINESS Curriculum during sessions to monitor FOI; exit interviews to discuss clinical experiences), which will be outside routine professional roles. We estimate it will take about 2-3 hours per month for study activities, during each month of the study. In sum, participation will total about 15 hours over the course of the study.

- ✓ Please Note: Your participation in study activities is voluntary. You are free to participate in this evaluation project or to withdraw at any time, without penalty. Any decision to participate, not participate, or withdraw participation at any point during the project will in no way affect your employee status, or your relationship with your school/district, USF, or any other party.

- ✓ Confidentiality of Your Responses and Study Risks: This program evaluation is considered minimal risk. Minimal risk means that study risks are the same as the risks you face in daily life. There are no known additional risks to those who take part in this study. You will receive no guaranteed benefits by participating in this study. Your privacy and records will be kept confidential. Your individual responses will not be shared with other employees, or anyone other than us and our research assistants. All participants will be assigned unique study code numbers to protect the privacy of information from all parties. Some discussions with the USF team will be audio recorded for program evaluation and quality assurance purposes. Consenting to participate in this project indicates your consent to be audio recorded during such exit interviews. In audio files, you will not be identified by name. Instead, your study number will be used to protect the confidentiality of your statements. No names will be attached to stored surveys or audio files. All records from the study will be destroyed five years after the study is completed. These records include completed surveys. Only approved study staff will have access to the password-protected files and locked file cabinets stored at USF that will contain records linking code numbers to participants' names, and/or consent forms. Note that if you complete portions of the study online (such as complete surveys electronically, or training sessions through Zoom), it is possible, although unlikely, that unauthorized individuals could gain access to your responses. Confidentiality will be maintained to the degree permitted by the technology used. No guarantees can be made regarding the interception of information sent via the Internet. However, your participation in this study using electronic surveys or meeting methods involves risks similar to a person's everyday use of the Internet.

- ✓ What We'll Do With Your Responses: We plan to use the information from this study to determine the effectiveness of the PPH Assessment and HAPPINESS Curriculum on clients' well-being. We plan to use the information from feedback forms and discussion to improve training and intervention materials. Findings will inform [redacted] on their assessment/curriculum and will include suggestions for refinement on how to improve it for other clinicians to use in the future to promote mental health and well-being. Results from data collected during this study may be published. However, the data obtained from you will be combined with data from other people in the publication. The published results will not include your name or any other information that would in any way personally identify you.

- ✓ Questions? If you have questions about this study, contact Dr. Suldo at (813) 974-2223.

- ✓ Want to Participate? To take part in this study, complete this consent form (titled "Consent to Participate in Program Evaluation") via DocuSign. You will be able to keep an electronic form on file for your records.

Sincerely,

Shannon Suldo, Ph.D. (Professor)
Frances Coolman M.Ed. (Project Coordinator)
School Psychology Program, College of Education
University of South Florida

UNIVERSITY OF SOUTH FLORIDA
USF RESEARCH & INNOVATION

Consent to Participate in Program Evaluation

I freely give my permission to take part in this study. I understand that by signing this form I am agreeing to take part in the program evaluation. I have received a copy of this form for my records.

Signature of Person Taking Part in Study	Printed Name of Person Taking Part in Study	Date

(Portion for USF): **Statement of Person Obtaining Informed Consent**

I certify that the person taking part in the study has been provided with an informed consent form that explains the nature, demands, risks, and benefits involved in participating in this study. I further certify that a phone number has been provided in the event of additional questions. This participant has provided legally informed consent.

Signature of Person Obtaining Informed Consent	Printed Name of Person Obtaining Informed Consent	Date

Appendix B: Positive Psychology Exit Interview Protocol

"Today I am wanting to learn more about your overall thoughts on positive psychology after learning about it and using it. This is not to learn about your specific thoughts around PPH and HAPPINESS, but instead to learn about how positive psychology has influenced your personal and professional life. Your answers will remain confidential and de-identified, they will be used to create further questionnaires that will learn more about other clinician's thoughts surrounding positive psychology as an intervention and it's impacts on them both professionally as well as personally"

- *What was your knowledge and awareness of positive psychology before learning and using PPH with [agency] team members in winter of 2022?*
- *What are your thoughts on positive psychology now that you have used it as a clinical tool?*

- *How have your thoughts on positive psychology as a clinical tool changed from before using PPH to now?*

- *What are your thoughts on using positive psychology interventions with your clients?*
- *How do positive psychology interventions compare to previous interventions and techniques you've been trained in and used?*
- *How did the positive psychology approach affect the therapeutic partnership between you and your client?*

- *Is the positive psychology approach something you think is appropriate for your role as a provider to clients in a school setting?*
- *How has positive psychology impacted your personal life?*

- *What are the biggest takeaways you've learned from using a positive psychology intervention?*
- *Has learning and administering this positive psychology impacted you personally? Please explain*
- *How will you use this new knowledge in your personal life going forward?*
- *How will you use this knowledge/intervention in your professional life going forward?*
- *What's your biggest takeaway with positive psychology?*
- *Anything else surrounding positive psychology and your recent experiences with it that would be useful for me to know?*

Appendix C: SWLS

SATISFACTION WITH LIFE SCALE (SWLS; Diener et al.)

This survey assesses your feelings about life. Below are 5 statements with which you may agree or disagree. Using the 1 - 7 scale, indicate your agreement with each item by selecting that response for each statement. Please be open and honest in your responding.

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
1. In most ways my life is close to my ideal.	1	2	3	4	5	6	7
2. The conditions of my life are excellent.	1	2	3	4	5	6	7
3. I am satisfied with my life.	1	2	3	4	5	6	7
4. So far I have gotten the important things I want in life.	1	2	3	4	5	6	7
5. If I could live my life over, I would change almost nothing.	1	2	3	4	5	6	7

Appendix D: FS

FLOURISHING SCALE (1985; FS; Diener et al., 2010)

This survey assesses your feelings about life. Below are 8 statements with which you may agree or disagree. Using the 1 - 7 scale, indicate your agreement with each item by selecting that response for each statement. Please be open and honest in your responding.

1. I lead a purposeful and meaningful life.	1	2	3	4	5	6	7
2. My social relationships are supportive and rewarding.	1	2	3	4	5	6	7
3. I am engaged and interested in my daily activities.	1	2	3	4	5	6	7
4. I actively contribute to the happiness and well-being of others.	1	2	3	4	5	6	7
5. I am competent and capable in the activities that are important to me.	1	2	3	4	5	6	7
6. I am a good person and live a good life.	1	2	3	4	5	6	7
7. I am optimistic about my future.	1	2	3	4	5	6	7
8. People respect me.	1	2	3	4	5	6	7

Appendix E: PANAS

POSITIVE AND NEGATIVE AFFECT (PANAS; Watson et al., 1998)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then circle the appropriate answer next to that word. Indicate to what extent you have felt this way during the past few weeks.

	Feeling or emotion:	**Very slightly or not at all**	**A little**	**Moderately**	**Quite a bit**	**Extremely**
1.	Interested	1	2	3	4	5
2.	Distressed	1	2	3	4	5
3.	Excited	1	2	3	4	5
4.	Upset	1	2	3	4	5
5.	Strong	1	2	3	4	5
6.	Guilty	1	2	3	4	5
7.	Scared	1	2	3	4	5
8.	Hostile	1	2	3	4	5
9.	Enthusiastic	1	2	3	4	5
10.	Proud	1	2	3	4	5
11.	Irritable	1	2	3	4	5
12.	Alert	1	2	3	4	5
13.	Ashamed	1	2	3	4	5
14.	Inspired	1	2	3	4	5
15.	Nervous	1	2	3	4	5
16.	Determined	1	2	3	4	5
17.	Attentive	1	2	3	4	5
18.	Jittery	1	2	3	4	5
19.	Active	1	2	3	4	5
20.	Afraid	1	2	3	4	5

Appendix F: PSS-10

PERCEIVED STRESS SCALE (PSS; Cohen et al., 1983)

Instructions: The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, indicate *how often* you have felt or thought a certain way.

In the last month…	**Never**	**Almost Never**	**Some-times**	**Fairly Often**	**Very Often**
1. How often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. How often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3. How often have you felt nervous and "stressed"?	0	1	2	3	4
4. How often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
5. How often have you felt that things were going your way?	0	1	2	3	4
6. How often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
7. How often have you been able to control irritations in your life?	0	1	2	3	4
8. How often have you felt that you were on top of things?	0	1	2	3	4
9. How often have you been angered because of things that were outside your control?	0	1	2	3	4
10. How often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

Appendix G: Self-Report of Fidelity of Use of PPH Assessment and HAPPINESS Curriculum

Q1. Which step(s) in the HAPPINESS curriculum did you access in today's session? (*check all that apply)*

- ☐ H – Understanding Happiness
- ☐ A – Assessing Where I Am Now
- ☐ P – Producing Positive Thoughts and Actions
- ☐ P – Practicing My Daily Habits
- ☐ I – Investigating a New Way of Doing Things
- ☐ N – Navigating the Bumps in the Road
- ☐ E – Examining My Successes
- ☐ S – Spreading My Strengths
- ☐ S – Savoring My Success
- ☐ None, I did not use the HAPPINESS curriculum in today's session

Q2. Within the HAPPINESS step(s) accessed today, which of the ACTS learning opportunities did you use in the session? *(check all that apply)*

- ☐ Activities
- ☐ Cognitive Copy
- ☐ Talking Points
- ☐ Simple Changes
- ☐ None of the ACTS; (briefly describe why not or what else was used in the session: _____

Q3. Approximately how much of this session did you use the PPH Assessment and HAPPINESS Curriculum?

- ☐ Nearly all (close to 100% of session content)
- ☐ Most (about 75% of session content)
- ☐ About half (about 50% of session content)
- ☐ Some (up to 25% of session content)
- ☐ None (0%)

Q4. What activities or interventions did you use in this session OTHER THAN the PPH?

- ☐ NONE; I only used the PPH Assessment and HAPPINESS Curriculum in this session
- ☐ I used... (briefly describe the activities or intervention that you used in this session that are not in the PPH manual)_____

Appendix H: IRB Approval

NOT HUMAN SUBJECTS RESEARCH DETERMINATION

November 22, 2021

Shannon Suldo, PhD
4202 East Fowler Ave., EDU 105
Tampa, FL 33620

Dear Dr. Suldo:

On 11/20/2021, the IRB reviewed the following protocol:

IRB ID:	STUDY003415
Title:	Evaluation of the PPH Assessment and HAPPINESS Curriculum

The IRB determined that the proposed activity does not constitute research involving human subjects as defined by DHHS and FDA regulations.

IRB review and approval is not required. This determination applies only to the activities described in the IRB submission. If changes are made and there are questions about whether these activities constitute human subjects research, please submit a new application to the IRB for a determination.

While not requiring IRB approval and oversight, your project activities should be conducted in a manner that is consistent with the ethical principles of your profession. If this project is program evaluation or quality improvement, do not refer to the project as research and do not include the assigned IRB ID or IRB contact information in the consent document or any resulting publications or presentations.

Sincerely,

Various Menzel
IRB Research Compliance Administrator