
Positive Psychology, Positive Prevention, and Positive Therapy

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Positive Psychology

Psychology after World War II became a science largely devoted to healing. It concentrated on repairing damage using a disease model of human functioning. This almost exclusive attention to pathology neglected the idea of a fulfilled individual and a thriving community, and it neglected the possibility that building strength is the most potent weapon in the arsenal of therapy. The aim of positive psychology is to catalyze a change in psychology from a preoccupation only with repairing the worst things in life to also building the best qualities in life. To redress the previous imbalance, we must bring the building of strength to the forefront in the treatment and prevention of mental illness.

The field of positive psychology at the subjective level is about positive subjective experience: well-being and satisfaction (past); flow, joy, the sensual pleasures, and happiness (present); and constructive cognitions about the future—optimism, hope, and faith. At the individual level it is about positive personal traits—the capacity for love and vocation, courage, interpersonal skill, aesthetic sensibility, perseverance, forgiveness, originality, future-

mindedness, high talent, and wisdom. At the group level it is about the civic virtues and the institutions that move individuals toward better citizenship: responsibility, nurturance, altruism, civility, moderation, tolerance, and work ethic (Gillham & Seligman, 1999; Seligman & Csikszentmihalyi, 2000).

The notion of a positive psychology movement began at a moment in time a few months after I had been elected president of the American Psychological Association. It took place in my garden while I was weeding with my 5-year-old daughter, Nikki. I have to confess that even though I write books about children, I'm really not all that good with them. I am goal-oriented and time-urgent, and when I am weeding in the garden, I am actually trying to get the weeding done. Nikki, however, was throwing weeds into the air and dancing around. I yelled at her. She walked away, came back, and said, "Daddy, I want to talk to you."

"Yes, Nikki?"

"Daddy, do you remember before my fifth birthday? From the time I was three to the time I was five, I was a whiner. I whined every day. When I turned five, I decided not to whine anymore. That was the hardest thing I've ever

done. And if I can stop whining, you can stop being such a grouch.”

This was for me an epiphany, nothing less. I learned something about Nikki, something about raising kids, something about myself, and a great deal about my profession. First, I realized that raising Nikki was not about correcting whining. Nikki did that herself. Rather, I realized that raising Nikki was about taking this marvelous skill—I call it “seeing into the soul”—and amplifying it, nurturing it, helping her to lead her life around it to buffer against her weaknesses and the storms of life. Raising children, I realized, is more than fixing what is wrong with them. It is about identifying and nurturing their strongest qualities, what they own and are best at, and helping them find niches in which they can best live out these positive qualities.

As for my own life, Nikki hit the nail right on the head. I was a grouch. I had spent 50 years mostly enduring wet weather in my soul, and the last 10 years being a nimbus cloud in a household of sunshine. Any good fortune I had was probably not due to my grouchiness but in spite of it. In that moment, I resolved to change.

But the broadest implication of Nikki’s lesson was about the science and practice of psychology. Before World War II, psychology had three distinct missions: curing mental illness, making the lives of all people more productive and fulfilling, and identifying and nurturing high talent. Right after the war, two events—both economic—changed the face of psychology. In 1946, the Veterans Administration was founded, and thousands of psychologists found out that they could make a living treating mental illness. At that time the profession of clinical psychologist came into its own. In 1947, the National Institute of Mental Health (which was based on the American Psychiatric Association’s disease model and is better described as the National Institute of Mental Illness) was founded, and academics found out that they could get grants if their research was described as being about pathology.

This arrangement brought many substantial benefits. There have been huge strides in the understanding of and therapy for mental illness: At least 14 disorders, previously intractable, have yielded their secrets to science and can now be either cured or considerably relieved (Seligman, 1994). But the downside was that the other two fundamental missions of psychology—

making the lives of all people better and nurturing genius—were all but forgotten. It was not only the subject matter that altered with funding but also the currency of the theories underpinning how we viewed ourselves. Psychology came to see itself as a mere subfield of the health professions, and it became a victimology. We saw human beings as passive foci: stimuli came on and elicited responses (what an extraordinarily passive word). External reinforcements weakened or strengthened responses, or drives, tissue needs, or instincts. Conflicts from childhood pushed each of us around.

Psychology’s empirical focus then shifted to assessing and curing individual suffering. There has been an explosion in research on psychological disorders and the negative effects of environmental stressors such as parental divorce, death, and physical and sexual abuse. Practitioners went about treating mental illness within the disease-patient framework of repairing damage: damaged habits, damaged drives, damaged childhood, and damaged brains.

The message of the positive psychology movement is to remind our field that it has been deformed. Psychology is not just the study of disease, weakness, and damage; it also is the study of strength and virtue. Treatment is not just fixing what is wrong; it also is building what is right. Psychology is not just about illness or health; it also is about work, education, insight, love, growth, and play. And in this quest for what is best, positive psychology does not rely on wishful thinking, self-deception, or hand waving; instead, it tries to adapt what is best in the scientific method to the unique problems that human behavior presents in all its complexity.

Positive Prevention

What foregrounds this approach is the issue of prevention. In the last decade psychologists have become concerned with prevention, and this was the theme of the 1998 American Psychological Association meeting in San Francisco. How can we prevent problems like depression or substance abuse or schizophrenia in young people who are genetically vulnerable or who live in worlds that nurture these problems? How can we prevent murderous schoolyard violence in children who have poor parental su-

pervision, a mean streak, and access to weapons? What we have learned over 50 years is that the disease model does not move us closer to the prevention of these serious problems. Indeed, the major strides in prevention have largely come from a perspective focused on systematically building competency, not correcting weakness.

We have discovered that there are human strengths that act as buffers against mental illness: courage, future-mindedness, optimism, interpersonal skill, faith, work ethic, hope, honesty, perseverance, the capacity for flow and insight, to name several. Much of the task of prevention in this new century will be to create a science of human strength whose mission will be to understand and learn how to foster these virtues in young people.

My own work in prevention takes this approach and amplifies a skill that all individuals possess but usually deploy in the wrong place. The skill is called disputing (Beck, Rush, Shaw, & Emery, 1979), and its use is at the heart of “learned optimism.” If an external person, who is a rival for your job, accuses you falsely of failing at your job and not deserving your position, you will dispute him. You will marshal all the evidence that you do your job very well. You will grind the accusations into dust. But if you accuse yourself falsely of not deserving your job, which is just the content of the automatic thoughts of pessimists, you will not dispute it. If it issues from inside, we tend to believe it. So in “learned optimism” training programs, we teach both children and adults to recognize their own catastrophic thinking and to become skilled disputers (Peterson, 2000; Seligman, Reivich, Jaycox, & Gillham, 1995; Seligman, Schulman, DeRubeis, & Hollon, 1999).

This training works, and once you learn it, it is a skill that is self-reinforcing. We have shown that learning optimism prevents depression and anxiety in children and adults, roughly halving their incidence over the next 2 years. I mention this work only in passing, however. It is intended to illustrate the Nikki principle: that building a strength, in this case, optimism, and teaching people when to use it, rather than repairing damage, effectively prevents depression and anxiety. Similarly, I believe that if we wish to prevent drug abuse in teenagers who grow up in a neighborhood that puts them at risk, the effective prevention is not remedial. Rather, it consists of identifying and amplifying the

strengths that these teens already have. A teenager who is future-minded, who is interpersonally skilled, who derives flow from sports, is not at risk for substance abuse. If we wish to prevent schizophrenia in a young person at genetic risk, I would propose that the repairing of damage is not going to work. Rather, I suggest that a young person who learns effective interpersonal skills, who has a strong work ethic, and who has learned persistence under adversity is at lessened risk for schizophrenia.

This, then, is the general stance of positive psychology toward prevention. It claims that there is a set of buffers against psychopathology: the positive human traits. The Nikki principle holds that by identifying, amplifying, and concentrating on these strengths in people at risk, we will do effective prevention. Working exclusively on personal weakness and on damaged brains, and deifying the Diagnostic and Statistical Manual (DSM), in contrast, has rendered science poorly equipped to do effective prevention. We now need to call for massive research on human strength and virtue. We need to develop a nosology of human strength—the “UNDSM-I”, the opposite of *DSM-IV*. We need to measure reliably and validly these strengths. We need to do the appropriate longitudinal studies and experiments to understand how these strengths grow (or are stunted; Vaillant, 2000). We need to develop and test interventions to build these strengths.

We need to ask practitioners to recognize that much of the best work they already do in the consulting room is to amplify their clients’ strengths rather than repair their weaknesses. We need to emphasize that psychologists working with families, schools, religious communities, and corporations develop climates that foster these strengths. The major psychological theories now undergird a new science of strength and resilience. No longer do the dominant theories view the individual as a passive vessel “responding” to “stimuli”; rather, individuals now are seen as decision makers, with choices, preferences, and the possibility of becoming masterful, efficacious, or, in malignant circumstances, helpless and hopeless. Science and practice that relies on the positive psychology worldview may have the direct effect of preventing many of the major emotional disorders. It also may have two side effects: making the lives of our clients physically healthier, given all we are learning about the effects of

mental well-being on the body; and reorienting psychology to its two neglected missions, making normal people stronger and more productive, as well as making high human potential actual.

Positive Therapy

I am going to venture a radical proposition about why psychotherapy works as well as it does. I am going to suggest that positive psychology, albeit intuitive and inchoate, is a major effective ingredient in therapy as it is now done; if it is recognized and honed, it will become an even more effective approach to psychotherapy. But before doing so, it is necessary to say what I believe about “specific” ingredients in therapy. I believe there are some clear specifics in psychotherapy. Among them are

- Applied tension for blood and injury phobia
- Penile squeeze for premature ejaculation
- Cognitive therapy for panic
- Relaxation for phobia
- Exposure for obsessive-compulsive disorder
- Behavior therapy for enuresis

(My book *What You Can Change and What You Can't* [1994] documents the specifics and reviews the relevant literature.) But specificity of technique to disorder is far from the whole story.

There are three serious anomalies on which present specificity theories of the effectiveness of psychotherapy stub their toes. First, effectiveness studies (field studies of real-world delivery), as opposed to laboratory efficacy studies of psychotherapy, show a substantially larger benefit of psychotherapy. In the *Consumer Reports* study, for example, over 90% of respondents reported substantial benefits, as opposed to about 65% in efficacy studies of specific psychotherapies (Seligman, 1995, 1996). Second, when one active treatment is compared with another active treatment, specificity tends to disappear or becomes quite a small effect. Lester Luborsky's corpus and the National Collaborative Study of Depression are examples. The lack of robust specificity also is apparent in much of the drug literature. Methodologists argue endlessly over flaws in such outcome studies, but they cannot hatchet away the general lack of specificity. The fact is that almost no psychotherapy technique that I can think of (with the

exceptions mentioned previously) shows big, specific effects when it is compared with another form of psychotherapy or drug, adequately administered. Finally, add the seriously large “placebo” effect found in almost all studies of psychotherapy and of drugs. In the depression literature, a typical example, around 50% of patients will respond well to placebo drugs or therapies. Effective specific drugs or therapies usually add another 15% to this, and 75% of the effects of antidepressant drugs can be accounted for by their placebo nature (Kirsch & Sapirstein, 1998).

So why is psychotherapy so robustly effective? Why is there so little specificity of psychotherapy techniques or specific drugs? Why is there such a huge placebo effect?

Let me speculate on this pattern of questions. Many of the relevant ideas have been put forward under the derogatory misnomer *nonspecifics*. I am going to rename two classes of nonspecifics as *tactics* and *deep strategies*. Among the *tactics* of good therapy are

- Attention
- Authority figure
- Rapport
- Paying for services
- Trust
- Opening up
- Naming the problem
- Tricks of the trade (e.g., “Let's pause here,” rather than “Let's stop here”)

The *deep strategies* are not mysteries. Good therapists almost always use them, but they do not have names, they are not studied, and, locked into the disease model, we do not train our students to use them to better advantage. I believe that the deep strategies are all techniques of positive psychology and that they can be the subject of large-scale science and of the invention of new techniques that maximize them. One major strategy is instilling hope (Snyder, Ilardi, Michael, & Cheavens, 2000). But I am not going to discuss this one now, as it is often discussed elsewhere in the literature on placebo, on explanatory style and hopelessness, and on demoralization (Seligman, 1994).

Another is the “building of buffering strengths,” or the Nikki principle. I believe that it is a common strategy among almost all competent psychotherapists to first identify and then help their patients build a large variety of strengths, rather than just to deliver specific

damage-healing techniques. Among the strengths built in psychotherapy are

- Courage
- Interpersonal skill
- Rationality
- Insight
- Optimism
- Honesty
- Perseverance
- Realism
- Capacity for pleasure
- Putting troubles into perspective
- Future-mindedness
- Finding purpose

Assume for a moment that the buffering effects of strength-building strategies have a larger effect than the specific “healing” ingredients that have been discovered. If this is true, the relatively small specificity found when different active therapies and different drugs are compared and the massive placebo effects both follow.

One illustrative deep strategy is “narration.” I believe that telling the stories of our lives, making sense of what otherwise seems chaotic, distilling and discovering a trajectory in our lives, and viewing our lives with a sense of agency rather than victimhood are all powerfully positive (Csikszentmihalyi, 1993). I believe that all competent psychotherapy forces such narration, and this buffers against mental disorder in just the same way hope does. Notice, however, that narration is not a primary subject of research on therapy process, that we do not have categories of narration, that we do not train our students to better facilitate narration, that we do not reimburse practitioners for it.

The use of positive psychology in psychotherapy exposes a fundamental blind spot in outcome research: The search for empirically validated therapies (EVTs) has in its present form handcuffed us by focusing only on validating the specific techniques that repair damage and that map uniquely into *DSM-IV* categories. The parallel emphasis in managed care organizations on delivering only brief treatments directed solely at healing damage may rob patients of the very best weapons in the arsenal of therapy—making our patients stronger human beings. That by working in the medical model and looking solely for the salves to heal the wounds, we have misplaced much of our science and much of our training. That by embracing the disease model of psychotherapy,

we have lost our birthright as psychologists, a birthright that embraces both healing what is weak and nurturing what is strong.

Conclusions

Let me end this introduction to the *Handbook of Positive Psychology* with a prediction about the science and practice of psychology in the 21st century. I believe that a psychology of positive human functioning will arise that achieves a scientific understanding and effective interventions to build thriving individuals, families, and communities.

You may think that it is pure fantasy, that psychology will never look beyond the victim, the underdog, and the remedial. But I want to suggest that the time is finally right. I well recognize that positive psychology is not a new idea. It has many distinguished ancestors (e.g., Allport, 1961; Maslow, 1971). But they somehow failed to attract a cumulative and empirical body of research to ground their ideas.

Why did they not? And why has psychology been so focused on the negative? Why has it adopted the premise—without a shred of evidence—that negative motivations are authentic and positive emotions are derivative? There are several possible explanations. Negative emotions and experiences may be more urgent and therefore override positive ones. This would make evolutionary sense. Because negative emotions often reflect immediate problems or objective dangers, they should be powerful enough to force us to stop, increase vigilance, reflect on our behavior, and change our actions if necessary. (Of course, in some dangerous situations, it will be most adaptive to respond without taking a great deal of time to reflect.) In contrast, when we are adapting well to the world, no such alarm is needed. Experiences that promote happiness often seem to pass effortlessly. So, on one level, psychology’s focus on the negative may reflect differences in the survival value of negative versus positive emotions.

But perhaps we are oblivious to the survival value of positive emotions precisely because they are so important. Like the fish that is unaware of the water in which it swims, we take for granted a certain amount of hope, love, enjoyment, and trust because these are the very conditions that allow us to go on living (Myers, 2000). They are the fundamental conditions of

existence, and if they are present, any amount of objective obstacles can be faced with equanimity, and even joy. Camus wrote that the foremost question of philosophy is why one should not commit suicide. One cannot answer that question just by curing depression; there must be positive reasons for living as well.

There also are historical reasons for psychology's negative focus. When cultures face military threat, shortages of goods, poverty, or instability, they may most naturally be concerned with defense and damage control. Cultures may turn their attention to creativity, virtue, and the highest qualities in life only when they are stable, prosperous, and at peace. Athens during the 5th century B.C., Florence of the 15th century, and England in the Victorian era are examples of cultures that focused on positive qualities. Athenian philosophy focused on the human virtues: What is good action and good character? What makes life most worthwhile? Democracy was born during this era. Florence chose not to become the most important military power in Europe but to invest its surplus in beauty. Victorian England affirmed honor, discipline, and duty as important human virtues.

I am not suggesting that our culture should now erect an aesthetic monument. Rather, I believe that our nation—wealthy, at peace, and stable—provides a similar world historical opportunity. We can choose to create a scientific monument—a science that takes as its primary task the understanding of what makes life worth living. Such an endeavor will move the whole of social science away from its negative bias. The prevailing social sciences tend to view the authentic forces governing human behavior as self-interest, aggressiveness, territoriality, class conflict, and the like. Such a science, even at its best, is by necessity incomplete. Even if utopically successful, it would then have to proceed to ask how humanity can achieve what is best in life.

I predict that in this new century positive psychology will come to understand and build those factors that allow individuals, communities, and societies to flourish. Such a science will not need to start afresh. It requires for the most part just a refocusing of scientific energy. In the 50 years since psychology and psychiatry became healing disciplines, they have developed a highly useful and transferable science of mental illness. They have developed a taxonomy, as well as reliable and valid ways of measuring such fuzzy concepts as schizophrenia, anger,

and depression. They have developed sophisticated methods—both experimental and longitudinal—for understanding the causal pathways that lead to such undesirable outcomes. Most important, they have developed pharmacological and psychological interventions that have moved many of the mental disorders from “untreatable” to “highly treatable” and, in a couple of cases, “curable.” These same methods, and in many cases the same laboratories and the next two generations of scientists, with a slight shift of emphasis and funding, will be used to measure, understand, and build those characteristics that make life most worth living. As a side effect of studying positive human traits, science will learn how to better treat and prevent mental, as well as some physical, illnesses. As a main effect, we will learn how to build the qualities that help individuals and communities not just endure and survive but also flourish.

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References

- Allport, G. W. (1961). *Pattern and growth in personality*. New York: Holt, Rinehart, & Winston.
- Beck, A., Rush, J., Shaw, B., & Emery, G. (1979). *Cognitive therapy*. New York: Guilford.
- Csikszentmihalyi, M. (1993). *The evolving self*. New York: HarperCollins.
- Gillham, J. E., & Seligman, M. E. P. (1999). Footsteps on the road to positive psychology. *Behaviour Research and Therapy*, 37, S163–S173.
- Kirsch, I., & Sapirstein, G. (1998). Listening to Prozac but hearing placebo: A meta-analysis of antidepressant medication. *Prevention & Treatment*, 1, Article 0002a, posted June 26, 1998. <http://journals.apa.org/prevention/volume1>.
- Maslow, A. (1971). *The farthest reaches of human nature*. New York: Viking.
- Myers, D. G. (2000). The funds, friends, and faith of happy people. *American Psychologist*, 55, 56–67.

- Peterson, C. (2000). The future of optimism. *American Psychologist, 55*, 44–55.
- Schwartz, B. (2000). Self-determination: The tyranny of freedom. *American Psychologist, 55*, 79–88.
- Seligman, M. (1991). *Learned optimism*. NY: Knopf.
- Seligman, M. (1994). *What you can change and what you can't*. New York: Knopf.
- Seligman, M. E. P. (1995). The effectiveness of psychotherapy: The Consumer Reports study. *American Psychologist, 50*, 965–974.
- Seligman, M. E. P. (1996). Science as an ally of practice. *American Psychologist, 51*, 1072–1079.
- Seligman, M., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*, 5–14.
- Seligman, M. E. P., Reivich, K., Jaycox, L., & Gillham, J. (1995). *The optimistic child*. New York: Houghton Mifflin.
- Seligman, M. E. P., Schulman, P., DeRubeis, R. J., & Hollon, S. D. (1999). The prevention of depression and anxiety. *Prevention and Treatment, 2*. <http://journals.apa.org/prevention/>
- Snyder, C., Ilardi, S., Michael, S., & Cheavens, J. (2000). Hope theory: Updating a common process for psychological change. In C. R. Snyder & R. E. Ingram (Eds.), *Handbook of psychological change: Psychotherapy processes and practices for the 21st century* (pp. 128–153). New York: Wiley.
- Vaillant, G. (2000). The mature defenses: Antecedents of joy. *American Psychologist, 55*, 89–98.

Positive Prevention What foregrounds this approach is the issue of prevention. In the last decade psychologists have become concerned with prevention, and this was the theme of the 1998 American Psychological Association meeting in San Francisco. How can we prevent problems like depression or substance abuse or schizophrenia in young people who are genetically vulnerable or who live in worlds that nurture these problems?Â I am going to suggest that positive psychology, albeit intuitive and inchoate, is a major effective ingredient in therapy as it is now done; if it is recognized and honed, it will become an even more effective approach to psychotherapy. But before doing so, it is necessary to say what I believe about "specific" ingredients in therapy.