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Counselors' Perspectives of Positive Psychology for the Treatment of Addiction: A Mixed Methods Pilot Study

Amy R. Krentzman, MSW, PhD and

University of Minnesota School of Social Work, St. Paul, Minnesota, USA

Stacey L. Barker, MSW, PhD

Department of Social Work, Eastern Nazarene College, Quincy, Massachusetts, USA

Abstract

Little is known about the use of positive psychology interventions (PPI) in addictions treatment. Questionnaires and interviews with alcohol and substance use disorder counselors explored theories of how PPIs might work, the degree to which they are used, and downsides. Results suggested that positive and pathology-based themes were attended in equal proportion, that substance abuse treatment should help clients develop a good life in recovery; that counselors already use PPI; and that PPI might counter negative cognitions and affect. Reservations for using PPI included relying on PPI exclusively and employing PPI indiscriminately without regard to client characteristics.

Keywords

Substance use disorders; addiction; positive psychology; counselors; theory

Positive psychology is dedicated to the scientific study of factors that enable individuals, groups, families, and organizations to flourish. It was founded in 1998 to counterbalance what was perceived as clinical psychology's disproportionate emphasis on pathology. The metaphor of traversing a landscape has been used to describe the field. If reductions in pathology enable a client to go from deficit to neutral, then positive psychology focuses on the terrain that is "north of neutral" (Peterson, 2006, p. 4), that is, the territory from neutral to active flourishing and robust well-being. Applying this framework to addiction, abstinence from addictive substances might enable the shift from deficit to neutral. "North of neutral," then, would describe the process of building a positive, satisfying, and reinforcing life in recovery.

Addictions theorists have long noted that development of a good and sustaining sober life is a strategy to fend off relapse (Marlatt & Gordon, 1980). Since the founding of positive psychology, researchers have developed and tested "positive interventions" to increase well-being rather than decrease pathology. These have included, for example, gratitude practices,

Contact information for Amy R. Krentzman: University of Minnesota School of Social Work, 1404 Gortner Avenue, Peters Hall 183, St. Paul, MN 55108. akrentzm@umn.edu.

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identification of character strengths, and acts of kindness. Meta-analyses have indicated small (Bolier et al., 2013) and medium (Sin & Lyubomirsky, 2009) effect sizes for the beneficial effects of such interventions on depression and well-being. Positive interventions might help individuals with addictions to build positive sober lives, although scientific exploration of this hypothesis is in its infancy (Krentzman, 2013).

Joseph and Wood (2010) stated that an important first step in applying positive psychology to clinical psychology would be to “ascertain the extent to which clinical psychology is already engaged in the practice of increasing positive functioning” (p. 831), in other words, to ask to what extent is the field already practicing positive interventions without necessarily calling them by that name. Addictions counselors might already recommend exercises and practices that are similar to positive psychology interventions. Consider the example of gratitude and its association with addiction recovery and 12 step programs. The 10th step of Alcoholics Anonymous (AA) explicitly recommends practicing gratitude on a regular basis (AA World Services, 1953). Knowing how one set of addictions counselors might or might not use positive interventions in their work and the ways in which such practices are similar to and different from published positive psychology interventions is an important first step to improving and standardizing such approaches and assessing their impact. Counselors’ perspectives on whether positive interventions work and, if so, how and for whom they work could inform theory development and future research design. This pilot study was designed to provide preliminary information about how a convenience sample of nine counselors use and think about positive psychology interventions in order to determine whether this is a fruitful line of further inquiry. Therefore, alcohol and substance use disorder counselors were surveyed and then interviewed in depth to answer the following research questions:

What do these nine substance-use-disorder clinicians feel about the utility of specific positive psychology interventions, including how and for whom they might work? Are these clinicians already employing positive interventions, and if so, what form do they take? Is it possible to quantify the degree to which this set of counselors attend to ‘positive psychology’ themes versus pathology-and-problem-based themes in a typical week? Would further development of such a measurement scale be of use to future research?

Method

Participants

Counselors were recruited from two substance use disorder treatment facilities in the Midwestern United States. Both facilities employed abstinence-based models of addiction treatment and offered multiple programmatic components. One program provided special groups for youth, health care providers, intensive outpatients, individuals in early recovery, individuals with dual diagnoses, as well as counseling to individual and couples and medication management. The other program provided a detoxification unit, outpatient clinics, a residential treatment program, and transitional housing. Counselor requirements for participation in this study included 1. Having a Master’s degree and a minimum of 2 years full-time counseling experience or a Bachelor’s degree and a minimum of 4 years full-time counseling experience, 2. Concurrently working full-time as a substance use disorder counselor, 3. Spending at least 50% of work time directly counseling individuals, couples, or

groups of people with alcohol and substance use disorders, and 4. Being a minimum of 21 years of age.

Participants were recruited via flyers, emails, and visits to program administrators and staff meetings. Eleven out of approximately 28 counselors expressed initial interest. Among those who expressed interest, one was not a full-time employee and one was unable to complete the study, therefore nine participated and completed the study. Four of the counselors were female (44.4%), and eight were European American (88.9%). On average, participants were 44.2 (SD 12.3) years of age and had been in the field an average of 10.9 (SD 8.0) years. All had Master's degrees in Social Work. One-third worked in residential treatment and the rest in outpatient settings. A third worked with families, and two-thirds worked with groups and individuals. The majority (88.8%) worked with clients who had a co-occurring alcohol and substance use disorders and mental illness.

Design

This study employed a convergent mixed-methods design that included qualitative and quantitative components collected concurrently (Creswell, 2014). The study paired a written questionnaire with an in-depth, semi-structured, individual interview. The questionnaire assessed counselor demographics, features of their work sites, and the frequency with which counselors addressed a range of topics with their clients. The interview elicited counselor opinions on positive psychology practices for use with individuals in treatment for substance use disorders. In this study, qualitative methods were primary and quantitative methods were secondary. Thus the sample size for the quantitative component is small and played a supporting role to the qualitative work. In this design, qualitative and quantitative data work together to lend insight into counselor use of positive psychology approaches that are distinct but overlapping to produce a more "enriched, elaborated understanding of the phenomenon" (Greene, Caracelli, & Graham, 1989, p. 258).

Measurement of counselors' focus on positive themes—The questionnaire asked counselors to estimate the frequency with which they addressed each of 45 therapeutic topics in their work with clients "last week," a typical full-time work week for all respondents. The therapeutic topics were first composed by the first author based on theory, clinical and research experience and then the list was examined by two expert substance-use disorder clinicians. The purpose of this inquiry was to take a preliminary step in determining if it is possible to use a questionnaire to quantify the degree to which substance-use-disorder counselors address positive themes with clients versus pathology-based themes. Of the 45 topics, 12 were selected by the first author to represent themes related to increasing well-being, such as hobbies, physical exercise, meditation, gratitude, pleasant activities, and spirituality. Twelve were selected to represent themes related to reducing pathology, such as relapse, psychiatric issues, cravings and urges, trauma, drink refusal skills, and detoxification. Counselors rated each topic on a scale of 1 to 10, representing the number of times they estimated addressing each topic "last week." The response format ranged from 1 to 10 and each number on the scale had a descriptive anchor: 1 = *Never or very rarely*, 2 = *Once a week*, 3 = *Twice a week*, 4 = *Three times a week*, 5 = *Once a day*, 6 = *Some days twice, some days once*, 7 = *Twice a day*, 8 = *Some days three times some days twice*, 9 = *Three*

times a day, and 10 = *Four times a day or more*. See Table 1 for a list of the 24 items and the degree to which counselors addressed these themes expressed as means and standard deviations, sorted from most to least frequently addressed. Well-being topics, $\alpha=.77$; pathology topics, $\alpha=.88$.

Qualitative Interview—Participants were provided with quotations from the research literature and were asked to read and consider them in advance of the interview. Quotations for discussion included definitions for “positive interventions” (Sin & Lyubomirsky, 2009, p. 469) and “flourishing” (Keyes & Haidt, 2003, p. 6). Descriptions of positive interventions included gratitude exercises (Emmons & McCullough, 2003, p. 379; Froh, Sefick, & Emmons, 2008, p. 220; Lyubomirsky, Dickerhoof, Boehm, & Sheldon, 2011, p. 395; Seligman, Steen, Park, & Peterson, 2005), “You at Your Best,” which involves thinking back on a time of optimal functioning (Seligman et al., 2005), “Best Future Self” which involves imagining and articulating the best future possible (King, 2001, p. 801), the identification of strengths and encouragement to use them (Seligman et al., 2005), the performance of acts of kindness (Sheldon & Lyubomirsky, 2004), an example of a “positive psychology group” (Akhtar & Boniwell, 2010), and two worksheets from the Project COMBINE substance use disorder treatment manual: “Menu of Possibly Pleasurable Activities” and “Characteristics of Successful Changers” (Miller, 2004) (pp. F39–F40 and p. F18, respectively). The quotations which defined “positive interventions” and “flourishing” were selected by the first author from key studies within the positive psychological literature. The positive psychology interventions included all of the interventions found by the first author as the result of a comprehensive literature review.

Face-to-face in-depth interview questions asked counselors about the role of treatment in general and the potential place of positive psychology within it. Counselors were asked to examine the interventions provided from the positive psychology literature and to describe the degree to which each might or might not benefit their clients, and if so, what would be the hypothesized mechanism (e.g., increasing motivation). Counselors were also asked whether they were already doing something similar, downsides they might foresee, modifications they might suggest, for whom specific interventions would work best or least well, and the degree to which such interventions might appeal to clients.

Procedure

Interested participants called the first author and scheduled meetings for the interviews, which took place over seven months in 2012 and 2013. Prospective participants were then emailed the informed consent document, the questionnaire, and the quotes from the literature. The study purpose was readily disclosed in the informed consent materials: “to learn about counselors’ views of the philosophies and interventions of positive psychology and their potential for use in substance use disorder treatment.” Interviews were conducted in person by the first author on location at the treatment centers or in the first author’s research office. They were audio-recorded and lasted an average of 1 hour 22 minutes ($SD = 19$ minutes). Participants were compensated \$50 for their time. The study was approved by the appropriate institutional review board.

Two participants, one from each treatment center, read and critiqued a final version of this manuscript in order to provide “member checks.” Member checks determine whether the interpretations and conclusions of the authors are accurate according to participants (Lincoln & Guba, 1985). Both participants affirmed that the results accurately reflected their experience based on their dual roles as study participants and experienced substance use disorder counselors.

Quantitative Data Analytic Procedure

Numeric responses to the quantitative questionnaire were converted to represent the number of times the topic was addressed by counselors in the previous week. Positive topic and pathology topic scores were summed separately. A ratio of positive topics to total topics was calculated to produce a variable representing the proportion of time counselors spent addressing 12 well-being themes as a percentage of all 24 themes. Next, descriptive parameters of this variable were calculated including means and standard deviations. Cronbach’s alphas were calculated. A Pearson’s correlation and a t test assessed relationships between the variable and length of time in the field and residential versus outpatient treatment setting, in order to gather preliminary data on whether variation in attention to positive themes might relate to other important markers.

Qualitative Data Processing and Analysis

All nine interviews were transcribed verbatim, excluding paralinguistic cues such as pauses and laughter. Statements were edited to improve clarity; utterances that did not add meaning (such as “you know” or “like”) were removed. The NVivo software program was used for data analysis (QSR International, 2013). Three interviews were initially coded by the first author line by line focusing on the main research questions using the participants’ own words. The codes from this analysis were then shared with the second author for validation and use with the remaining six interviews. The first and second authors met face-to-face twice to come to an agreement on codes. After all interviews were coded, the second author organized the codes into higher-level categories and then organized the categories into major themes, and then interpreted the results to provide holistic impressions of the data from this pilot study.

Results

The ratio of positive themes as a function of total themes addressed by counselors with their clients in the previous week ranged from 45% to 64% (mean 52%, SD 7%), suggesting that these counselors attended to the positive themes and pathology-based themes in approximately equal proportions. The Pearson’s correlation between this variable and counselors’ years of practice experience was not significant, but the magnitude of the relationship suggested that a trend might emerge in a larger sample ($r = -.56$, $p = .115$). The linear relationship is negative, suggesting that as years of practice increase, time spent on positive themes decreases. A significant difference was observed between counselors who worked in residential settings ($n=3$) and counselors who worked in outpatient settings ($n=6$). Counselors in residential settings endorsed a higher ratio of positive themes to total themes than counselors in the outpatient setting (means of .60 versus .48, respectively, $t(7) = 5.73$, p

< .01), in fact, the three highest scores were endorsed by the three residential counselors (.57, .58, and .64). Outpatient counselors' scores ranged from .45 to .51.

Four major themes emerged from the analysis of the qualitative data: (1) treatment should go beyond initiating abstinence and help clients develop a good life in recovery; (2) counselors are already using variations of these interventions; (3) positive interventions would be useful because of their potential for countering negative thinking and negative mood (by increasing hope and optimism, improving relationships, elevating self-esteem, increasing confidence in the ability to solve problems and work toward goals, and offering substitutes for drinking/drug use); and (4) reservations for using positive psychology interventions.

Treatment Should Go Beyond Initiating Abstinence

Counselors unanimously agreed that treatment should do more for clients than initiate abstinence. These counselors felt that stopping negative behavior alone would not be enough to sustain people:

I would say [treatment] is twenty percent stopping a negative behavior and eighty percent doing the rest. The way I talk about it to clients ... is if we stop this thing that is a block for you, it will allow the rest of the good things to happen in your life.

Another counselor said that her objectives for clients is for them to "*feel fully alive and [that] life is meaningful ... [to experience] overall satisfaction in both their private and social lives.*" A number of counselors agreed that treatment should provide a sense of hope, and that the counselors' hope and optimism can be "lent" to the client until the client is able to feel this for themselves: '*They have to borrow hope first sometimes. And I offer the hope to borrow.*' Similarly, another counselor stated, '*...Instilling somebody with hope is the first step for recovery ... you have to have positivity for them because they don't have it for themselves.*' Counselors felt treatment should focus on strengths, including their identification and use for recovery-oriented goals and problem solving. Finally, counselors felt that treatment should connect clients to individuals who were successfully recovering from addiction in the community via 12-step programs, in order to provide them with models of long-term recovery and nurturing relationships.

Counselors also spoke of the mechanisms through which positive interventions would aid recovery. They thought that positive interventions would primarily support treatment efforts by countering the negativity that often pervades the thinking and world view of individuals with substance use disorders. One counselor described it this way:

Our clients, with good reason, see the world as a dangerous, unsafe place where bad things happen and the other shoe is always about to drop, and they have a lot of evidence that that is the case based on their past experience.

Another counselor described how the time in treatment can be particularly difficult, marked by a feeling of emptiness: '*[There is] a sense of hopelessness in between the old and the new period of time in your life—the time where you're in a cycle of addiction and the time when you are trying out recovery.*' Counselors believed that positive psychology exercises would be welcomed by clients, with one counselor emphatically stating that, given the clients'

abundant exposure to negative consequences and negative mood, *‘They crave this kind of thing.’*

Counselors are Already Using Variations of These Interventions

In fact, the need to boost the mood of individuals in treatment, to cultivate a sense of optimism, to inspire clients to hang in until things get better, and to instill a sense of self-worth was so great that counselors readily provided examples of things they were already doing that were similar to each of the positive psychology interventions from the literature. For example, counselors recommend acts of kindness: *‘People have interventions on their recovery plans that say things like, “Do nice things for your group members without telling them once a day or a couple times a week for the next few weeks.”’* One counselor stated that having clients identify their own strengths *‘is always very difficult,’* but she found a way to accomplish the task using the group: *‘[P]eople who [have] known each other for a few weeks offer their knowledge of [each other’s] strengths and people are always shocked at how somebody has picked up on their strengths [that] they can’t identify [themselves]....’*

Best Future Self reminded counselors of their use of the Miracle Question from Solution-Focused Therapy in the way that it envisions an ideal future. Another counselor helped her clients to see the ways in which that future is already starting to become real:

I often have clients do an assignment where they write out in detail the person they were in their culture of addiction versus the person they want to be in the culture of recovery and then to ... ask people for feedback about the ways that they are already becoming that good person in recovery.

Gratitude practices were widespread: *‘The gratitude list is a fairly standard thing. I’ve even had people laminate it and put it in their wallet or their purse.’*

Why Positive Interventions are Useful

In addition to describing similar exercises currently employed, counselors provided their theories for why such interventions are helpful to individuals who are struggling with addictions. Counselors’ comments taken together described positive interventions working along five general pathways: by increasing hope and optimism, by improving relationships, by raising self-esteem, by increasing confidence in the ability to solve problems and work toward goals, and by presenting substitutes for drinking and/or drug use.

Increasing hope and optimism—The Best Future Self exercise was seen as one that would cultivate the idea of a positive future worth working for:

People are always thinking about the future. “What can I become?” And often times, that’s what’s creating so much pain in their present is that their sense of what will eventually happen sometimes messes up their present. But I think it’s also an opportunity to accentuate hope. That even though things are bad now, even though things are difficult now, it won’t always be.

Another counselor described how imagining a bright future can elucidate paths for getting there: *‘There is a lot to be said about imagery, if you can imagine the positive, if you can*

physically see yourself in that place, how do you move towards it?’ The You at Your Best exercise was described as working similarly:

If you’ve been depressed for a long time or you’ve been only happy when you’re under the influence for a long time it’s easy to think that you were never happy before and that you always felt so powerless. This activity helps stimulate people to remember that that wasn’t the case, and if they were okay in the past, maybe they can be okay in the future.

Gratitude exercises were also endorsed for promoting optimism: *‘Gratitude is a great tool for continued sobriety because it helps people focus on what is going right instead of what is going wrong. What they appreciate about their life rather than what needs to be changed still.’*

Improving relationships—Acts of Kindness was seen as an exercise that could provide multiple benefits. Not only could such exercises improve relationships and build *‘community and self esteem,’* but they could be processed in therapy to help clients better understand the nature of selfless acts that are divorced from ego-oriented motives:

I ask them to do something that is nice for someone, and don’t tell a soul... and come back and tell me that you did it. Not who for, or what you did, but ... how it feels. And how hard is it to keep quiet about it? How hard is it not to tell the person?

The Gratitude Letter, written to enumerate kindnesses bestowed by another person, and then reading that letter to the person, was seen as something that would strengthen relationships, especially ones that were negatively affected by addiction: *‘It’s amazing how not feeling appreciated can affect somebody ... it can be powerful to read a letter like this.’*

Elevating self-esteem—Acts of kindness were seen as exercises that could improve a person’s sense of self-worth, reminding them that they have the capacity to bring joy to others:

...When someone is in an addictive cycle, it usually looks from the outside as pretty selfish, lack of empathy for other people. [Performing acts of kindness] can help somebody to remember that, first of all, there is good in them and the capacity to do things that make other people happy [which can be particularly impactful] when you are getting so much reinforcement of what a disappointment you are.

Activities to identify strengths can balance and strengthen one’s view of self:

We want you to identify several of your strengths, identify several of your weaknesses, and then the hope is that sometimes individuals will see a long list of strengths, a shorter list of weaknesses. We can say, “See? There are a lot of strengths going on here.”

The You at Your Best exercise was seen as a tool for remembering better times which might awaken a sense of self-confidence. Such an exercise may help someone feel that they are not, as one counselor poignantly put it, *‘broken beyond repair’*:

Once somebody is talking about their strengths, their mood changes—instead of defensive [and] focusing on their shortcomings. If I was [a] patient and I picked ‘knowledgeable’ [as a strength], then I would talk about why, and it might bring back positive associations of a time where I felt more capable.

Exercises counselors used that were similar to You at Your Best and Best Future Self were experienced by clients as affirming in how they illuminate changes that have already occurred and promote optimistic visions of the future:

Usually what clients will say is, “I did not realize that I was already making so many changes,” or “I did not realize that I would be able to articulate what I wanted out of recovery, it makes me really hopeful that I can do that.”

Increasing confidence in the ability to solve problems and work toward goals

—Several exercises were seen as offering benefits related to skill development, problem solving, and building a life worth living. For example, acts of kindness, such as volunteering at the program’s detoxification unit, could model a behavior that can be drawn upon in the future to stabilize mood:

People learn that when I am feeling crazy, I can go to detox and either help them clean up or help them cook or just talk to someone who just got there about how they are doing. So they learn that getting out of themselves is part of the solution, it is a coping skill.

Similarly, Acts of Kindness could affirm a person’s self-worth:

“I have something to offer. I am not helpless, I have power”... It has everything to do with staying sober, because if I know that I can do something to make myself feel better, that’s what a lot of these folks used to turn to drugs for. It gives them another option. They know that they have things that they can do that help them feel better, and they aren’t trapped in the old cycle of behavior....

Gratitude exercises were seen by one counselor as encouraging and *‘motivating rather than heavy.... Reinforcing to continue to change in the positive direction rather than feeling overwhelmed with what’s [not been] done yet.’* Gratitude practices also were thought to reduce extremes in thinking that might inspire more adaptive functioning:

[Gratitude] helps with black and white thinking, that either things in my life are going horrible or things in my life are perfect. It allows room [for], “I’m struggling right now but I’m still grateful for my parents,” or “I still had a nice lunch.” Less black and white thinking can help people tolerate distress and be able to create more positive experiences as opposed to just giving up on a whole day because you have one negative interaction.

Eliciting a client’s strengths was viewed as motivating, because strengths inspire a sense of self efficacy, confidence, and ability:

Any time that we are looking at something more strengths based, it is more motivational than saying, “okay these are the things that you are doing that aren’t right, these are the things that are wrong, so let’s fix them.” Then you are asking

the client to focus [on] a lot of things that feel out of their control. If they had the ability to fix those problems they wouldn't be in ... treatment. So we are asking them to focus on the things that are more in their control.

Elicited strengths have the potential to be leveraged to solve problems or successfully pursue a meaningful goal: *'If we come across a challenge we say, well, one of your strengths is this so let's use that to address this issue.'* The You at Your Best exercise was seen as one that identified former strengths which could be leveraged by

...really bringing them back to that time: what were you like, what were you doing, who were you with, how were you taking care of yourself. What do you think you were doing so that you were meeting your potential at that time and do you think that still fits? Do you think if you start doing some of those things again it would help?

Offering substitutes for drinking/drug use—One counselor spoke of exercise, meditation, and relaxation as healthier sober methods of stabilizing mood. About people in treatment, he stated:

Their bodies [are] going to demand that they address their moods, either in healthy way or an unhealthy way. So, if you don't do the healthy, you're going to do the unhealthy. The unhealthy, though, don't [require] ... discipline, [they] require very little effort, the results are predictable and usually more intense. It's tough to compete with that, and yet, [healthy approaches] are more self-sustaining, more fulfilling, and last longer.

The "Menu of Possible Pleasurable Activities" represented sources of fun, pleasure, and happiness that stem from experiences outside of drinking and drugging. One counselor explained how *"lying on the grass, just going outside to be present with what is around you"* can help stabilize mood and introduce alternate forms of release and enjoyment. One counselor described how he would use the menu:

I would hand it to a person. I will say they need balance. Play is a four letter word but I do believe in it. So, what would they do for fun? We spend a good deal of time on that...Some people say, "I don't have any fun at all." But it's finding something, anything, that you might enjoy.

Reservations/Downsides to Using Positive Psychology Interventions

Counselors identified a few cautions when incorporating these interventions in practice. First, a focus on pathology, trauma, and circumstantial challenges in treatment is important, so positive interventions need to be balanced. A counselor said, *'You have to have a real view. You can't just expect everyone to be grateful because they have very real problems. You don't want to gloss over that.'* Another counselor said, after having had the chance to review the interventions presented, *'I don't think anything I have seen here I would say, "That is harmful for our clients." I think it all could be used as part of a treatment. The downside would be if you are relying solely on these positive therapy interventions.'* Another counselor emphasized that positive interventions have to be realistic. Some approaches, he said, *'can be too positive, not focused enough on real world realities and*

focus too much on let's create a life that's not actually possible for somebody in the long run.'

Another caution is that positive psychology interventions should be used differentially:

I don't think that you can use just one therapeutic intervention on every population or every person within this population. Some people need to have more gratitude; some people need to spend a lot of time focusing on their strengths because otherwise they do not know they have them. There are other people whose ego is already a big enough struggle and [identifying strengths] is not going to help them.... I am going to help them work on humility and reaching out to other people or remaining teachable.

The final caution expressed by these counselors is that certain interventions might not resonate with all therapists. For example, one counselor said about the gratitude letter, *'That doesn't strike me as me... (it's) not my style.'* Another counselor said he avoids looking into the future, as would be prescribed by the Best Future Self exercise: *'I am more focused on here and now so I am trying to get away from forecasting. So, I avoid this one or anything like that.'*

Discussion and Conclusions

The results of this study suggest that these counselors believe treatment should do more than help clients stop using addictive substances, that counselors are already using variations of positive interventions, that such interventions should be selected based on client characteristics, that fit with counselor style is an important consideration, and that attention to problems and pathology is a necessary component of treatment. These counselors' theories for how positive interventions might work to promote and maintain recovery described how such interventions could counter negative mood. Negative thinking and negative mood are deeply implicated in the process of addiction have been identified as central to conceptual frameworks that explain drinking (Cooper, Frone, Russell, & Mudar, 1995), ongoing substance use (Carrico, 2014), and relapse (Lowman, Allen, Stout, & Group, 1996; Marlatt & Gordon, 1980). Counselors described how positive psychology interventions might disrupt this negativity by inspiring hope and optimism, improving relationships, fostering self-esteem and self-efficacy, and providing a substitute for drugs and alcohol.

Both the quantitative and qualitative results suggest that counselors in this study address positive themes with their clients. Quantitative results depict variation in the degree to which these counselors address positive themes with patients, with counselors in residential settings spending more time on positive themes. Counselors who work in residential settings might spend more hours per week overall with each client than outpatient counselors, affording them additional time for topics such as gratitude, hobbies, and visions for a sober life. We tentatively conclude that such a variable could be useful in future research to enhance understanding of positive interventions in the field of addictions. Future research using larger samples could ascertain whether differences on such a variable are clinically meaningful and whether the variable is associated with other important counselor

dimensions. Future research could identify when during treatment and recovery positive interventions might be most relevant and impactful. Emotional exhaustion and high rates of employee turnover have been documented among substance use disorder counselors (Knudsen, Ducharme, & Roman, 2006, 2008). An interesting hypothesis for future study is whether counselors who spend more time addressing positive themes feel more gratification and optimism in their work, and therefore less burnout. A related hypothesis could address the relationship between the use of positive psychology interventions and enhanced therapeutic alliance. If these research directions prove promising, then the development of a more sophisticated psychometric instrument to assess the degree to which counselors attend to positive psychology themes would be warranted.

Limitations and Future Research

The quantitative questionnaire was based on theory and expert consultation, and Cronbach's alphas are reported herein for this sample, however, there is no other established evidence for its reliability or validity. In addition, the questionnaire was administered to this sample in order to initiate inquiry into whether such a variable could be constructed, and if so, whether it might covary with other variables of interest. Therefore, conclusions based on the variable should be interpreted with caution. Counselors were informed of the topic of the study in advance and this might have influenced them to speak approvingly of positive psychology interventions. Also, counselors who chose to participate may have been favorably disposed to positive psychology.

All participants held a master's degree in social work. The use of positive psychology interventions is compatible with the social work strengths perspective, an approach to intervention in which a client's micro, mezzo, and macro strengths are leveraged to solve problems (Saleebey, 2011). Social workers tend to be trained to use the strengths perspective and tend to embrace a holistic view of human behavior. This may explain why this particular group of counselors strongly endorsed positive interventions. This study should be repeated with clinicians from other disciplinary perspectives, such as psychiatrists, psychologists, and recovery coaches.

All of the counselors reported that they are using some type of positive interventions in their work. In the current study, however, counselors were not asked about their previous exposure to positive psychology. Future research can discern whether counselors are being trained to use positive psychology interventions in social work programs or other training venues, or whether they using the interventions because they "make sense" in the work they're doing.

Conclusions

Overall, these nine counselors endorsed the judicious use of positive interventions in substance use disorder treatment. Treatment goals targeting pathology remain essential and positive interventions should be matched to client goals, behavior, and personality. However, theories were readily provided for the ways in which positive interventions might work by countering the underlying negative patterns of thought, affect, and behavior that pervade individuals during this vulnerable time in life. Taken together, results suggest that counselors

in this study were compelled to use positive interventions to enrich and improve their clients' lives in order to give them the best edge in achieving and maintaining successful recovery. Helping clients to discontinue the use of addictive substances was a critical goal, but the work of these counselors extended a great deal beyond that objective.

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Table 1

In the last week, how many times would you say you addressed each of the following therapeutic topics directly with your clients? (N=9)

Topics Related to Increasing Well-being ($\alpha=.77$)			Topics Related to Decreasing Pathology ($\alpha=.88$)		
	Mean	SD		Mean	SD
Providing support and validation	16.3	5.5	Consequences of drug/alcohol use	14.6	6.7
Increasing positive social interactions	12.1	6.4	Relapse prevention	14.3	6.4
Visions for a sober life	9.6	7.6	Psychiatric issues	10.8	5.0
Fun, positive, pleasant activities	9.2	4.9	Cravings and urges	10.5	6.8
Spirituality	8.9	6.1	Relapse	9.4	7.9
Service or kind acts toward others	6.6	6.3	Trauma (history of abuse)	8.1	6.0
Exercise	5.8	4.9	Drink/drug refusal skills	6.5	5.4
Meditation	5.2	5.3	HALT (hungry, angry, lonely, tired)	6.1	6.2
Hobbies	5.2	4.4	Enabling	4.7	3.7
Communication skills	5.1	3.7	Other addictions	3.6	3.5
Gratitude, or making a gratitude list	4.9	3.4	Antibuse, Bupinorphine, other meds	1.8	2.7
Job search or occupational skills	3.2	2.4	Detoxification	1.6	2.3

Note. Figures represent average number of times each topic was raised "last week," a full-time work week for all counselors. Counts are standardized to represent 25 hours of direct counseling. Topics are listed from most to least frequently addressed.