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On the Integration of Cognitive-Behavioral Therapy for Depression and Positive Psychology

Leslie Karwoski, MA
Genevieve M. Garratt, MA
Stephen S. Ilardi, PhD
University of Kansas, Lawrence

Cognitive-behavior therapy (CBT) has received extensive empirical support as an efficacious intervention for the acute treatment of major depressive disorder and the prevention of depressive relapse. Nevertheless, many patients do not respond favorably to CBT, and the specific active ingredients of CBT remain unclear. With its emphasis on identifying and cultivating individual strengths, however, positive psychology appears to have considerable potential to enhance the efficacy of CBT and to help clarify the processes that mediate its salubrious effects. We outline existing areas of conceptual and technical overlap between CBT and positive psychology, and discuss how CBT may be extended and improved through the incorporation of positive psychological principles.

Keywords: cognitive-behavioral therapy (CBT); integration; positive psychology; depression

The lifetime prevalence of major depressive illness in the United States is estimated at nearly 20% (Kessler et al., 1994), and the risk of depression appears to be steadily *increasing* among younger age cohorts (e.g., Garber & Flynn, 2001). Because depression commonly engenders substantial impairment of both occupational and social functioning, it ranks among the most costly and debilitating of illnesses worldwide (Keller & Boland, 1998). Indeed, an increased public recognition of the devastating personal and financial toll of depression has helped catalyze in recent decades a burgeoning research effort to identify effective acute and prophylactic psychological interventions for this disorder, and the most intensively researched of these, by far, is Aaron Beck's (1967) cognitive-behavioral therapy (CBT).

The two principal treatment goals of CBT are: (a) teaching patients to modify their dysfunctional thoughts as a means of ameliorating depressive symptomatology; and (b) endowing patients with a set of enduring cognitive skills to reduce the risk of subsequent relapse. Numerous published controlled clinical trials have documented the acute efficacy of CBT (reviewed in Craighead, Hart, Craighead, & Ilardi, 2002)—an efficacy that appears to be comparable in magnitude to that of antidepressant medication (Gloagen, Cottraux, Cucherat, & Blackburn, 1998). Approximately two-thirds of depressed individuals treated with CBT will evidence a

favorable short-term response, and the posttreatment risk of relapse among CBT responders appears to be considerably lower than that found among patients treated solely with antidepressant medication (Young, Weinberger, & Beck, 1999).

Although such findings have helped establish Beck's CBT for depression as one of the most rigorously supported of all psychosocial interventions, it remains the case that a substantial subset of individuals who undertake CBT do not get well. Indeed, *fewer than half* of those who enter CBT treatment will experience complete and long-lasting recovery from their depressive symptoms (e.g., Elkin et al., 1989). Additionally, despite several decades of intensive research aimed at identifying the active ingredients of CBT, the precise mediational mechanisms of change within this intervention remain poorly understood (e.g., Ilardi & Craighead, 1999). We believe, however, that the emerging field of positive psychology—with its emphasis on the cultivation of existing and latent strengths—offers promise in (a) clarifying *why* CBT is a particularly efficacious intervention for depression, and (b) identifying how the protocol may be refined and improved. As Seligman (2002) has suggested, "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" (p. 6).

In this article, we will detail the considerable conceptual and technical overlap between CBT and positive psychological approaches. We will then discuss specific ways in which elements drawn from positive psychology may be used to enhance the efficacy of CBT.

Conceptual Overlap

Although the CBT protocol is amenable to some degree of modification and tailoring to suit each specific patient (Beck, Rush, Shaw, & Emery, 1979), there are a number of foundational principles that underlie all CBT interventions. In this regard, Judy Beck (1995) has identified a set of ten core CBT principles, many of which (as outlined below) share considerable conceptual overlap with positive psychological approaches.

Establishing a Strong Therapeutic Alliance. The cultivation of a strong positive therapeutic alliance between the patient and therapist is held as a necessary, though not sufficient, condition for the effective implementation of CBT (Beck et al., 1979). Specifically, such an alliance is considered an essential precursor to the effective implementation of cognitive and behavioral interventions. Positive psychological theorists likewise have emphasized the importance of establishing a therapeutic alliance as a means of facilitating subsequent therapeutic gains (e.g., Keyes & Lopez, 2002). However, whereas Beck and his colleagues generally have viewed the therapeutic alliance as merely a means to an end (i.e., the alliance helps facilitate the work of cognitive restructuring—CBT's hypothesized active ingredient), positive psychologists are more inclined to regard it as a worthwhile therapeutic goal in and of itself (Seligman, 1998). This latter stance is consistent with emerging evidence that the quality of the therapist-patient relationship accounts for a large proportion of treatment outcome variance across a wide range of interventions and disorders (e.g., Lambert, 1992; Summers & Barber, 2003).

Focus on Discrete Goals. CBT maintains a distinctive focus on the therapist and patient working toward a set of clearly specified goals. Similarly, positive psychologists have emphasized that the process of striving after meaningful goals may promote the experience of positive affect (e.g., Snyder et al., 1996; Watson, 2002). Hence, positive psychology and CBT both underscore the need to be working toward discrete goals as integral to the therapeutic process.

Focus on the Here-and-Now. Beck (1995) suggests that CBT has as its focus the amelioration of current problems, with material from the past addressed only inasmuch as it subserves the aim of improving the here-and-now. This emphasis on the present is congruent with that of several positive psychological interventional approaches. For example, mindfulness meditation involves fully attending to the present moment (Langer, 2002), and optimal *flow* experiences

reflect complete attentional absorption in the present rather than the past (Nakamura & Csikszentmihalyi, 2002).

Cognitive Reappraisal. Teaching depressed patients to identify overly negative thought processes and to replace such thoughts with more realistic appraisals of ongoing events is the *sine qua non* of CBT (Beck et al., 1979). Indeed, cognitive modification is hypothesized as the primary means of reducing the intensity of negative affective states. This reappraisal process is congruent with the positive psychology construct of reality negotiation (Higgins, 2002; Snyder, 1989; Snyder & Higgins, 1988), which requires the individual to consider alternative interpretations of events, and oftentimes entails a modification of original appraisals in favor of slightly positively biased (albeit workable) ones. Likewise, the cultivation of mindfulness (Langer, 2002) includes an implicit element of reappraisal, inasmuch as it involves merely *observing* thoughts and feelings, without becoming attached to them, as a means of facilitating less negatively biased and distorted perspectives on events.

Patient as Collaborative Partner. The CBT patient is viewed as a full and active partner in the therapeutic collaboration. In essence, the patient is trained to become his or her own therapist, a process that is hypothesized to reduce the risk of posttreatment relapse (Beck, 1995). Positive psychological interventions also tend to emphasize active patient engagement with the treatment process (e.g., Thompson, 2002), although the rationale for such an emphasis is typically somewhat different from that found within CBT. According to Thompson (2002), for example, the goal of this process is to help patients experience the positive psychological and physical health benefits derived from therapeutic collaborations that enhance their perceived *personal control.*

Overlap of Technique

The positive psychology movement has integrated numerous concepts and therapeutic techniques drawn from an array of distinctive psychotherapeutic approaches, including many that derive from Beck's CBT. Moreover, although the primary aim of CBT is to reduce symptoms (i.e., an apparently negative rather than a positive focus), there are several CBT-based techniques that are congruent with the positive psychology aim of building on the patient's existing strengths to enhance emotional well-being. In this section, we describe a set of CBT techniques with strong similarities to positive psychological interventions.

Pleasant Activities Scheduling. Within the first few treatment sessions, the CBT patient typically is encouraged to identify and schedule a number of subjectively pleasurable daily activities. Patients initially are asked to monitor their daily activities and to rate each one for its corresponding level of pleasure and perceived accomplishment. Those activities rated as pleasurable are subsequently scheduled with greater frequency as a means of inducing positive affect (Beck, 1995). This approach is consistent with the thrust of a burgeoning positive affectivity literature, in which it is emphasized that "high levels of positive mood are most likely when a person is focused outward and is actively engaging the environment" (Watson, 2002, p. 117).

Identifying and Reviewing Success Experiences. Because depression is typically characterized by a pervasive sense of helplessness, CBT patients often are asked to identify and review their experiences of success (Beck, 1995). Within the positive psychology literature, this process has been described in terms of enhancing the patient's self-efficacy in target domains (Maddux, 2002). Indeed, the CBT protocol—by virtue of its collaborative emphasis on setting and monitoring progress toward attainable short-term patient goals—appears well-suited to enhancing the patient's perceived efficacy (Ilardi & Craighead, 1994).

Mood Monitoring. CBT patients may be asked to keep a chart detailing the mood states that characterize various daily activities (Beck, 1995). Such mood tracking has been hypothesized to subserve the positive psychological aim of increasing positive affectivity. "By monitoring our

moods and becoming more sensitive to these internal rhythms, we should be able to maximize feelings of efficacy and enjoyment, while minimizing stress and frustration" (Watson, 2002, p. 116).

Relaxation Training. Relaxation training is commonly presented in CBT as an optional technique that may be used during treatment as a means of decreasing state anxiety (Beck, 1995). However, the psychological benefits of relaxation training as a means of enhancing subjective well-being have been well-documented (see Blumenthal, 1985), and numerous methods of inducing relaxation, such as imagery exercises, progressive muscle relaxation, meditation, and yoga, have been employed in the treatment of a variety of psychological disorders. From a positive psychological vantage point, relaxation training may be viewed as a particularly effective technique to enhance one's sense of contentment, and thereby to "build enduring psychological resources and trigger upward spirals toward emotional well-being" (Frederickson, 2002, p. 127).

Problem-Solving. Problem-solving training often is introduced as early as the first CBT session as a means of helping the depressed patient gain enhanced confidence in his or her ability to formulate solutions to target problems (Beck et al., 1979). The desirability of problem-solving training also has been discussed within the positive psychology literature. For example, a growing body of empirical research supports the claim that a shift toward more positive problem-solving appraisals (i.e., the perceived ability to solve existing problems) is associated with an improvement in depressive symptoms (reviewed in Heppner & Lee, 2002).

Positive Psychology and the Enhancement of CBT

A cardinal principle of positive psychology is that psychologists should not just "fix" people's problems; rather, they also should assist them in achieving fuller, richer, and happier lives. As Seligman (2002) notes, 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" (p. 3). CBT focuses on repairing "the worst things in life," and it is quite effective in doing so. Nonetheless, as noted previously, a sizable subset of depressed patients treated with CBT do not achieve full and lasting recovery. Accordingly, we believe that CBT may be improved through the incorporation of a more explicit positive psychological focus on "building the best qualities in life." We now will discuss several possible directions for integrating CBT and positive psychology.

Moving Beyond the Reduction of Negative Affectivity

Although the DSM diagnostic system classifies individuals solely on the basis of their identified symptomatology, Keyes and Lopez (2002) have suggested that mental health may be conceptualized not only as the absence of psychopathology, but also as the presence of emotional well-being. On this basis, they have proposed four categories for describing an individual's overall mental health: (a) *flourishing,* for people with no diagnosable mental illness and a high level of emotional well-being; (b) *languishing,* for nonmentally ill individuals who nonetheless experience a low overall sense of well-being; (c) *floundering,* for people with diagnosable mental illness and a low level of well-being; and (d) *struggling,* for people who have diagnosable mental illness and yet a high level of well-being. Accordingly, we observe that the mere removal of the patient's acute depressive symptoms during therapy—the principal goal of CBT—is not sufficient to guarantee the patient's flourishing state at posttreatment. Indeed, for the CBT patient whose baseline level of functioning (prior to depression onset) has been characterized by generally low positive affectivity, even the complete amelioration of depressive symptoms during acute treatment will likely be sufficient only to return her to a languishing state upon treatment

termination, inasmuch as the CBT protocol includes very little that directly addresses the patient's attenuated ability to cultivate positive affective states.

The CBT protocol appears implicitly to reflect the notion that a reduction of negative affectivity (via modification of the patient's distorted negativistic cognitions) will be tantamount to an increase in positive affectivity. It is becoming increasingly clear, however, that negative and positive affectivity are largely orthogonal, independent constructs (Bradburn, 1969; Watson & Clark, 1997). An acute reduction in negative affect—again, the principal treatment goal of CBT—does not necessarily induce a commensurate increase in positive affect (Diener, Lucas, & Oishi, 2002). In a thoughtful review of the link between affectivity and depressive illness, Clark and colleagues (1994) observed that low levels of positive affectivity predict both slower recovery from depressive episodes and an increased risk of subsequent relapses. We believe, therefore, that the acute and long-term efficacy of CBT can be enhanced by integrating principles of positive psychology—specifically, those related to cultivating and enhancing positive affectivity and overall well-being. In other words, symptom reduction is only a first step. Following the amelioration of acute symptoms, "treatment may fruitfully pursue loftier goals of promotion of quality of life and, possibly, flourishing in life" (Keyes & Lopez, 2002, p. 50).

Although there is a substantial genetic component to each individual's baseline level of positive affectivity (Diener et al., 2002)—with perhaps as much as half of interperson variability accounted for by genetic factors (Tellegen et al., 1988)—there still exists considerable potential for intervention-induced change in perceived level of well-being. Diener et al. (2002) detail several means of enhancing emotional well-being: the recognition of existing strengths; the cultivation of flow experiences; the pursuit of meaningful goals; and the cultivation of hope, optimism, and expected control. Following is a brief discussion of these factors as they pertain to the treatment of depression in CBT.

Capitalizing on Strengths. In a trenchant discussion of possible clinical extensions of positive psychology, Wright and Lopez (2002) urge clinicians to move beyond an exclusive focus on patient difficulties and deficits, and to take patient strengths into greater account during assessments and treatments. There is, in fact, increasing evidence that empirically supported psychotherapies for depression may owe their efficacy, at least in part, to an inadvertent capitalization on existing patient strengths. For example, in the largest psychotherapy trial for the treatment of depression conducted to date—the National Institute of Mental Health Treatment of Depression Collaborative Research Program (Elkin et al., 1989)—differential response to CBT or interpersonal psychotherapy (IPT) was predicted by patient strengths that matched the targeted focus of each respective protocol. Specifically, favorable response to CBT was predicted by *low* pretreatment levels of cognitive dysfunction (i.e., the pre-existence of the very cognitive skills that serve as the focus of intervention), whereas high pretreatment levels of social skillfulness—the target of IPT intervention—predicted favorable treatment outcome in interpersonal psychotherapy (Elkin, 1994).

Indeed, it does not appear that CBT works primarily by effecting long-term change to cognitive structures (Barber & DeRubeis, 1989)—that is, repairing patient cognitive dysfunction—but rather by capitalizing on existing patient cognitive abilities, albeit those that may become temporarily compromised because of acute depressive symptoms. By extension, then, we suggest that the CBT therapist would do well to conduct a thorough pretreatment assessment of patient strengths across multiple domains (including the set of temporarily dormant strengths that existed prior to the onset of the depressive episode), and to attend closely to emerging opportunities to capitalize on such strengths throughout the treatment process. This will be an especially important consideration for those patients whose high pretreatment levels of cognitive dysfunction would otherwise predispose them to poor CBT treatment response.

Hope. The aforementioned finding—that CBT works best for those patients who would appear to need its core cognitive interventions the least (see Rude & Rehm, 1991, for a review)—

is not easily reconciled with Beck's (1967) cognitive model of depression. The finding is quite congruent, however, with Snyder's *hope theory,* a positive psychological framework that details the manner in which the cultivation of hope may work to reduce dysphoria and to induce positive affectivity (Snyder, 2002; Snyder, Feldman, Taylor, Schroeder, & Adams, 2000). Because hope is generated by the experience of movement toward meaningful goals, it follows that the subset of CBT patients who are most readily capable of moving toward the primary therapist-specified goal—that is, the goal of applying CBT's cognitive techniques—will be the very patients who experience the greatest surge in hope, and hence the greatest reduction in depressive symptomatology. Indeed, on the basis of an extensive review of the extant CBT literature, Ilardi and Craighead (1994, 1999) have concluded that the bulk of clinical improvement that occurs in CBT may be attributable to the protocol's inadvertent induction of patient hopefulness rather than to cognitive modification, per se. Building on the seminal work of Jerome Frank (1961), these investigators note that CBT may be especially effective when the therapist works to accentuate the hope-inducing elements of the CBT protocol, including: provision of a highly credible treatment rationale, incorporation of specific and achievable patient homework assignments, establishment of an empathic therapeutic alliance, and the therapist's ownership of the role of expert and "culturally sanctioned healer" (Ilardi & Craighead, 1994).

Flow. Being fully absorbed in the present moment and enjoying an activity for its own intrinsic rewards has been described as the experience of *flow* (Nakamura & Csikszentmihalyi, 2002). The flow state most commonly occurs during somewhat challenging activities that require a high level of skill and attentional engagement—for example, rock climbing, playing a musical instrument, participating in emotionally meaningful conversation, painting, skiing, etc. Not only do flow experiences tend to induce positive mood, but the amount of time spent in a state of flow appears to be predictive of one's overall level of positive affectivity (Adlai-Gail, 1994). Accordingly, clinical researchers have begun to explore the incorporation of flow-based techniques in psychotherapy. For example, the Flow Questionnaire (Csikszentmihalyi & Csikszentmihalyi, 1988) may be used to identify activities that reliably induce a state of flow for the depressed patient (or, at least, those that did so prior to the onset of depressive illness), with the therapeutic aim of helping the patient cultivate more such activities (Nakamura & Csikszentmihalyi, 2002). Despite the fact that the CBT protocol includes an optional set of techniques that may be used to help patients identify and schedule a greater number of pleasant activities, this process is not optimally designed to increase the CBT patient's experience of flow on an ongoing basis because: (a) many of the pleasant activities most commonly identified by patients (e.g., watching a movie, taking a long bath, going for a walk, etc.) do not contain a sufficient degree of intrinsic challenge to induce the flow state; (b) activity scheduling is not regarded as an essential element of the CBT protocol, and thus may not be included at all during any given patient's course of treatment (Beck et al., 1979); and (c) even when activity scheduling is used, it typically occurs only early in treatment, when the patient's depression-induced loss of energy may preclude participation in more challenging, flow-inducing activities. On the basis of the aforementioned considerations, however, it would appear that only a slight modification of the existing CBT pleasant activities component would be required to incorporate the cultivation of flow experiences into the existing CBT protocol.

Mindfulness. Mindfulness refers to a state of full awareness of the present moment (Kabat-Zinn, 1990), and techniques designed to induce mindfulness already have been integrated into several psychotherapeutic approaches, including dialectical-behavioral therapy (Linehan, 1993) and *mindfulness-based cognitive therapy* (Segal, Williams, & Teasdale, 2002; Teasdale et al., 2000). Although mindfulness training is of interest to positive psychologists for its value in promoting a heightened sense of relaxation, alertness, and overall well-being, the cultivation of mindfulness also has clear benefits in the treatment of many forms of psychopathology, including depression. Because mindfulness may be viewed as a heightened state of attentional control, it has been

found to be useful in combating the mindless rumination that typifies depressive and anxious states. Indeed, inasmuch as the process of ruminating about negatively themed events typically escalates the intensity of existing negative mood states (e.g., Nolen-Hoeksema, 1991), mindfulness-based cognitive therapy is especially valuable as a means of teaching patients how to effectively disengage from ruminative negative thoughts, thereby preventing the intensification of negative mood. In fact, this therapeutic approach has been shown to reduce the risk of depression relapse among patients with recurrent depression (Teasdale et al., 2000).

Addressing Unsolvable Problems. Although CBT is effective in helping patients view situations more realistically, it offers little in the way of enabling patients to cope with situations characterized by intrinsically *unsolvable* problems. For this subset of intractable life circumstances, CBT offers little beyond helping patients address the possible occurrence of any irrational (i.e., overly negativistic) thoughts that such situations might engender.

There are areas of positive psychology, however, that have direct relevance concerning those patient problems that cannot be solved. For example, the construct of *secondary control* (Rothbaum, Weisz, & Snyder, 1982)—which refers to an enhanced sense of personal control over uncontrollable events by virtue of exercising control over one's reactions to such events—is one that has been of interest to positive psychologists by virtue of its association with positive outcomes in the face of adverse circumstances (see Thompson, 2002, for a review). Enhanced secondary control over problematic situations may be achieved by numerous means, among them the strategy of benefit-finding (Tennen & Affleck, 2002), the identification of a sense of meaning (e.g., religious, existential, philosophical, etc.) to be derived from the situation (Thompson, 2002), or a *radical acceptance* of the situation via the practice of mindfulness meditation (Linehan, 1993). Although it also is possible that the CBT therapist might increase the patient's sense of secondary control over problematic situations through the use of standard CBT cognitive reframing techniques (e.g., by challenging catastrophic interpretations of the situation), we believe the incorporation of the aforementioned secondary control techniques could be of great potential value in CBT, especially for the subset of depressed patients who are legitimately distressed by the occurrence of uncontrollable negative life events.

Optimism Training. Optimists are famously good at coping with adversity. As a result, in addition to an array of positive mental health benefits, optimists have been shown to be at reduced risk for developing depressive symptoms (Carver & Scheier, 2002). Optimists are especially likely to use problem-focused coping, and as noted previously, such coping strategies are emphasized within CBT. When problem-focused coping is not a possibility, optimists are apt to use strategies that enhance a sense of secondary control, such as acceptance, positive reframing, or humor (Carver et al., 1993). In contrast, pessimists tend to cope with difficulties through overt denial and disengagement from the goals with which such difficulties may be interfering. Although Carver and Scheier (2002) have observed "trying to turn pessimists into optimists seems an apt characterization of the main thrust" (p. 240) of CBT, it is worth noting that Beck and colleagues have designed the CBT intervention with the goal of producing *realists,* not optimists (Beck et al., 1979). In fact, CBT protocol is replete with admonitions to the therapist to attempt to induce in the patient a realistic (not optimistic) appraisal of his or her circumstances.

Consequently, Martin Seligman (2002), in his program of *learned optimism training,* has extended the CBT approach in a fashion more unabashedly aligned with the sensibilities of positive psychology, that is, with the ultimate aim of turning both children and adults into functional optimists (as opposed to realists). Likewise, Snyder's *hope theory* emphasizes the clinical importance of enhancing the patient's optimism regarding his or her capacity to achieve important goals and to generate plausible strategies for achieving them (Snyder, 2002). Psychotherapeutic interventions explicitly informed by hope theory have been evaluated in several recent clinical trials, and have proven to be successful both in increasing hopeful thought and

in decreasing acute psychopathological symptoms (see Cheavens, Feldman, Woodward, & Snyder, this issue).

Meaning. It has been shown that endowing life events with a sense of meaning and purpose may engender positive effects on both physical and mental health (reviewed in Baumeister & Vohs, 2002). Of course, there are many potential levels of meaning for a given activity, and some are deeper and more satisfying than others. Watson (2002) goes so far as to claim that "few of the events in our lives truly are important in any objective, absolute sense. Nevertheless, it is essential that we perceive these things to be important and as representing goals that are well worth pursuing. In other words, although little of what we do in life really is important, it is crucial that we do them, and that we see them as important" (p. 116). Within our own extensive experience utilizing the CBT protocol, a large proportion of patients have been observed spontaneously to introduce themes of meaning and purpose during the course of therapy—a phenomenon that, when validated and encouraged by the therapist, appears to increase the patient's motivation to engage in core CBT interventions. We note, however, that there is no overt or explicit treatment of "meaning-making," per se, within CBT. In light of the aforementioned discussion, we believe the protocol may be amenable to using the patient's own meaning-generation proclivities.

Humor. In their seminal CBT treatment manual, Beck and colleagues (1979) briefly describe the use of humor in treatment, noting its potential utility as a means of distracting the patient from negative feelings or gently challenging entrenched beliefs. In an influential recent CBT manual (Beck, 1995), however, there is no mention of humor as a treatment element. Nonetheless, there exists some empirical evidence that humor may act as a buffer against the experience of depression (e.g., Nezu, Nezu, & Blissett, 1988). If humor does indeed serve as such a protective factor, it is reasonable to infer that CBT might be enhanced by attending more closely to the process of increasing patients' capacities for humor. Although there exists little research evidence to guide clinicians in selecting interventions that may enhance the patient's sense of humor, it has been suggested that "the encouragement of flexible thinking, of learning to generate multiple responses to singular stimuli, and lessening the fear of rejection for attempts at being comical or provoking laughter could be good starting points for those investigators wishing to enhance the humorous capacity of their subjects" (Lefcourt, 2002, p. 628–629). The cultivation of humor during treatment might make therapy a more enjoyable process, and perhaps provide some patients with another potent coping mechanism to use outside of the therapy session. Moreover, as noted previously, the effective use of humor may promote secondary control over otherwise uncontrollable aversive circumstances.

Physical Exercise. Engaging in physical exercise to enhance psychological well-being is a practice congruent with the positive psychological framework (e.g., Watson, 2002). In fact, consistent with the claim that "exercise is medicine" (Elrick, 1996), James Blumenthal and his colleagues have recently observed an acute antidepressant effect for regular aerobic exercise equivalent in efficacy to that of SSRI medication in a controlled randomized clinical trial (Blumenthal et al., 1999), and there is accumulating evidence that physical exercise may be a potent and efficacious intervention for depression (Blumenthal & Gullette, 2002), albeit one that has not yet been widely recognized as such by clinicians. Accordingly, we believe there is considerable potential for augmenting the existing CBT protocol with the judicious assignment of regular aerobic exercise as a form of patient "homework." We note, however, that considerable research is warranted in order to clarify: (a) which subset of CBT patients would be likely to derive the most (or least) benefit from aerobic exercise; (b) at what point during treatment (early, middle, late?) to introduce the exercise; and (c) which among an array of possible therapist interventions (e.g., psychoeducation, provision of a detailed exercise regimen, addressing negative beliefs about exercise, etc.) would be most helpful in motivating patients to adhere to an exercise program.

Concluding Remarks

Innovation and experimentation are hallmarks of the scientific process, and these principles are perhaps nowhere more evident than in the domain of clinical research. Indeed, a glance at a list of designated empirically supported treatments for psychological disorders (Sanderson & Woody, 1998) reveals a set of interventions that were developed only within the past few decades. Nevertheless, the breathtaking pace of clinical innovation that characterized the 1960s and 1970s appears to have slowed somewhat in recent years—a troublesome development that has led some influential psychotherapy researchers to lament the field's increasing potential for stagnation (Foa & Kozak, 1997). In this context, we are inclined to view the positive psychology movement, with its novel focus on identifying individual strengths and "building the best qualities in life" (Seligman, 2002), as a very hopeful development—one that appears to carry considerable promise for catalyzing innovations via the integration of positive psychology principles with existing forms of clinical interventions. Accordingly, we have outlined numerous ways in which the principles and methods of positive psychology might be successfully integrated with CBT for depression. Our goal is that these positive psychology ideas will help future psychotherapy researchers in finding ways to enhance CBT's acute efficacies and long-term prophylactic benefits.

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